Women & Drug Users
Seminar Report
St. Mary's Hospital
Manchester
October 1994

Drug Using Women
Are Our Services Meeting Their Needs?
Seminar Report
Spring 1994

Introduction

The seminar was organized by a multi agency steering group who were bought together by two factors:the tragic death of a three year old child who overdosed on methodone, and the range of statutory and voluntary agencies working together around issues to do with drug use at the Zion Community Health and Resource Centre.
The steering group included workers from Dash, Linx, Probation services, Zion Community Health and Resource Centre, Central Drugs Team, Central HIV Team, Social Services, Hulme Supported Housing Forum, and included Health Visitors and Midwives. The overriding question facing the group was, what can we do? How can we support drug using women and their families better?

It is no easy task for the groups and individuals involved to look objectively at the services we provide, and see where they could be improved.
Fortunately, this has been one of the strong points of the steering group and a great deal has been achieved in a short period of time.

1) an ante natal clinic in the community for drug users has been established.
2) a Directory of Services for drug users has been produced.
3) we are planning training for staff and volunteers working with this client group.
4) we have supervised a student who has supported pregnant drug users and who has written up the experiences of women using our services
5) organizing this seminar.

There is more information about these developments in this seminar report.
The seminar was not the end but the beginning of our work in this area. We hope to now be able to continue to take on an innovative approach to our service delivery, and to continue to make our services more accessible and appropriate to the needs of drug using women and their families.

Fay Selvan
Chair of Seminar
Co-ordinator - Zion Community Health & Resource Centre.

Hilary Klee
Director of Research Manchester Metropolitan University

It is estimated that women represent between a quarter and one third of opiate misusers in the United Kingdom. However they are under represented among drug agency clientele. One reason they are reluctant to seek help is possibly because they feel that the revelation of a drug problem will lead to their children being taken into care. Pregnant drug users often rely upon partners, friends and family for support, and attempt to conceal their drug use from health professionals. This means that nurses, midwives, obstetricians and other health professionals cannot provide adequate ante-natal and post-natal care, which can risk damage to both the foetus and to the mother. Stress is likely to be particularly acute in drug using women. They face discrimination because of their negative stereotype and risk hostility from those whose responsibility it is to care for them.

Fear of exposure, judgement by others and the concern about possible damage to the foetus conflicts with their need for drugs.

Drug management was the main source of concern for a majority of women using drugs during pregnancy. Often women tried to get information about the consequences for the foetus, but the information they received did not remove their uncertainties. Advice was sought from various people, friends as well as drugs workers, midwives and doctors. The traditional image of a selfish, irresponsible drug user is not confirmed in the interviews carried out by our team. Pregnancy and childbirth was a potentially threatening experience because women were forced to extend their contacts beyond those of their drug sub-culture and reveal themselves to people who were unlikely to be sympathetic. Feelings of defensiveness and non compliance in some of the women could lead to mutual hostility between hospital staff and patients; however a lack of sensitivity or understanding by some staff often precipitates this hostility.

The policy of hospitals varied considerably across the region. In some there was automatic removal of a drug-using woman's infant to the Special Care Unit. This is said to be for observation only and most women knew that this was to happen. Usually the period for observation was for 5 days, which could pose problems for women who had other children and had to return home. For many mothers the placing of their baby in a Special Care Unit was painful not just because of the seperation, but because they assumed it would be seen by others a a failure or neglect. The needs of the child had to be set against the needs of the mother and were in conflict with them. The women's own self image was not of an uncaring woman and they did not want to be stereotyped as such. Mostly they simply wanted to be treated like everyone else. The fears of these women significantly increased their stress. In some cases the fears were justified by careless behaviour. The causes of these breakdowns in care and service delivery however were complex, sometimes caused by a lack of training or understanding or sympathy by health care staff. Where the relationships between the client and health professionals were consistently good was in those clinics and hospitals in which a specific policy for drug users had been developed.

An understanding of the needs and fears of pregnant drug users is needed. Unfortunately there is little social research that has investigated the problems of pregnancy and early motherhood from the woman's point of view. Women typically wanted to be treated as every other woman and derived some comfort from the anonymity and normality when they were.

Sarah Crosby
Manchester Action on Street Health (MASH)

Mash is a sexual health promotion/HIV prevention service for women and men who work as prostitutes. Mash provides free condoms, operates a needle exchange scheme and offers information and advice around safer sex and safer drug use. The project also offers first aid, pregnancy testing and informal counselling as well as advice on issues ranging from welfare rights to housing.

Through working with this client group, Mash has contact with large numbers of drug using women, primarily opiate users but also amphetamine users and those using other drugs. Many of these women have children and often continue to work throughout their pregnancy. It is problems with housing, social security and avoiding arrest that are of a far more pressing and immediate concern. As a consequence of their sexual activity and drug use, in addition to the low priority accorded to personal health care, many of these women face a potentially high risk from sexually transmitted diseases, including HIV, and other drug related infections. This obviously has serious implications for both mother and child during and after pregnancy.

As service providers, we must all accept that our services are not always the most accessibe, particularly for drug using women who are also working as prostitutes. There is a distinct wariness amongst our clients in using mainstream health care services. Many of them feel that these services are remote and percieve them to be hostile, judgemental or simply failing to meet their needs.

In Manchester, there is a need for a more coherent strategy, which has an inter-agency approach as well as a central core. Any future service needs to be based on a broader model, which incorporated for example, genito-urinary facilities, ante and post natal care counselling, welfare rights, legal advice and so on. In this way both medical and non medicalissues can be addressed in an informal and non judgemental environment. It is crucial that any such service offering a variety of services is available as a 'one stop' facility, where self referrals can be made. This would make attendance for drug using women easier, as their lifestyles can be chaotic.

A good example of inter agency working is the new Community Midwife Service for drug using women at Hulme Clinic. This came about through several organizations working together, including Dash (Drug Advice and Support in Hulme), Linx, Zion Community Health & Resource Centre, Mash and Central Manchester Healthcare Trust. Clients of some of these projects are more likely to use a service that is available in a more community based setting, which is easy to access and user friendly and centred. The hope is to encourage women to make contact with a midwife early on in their pregnancy, and to try and avoid the all to common scenario where drug using women access ante natal services at the last possible moment, if at all during their pregnancy.

It is my belief that voluntary sector input is vital as part of a multi agency approach to this issue. Whilst services remain wholly medicalized, women will continue to under use them. Often this is because of the fear that admitting drug use or prostitution may result in losing custody of their children. Any attempts to provide a service specifically for drug using women needs to break away from an institutionalized medical model, and build upon the exisiting foundations laid by community organizations.

I hope that the outcome of this seminar will be the movement towards a co-ordinated network of services working with women drug users. The underlying ethos of any such work needs to be based on building long term relationships with drug using women, and not merely about crisis intevention.

Faye Macrory
Midwife, St. Mary's Hospital

In 1989 - 1990 there were an average of 10 births per year to drug dependent women in St. Mary's Hospital, Manchester. By 1992 - 1993 this had increased to an average of 34 per year. At present there is no co-ordinated plan of care and support for this particularly vulnerable group of women and their families. Drug use correlates very closely with socio-economic deprivation, and both are reported to be associated with poorer pregnancy outcome and with less effective service use. The aims of this seminar included addressing the need for change in existing services in order to make them more accessible and appropriate to this particular group.

Our model would be based on the philosophies of the Glasgow Women's Reproductive Health Service (WHRS). This community based service attempts to offer sympathetic,supportive and non judgemental help which through a multi-disciplinary one door approach addresses the whole range of problems both medical and non medical, encountered by the women and their families. (Hepburn 1990)

Women attending would be seen as partners in the management of their own care and encouraged to contribute to decisions relating to that care.

Closer collaboration with Social Services and other voluntary agencies ante-natally would assist in avoiding the situation of 'crisis intervention' following delivery, and the present policy of admitting all babies of drug using women to the Special Care Baby Unit could be revised.

The appointment of a specialist midwife would enable care to be co-ordinated, and communication improved between hospital, community and other involved agencies.

This extended role would include in-service education for other health professionals involved in the provision of care to this client group.

The way forward is to continue to try and create a service which drug using women and their families perceive as meeting their individual and specific needs - specialized care without stigmatization.

Jan Owens
Social Services

Social services Policies and Procedures apply to all service users; there are no specific policies related to drug users. Our policies, procedures and practice are determined by the Children Act 1989.

One of the main points of this is act that the welfare of the child is paramount. Drug use in itself is not a cause for concern in child care. It would be inappropriate to include all drug use as an issue in child protection as it may well discourage drug users from using services and be detrimental to themselves and their children. Child protection is only appropriate when the standard of parenting falls to a level which may have a detrimental effect on the child's health and development. In these circumstances whether drug related or not, children should be considered under the Child Protection procedures.

Confidentiality for all professionals is over ruled by government guidance if a child is being harmed. If the child is being abused in any way or neglected, a Child Protection Case Conference will be convened. This is a multi - agency meeting with the parents, and the child's name may be placed on a Register and a Child Protection plan drawn up. In other instances where there are specific concerns about the health or development of a child, Social Services or any other agency may call a meeting to which the parents are invited. It is normal policy to do this and share concerns openly with parents. All plans of action will involve the parents, specifying what changes they need to make and what each agency will do to help them. These plans are reviewed regularly with parents and their workers.

New guidance for workers in the drugs field is presently being developed with clients using drugs and these will be issued before the end of 1994.

Pat O'Dea
Community Drugs Team

Community Drugs Team (CDTs) were established in the mid 1980's to offer information, advice, support, and training to other professional groups to assist them in addressing the growing incidence of problem drug use.
However other agencies did not take up the challenge of addressing problem drug use and CDTs became front line providers of services for drug users, especially the provision of prescribing services for opiate users.
The CDT in common with most agencies in the field operated a harm reduction rather than an asbtinence based service. That is we accept that abstinence may be a long term goal and there are intermediate goals such as,

- the reduction of needle sharing
- changing from injecting to oral drug use, etc.,

can be seen as positive interventions. It is important that illicit drug use is not demonised, but is seen in the context of other harmful activities such as alcohol and cigarette use.
It is important thath we are open and honest with pregnant drug users especially about statutory powers and responsibilies and how they can and should be exercised. Women in this position are often burdened with feelings of guilt and we should not exploit this to ensure compliance with our plans, but should work to their agendas otherwise they will not come forward and use services.
The extent and nature of problem drug use and the scarcity of resources means that it is imperative that agencies in the field of health and social care, both in the statutory and voluntary sector work together to address this problem.

Dr. Mary Hepburn
Consultant Obstretician and Gynaecologist Glasgow

From 'Osbtetrics, women and drug use in the context of HIV.'
HIV infection in women in Britain and especially Scotland is drug related. Pregnant women who are or maybe HIV positive will have other worries which may include housing, attitudes of neighbours, employment problems, as well the health education and welfare of existing and future children. Services must therefore also address the social problems which predispose to and accompany drug use.
Many services at the moment tend to be only hospital services dealing with HIV, drug problems and obstetric care individually but not social problems. They make women feel pressurised when making decisions with very little freedom of choice. Fears about child custody are very real. Women may therefore perceive services as hostile and failing to meet their needs. For many women failure to use services may simply result from the number of other problems they experience which have greater and immediate urgency.
In Glasgow, we have been providing a service for women with or at risk of HIV infection since 1986. The service began with provision of maternity care, but has developed and expanded to provide a full range of reproductive health care. We have found that it is important to have the services community based and easily accessible with no rigid appointment system. We have six community clinic where women are able to call in without an appointment and gain access to a range of support from health visitors, drugs workers, welfare rights advisors, obstetricians and gyaecologists. When a woman has a pregnancy confirmed, she is able to continue her ante natal care, birth and return to home with the same staff supporting her. She is made aware that she will be assessed to see if all her needs are being met and if not how they could be. This may include the involvement of social services but most women now see this as a right rather than a threat. Any care that is provided is carefully negotiated with the women to ensure it is appropriate and is going to be successful.
Our comunity based service attempts to offer sympathetic, supportive, non judgemental help which through a multi disciplinary one door approach addresses the whole range of problems both medical and non medical encountered by the women and their families. In developing our service, we have attempted to take account of the women's views and to tailor management to meet the needs of the individual.

Drug using women - Are our services meeting their needs?
Questions, Answers and Contributions

1. A local health visitor raised the concern that methodone is not required to be put in bottles with child proof lids. There are no warning labels advising people that even very small doses of methodone can be lethal to young children.
2. It was suggested that manufacturers could also be encouraged to make methodone with an off putting taste.
3. Nurses working on the SCBU felt stongly that babies born to drug users should not automatically go on to the SCBU, as they were not generally 'ill',
4. However, once babies are discharged with their parent(s) there is very little follow up or support in the community, and this was recognized as a failing.
5. Some questions were asked about how to decide when treatment was needed. Paediatricians responded that generally it depends on how 'irritable' the baby is,(assessed by paediatrician).
6. Babies are generally kept on the SCBU for a minimum of a week.
7. It was generally felt that the staffing needs of women with social needs were higher than what is presently available, and this should be taken into account of when looking at changing our services.
8. Visitors can be a bigger problem on the ward than the mothers. This can be overcome as it is in Glasgow by staff doing work in the community and building links with 'families'.
9. It was felt to be important for Social Services to be seen not as the agency which take your children into care. Jan Owen responded that Social Services are clear in their guidelines that just because a woman uses drugs, it is no reason in itself to remove a child from custody. However there is still suspicion of statutory services by drug users.
10. There are less women drug users who access services in Glasgow. About one third of all service users are women. This shows that women drug users are underidentified, not that there are less women than men who use drugs.It means that we need to make our services more accessible to women.
11. Questions were asked of Mary Hepburn about how they deal with disruptive behaviour an the ward at Glasgow, for example stealing and dealing. She responded that most women see the unit as 'theirs' and will deal with problems that arise themselves or tell staff about them. Often, they are involved in negotiating to try and identify why a woman is behaving in a particular way. In extreme cases support at home is offered instead of on the unit, and it is suggested that women return at another time. Usually, women are often only hostile if they feel staff are hostile to them.

Summing up
Wendy Henry.
Linx Project

The speakers and audience at the seminar clearly outlined not only the difficuties and discrimination faced by women drug users, but also their fears regarding their own and their children's health. In particular a fear of their baby being taken away into care should they become involved with statutory services. In addition to these factors, the 'chaotic' lifestyle of some clients makes access to health and social care a real problem.

Looking at the model of the 'Womens' Reproductive Health Service' in Glasgow and our own experiences as workers in the field led to the following suggestions as to how improvements can be made in our service provision, this includes:

- Where possible taking a holistic approach eg. a central service where a variety of needs can be met. This might include ante and post natal care, welfare rights, housing advice, social workers, drugs couselling and advice, access to Methodone, childcare a GUM clinic etc.

This service would ideally aim to be user friendly, ie., offering a supportive non judgemental environment which operates at hours that suit its clients lifestyle, encourages 'self referral' and has a drop - in facility.

- The production and circulation of accurate information for both clients and 'professionals'
- Training on issues around drug use, HIV and attitudes to clients for workers - including midwives, drug workers, receptionists, health visitors, doctors and social workers.
- The development of a specific 'city wide' policy for agencies working with women drug users.
- The possibility of a drug specialist midwife based in a central location.
- An awareness of the importance of street based voluntary sector agencies, who are sometimes felt to be more approachable by drug using clients.
- Close liaison between workers and agencies and liaison between voluntary and statutory agencies.
- A campaign for pharmasists to put methadone in child proof bottles
- A campaign for manufacturers to be encouraged to put off putting, instead of sweet tastes into methadone.
- Review of the existing policy in St. Mary's of placing all babies born to drug users onto SCBU.
- Greater co-operation between agencies in the care of parent drug users and their children starting at an earlier stage to prevent 'crisis' decisions having to be made.

The seminar was only the beginning of changes which will hopefully be made within our own working practise and service provision and act as a catalyst for those ideas to become a reality.

Acknowledgements

Thanks to everyone who attended the seminar. To all the speakers who gave up their time and energy.
In particular, thanks to Mary Hepburn who travelled all the way from Glasgow, and to the organizers;

Julie Rickerby - Central HIV Team
Faye Macrory - St. Mary's Hospital
Wendy Henry - Linx Project
Sarah Crosby - Mash
Fay Selvan - ZCHRC

For further information contact:

Julie Rickerby
Central HIV Team - Health Promotion
Withington Hospital
Nell Lane
West Didsbury
M20 8LR

or

Fay Selvan
Zion Community Health and Resource Centre
Zion Crescent
Hulme
Manchester M15 5BY