



**The 'Can Do' Initiative:  
Managing Mental Health and Substance Use in General Practice**

***'Can Do' for Young Mothers***

***Facilitator's Notes***

***Presentations and facilitator's notes  
Case studies and facilitator's trigger questions***

Joint learning module for general practitioners, allied health practitioners and other service providers involved in the provision of care for young mothers at risk of or experiencing mental health and substance use issues.

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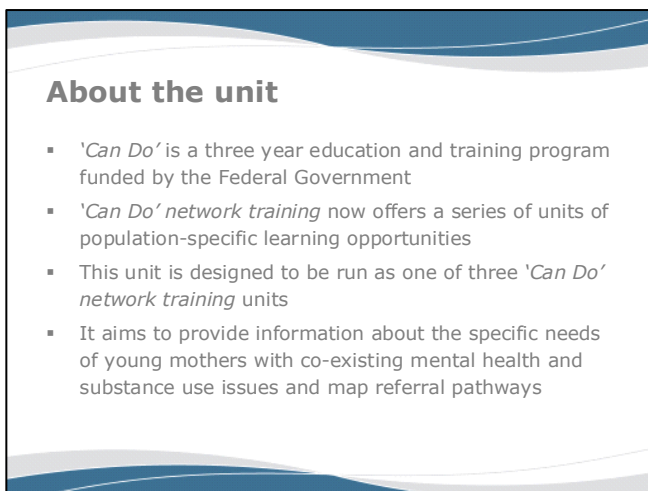
## Slide 1: Title page



This is the title slide. You may use this slide as participants arrive and during the welcome. As the facilitator it is important that you familiarise yourselves with the slides and notes.

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## Slide 2: About the unit



**About the unit**

- 'Can Do' is a three year education and training program funded by the Federal Government
- 'Can Do' network training now offers a series of units of population-specific learning opportunities
- This unit is designed to be run as one of three 'Can Do' network training units
- It aims to provide information about the specific needs of young mothers with co-existing mental health and substance use issues and map referral pathways

This slide provides an overview of how this unit fits into the 'Can Do' initiative.

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### Key points

- The 'Can Do' initiative is a three year education and training program, funded by the Australian Government Departments of Health and Ageing and Veterans' Affairs. This unit has been developed to provide information about the specific needs of young women who have children and who experience co-morbid mental health and substance use issues. A multidisciplinary team focus has been taken, with the aim of involving a range of health and community service providers
  - The unit aims to provide key information related to the topic area, and encourages interactive learning via discussion of the 'stories' of two young women and the opportunity to network and 'map' local service providers
  - It has been developed for a range of professionals and provides the opportunity to increase awareness of local networks and referral pathways
  - The unit is intended to be used alongside other 'Can Do' units
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## Slide 3: Learning objectives

**Learning objectives**

- Highlight the needs of young mothers
- Increase awareness of the mental health and substance use issues relevant to young mothers
- Increase understanding of why young mothers may use substances
- Identify the physical, psychological and social risks to mother and child associated with substance use and mental health issues
- Improve knowledge of strategies to address these risks, and available resources

The overarching goal of the unit is to inform participants about the specific needs of young mothers between 12 and 25 years old, with reference to co-occurring mental health and substance use problems. The population group 'young mothers' potentially encompasses women from 12 to 25 years of age, however this group can be further divided into adolescent women (12 to 17 years of age) and young adults (18 to 25 years of age).

### Key points

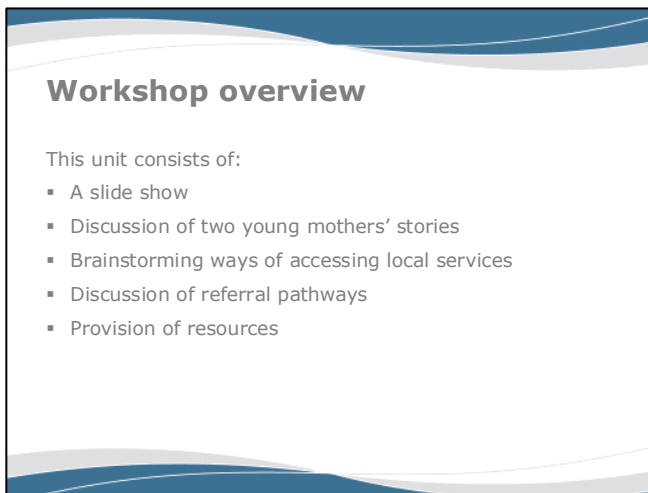
On completion of this program, participants should be able to:

- describe the physical, psychological, social, spiritual and cultural needs of young mothers between 12 and 26 years old
- demonstrate an increased awareness of the mental health and substance use issues relevant to young mothers
- demonstrate an increased understanding of why young mothers may use substances
- identify the physical, psychological and social risks to mother and child associated with substance use and mental health issues, both during pregnancy and after delivery
- demonstrate an increase the capacity of general practitioners, allied health professionals and other service providers to work with young mothers at risk of or experiencing mental health and substance use issues
- demonstrate increased confidence in providing support and understanding required by young mothers with mental health and substance use issues
- identify health and community services at the local level, particularly those that engage with young mothers
- demonstrate an increase in ability and confidence in developing appropriate pathways of referral and care for people with mental health and substance use issues and their families and carers.

The learning objectives will be achieved by:

- encouraging multidisciplinary and solution-focused approaches
- facilitating interactive learning and peer discussion
- fostering networking and mapping of local services and referral pathways
- improving knowledge about local services
- ensuring skills gained are transferable to clinical practice.

## Slide 4: Workshop overview



**Workshop overview**

This unit consists of:

- A slide show
- Discussion of two young mothers' stories
- Brainstorming ways of accessing local services
- Discussion of referral pathways
- Provision of resources

The unit is intended as an overview of the main issues when working with young mothers, however it is important to note that this subject is an extensive and complex one.

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### Key points

This unit consists of:

- a brief slide show to provide participants with an overview of relevant background information about young mothers and substance and mental health issues
  - discussion of two young mothers' stories to provide an opportunity to share knowledge, skills and practical advice on working with this population group
  - brainstorming ways of accessing local services during the discussion of the young mother's stories and a service mapping exercise – service providers will be given an opportunity to introduce their service in the service mapping exercise
  - discussion of referral pathways - details of local agencies and the process of appropriate referral; who is able to refer, what details to include in the referral letter/form
  - a number of handouts will be provided and a comprehensive list of resources can be found at the end of the unit.
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## Slide 5: Young women

**Young women**

- Young women are defined as being 12-25 yrs old
  - adolescence 12-17 yrs
  - early adulthood 18-25 yrs
- Many challenges: bio-psycho-social-spiritual
- Key issues: identity formation, peer relationships, becoming sexually active, experimentation, developing independence
- Cultural influences need to be considered

The population group, 'young women', encompasses females from 12 to 25 years of age. However, this group can be further divided into adolescent women (12 to 17 years of age) and young adults (18 to 25 years of age). It is important to highlight differences between these two subgroups during the discussion, in terms of maturity levels and likely risks and challenges. Young women face a number of issues and challenges related to both their developmental stage and their individual context (i.e. culture, family, socio-economic status).

### Key points

- Young women are defined as 12-25 years of age
- Young women encompasses the adolescent age group between 12 and 17 years of age, and the period of early adulthood between 18 and 25 years of age
- Young women face many challenges, which can be considered from bio-psycho-social-spiritual perspectives
- The key issues for young adolescent women include identity formation and independence, peer relationships, becoming sexually active and experimentation
- The key issues for young women 18 to 25 years of age are developing independence and assuming social responsibility
- Differences between individuals need to be considered i.e. physical, emotional and cognitive maturity, resilience, personality factors, socio-economic status, cultural background and family environment
- Cultural influences should also be considered eg cultural identity formation including acceptance or rejection of traditional values, conflict in relation to drug use or peer relationships/sexual activity, cultural views of mental health.

### Additional information

Geldard & Geldard (2005) suggest a number of issues be considered:

- *Biological challenges*: this may include major physical changes, puberty, production of sexual hormone and sexual development.
- *Emotional changes*: there are many influences on a young woman's emotions. The increase in sexual hormones, as well as major changes in social relationships, beliefs and attitudes, may have an impact.
- *Cognitive changes*: thinking moves from concrete to abstract/critical thinking i.e. from logical, practical thinking, to being able to understand ideas and theories such as good and evil.

- *Egocentric view of the world*: this style of thinking is particularly common in adolescence, and often means that the adolescent female believes that no one else can understand where she is coming from.
  - *New identity and individuation*: development of independence a key task, learning to stand alone as an adult, and formation of the young woman's own personal identity as separate from her parents and family.
  - *Social*: accepting self, new peer relationships, preparing for occupation, acquiring social responsibility and values and dealing with (perceived) expectations of society.
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**References**

Geldard, K., & Geldard, D. (2005). *Counselling adolescents* (2nd ed.). London: Sage.

## Slide 6: Why young women use drugs

**Why young women use drugs**

- To relax
- To decrease boredom
- To become intoxicated
- To enjoy company
- To increase confidence
- To manage mental health issues – self-medication
- To feel euphoric
- To stay awake

### Key Points

Young women may use drugs for a variety of reasons, but they generally use them for their recreational, stimulant and/or sedative effects. The top five reasons for young people to use drugs were: "help relax", "get intoxicated", "keep going", "enhance activity", and "feel better" (Boys, Marsden & Strang, 2001). Young women may also use drugs in an attempt to manage social and mental health problems.

The following reasons can be attributed to specific drugs or drug groups:

- Alcohol: to relax, become intoxicated, enjoy company, increase confidence, feel better, decrease boredom
- Tobacco: to relax, enjoy company, increase confidence, decrease boredom or lose weight
- Cannabis: to relax, enhance activity, decrease boredom, increase confidence, stop worrying
- Amphetamines: to keep going, stay awake, enhance activity, feel elated/euphoric, enjoy company
- Opioids: to feel euphoric, to relax, prevent withdrawal
- Ecstasy: to keep going, feel elated/euphoric, stay awake, lose weight
- LSD: to get intoxicated, feel elated/euphoric, enhance activity, enjoy company, keep going
- Cocaine: to keep going, stay awake, increase confidence, get intoxicated, feel better, lose inhibitions, stop worrying, lose weight.

### Additional information

- Boys, Marsden & Strang (2001) studied 364 poly drug users (average age 19.3 years) in the UK to determine the reasons for drug use among young people. They found that drugs were generally used by young people for their stimulant, sedative and hallucinogenic effects.
- Although young people use drugs for many different reasons there were certain drugs that were more commonly used to gain a specific effect. For instance, cannabis and alcohol were used for relaxation or to get intoxicated, while amphetamine and ecstasy users reported using drugs to keep going. Alcohol and cannabis were often used to feel better.
- Alcohol and cannabis have sedative effects. Amphetamines, ecstasy and cocaine are stimulant drugs which increase nervous system arousal. Drugs are also used for a variety of sexual purposes i.e. as an aphrodisiac or to enhance sexual performance.
- The importance of being fashionable to young people, and the emphasis placed on having a certain body shape or 'look' may lead to drug use. Young women, in particular, may use drugs to maintain a fashionably low body weight and shape. Consider the effects of media.

- Drug use and alcohol consumption tend to occur together. High levels of alcohol consumption are also related to a greater risk of engaging in unprotected sex.
  - Drugs are also used for a variety of sexual purposes i.e. as an aphrodisiac or to enhance sexual performance.
  - Amphetamines, ecstasy, LSD and cocaine are stimulant drugs which increase nervous system arousal.
  - The use of ice (crystal meth) has become more popular in Australia over the past few years. Ice is a stimulant, and is often related to the nightclub/rave scene.
  - Young people might combine the use of multiple drugs i.e. to improve effects from other drugs, to help manage after effects of other drugs.
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#### References

Boys, A., Marsden, J., & Strang, J. (2001). Understanding reasons for drug use amongst young people: a functional perspective. *Health Education Research: Theory & Practice*, 16(4), 457-469.

National Drug & Alcohol Research Centre. NDARC fact sheet: ice/crystal. Retrieved 24 November, 2007, from [http://www.unsw.edu.au/NDARCWeb.nsf/resources/NDARCFact\\_Drugs7/\\$file/ICE+FACT+SHEET+2.pdf](http://www.unsw.edu.au/NDARCWeb.nsf/resources/NDARCFact_Drugs7/$file/ICE+FACT+SHEET+2.pdf)

## Slide 7: Young women and substance use

**Young women and substance use**

- Prevalence of risky drug taking is increasing
- 20% of women 18–23 yrs old smoke regularly
- 70% of young women engage in "binge drinking" at some time, 19% on a weekly basis
- Cannabis is the most widely used illicit substance
- Drug use may be related to peer group pressure, social and psychological factors
- Limited data is available for Indigenous Australian women

It is recognised that there are often comorbid substance use and mental health issues. Comorbidity issues are discussed in later slides.

### Key points (Carr-Gregg et al., 2003)

- There seems to be an increasing range and prevalence of risky drug-related behaviours associated with young women, notably in their use of alcohol and marijuana.
- One fifth of women 18–23 yrs old smoke regularly - 20% of 18-23 yrs old females smoke regularly, and another 12% smoke occasionally.
- 70% of young women engage in "binge drinking" (>5 drinks on one occasion) at some time, with 19% doing so on a weekly basis.
- Cannabis was the most widely used illicit substance by males and females (rates of lifetime use 45%).
- Research suggests that such health risk behaviours may be related to psychological factors such as stress and depression.
- While 38% of 14-19 yr olds reported use of drugs, 20-29 yr olds reported the greatest proportion of recent use (40%).

### Additional information

- 22% of women in Australia aged 14-19 years consume between 9 and 30 alcoholic drinks in one day.
- About half of 12-17 yr olds drink premixed spirits, which may appear similar to a soft-drink.
- Excessive alcohol use is associated with unsafe sex, unwanted pregnancy, drink-driving and road accidents, violence, and criminal activity (Carr-Gregg et al., 2003; Jonas, 2000).
- The rate of smoking among young women increases rapidly between the ages of 12 and 17: 6% of 12 yr old females and 30% of 17 yr old females are current smokers.
- Among women aged 22 -27 years, 58% reported having used an illicit drug at some time with most (57%) having used cannabis. Amphetamines and ecstasy were the next most commonly used drugs (Turner, Russell & Brown, 2004).
- More young women have experimented with cocaine and heroin than males - 2.5% of 14-19 yr old females have experimented with cocaine compared to 1% of 14-19 yr old males, and 2.3% of 14-19 yr old females compared with 1.1% of same age males have experimented with heroin.

### Patterns of drug use risk and harm among Indigenous Australians

- There is limited data on drug use among Indigenous Australians, and it is therefore difficult to find information on young women and drug use patterns (Putt, 2006). However, there is

evidence to suggest that young Indigenous men are more likely to use drugs and alcohol than females (Linacre, 2002).

- It is reported that similar proportions of the Indigenous and non-Indigenous populations smoke; however, Indigenous people tend to take up smoking at an earlier age, and tobacco-related mortality is significantly higher among Indigenous than non-Indigenous Australians (Loxley, Toumbourou, Stockwell, Haines, Scott, Godfrey, et al., 2004).
- The recent National Aboriginal and Torres Strait Islander Social Survey (Linacre, 2002) found that 47% of Indigenous Australian women were current smokers. Indigenous smokers also reported higher rates of other substance use. Those who smoked regularly were also more than twice as likely as those who did not smoke to consume risky amounts of alcohol.
- Regular smokers in non-remote areas were 2.5 times likely as non-smokers to have regularly used illicit substances (especially marijuana) (Trewin & Madden, 2005).
- ATSI people are less likely than non-indigenous Australians to consume alcohol; however, those who do are more likely to drink at dangerous levels. Heavy drinking is associated with both criminal offending and being a victim of alcohol-related violence (NHMRC, 2000).
- For communities, there is an increased potential for social disruption such as that caused by domestic violence, crime and assaults (Gray, Sputore, Stearne, Bourbon, & Stempel, 2002; McAllister & Makkai, 2001).
- Alcohol consumption is higher for Indigenous respondents with child protection issues, while opioid use is higher in other groups (Loxley et al., 2004).
- Group drinking, kinship, social effects of unemployment, boredom and personal isolation are compounding factors.
- One quarter of indigenous people aged 15 years and over in non-remote areas reported having use an illicit substance in the previous 12 months and 40% reported having tried at least one illicit substance in their lifetime (Trewin & Madden, 2005).
- Marijuana was the most commonly reported illicit drug used by ATSI people in 2002. Amphetamines/speed and analgesics (for non-medical use) were the next most frequently reported substances (Linacre, 2002).
- Indigenous people are the only culture reported to use solvents, with 7% of Indigenous respondents reporting having inhaled solvents. Of those, 4% had inhaled petrol, and 3% had used glue (Loxley et al., 2004).
- Indigenous Australians are acutely aware of many of the health and social consequences of excessive alcohol and other drug use (Loxley et al., 2004).

### Culturally and Linguistically Diverse populations

Substance use in some ethnic groups has been associated with negative experiences of migration such as social isolation, dissonance with mainstream cultural values, refugee experience and youth unemployment (ARACY, 2006).

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## Slide 8: Young women and mental health

### Young women and mental health

- In this age group the onset of depression, anxiety & substance use disorders is common
- The highest prevalence of depression in women is during the child-bearing years
- 10-16% of pregnant women fulfill the DSM-IV diagnostic criteria for major depression
- 10-15% of mothers develop post-natal depression within 6-8 weeks of giving birth

It is recognised that there are often comorbid drug and mental health issues – this slide provides an introduction to mental health issues experienced by young women. Later slides will discuss comorbidity issues.

### Key points

- During adolescence and early adulthood the onset of depression, anxiety and substance use disorders is common (Andrews & Wilkinson, 2002).
- Highest prevalence of depression in women is during child bearing years.
- Of pregnant women, 10-16% fulfill the DSM-IV diagnostic criteria for major depression.
- 10-15% of mothers develop post-natal depression within 6-8 weeks of giving birth.
- Psychological disorders may develop as a response to stress, particularly if the young woman is not able to deal adaptively with the stressor (Geldard & Geldard, 2005).
- Co-morbidity with other mental health problems is common in adolescence (Bhatia & Bhatia, 2007).
- The Australian Institute of Health and Welfare (2007) found that among young Aboriginal and Torres Strait Islander women, the main reason for mental and behavioural disorder hospital separations were psychoactive substance use (25-29% caused by alcohol use alone), reaction to severe stress and adjustment disorder (16%) and schizophrenia (15%).

### References

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## Slide 9: Substance use and mental health comorbidity

**Substance use and mental health co-morbidity**

The current literature outlines four hypotheses:

1. Drug use as a way of coping with mental health problems
2. Drugs potentially leading to mental health problems
3. Combination of genetic and environmental factors
4. Berkson's paradox: high rates of co-morbidity are reflective of the treatment setting being studied

There is no consensus in the literature about the reasons for the frequent co-morbidity of substance use and mental health problems. However, there are a number of theories as to why co-morbidity may occur. Also, given that mental health problems are commonly experienced by young women and substance use is common in young women, it is not surprising co-morbidity frequently occurs. This slide details four hypotheses for the co-occurrence of substance use and mental health issues. It is possible that a combination is responsible.

### Key points

There are four possible explanations for co-morbidity of mental health issues and substance use:

- *A way of coping*: mental health problems lead to drug use or abuse
- *Drugs as 'causal' - influential/exacerbating*: substance use and or abuse directly or indirectly leads to mental health problems (Meyer, 1986)
- *Context is key*: a combination of genetic and environmental factors (socio-economic disadvantage, emotional deprivation, social disorganisation, childhood abuse, genetic loading and childhood trauma) interplay to increase the likelihood of co-morbidity
- *Berkson's paradox*: high rates of co-morbidity are reflective of the treatment setting being studied - i.e. hospital and treatment service settings have a greater than average proportion of attendees who experience co-morbid mental health and substance use problems.

### Additional information

- Young women experiencing co-morbid mental health and substance use problems may be less likely to engage in, and respond to, treatment, due to the complexity of their situation.
- Many young women may not link their use of substances to their mental health issues. Raising their awareness of the possible connection may be a key role for the health professional involved.
- The young woman may also not see their substance use as a problem – in fact, they may believe that it is the only reliable coping strategy they have.

### Reference

Meyer, R.E. (1986). How to understand the relationship between psychopathology and addictive disorders: another example of the chicken and the egg. In R.E. Meyer (Ed.), *Psychopathology and addictive disorders* (pp.3-16). New York: Guilford.

## Slide 10: Young women and pregnancy – general issues

**Young women and pregnancy: general issues**

- 46% of females in Year 12 report having had unsafe sex
- Teenage women account for 5.3% of confinements
- 5% of live births were to females aged <19 yrs; 15% were to females aged 20-24 yrs
- Almost half (49.8%) of births to Indigenous women were to women <25 yrs of age
- Pregnancy Support Counselling Initiative – nondirective support

This slide highlights general issues regarding young women and pregnancy. It includes information about the Pregnancy Support Counselling Initiative.

### Key points

- 46% of females in Year 12 reported having unsafe sex (Carr-Gregg et al., 2003). This statistic may reflect issues such as peer pressure, lack of sexual health education, and difficulty accessing/reluctance to use contraception.
- Teenage women account for 5.3% of confinements (SHineSA, 2007) - SHineSA cites data showing that the teenage confinement rate has been relatively stable over the last five years; however, there is a recent trend towards women becoming pregnant at an older age (>30 years)
- 5% of live births were to females aged <19 yrs, while 15% were to females aged 20-24 yrs (AIHW, 2003). There is evidence of an increase in confinement rates to teenagers from low socio-economic backgrounds
- Almost half (49.8%) of births to Indigenous women were to women <25 yrs of age (Pitman et al., 2004) - Indigenous teenage women account for 21.6% of teenage confinements
- Pregnancy Support Counselling Initiative: a Federal government initiative providing non-directive pregnancy support counselling for women concerned about a current or recent pregnancy (further information provided below).

### Additional information

Current data shows:

- There were 937 confinements for women aged 15-19 years of age (a rate of 18.3 per 1000).
- In 2003, 102 confinements were to women of school age.
- 42.7% of teenage mothers smoked during pregnancy compared to an overall rate of 20.4%.
- The current education participation rate is 70.6%; however, for pregnant and parenting teenagers the figure is believed to be much lower than this.

For local information, participants are recommended to visit their state or territory's sexual health and family planning website:

- National - [www.shfpa.org.au](http://www.shfpa.org.au)
- Australian Capital Territory - [www.shfpact.org.au](http://www.shfpact.org.au)
- New South Wales - [www.fpahealth.org.au](http://www.fpahealth.org.au)
- Queensland - [www.fpq.com.au](http://www.fpq.com.au)
- Tasmania - [www.fpt.asn.au](http://www.fpt.asn.au)
- Victoria - [www.fpv.net.au](http://www.fpv.net.au)

- Western Australia - [www.fpwa.org.au](http://www.fpwa.org.au)
- South Australia - [www.shinesa.org.au](http://www.shinesa.org.au)
- Northern Territory - [www.fpwnt.com.au](http://www.fpwnt.com.au)

### **Overview of the Pregnancy Support Counselling Initiative** (Items 81000 to 81010)

The Pregnancy Support Counselling initiative commenced on 1 November 2006. It provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months, by an eligible medical practitioner (including a general practitioner, but not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner.

#### Eligible patients

Items 81000-81010 inclusive are available to women who are concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, and where the patient is referred to an eligible allied health professional by a GP. The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

#### Eligible pregnancy support counselling services

There are four new MBS items for the provision of non-directive pregnancy support counselling services:

Item 4001: services provided by an eligible GP.

Item 81000: services provided by an eligible psychologist.

Item 81005: services provided by an eligible social worker.

Item 81010: services provided by an eligible mental health nurse.

Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia. Medicare benefits are available for up to three eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided they use items 81000, 81005, 81010 and 4001. The Medicare benefit payable for an eligible service provided using item 81000, 81005 or 81010 is \$55.00. Partners of eligible patients may attend each or any counselling session; however, only one fee applies to each service.

For more information refer to the Department of Health and Ageing website listed in 'References' below.

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## Slide 11: Young women with drug and mental health issues - contraception

**Young women with substance use and mental health issues: contraception**

- Contraception options (e.g. Implanon)
- Pre-contraception counselling important (exclude pregnancy)
- Consider effect of drugs on contraception
- Address consent issues in minors
- Termination of pregnancy – counselling initiatives

This slide deals specifically with young women with drug and mental health issues and the use of contraception to prevent pregnancy. Some specific tips on working with young women of school age who are pregnant are provided below.

### Key points

Contraception options in young women with drug and mental health issues:

- The full range of contraceptive options are available, but commonly progesterone-only preparations such as Depot preparations or 'Implanon' are used. Implanon is inserted under the skin, lasts for several years and avoids the need to take daily medication such as the Pill. Myths need to be addressed, such as that 'Implanon often breaks or pops out'
- Pre-contraception counselling is very important, including contraception options and explanation of potential issues, such as initial irregular bleeding with Implanon
- Protocols are needed to ensure the young woman is not pregnant
- Consider effect of drugs on contraception eg. forgetting to take oral contraceptives due to the effect of recreational drugs, or vomiting after alcohol binge causing contraceptives to not taken or absorbed
- Address consent issues in minors: two doctors must assess that the young woman has sufficient maturity and understanding to make a decision about contraception (there may be 'two doctor' sexual health clinics available locally).
- Termination of pregnancy may be requested; General Practitioners and allied health professionals will be involved in providing information to and counselling the young woman – see outline of the Pregnancy Support Counselling Initiative below.

### Additional information

The following information is aimed at supporting the health professional to engage effectively with pregnant and/or parenting young women of school age (SHineSA website, 2008):

- Setting the scene: build a relationship.
- Does the young woman have support?
- Is the young woman accessing antenatal care?
- Does the young woman need financial assistance?
- Does the young woman need housing assistance?
- Does the young woman have health care support for her and her baby?
- Is the young woman still at school?
- Is the young woman accessing child care?

Maternal substance use is associated with:

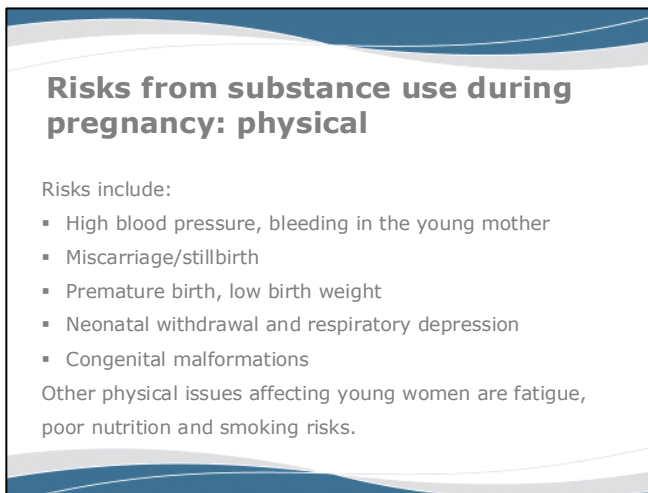
- A sub-optimal antenatal environment.
  - Low rates of engagement with services.
  - A range of direct toxicological obstetric and neonatal complications (Winstock, 2007).
- 

**References**

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## Slide 12: Risks from substance use during pregnancy - physical



**Risks from substance use during pregnancy: physical**

Risks include:

- High blood pressure, bleeding in the young mother
- Miscarriage/stillbirth
- Premature birth, low birth weight
- Neonatal withdrawal and respiratory depression
- Congenital malformations

Other physical issues affecting young women are fatigue, poor nutrition and smoking risks.

This slide lists the physical risks associated with the use of various substances during pregnancy.

### Key points

Many drugs cross the placenta and can affect the young mother and the foetus. The effects of different drugs are outlined below and a summary is provided on the slide:

#### Alcohol

- Congenital malformations
- increase risk miscarriage/stillbirth
- Foetal Alcohol Spectrum Disorder – see next slide for more detail

#### Tobacco

- smoking has been linked to miscarriages, low birth weight, premature births, stillborn births, neonatal problems including respiratory problems and being more susceptible to Sudden Infant Death Syndrome

#### Benzodiazepines

- cross placenta easily and can affect the foetus
- small increase in rates of congenital malformations when taken in early pregnancy, including cleft lip and palate, urinary tract and nervous system malformations
- When taken later in pregnancy baby may become addicted and experience withdrawal after birth
- babies may be floppy with low temperature
- sleepy and respiratory depression if mother takes benzodiazepines just before delivery

#### Amphetamines

- during pregnancy can increase risk of high blood pressure, bleeding due to separation of the placenta from the uterus, premature labour
- can cause foetal distress, reduced birth weight and head circumference

#### Ecstasy

- rise in pulse rate, blood pressure and body temperature, increased muscle tension – may cause serious side-effects in pregnancy
- associated with congenital abnormalities such as club foot

#### Heroin

- increase risk of miscarriage
- newborn may experience withdrawal symptoms

Other physical issues affecting young women who use substances during pregnancy include:

- fatigue

- accidental injury
  - sexual exploitation
  - driving under the influence
  - putting self at risk in hope of aborting the foetus (i.e. by becoming undernourished/underweight)
  - morning sickness and dehydration
  - Sleeping problems (too much or too little)
  - over-exercise
  - Drug and alcohol withdrawal effects
  - nutritional issues, including lack of folate
  - low immunisation status
  - smoking risks
  - sexually Transmitted Diseases and HIV/Aids
  - poor physical health and fitness.
- 

#### References

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## Slide 13: Foetal Alcohol Spectrum Disorder

### Foetal Alcohol Spectrum Disorder

- Australian rates are not known; international data suggests 1-1.5 cases per 1,000 live births
- FASD can cause: facial abnormalities, impaired growth and effects on the central nervous system. May involve lifelong problems such as learning difficulties, increased rates of mental illness and/or drug and alcohol problems
- Damage to foetus depends on the quantity, frequency and timing of alcohol consumption
- Women who are pregnant or planning to become pregnant should avoid drinking any alcohol

This slide outlines key information on Foetal Alcohol Spectrum Disorder (FASD), and highlights the Australian alcohol guidelines for low risk-drinking.

### Key points (Riley & McGee, 2005)

- There is no national data on rates of FASD in the Australian community. Internationally the most widely used summary prevalence estimate of FASD is 1-1.5 cases per 1,000 live births (with great variation due to ascertainment strategies) (Abel, 1995; Burd et al., 2003).
- FASD involves facial abnormalities, impaired growth and abnormal function or structure of the central nervous system. There may be lifelong problems including learning difficulties, increased rates of mental illness or drug and alcohol problems.
- A number of other alcohol-related birth defects and alcohol-related neuro-developmental disorders have been described.
- Damage to foetus depends on the quantity, frequency and timing of alcohol consumption and is influenced by maternal factors. It is therefore very important for women who are pregnant or planning to become pregnant to avoid drinking alcohol at levels sufficient to cause intoxication.
- Exposure of the foetus to alcohol in the third trimester is related to damage to the cerebellum, hippocampus and prefrontal cortex.
- Infants with FASD have a 3.5 times elevated mortality rate.

### Additional information

#### Alcohol and Pregnancy (NHMRC guidelines)

- If pregnant or considering becoming pregnant, the woman should consider not drinking at all and should never become intoxicated; if the woman chooses to drink, they should have less than 7 standard drinks over a week, and no more than 2 standard drinks on any one day.
- Most risk occurs in the earlier stages of pregnancy.

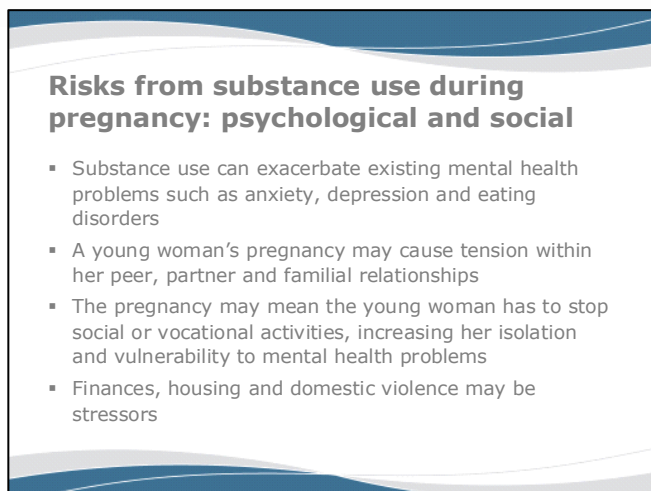
#### Australian alcohol guidelines for low-risk drinking (draft) 2007

- For women who are pregnant, or who are planning a pregnancy or are breastfeeding, not drinking is the safest option.
- Harm increases with an increased dose of alcohol. The most serious outcomes occur when pregnant women consume high levels frequently, particularly during the first trimester.
- It is suggested that low to moderate alcohol intake may result in adverse neuro-developmental (learning and memory) and behavioural (e.g. aggression) outcomes, or declines in later school performance. However, interpretation of existing literature is hampered by methodological problems, including accurate documentation of alcohol intake and controlling for confounding factors e.g. nutrition, polydrug use, maternal age.

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## Slide 14: Risks from substance use during pregnancy – psychological and social



**Risks from substance use during pregnancy: psychological and social**

- Substance use can exacerbate existing mental health problems such as anxiety, depression and eating disorders
- A young woman's pregnancy may cause tension within her peer, partner and familial relationships
- The pregnancy may mean the young woman has to stop social or vocational activities, increasing her isolation and vulnerability to mental health problems
- Finances, housing and domestic violence may be stressors

This slide describes some of the psychological and social risks associated with the use of various substances during pregnancy.

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### Key points

- Substance abuse can exacerbate existing mental health problems such as anxiety, depression and eating disorders.
- A young woman's pregnancy may cause tension within her peer, partner and familial relationships.
- The pregnancy may mean the young woman has to stop work or studies, increasing her isolation and therefore her vulnerability to mental health problems.
- Finances and housing may become an issue – these situational stressors can have a negative psychological impact. Domestic violence may complicate the situation.

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### Additional information

Other psychological impacts may include:

- decreased self-esteem
- increased worry about relationships (i.e. with the baby's father and with peers)
- concerns about body image (i.e. worries about putting on weight and changing body shape)
- anxiety about relating to the baby and being a "good mum".

In addition, the young mother may have trouble adjusting to the idea of having a baby and feel like she is no longer in control of her own life.

In terms of social impacts, the young mother may experience disagreements with, or stresses around, her and her partner's family (if applicable). Other issues to consider include:

- decreased self-esteem
- religious pressures regarding the acceptability of the pregnancy and how the young woman should proceed
- feelings of loneliness and alienation from peers and friends
- negative peer reactions to the pregnancy
- rural/remote isolation
- domestic violence
- stigma around pregnancy related to cultural issues
- possible discrimination faced as a young mum with substance use and mental health issues
- transportation problems
- the need for steady housing and adequate supplies following the birth of the baby.

## Slide 15: Issues following the birth

### Issues following the birth

General issues to consider:

- Constant fatigue, pain from giving birth, difficulties with breastfeeding and settling the baby, nutritional problems, cravings, hormonal fluctuations, unsettled baby

Substance use and mental health issues to consider:

- Drug withdrawal (mother & baby), continued addiction or relapse of the mother, failure to thrive or neglect problems (baby), impact on breastfeeding
- Co-existing mental health issues

This slide describes some of the physical issues that young mothers may face following the birth, and issues to consider when there are substance use and mental health problems. It is important to remember that pregnancy and having a child can be an opportunity for the individual to make progress and manage the drug and mental health issues.

### Key points

General issues to consider:

- Constant fatigue
- pain from giving birth (episiotomy, caesarean, etc)
- difficulties with breastfeeding and settling the baby
- nutritional problems
- cravings
- hormonal fluctuations
- unsettled baby (i.e. colic, reflux)

Substance use issues to consider:

- Withdrawal (mother and baby)
- continued addiction or relapse of the mother
- failure to thrive or neglect problems (baby)
- impact on breastfeeding (see additional information below)

Mental health issues to consider:

- Co-existing mental health issues e.g. worsening of anxiety or depression
- opportunity to consolidate treatment and improve well-being.

Note: the next slide also covers mental health and other issues.

### Additional information

Breastfeeding:

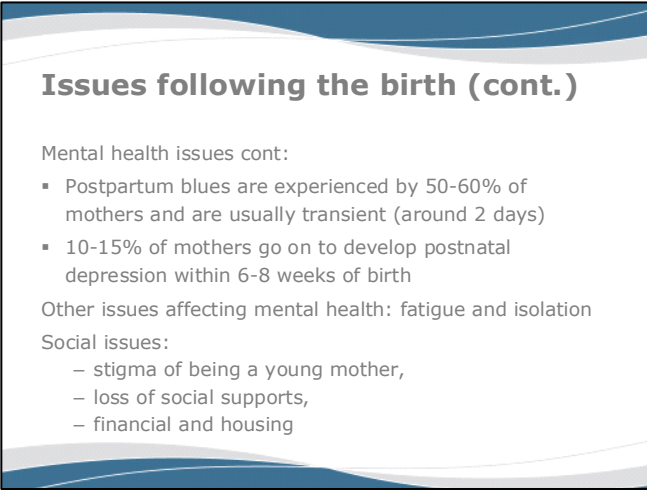
- Substances used by a breastfeeding mother may cross into their milk supply, adversely affecting their baby.
- Depending on the substance, this may result in sedation or intoxication of the infant.
- Mothers who are drug dependent should be encouraged, with appropriate support and precautions, to breastfeed.
- Mothers should also be advised not to feed when intoxicated or when high levels of drug are likely to pass to child (dependent upon the drug's half-life).

- It is now recognised that skin-to-skin contact is important, regardless of feeding choice, and needs to be actively encouraged for the mother who is fully conscious and aware and able to respond to her baby's needs.
- Breastfeeding mothers are advised not to exceed the recommended drinking levels during pregnancy.

Contraindications to breastfeeding

- HIV or Hepatitis C positive
  - high dose benzodiazepine use
  - poor nutritional status/systemic illness.
-

## Slide 16: Issues following the birth (cont.)



**Issues following the birth (cont.)**

Mental health issues cont:

- Postpartum blues are experienced by 50-60% of mothers and are usually transient (around 2 days)
- 10-15% of mothers go on to develop postnatal depression within 6-8 weeks of birth

Other issues affecting mental health: fatigue and isolation

Social issues:

- stigma of being a young mother,
- loss of social supports,
- financial and housing

This slide describes some possible psychological and social issues faced by young mothers in the postnatal period.

### Key points

#### Mental health issues

- Post partum blues (PPB) are experienced by 50-60% of mothers and are usually transient (lasting around two days) and commencing 3 to 5 days after birth (Winstock, 2007).
- 10-15% of mothers go on to develop post-natal depression within 6-8 weeks of birth (Winstock, 2007).
- Other issues that may affect a young mother's mental health in the postnatal period include physical and mental fatigue, sleep deprivation, increased isolation and worries about not living up to previous standards (i.e. with housekeeping or socialising).
- Pregnancy and birth can be an opportunity to manage the drug and mental health issues more effectively.

#### Social issues include:

- stigma of being a mother at a young age
- stigma having drug use and mental health issues
- reduced contact with support services
- reduced interactions with social support networks
- fear of child being removed from care
- financial strains
- housing problems.

### Additional information

Also consider self-esteem issues, negative body image, adjustment to the 'mother' role, feelings of anxiety, reduced ability to problem-solve due to mental health issues and/or drug and alcohol use, setting unattainable standards for self, lack of motivation, loss of freedom and feeling trapped, loss of identity, pressure to be a 'perfect mother', worries about the baby, feelings of futility, guilt and frustration and mood swings.

#### Consider the impact of:

- domestic violence
- potential lack of partner, having children to different fathers, or having a blended family
- moving location or changing housing arrangements
- transience

- messages or pressure from family members or friends on mothering skills
- lack of adult conversation and interaction
- social isolation
- not being able to relate to people who don't have children
  
- feelings of inadequacy i.e. "I'm just a mum" and not living up to own comparisons with other mums.

Parental drug and alcohol misuse can contribute to the potential for parental physical and sexual abuse as well as neglect of children (Australian Research Alliance for Children & Youth, 2006).

Drug withdrawal symptoms may cause symptoms of depression and anxiety.

Post partum blues (PPB) and post natal depression (PND):

- PPB symptoms can include crying, irritability, labile mood and feeling depressed.
- Severe PPB is associated with an increased risk of post-natal depression.
- Post-natal Depression is often missed, stigmatised and dismissed early on as the 'baby blues'.
- PND risk factors include (Winstock, 2007):
  - Past psychiatric history
  - Life events
  - Younger age
  - Marital problems
  - Poor support
  - Unplanned pregnancy
  - Not breastfeeding
  - Unemployment
  - Early discharge (<72 hours)
  - Past history sexual abuse in 50% of sufferers
  - Deep sadness
  - Tearfulness
  - Negative self-assessment as a mother
  - Marked anxiety about the baby's health and status as 'normal'
  - Other depressive features.
- Also be aware of young women with bipolar disorder, who are at high risk of experiencing post-partum psychosis. Onset is usually a few months or days post delivery (Yonkers, 2004).

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#### References

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## Slide 17: Attachment

### Attachment

- A term used to describe the relationship between a child and its primary caregiver from infancy to 4 yrs old
- Plays a key role in the infant's exploration of their environment and their concept of self
- Two main positive factors that influence the development of attachment are accessibility and responsiveness
- The accessibility and responsiveness of the parental figure may be negatively affected by mental health and substance use issues

This slide describes the concept of attachment, and how this may be adversely affected by a young mother's mental health and substance use problems.

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### Key points

- Attachment is a term used to describe the relationship between a child (from infancy to four years of age) and its primary caregiver. It is the secure base from which an individual explores and learns about their environment. It is the central feature of a young child's social and emotional development.
  - Attachment plays a key role in the infant's exploration of their environment, their concept of self and their perception of relatedness with other human beings. Normal attachment is the deep psychological bond that develops between infant and primary caregiver, traditionally the mother, beginning in the first year of life, and developing over the child's first four years of life.
  - Two main factors that influence the development of secure attachment are **accessibility** (i.e. the parent is present and available, both physically and emotionally, to the infant and child) and **responsiveness** (i.e. the parent is able to sensitively and accurately address the child's needs). Both of these factors may be negatively affected by the mental health and substance use issues of their primary caregiver.
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### Additional information

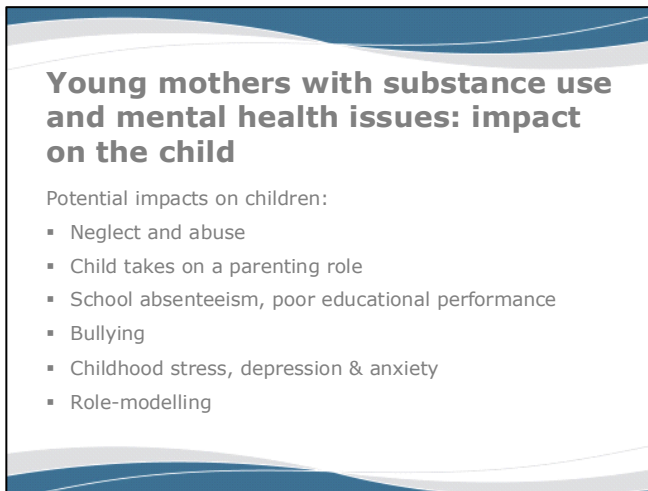
Assessment: consider using the Edinburgh Postnatal Depression Scale and Antenatal Risk Questionnaire, and refer to an appropriate perinatal agency for further assessment.

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### References

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## Slide 18: Young mothers with substance use and mental health issues – impacts on the child

A rectangular box with a blue and white wavy border at the top and bottom. Inside, the text is as follows:

**Young mothers with substance use and mental health issues: impact on the child**

Potential impacts on children:

- Neglect and abuse
- Child takes on a parenting role
- School absenteeism, poor educational performance
- Bullying
- Childhood stress, depression & anxiety
- Role-modelling

This slide highlights the impact on older children of having a young mother with mental health and substance use issues.

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### Key points

Consider potential impacts on children:

- Neglect, poor nutrition and abuse - children of parents with drug abuse issues are more likely to suffer from neglect and various forms of abuse
- Child takes on a responsible parenting role
- School absenteeism, Poor educational performance
- Bullying – being bullied or bullying
- Childhood stress, withdrawal, depression and anxiety
- Child potentially models future drug use on parents drug use patterns - parental patterns of drug use have a role in influencing children's drug use as young adults due to modelling. However, research on substance abusing parents is limited, and there is some evidence that parents who use drugs provide adequate care for their children and put in place strategies to protect their children (Loxley, 2004).

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### References

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## Slide 19: Young mothers with substance use and mental health issues – assessment and treatment approaches

**Young mothers with substance use and mental health issues: assessment and treatment approaches**

- Establish relationship, take a non-judgmental approach
- Assessment
- Provide information
- Establish preferences for antenatal care: hospital-based, shared care options

This slide describes key points related to approaches to assessment and treatment for young mothers with drug and mental health issues. The age of the young mother (12-17 yrs vs. 18-25 yrs) will need to be taken into account, in terms of the young woman's knowledge and resilience, and also the most appropriate communication style of the professional.

### Key points

The key points are as follows. They are explained in greater detail below.

- Establish relationship and rapport, take a non-judgmental approach
- Assessment: full history including genogram, social situation, personal and family history, cultural background, past medical and psychiatric history, drug and alcohol history and medications, obstetric history, mental state examination, risk assessment; physical examination, confirmation of pregnancy, blood tests
- Provide information: pregnancy counselling, treatment options, support services, potential risks, harm minimisation.
- Establish preferences for antenatal care: hospital-based, shared care options.

### Additional information

#### Establish relationship and rapport

- Maintain a non-confrontational supportive manner and non-judgmental approach.
- Fear and denial can lead to difficulty disclosing substance use (Taylor & Kroll, 2004).
- Use open questions and reflective listening, be mindful of language and not using jargon.
- Determine what the young woman sees as the main issues and focus on these initially. Once the rapport is established, other issues can then be addressed.
- Take into account the age of the young woman and related confidentiality and consent issues.
- Ensure confidentiality (unless risk of harm to self or others) from the outset.
- Have a positive, solution-focussed approach.
- Involve a partner or support person if appropriate.

#### Assessment

This may include:

- presenting issues
- confirm pregnancy
- social history: education, support, job, finances, housing

- cultural background
- genogram
- general health
- past medical history
- past gynaecological and obstetric history
- dental history (including physical examination)
- current medications and contraception use
- drug and alcohol use/history
- psychiatric history
- family history of mental illness
- forensic history (police/court matters)
- mental state examination
- risk assessment for the mother and infant
- psychological assessment tools as appropriate.

#### Examination & investigations

Antenatal blood screens, including hepatitis B, C, HIV.

#### Establish preferences for antenatal care

- Hospital-based programs.
- Hospital - General Practitioner (GP) shared care options.
- Hospital - youth health service antenatal programs.
- Involvement of Drug and Alcohol Services during antenatal period.

#### Other issues during the antenatal period

Another important issue relates to addressing the risks/benefits of medication for mental health problems of the pregnant woman or young mother (see slide 23, "Use of medication for mental health problems during pregnancy and breastfeeding"). A series of articles were recently published in the Australian Prescriber journal (2007) on treating depression and psychosis during pregnancy and in the post-natal period. For more information see the Australian Prescriber website:

<http://www.australianprescriber.com>.

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## Slide 20: Assessment and treatment approaches (cont.)

### Assessment and treatment approaches (cont.)

Treatment may be best managed with a team care approach. Potential team members include:

- The young mother and partner/support person/carer
- GP, Mental Health Nurse, Occupational Therapist, Psychiatrist, Psychologist, Social Worker, ATSI Health Worker, Youth Worker, School Counsellor, Drug & Alcohol Specialist, Young women's associations, Personal Helpers and Mentors
- Other services may also become involved in care

Treatment may be best managed with a team care approach. This slide describes potential team members and services. Again, note that some services will be more appropriate than others depending on the young woman's age, and there may be specific services available eg. for teenage mothers.

### Key points

Team-based care provides a comprehensive multidisciplinary approach, which benefits both the young mother and the team members involved.

Potential team members include:

- the young mother and partner/support person
- GPs; GPs in youth health services
- Mental health nurses
- Occupational Therapists
- Psychiatrists
- Clinical psychologists/psychologists
- Social workers
- Aboriginal and Torres Strait Islander health workers
- Drug & alcohol specialists/counsellors
- Youth workers, school counsellors, teachers
- Personal helpers and mentors.

Other services may become involved in care:

- youth services
- housing services
- domestic violence services and shelters
- public and private mental health services, including specialist perinatal units
- community based psychiatry services
- drug and alcohol services
- family and community agencies.

### Additional information

Currently there is no clear evidence for any one particular treatment for individuals with co-morbid mental health and substance use problems. Co-morbidity is unfortunately noted to have a poorer treatment outcome. However, given the influence of drug and mental health issues on each other, it

is likely that a combined treatment approach would be more effective (The Cochrane Collaboration, 2000; Loxley, 2004).

Substance abuse often co-exists with a range of health, mental health and criminal issues which involves child protection services. Obstacles to collaboration between the human services sectors may be 'silos' of care i.e. different agencies operating with their own missions and without good communication with other agencies. Training and improved pathways to care are necessary to enhance the responsiveness of services to both the needs of the child and the parents experiencing substance use problems (ARACY, 2006).

According to the National Mental Health Plan a multidisciplinary team is an "identifiable group of mental health personnel comprising a mix of professionals responsible for the treatment and care of people with a mental illness" (Australian Government, 2003).

Drug and alcohol counsellors:

- can come from a variety of professional backgrounds, including nursing, psychology and social work
- respond to clinical presentations arising from use of and dependence on alcohol, tobacco and other drugs
- deliver treatment services, including referrals to medical or psychiatric services, assessment for substance use and screening for mental health problems, treatment planning, case management and care coordination, drug withdrawal services, opioid maintenance, brief and early interventions, relapse prevention and referral to appropriate services.

*Personal Helpers and Mentors (PHaM) program* has been funded at \$284.8 million over five years for approximately 900 full-time equivalent Personal Helpers and Mentors from May 2007. The role of the Personal Helper and Mentor can be broadly described under three main types of activities:

1. Direct involvement: including needs assessments, developing Individual Recovery Plans and linking with clinical case management, advocacy, peer support, personal development, supporting family relationships, mediation and supporting people to manage their daily activities.
2. Referrals to relevant services: including to housing support, employment and education assistance, drug and alcohol rehabilitation, independent living skills programs, clinical services and allied and other mental health services as required.
3. Monitoring and reporting (non face to face): including monitoring participant referrals, monitoring progress against Individual Recovery Plans and reporting.

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## Slide 21: Strategies to address physical, psychological and social risks

**Strategies to address physical, psychological and social risks**

- Appropriate assessment and care planning is important
- Consider treatment options for substance use and mental health problems
- Consider early referral for maximum assistance
- Support the young mother to access appointments with the baby
- Assertive and pro-active follow-up is paramount
- Ongoing risk assessment of the wellbeing of the mother and child/children should be undertaken

This slide describes some possible ways of addressing the physical, psychological and social risks to young mothers with drug use and mental health issues described in earlier slides. It is important to emphasise both the importance of adequate care planning at the outset of treatment, and of being proactive in following up this population group which can be transient and inconsistent in attending appointments.

### Key points

- Appropriate assessment and care planning is vital (refer to earlier slides)
- Consider treatment options for co-morbid substance use and mental health problems (eg. quit smoking or methadone programs, outreach mental health services)
- Consider early referral for maximum assistance – use a team approach, and refer for assistance with areas outside own expertise
- Support the young mother to access appointments with the baby, such as help with transport or childcare or in-home visits
- Assertive and pro-active follow-up is paramount: active follow-up by the referring provider to ensure that the woman has engaged with the service (see additional information on assertive follow-up)
- It is vital to carry out ongoing risk assessment of the wellbeing of the mother, child/children should be undertaken.

### Additional information

- The care providers should be aware that families with drug and alcohol use issues may be difficult to engage in care.
- Consider transport assistance: link to buddy systems, non-government organisations.
- Monitoring of drug and alcohol use is vital – the GP plays an important role here.
- Be aware of drug treatment, including methadone programs, which may be appropriate for young mothers.
- Assess risks to the mother and baby, and refer on early for maximum assistance
- Medication issues - refer to slide 23 'Use of medication for mental health problems during pregnancy and breastfeeding' in this presentation.

Assertive followup (NHRMC, 2007):

- Mothers with a history of problematic drug or alcohol use may require support to access appointments with the baby (e.g. help with transport or childcare). One reality often overlooked by funding bodies is that many women who need treatment have childrearing

responsibilities. Lack of services for mothers and children together, and the lack of child care and children's treatment, are major barriers to treatment for substance abusing mothers.

- The referring provider should actively follow up with community services to ensure that the woman has engaged with the service.
- Where engagement has not occurred, the provider should actively follow up with the woman/family.
- The receiving community provider should be aware that families with drug and alcohol use issues may be difficult to engage in care.
- At all points of contact, ongoing risk assessment of the wellbeing of the child/children should be undertaken. This should be done sensitively. Many mothers do not enter treatment for fear that they will lose custody of their children. Some service providers believe that women can not concentrate on their recovery with children present, and overlook that true recovery for a mother usually works only when it includes her children.
- In-home visiting may be used with families who do not engage well with community services.
- Early intervention of children with FAS to promote all aspects of child development.

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## Slide 22: Strategies to address physical, psychological and social risks (cont.)

### Strategies to address physical, psychological and social risks (cont.)

- Educate the young mother on risk-reduction strategies/identify protective factors in the young mother's life
- Increase access to social and healthcare support networks
- Provide practical information
- Consider options for assistance in domestic violence
- Consider specific therapeutic approaches

### Key points

- Educate the young mother on risk-reduction strategies/identify protective factors in the young mother's life.
- Increase access to social and healthcare support networks - be aware of and utilise community services such as services for young mothers which provide accommodation and education.
- Provide practical information e.g. the young mother will often need practical help with finances, child health issues, etc.
- Look at options for assistance in domestic violence situations e.g. safety plan, working with the partner, relevant help lines, local services.
- Consider specific therapeutic approaches e.g. psycho-education, problem-solving skills (see additional information below).

### Additional information

#### Specific therapeutic approaches

- psycho-education
- motivational interviewing techniques
- teaching problem-solving skills and physical care management
- enhance protective factors in the individual eg social connectedness (young mothers groups, nursing mothers groups)
- cognitive-behavioural therapy approaches
- narrative approaches – focussing on strengths of the client
- social skills training and increasing social networks
- coordinated case management: therapeutic interventions/support for the child may involve child protection, liaison with pre-school/school.

## Slide 23: Use of medication by the young mother during pregnancy and breastfeeding

### Use of medication by the young mother during pregnancy and breastfeeding

- Potential mental health diagnoses include mood disorders, anxiety disorders, psychosis, personality disorders
- The decision to prescribe medication during pregnancy will depend on risks vs. benefits for the pregnant woman and foetus
- Medications may be transferred to the infant in breast milk – again, the risks and benefits of medication must be weighed up carefully
- Medications for opioid dependence in pregnancy are available

### Key points

- Mental health diagnoses may include mood disorders, anxiety disorders, psychosis, personality disorders
- The decision to prescribe medication will depend on examining the risks vs. benefits for the pregnant woman and foetus/infant eg. the potential effects of such medications on the developing foetus vs. the impact of the mental health problem on the mother's wellbeing
- Medications may be transferred to the infant in breast milk – again the risks and benefits are weighed up carefully
- Medications for opioid dependence include methadone and buprenorphine. Methadone is effective and there is less evidence for buprenorphine. Detoxification and withdrawal from opioids without medication has been shown to be ineffective and relapse is common. In terms of pregnancy and breastfeeding, methadone is related to neonatal withdrawal syndrome, low birth weight and increased stillbirth rates. It can also cause respiratory depression in the newborn infant. Methadone is safe in breastfeeding. There is limited data regarding the use of buprenorphine in pregnancy and breastfeeding. These drugs should be used in consultation with drug and alcohol specialists (Therapeutic Guidelines Limited, 2003).

### Additional information

A series of articles on treating depression and psychosis during pregnancy and in the post-natal period were recently published (2007) in the journal Australian Prescriber. For more information see the Australian Prescriber website: <http://www.australianprescriber.com>.

#### Antidepressant Medication

The risks of the depression and its consequences must be weighed against the risks of the medications to both mother and infant during the different phases of pregnancy and lactation. Careful history taking, close monitoring and good psychosocial care may be sufficient for many women with depression during pregnancy. When antidepressants are needed, the baby should be monitored postnatally for feeding, neurological and respiratory difficulties. Prescription of SSRIs postnatally appears less hazardous than in antenatal use, and potentially of benefit to mother and child. (Sved Williams, 2007, p.127)

#### Antipsychotic Medication

The potentially harmful effects of taking an antipsychotic drug in pregnancy have to be balanced against the harm of untreated psychotic illness. Data are limited, particularly for the atypical antipsychotic drugs, but there are no clear associations with specific congenital abnormalities. The benefits of breastfeeding are likely to outweigh the potential harm of medication. Women who wish to breastfeed should be managed with a single antipsychotic drug if possible. All antipsychotic drugs

are sedating and have relatively long half-lives so babies should be observed for lethargy, sedation and appropriate development milestones, particularly if multiple antipsychotic drugs are used (Kennedy, 2007, p.162)

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## Slide 24: Story vignettes and case discussion – part A

**Story vignette A - Deanne**

**Discussion points**

1. What are the important issues for Deanne and her unborn baby?
2. If Deanne was telling you this story, how would you engage with her?
3. What are the risks and what assessments might you use?
4. How would you prioritise the risks to Deanne and her unborn baby?
5. What interventions would be useful at this consultation?
6. What support could local health services offer at this point, and how would you access them?

*"I've just found out I'm pregnant, I can't believe it. I'm only 20 years old, this wasn't supposed to happen til I was older. I thought I was safe cause we used a condom. My boyfriend Dave is pissed and thinks I should get rid of it. He gets so intense, I feel scared to say no to him, but I'm really not sure what to do.*

*He says the baby will be deformed anyway because of all the drugs we've been doing. I'm really paranoid about what the drugs have done to it. I hope it's ok. We've been into everything lately: E, speed, dope, plus the usual fags and grog.*

*Then Dave says that even if it's not deformed, I'll be no good as a mum... He says I'm depressed all the time anyway. I suppose he's right about me not being able to look after a baby – I haven't got a job, a house, any money, and I can't even see my own family anymore because of what dad did to me when I was a kid. I don't know what I'll do if Dave leaves too.*

*I think I want to keep the baby."*

---

### Points for discussion

1. What are the important issues here for Deanne and her unborn baby?
  2. If Deanne was telling you this story, how would you engage with her?
  3. What are the risks and what assessments might you use?
  4. How would you prioritise the risks to Deanne and her unborn baby?
  5. What interventions would be useful at this consultation?
  6. What other therapeutic strategies might be helpful?
  7. What support could local health services offer at this point, and how would you access them?
- 

### Story vignette - feedback session:

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic.

### Facilitator's notes

- Discuss Deanne's story - what other history would you want to obtain from her?
- Does Deanne want her partner involved?
- Discuss the options that are open to Deanne for management of her pregnancy, including termination, shared care during pregnancy and other options open to Deanne and her partner.
- Ask participants how they would engage with both Deanne and her partner to allay fears and provide appropriate information and support.
- Ask participants to consider key points at which problems could have been identified and potentially prevented or short circuited.
- Discuss the possible effects of the mix of drugs that Deanne is taking (to her and her baby) and the physical and psychosocial risks that may result.
- What role can a GP play in Deanne's health care?
- Ask participants to investigate how a GP would review and assess Deanne's health and wellbeing at the present time and how the GP would gain the support of other services in the area in developing a care plan for Deanne.
- How might Deanne be helped to access a GP? And would the GP be the primary health care provider?
- What local services are available that can support a young woman like Deanne (and her partner) through the antenatal period and early years of her child's life?

### Note:

Participants may have strongly conflicting views about Deanne's options for care during pregnancy and termination may be a contentious option for some participants. Focus on Deanne's best interests and wishes and on the provision of accurate and open advice.

Be mindful of potential conflict. Participants may focus on service deficiencies, vent their frustrations or recount negative experiences. Contain the discussion by:

- acknowledging the difficulty/frustration
- identifying the problem or issue
- problem solving as a group (if time permits).
- If time doesn't permit, offer an alternative e.g. agree to meet about later or pass the issue on to relevant people.

Above all, maintain a sense of humour and encourage participants to do so as well!

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## Slide 25: Story vignettes and case discussion – part B

### Story vignette B - Ellie

**Discussion points**

1. What are the important issues for Ellie and her baby?
2. What additional information would you seek from Ellie?
3. What is the problem that carries the most risk?
4. What interventions are possible, and who might coordinate these?
5. How could you ensure effective follow-up?
6. Would you involve Ellie's family? If so, what factors would you need to consider and how would you do this?
7. How could Ellie be effectively managed using the services and resources in your local area?

*"I thought having a baby would make me feel better: someone to love me no matter what. It hasn't turned out the way I wanted. I'm only 15 and I feel terrible all the time.*

*I reckon I've been depressed and panicking since I was 12 years old. I went to the school counsellor but he just said I need to do more homework and then I wouldn't panic as much. Hell! If I could've done any more homework I wouldn't have been panicking in the first place.*

*Luckily I told a friend what was happening to me and she helped me a lot. She gave me some dope and I found it really relaxed me like nothing else could. I've been using it to block out the bad feelings for four years now. Well, that and binge drinking, but the drinking only started when I was 14 years old. That's kind of how I got pregnant with Brittany. Too many drinks I suppose with a guy from my class at school.*

*I tried not to drink so much when I was pregnant, but I couldn't give up the dope. I knew it was bad, but I just got so anxious. Somehow I made it through the pregnancy.*

*Brittany's 10 weeks old now and even though she's cute and everything I don't see how I can finish school and still look after her. A lot of my friends have really backed off, I don't reckon they can really understand what it's like for me at the moment – they just don't get it. All they think about is what party is happening this weekend, what they're going to wear tomorrow and stuff. Mum and dad are good, but they both have to work just to make ends meet. Sometimes I just feel like I can't do it anymore and that everything's hopeless. I don't know where to turn anymore. I don't know how this is all gonna work out"*

---

### Points for discussion

1. What are the important issues for Ellie and her baby?
2. What additional information would you seek from Ellie?
3. What is the problem that carries the most risk?
4. What interventions are possible, and who might coordinate these?
5. How can you ensure effective follow-up?
6. Would you involve Ellie's family? If so, what factors would you need to consider and how would you do this?
7. How could Ellie be effectively managed using the services and resources in your local area?

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### Story vignette - feedback session:

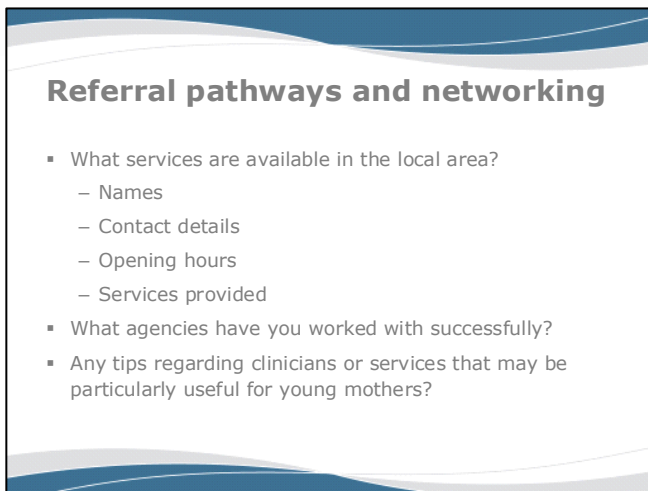
- The points for discussion are to trigger group discussion

- Use the whiteboard to write up main ideas
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic

**Facilitator's notes**

- Encourage participants to discuss Ellie's situation.
  - What does she mean by 'Mum and Dad are good'? Could the family be involved more in Ellie's health care and wellbeing?
  - Consider the burden of care that Ellie is carrying and the isolation from her peers.
  - Does Ellie get 'time out' to do things with her friends? How could this be encouraged and supported?
  - Encourage participants to identify ways to assess Ellie's current mental health and substance use status.
  - Consider strategies that have worked for her in the past to manage her mental health and substance use?
  - Discuss the important aspects of Brittany's early development.
  - What's available locally to support Ellie in her parenting skills?
-

## Slide 26: Referral pathways and networking



**Referral pathways and networking**

- What services are available in the local area?
  - Names
  - Contact details
  - Opening hours
  - Services provided
- What agencies have you worked with successfully?
- Any tips regarding clinicians or services that may be particularly useful for young mothers?

### **Service mapping exercise:**

Participants are provided with a service mapping template which they should complete and bring with them to the training session. If they have not, ask them to spend a few minutes completing the template.

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### **Key points**

- Participants share information about their services based on the areas outlined in the slide.
  - Map key services on the white board or ask the coordinator to scribe information.
  - Be as precise as possible and include contact phone numbers and key information.
  - Where possible, include other agencies and services such as non Government Organisations and community or Council programs.
  - Ask participants for consent to circulate the information provided to all participants.
  - Following the workshop, ensure the coordinator circulates a copy of this information to all participants.
- 

### **Additional information**

- Revisit the two stories discussed and 'map' the services identified so that participants are aware of the service location, referral procedures, opening hours, contact numbers, and other relevant information.
  - Appoint someone to note the details of local service providers on the whiteboard. If possible, ensure all attendees receive a copy.
-

## Slide 27: In summary

**In summary**

- Meeting the needs of the patient and their families and carers
- Including families and carers
- Utilising other services
- Creating partnerships
- Identifying roles and responsibilities
- Maintaining defined boundaries
- Encouraging professional collaboration
- Establishing workable procedures for realistic and sensible referral

***What will you do differently now?***  
*(Please take a minute to complete your evaluations)*

An opportunity is now provided for the audience to address any questions to the facilitators and conclude the discussion of this topic.

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### Key points

- This unit aimed to:
    - increase participant awareness of the mental health and substance use issues relevant to young mothers
    - increase participant understanding of why young mothers may use substances
    - identify the physical, psychological and social risks to mother and child associated with substance use (both during and after pregnancy)
    - improve participant knowledge of strategies to address these risks, and resources available to assist.
  - Ask each participant to say one or two words on what they thought about the unit
  - Ask the question: *What will you do differently?* (as a result of knowledge and information received at the training sessions).
  - Ask participants to complete the post test evaluation.
  - Hand out information packs.
-