清音 CS voice

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Advocacy

Providing comprehensive support to mothers with substance abuse behaviour for the protection of the long term interest of children

According to current child protection policies in Hong Kong, if a medical officer or a social worker discovers that a substance abused woman continues to take drugs during pregnancy or before giving birth, and the content of illicit drug was found in the first urine sample of the newborn baby, the medical officer and social worker will call for a "Multi-disciplinary Case Conference on Child Abuse" (MDCC) to examine the cause for concern, assess the level of risk and make recommendation on the welfare planning for the child. During the conference, if the mother cannot provide sufficient "evidence" that she has stopped taking illicit drugs, or no other relatives can shoulder the responsibility of taking care of the baby, the MDCC will make a recommendation to reside the baby in residential care service. In recent years, the number of these cases has increased drastically, leading to a short supply in residential childcare placements. There was a case that the baby was stuck in the hospital for more than six months after the MDCC due to the lack of placement in residential child care service. In addition, based on frontline observations, we have seen many cases where children of substance-abusing parents have to stay at a child residential centre for several years, and some even stay until aged 18 when they must leave the centre. Staying away from homes for years has weakened the connection between these children and their parents, and the long-term stay at child residential centres has hampered their abilities to develop a stable or attachment relationship with people, all of which pose challenges to the growth of these children. These children and youth have, as a result, developed various behavioural problems, and some even repeated the same mistakes as their parents and become second-generation substance abusers.

For the long term interest and development of children, our child protection mechanism should not only focus on the immediate care but also a comprehensive social service and medical support for this kind of families, in order to facilitate a favourable condition for the children to grow up in their own homes.

清音 CS voice

Medical care to eliminate stereotype since pregnancy

In order to stop this vicious cycle effectively, early identification and intervention are important. Same as other pregnant women, many substance abuse pregnant women are very concerned about the condition of the fetus. The desire to have a healthy baby often gives them impetus to give up drug habits or use other methods to alleviate the harm of drugs to the fetus. However, pregnant substance abusers are reluctant to assess to prenatal care service or tend to seek medical care rather late due to different reasons such as fear of losing custody of children, fear of forced treatment or criminal prosecution, lack of treatment readiness, coexisting mental illness, guilt and denial or embarrassment regarding their substance use, which pose further challenges to the identification of their problems (Macrory & Boyd, 2007; Roberts & Pies, 2011). As early as the 1990s, authorities in the United Kingdom and the United State started paying attention to the situation of pregnant women with substance abuse behaviour and addicted women. For instance, a cross-disciplinary committee was established and drug liaison midwives were hired in Manchester to coordinate obstetric hospitals and drug treatment services in the district, so as to develop specific service policies and models for pregnant drug users, as well as follow up and coordinate cases (Macrory & Boyd, 2007). In Hawaii, the Perinatal Addiction Treatment Clinic was set up to provide a one-stop service to drug abused women. On the same day of attending prenatal examination, they can also get drug counselling, parenting advice or participate in other health-related activities (Wright et al, 2012).

All these services are medical-oriented, focusing on an understanding of the pregnant substance abusers' situation, accepting their ups and downs and struggles in the drug detoxification process, as well as getting rid of the moral judgement of pregnant substance abusers as irresponsible mothers. After the implementation of the above mentioned programmes, the number of people proactively seeking help has increased every year. Instead of spending time and energy to identify and locate them, service providers can then focus on providing prenatal counselling and all kinds of parenting support so as to strengthen their ability to become "mothers". And it is worth noting that all these services do not set detoxification as the only objective but adopt the concept of harm reduction. To quote the Perinatal Addition Treatment Clinic in Hawaii as an example, the majority of substance abusers s quit addition during pregnancy, with only 5% of them remains addicted. And the clinic has discovered the health conditions of these newborns were the same as other newborns (Wright et al, 2012).

清音 CS voice

Relieving parenting pressure to facilitate drug treatment

Pregnant substance abusers need to face changes in their role and postnatal environment during the postpartum period, which includes adapting to the new life and facing problems such as poverty, housing and even chronic diseases. The lack of childcare skills and inadequate social support create further pressures and challenges that increase the risk of addiction relapse. It is particularly important for the society to provide services such as occasional child care service, escorting service and parenting skills guidance, or other material assistance, to families experiencing difficulties in the preschool stage, so as to enhance their parenting skill and enable toddlers to live with their parents to develop a stable attachment and reduce the demand for child protection and residential care service.

Facilitating cross-disciplinary coordination and updating child protection guidelines

Despite many pregnant women with substance abuse behaviour have a chaotic lifestyle and are skeptical of the medical and social service, if service providers are perceptive of their unique situation and can gain their trust through continuous outreaching work and family visits, they are more likely to be drawn back to mainstream medical and social service, facilitating more positive results in various aspects (Barnard & McKeganey, 2004). In addition, as substance-abusing pregnancy and child protection are rather complicated issues, professionals handling these cases might not possess cross-disciplinary knowledge. Hence, guidelines on medical intervention and child protection relating to substance-abusing pregnancy should be set up to enable professionals to provide a more evidence-based and accurate intervention, and to facilitate inter-disciplinary collaboration and establish an effective communication platform. In fact, many European countries and the United States have formulated related guidelines in recent years. For examples, the health department of New South Wales in Australia formulated the "Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period" in 2014 and the National Children's Bureau in the UK devised "Assessing the impact of parental drug use - a toolkit for practitioners" which provided detailed guidelines on assessment and practical operations for drug-abusing mothers' health and child protection. Currently, the Social Welfare Department is reviewing and updating the local child protection guideline. We suggest the Department and the social welfare sector to make reference to overseas experience to introduce major additions and adjustments to the guidelines and review all stakeholders' roles and positioning in child welfare service in the long term so as to provide guidelines and lay a foundation for future discussion for service providers

清音 CS voice

as well as to achieve the best interest for the children.

Lastly, for the comprehensive support to mothers with substance abuse behaviour and the long-term interest of their children, medical healthcare and social service providers in different districts should review the existing collaboration models and establish a long-term communication platform to work together and fight for more resources to fill the service gaps.

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