DRUG ADDICTION IN PREGNANCY – THE IRISH SCENE

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The use of illegal drugs has risen rapidly in our society over the last three years. The National Drug Advisory & Treatment Centre reported a 503% increase in the number of new patients over a two year period - 1980-1982. As the number of new referrals has increased, there has been a parallel rise in the number of infants born to addicted women. A paper published recently on the Emergence of Maternal Addiction as a Problem in Ireland, has reported that a major maternity hospital delivered as many babies of drug addicted mothers in 1981 as they had in the previous eight years. This trend is also reflected in the increase in the number of girls attending the National Drug Advisor/ & Treatment, Centre who have had babies.

Since the opening of the clinic in 1769 to date we have recorded thirty girls who have attended for treatment while pregnant. Seven of these were confined twice, making a total of 30 babies born. However, there are 14 girls currently attending for treatment while pregnant - over a third of the total number reported in the last 14 years. The ratio of male to female patients is 6:1 and has remained stable despite a vast increase in attendances. As all our female patients are of child-bearing age, the average age of new female patients being 21.4 years, we can expect that the continuing escalation of the drug problem will result in increasing numbers of babies being born to addicted mothers.

The first reviews of neonatal drug addiction began to appear in the literature in 1956. Many of these have concentrated on the physical effects of taking drugs on the foetus. The most common medical complications reported have been a high incidence of prematurity, low birth weight and small size for gestational age among the infants of drug dependent women.

The drug addict is greatly at risk from serum hepatitis. Venereal disease, pulmonary infections, cardiac disease (e.g. bacterial endocarditis) and skin abscesses are also common. The risk of intrauterine asphyxia and its occurance has also been covered extensively. Withdrawal symptoms in the infant and their management have been discussed elsewhere.

In the most recent study published in this country, it was stated that the main problems with the patients included in the sample were social. We will therefore take a look at the profile of" the typical pregnant female who presented for treatment at the National Drug Advisory & Treatment Centre between November, 1969 and April, 1983 with a view to formulating a comprehensive approach to their management. Such an approach would include active intervention to ensure proper ante natal care, and nutrition; a lowering of multiple drug abuse prior to delivery and the provision of close follow up care for the mot her and child.

Although the average length of time on drugs when they first present for treatment is the same for our total number of female patients and those that have had babies while attending, i.e. three years, the average age at first contact with the clinic is younger for our sample by 1½ years - i.e. 19½ years. This may indicate that as a group they are more chronic than the norm, having started to abuse drugs at quite an early age.

As can be seen from Table I, only a third of the sample were married and living with their husbands at the time of the birth, again indicating a fairly unstable situation for mother and child.

TABLE I. Profile of pregnant female patients who Presented for treatment at the National Drug Advisory & Treatment Centre between November, 19&9 and April, 1983.

n = 30			
Average Age of first contact at Clinic = 19½ yrs		Average length of time on drugs = 3 yrs	
Marita1 Status:		Referral Source when Pregnant:	
Single	= 13	Hospital	= 51%
Married	= 12	Self	= 40.5%
Married/Separated	= 5	Law	= 5.5%
		Family	= 3%

The referral sources of the patients while they were pregnant indicates that only half attended for ante natal care at an early stage, the remaining fifty per cent requiring constant pressure and support from the staff here to attend a maternity hospital.

A review of the family background and childhood of the girls indicated that the environment in which over 50% of them were brought up was basically unstable. A quarter of their mothers had a nervous or psychiatric

problem or drank to excess. Among the fathers, one third drank to excess and a quarter were reported as being criminal or violent. A quarter of the girls came from families where only one parent was alive.

The high leve1 of emotional insecurity in the home was reflected in the incidence of psychiatric or behavioural disorder prior to drug taking (Table II).many had truanted from school and their level of educational attainment was low, even in the context of referrals to the clinic in general. The majority were therefore in poor emotional condition for pregnancy, and lacked many of the coping skills necessary to bring up a baby on their own.

TABLE II. Background data on pregnant female patients who attended the National Drug Advisory & Treatment Centre between November, 1969 and April, 1983.

n = 30		
Frequency of Traumatic Factors in the Family Background:	Data on Childhood/Adolescence:	
No. of factors operating:	Left School before 16	= 87%
1 = 23.3%	Behaviour Disorder	= 33.3%
2 = 26.6%	Psychiatric Treatment	= 40%
3 = 3.3%	Single Parent Family/	
4 = 3.3%	Brought up in home	= 17%

The most positive aspect of their background and domestic situation seems to be that over half the patients receive on going support from their own mothers and almost half were described as having a good relationship with their own family. It has been the experience of the clinic that in many cases it is really the girls' mothers who take on responsibility for the maintenance and welfare of their daughters' baby, and it is often the mothers who are the most reliable source of information on the baby's well being, and on the daughters' level of drug taking and addiction.

As noted, about one third of the girls were married by the time of their first child subsequent to abuse. These tended to be more secure in social circumstances than the remainder. Among the latter, there was a younger group who still lived at home and an older group who had a nomadic existence between flats, depending on Unemployment Assistance and petty theft to support their lifestyles.

As shown in Table III, most of the husbands/boy-

friends o f the girls were drug abusers themselves and a third had a record o f crime and violence. The relationship between the parents tended to be stormy and inadequate, and only in three cases were the fathers reported as giving consistent support and assistance during pregnancy.

TABLLE III. Domestic situation of female patients who attended the National Drug Advisory & Treatment Centre between November, 1969 and April, 1983, while they were pregnant.

n = 30	
Financial/Living Conditions:	Information on Husband:
	Drug/Alcohol abuse = 83%
Dependent on Social Assistance = 60%	Criminal/Violent =- 37%
Dependent on Parents = 20%	Relations with Own Family:
Dependent on Crime = 20%	
Living with Parents/	Good = 43%
Husband's Parents	Bad = 23%
Council House = 33.3%	Reasonable = 16.6%
Squatting = 16.6%	Nil = 16.6%

Most of the patients now attending the Notional Drug Advisory & Treatment Centre are abusing opiate drugs. This is reflected in the choice of drugs of abuse of the present sample. All the girls who have attended in the last three years have been Heroin abusers and the majority have been abusing intravenously –'mainlining'. In earlier years, hallucinogens and sedative type drugs were more popular. It has been shown in the research that opioid use is characterised by a group more deprived and delinquent than others. If this is the case, we are now dealing with a more damaged and inadequate group at present than in previous years.

The current practice in the National Drug Advisory & Treatment Centre is to maintain the pregnant woman on a low dose of methadone (Physeptone linctus - Wellcome, methadone hydrochloride 2mg. per 5 ml.) at approximately 25 mg. daily, throughout the course of her pregnancy. It has been shown that programmes in which the mother is maintained on methadone, which is administered orally on a daily basis, have decreased the morbidity associated with addiction by reducing parenteral drug use. It also encourages better antenatal care and a more stable drug environment for the mother and child.

However, not all our patients have been willing to

come to the clinic on a daily basis to receive their medication and have requested to be detoxified fully. Others have not been motivated enough to attend and have slipped back into serious addiction. However, 40% of the sample did follow a programme from the time they first contacted the clinic when pregnant to after the birth. Some of our patients of previous years did not require a programme of medication while they were pregnant as they did not abuse opiates. They were able to reduce their use of sedative or other drugs. However, they did attend the clinic for ongoing counselling arid support.

TABEL IV. Drug history of pregnant female patients who presented for treatment at the National Drug Advisory & Treatment Centre between November, 1969 and April, 1983.

n = 30			
Drug Abused:		Method of Abuse	
Heroin only	= 23.3%	Mainline	= 76.6%
Heroin + Morphine/		Snort /smoke	= 6.5%
Diconal/Palfium	= 46.6%	Oral	= 16.6%
Heroin + Barbs	= 10%		
Barbs + alcohol +			
Tranquillisers	= 13.3%	Treatment while Pregnant:	
Hallucinogens	= 6.5%		
		Maintained on	
		Methadone	= 40.5%
Motivation to remain Drug		Detoxified	= 8%
Free while pregnant:		Dropped out of	
		Programme /abused	= 30%
Quite good	= 16.6%	Maintained Contact/	
Questionable	= 36 .6%	No Medication given	= 21.5%
Nil	= 46.6%		

As can be seen from Table IV, the motivation to remain drug free when pregnant was very questionable or non-existant, in the vast majority of cases. This is also reflected in the rate of relapse into illegal drug abuse after the birth and the discontinuation of methadone.

Both the addicted mother and her baby present hospital staff with numerous problems which inhibit tine opportunity for proper postnatal care. The mother usually waits until the last possible moment to enter the hospital and has often taken drugs prior to admission. It can be difficult to convince the addict to remain in hospital once her child is delivered. Understandable anxiety, among medical and social staff, concerning the

welfare of the child and the social conditions the baby was returning to, led to longer hospitalisation of the infants and separation from their mothers at an early age.

Most infants were eventually discharged to the care: of their mothers, and the fate of many of them after leaving hospital can he difficult to monitor. Rathstein and Gould have developed a system of assessing the risk to the infants of sending the child home with the mother. High risk factors include a mother less than 18 years one a home situation where other members of the family also abuse drugs. Active participation in a drug programme, o short history of drug abuse and a mother who has raised other children without problems, offer a lower risk to the infant. Most of our patients would fall into the former category.

However, many of the girls in our sample were very resistant to any Health Board involvement with their babies, and many refuse to attend for the normal developmental checks and vaccinations. We do know that at least 65% of the mothers returned to serious drug abuse and we can assume that many of those who lost contact with the clinic, did so as well. This naturally has implications as regards their ability to care adequately for the children in their care. We do know that in the case of three mothers the Health Board have stepped in and taken out an Unfit Persons Order on the mother, and removed the children to foster care.

TABLE V. Follow-up of female patients who attended for treatment at the National Drug Advisory & Treatment Cent re between November, 1969 and April, 1983.

		n = 30	
Baby:		Drug History Following Birth:	
Kept by Mother/Ongoing			
Health Board		Return to Drug Abuse/	
Monitoring & Concern	= 70.3%	Treatment	= 65%
Kept by Mother/	= 11%	Lost Contact	= 21.5%
Grandmother		Rehabilitated/Drug	
Adopted/Fostered		Free	= 11%
Other		Other	= 2.5%

CONCLUSION

As the outline of the female addicts attending the National Drug Advisory & Treatment Centre while pregnant shows, they are a very damaged and desocialised group: A young mother, with a long history of abuse of hard drugs,

dependant on family or state for financial support and a place to live, a spouse who abuses drugs or alcohol. Most of these girls have been unwilling to participate in any rehabilitation programme, and most have returned to drug abuse after the birth of their child. However, most have been quite determined to keep their children. This is an area which probably causes the greatest concern to professionals dealing with “these cases. Their acquaintance with “the infant is usually short-lived. Few of the mothers understand the necessity for developmental follow up, and can be very rests t ant to give any public health workers access .to or information about the environment in which the infant is being reared. It is difficult, therefore, to minimize the hazards to these children by early intervention. They return to homes with inadequate young mothers who are ill-equipped to cope, who will only seek help from an outside agency when their problems really are out of their control, and their children have been neglected as a result.

The maternity hospitals in the Eastern Health Board area have been issued with questionnaires designed by Consultant Obstetricians and the staff of the National Drug Advisory & Treatment Centre. The answers in the questionnaire will be collated and presented as an up-to-date finding, to the 7th International Congress on Psychosomatic Obstetrics and Gynaecology - a copy of the questionnaire is in Appendix A.

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DRUG ADVISORY & TREATMENT CENTRE
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NUMBER OF PATIENTS ATTENDING
THE DRUG CENTRE WHILE PREGNANT.

YEAR	**NUMBER**
1969 – 1979	25 (1/2 per year)
Jan – Dec 1980	5
Jan – Dec 1981	10
Jan – Dec 1982	15
Jan – Dec 1983	25