UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF SOCIAL WORK AND SOCIAL POLICY

ILLICIT DRUG AND ALCOHOL USE DURING PREGNANCY AS A CHILD PROTECTION ISSUE

Multi-disciplinary views

A thesis submitted in partial fulfillment of the M. Sc.
in Child Protection and Welfare

Author: Liam Curran

DECLARATION

I hereby declare that:

1. This thesis has not been submitted as an exercise for a degree at any other university.

2. This is entirely my own work.

3. The Library of Trinity College, Dublin may lend or copy this thesis, upon request.

Signed _____

Liam Curran

ABSTRACT

This thesis examines the views and explores the experiences of fourteen professionals who deliver services to pregnant women, some of whom use alcohol and illicit drugs during pregnancy. This is an area that appears to receive little attention within child welfare and protection policy, and remains somewhat of a contested area of practice. Ireland is unique within international jurisdictions due to the Constitutional protection it affords the unborn under Article 40.3.3 of the Constitution (Bunreacht na hEireann 1937). However, the foetus may suffer harm as a result of drug and alcohol habits during pregnancy. The study sought professional views from three key areas of service delivery to these women, and posed the question; **"Is parental consumption of drugs and alcohol in pregnancy a child protection concern for them as professionals?"**

The study reviews the relevant literature, looking at international developments in the in the field of drug and alcohol use/misuse during pregnancy. The study examines the issues of illicit drugs, seeking to demonstrate recent developments, as it concentrates on the issues of alcohol consumption in pregnancy. It looks at the issues of legislation, policy and procedure. It examines the practice of multi-disciplinary inter-professional work in this emerging area of social care practice.

The study was undertaken by adopting qualitative techniques of semi-structured interviews with the professionals concerned. The analysis of data was structured around five key themes which are reviewed and analyzed within this study.

The research findings and discussion help to shed light on this contested area of practice. The findings demonstrate that there is a significant level of concern among professionals engaged in the services studied. Concerns were expressed about the lack of clarity and procedure, the ad hoc service structures and the lack of clarity on the rights of the unborn.

The study closes with seven key recommendations for future consideration and deliberation.

ACKNOWLEDGEMENTS

I wish first to thank all the respondents of this research study who gave me their time and commitment, without which this study could not have taken place. They participated in the study against a backdrop of work pressures and time demands, a constant feature for those providing public services.

I wish to extend a sincere thank you to my university tutor Marguerite Woods who gave her time so freely. Her empowering tutorials, guidance and wealth of knowledge are truly significant factors in my submission of this completed thesis.

Much appreciation is due to Dr. Ruth Emond for her invaluable guidance on the art of research. Terrie Heelan in the post-graduate office deserves a special mention. She never failed in solving my little university worries throughout the past two years.

I wish to thank most sincerely my classmates, especially those who have shared this journey from the start of post-graduate studies in 2005 to the present day. I am deeply grateful for the support and friendship offered, for the motivational coffees in the coffee dock when giving up seemed so real.

I want to acknowledge my sister Margaret Fennelly for her words of encouragement when giving up seemed the right thing to do. Appreciation is given to Mary Nicholson for her informal tutoring in Starbucks, when direction was missing and confusion reigned - she helped me refocus more than once!

Special thanks are extended to all my HSE colleagues on the 3rd Floor, Park House. I would like to give particular mention to Mary Troy, Mary Russell and Angela King (Health Promotion) and Noelene Dowling (Registration & Inspection), for their kindness and support over the past year. Finally, Mary Meyler for her kindness and assistance with final proofing of the work.

Table of Contents

Chapter 1- Introduction

Introduction

The practice of offering protection to the unborn in legal, medical and social work practice, is one that has gained considerable attention over the past two decades in many jurisdictions outside the Irish state. The United Kingdom (UK) child welfare and protection system has offered guidance to multi-disciplinary social care professionals since 1989 through the *Working Together* publication. This states:

> *"The legal status of a child before it is born is significantly different to its status post birth. However, if there is reasonable cause to suspect that a child is at risk of harm before it is born, during its birth, or after its birth, it is appropriate to take action to identify and address the risks" (Department of Health, 1989).*

Research in the UK has shown that this area of child protection of the unborn is fraught with complexity, and is handled differently in different areas of UK child protection services (Barker, 1997). As Irish literature on the topic begins to emerge in the medical field, (Barry et al 2007; Fagan & Keenan 2006) and in legal discourse (Charleton et al 1999, Schweppe 2005; 2006), it suggests the need to consider the welfare and protection of the unborn where drugs and alcohol are consumed during pregnancy. Alcohol and substance use are being increasingly identified as core public health issues (Rawaf, 1998, Health Research Board 2000, Butler 2002b, Butler & Mayock 2005) and in pregnancy (King, 1991; Becker & Duffy 2002; Buchanan & Corby; Schweppe 2006).

Irish medical studies (Coghlan et al, 1999; Clarke and Fitzpatrick, 2005; Fagan & Keenan 2006; Barry et al 2007; Mc Millian et al 2007) all concur that early intervention is essential to achieving the safe passage of the unborn to a healthy post-birth outcome. These studies call for a co-coordinated and focused multi-disciplinary response to the issues of drug and alcohol use during pregnancy, suggesting that multi-agency and multi-disciplinary interventions are imperative in the pre-birth stage in order to address issues of risk and potential harm and to promote the welfare of the unborn.

The Irish child welfare service is one which has developed rapidly in recent years. Various signposts demonstrate this period of growth from the implementation of the Child Care Act 1991[1] to the publication of the House of the Oireachtas[2] Report (2006) on child protection. The publication of *Children First* (1999), although not a statutory instrument, has played a significant role in this culture of change. However, none of these documents, either statutory instruments or policy publications, make any reference to the life, welfare or needs of the unborn. In contrast, recent statistics from the UK child protection system suggest that the issues of child protection for the unborn are real and apparent. Of 25,900 child protection registrations in the year ending 31st March 2005, 310 of these registrations were unborn children (Department of Education and Skills (2006). Similarly, other international jurisdictions, such as Canada, the USA and Australia are all proactively addressing the subject of protection and welfare of the unborn.

Such comparable data of state interventions for the welfare of the unborn are unavailable in an Irish context. Recently published data for the Department of Health (2005) record the number of notifications - (these deem a child to have suffered harm) in Ireland at the end of December 2003 at 5,995. These published figures do not collate or refer to the status of the unborn. This raises certain questions. Are we remaining silent on what some suggest is a relevant part of the child welfare policy? If the answer is in the affirmative, are we failing to understand wider social and medical issues of concern within our society? Could we do better at promoting the welfare of the unborn? A number of medical based studies over recent times have all suggested that closer working relationships between professionals in key services areas are imperative to effective treatment of drug and alcohol using pregnant women.

A study of Neonatal Abstinence Syndrome (NAS) at the *Rotunda Hospital* in1999 found that preventative measures should include “Collaborative community health, obstetric and paediatric approach should heighten

[1] Department Of Health and Children (1991) Child Care Act, Dublin, Stationery Office
[2] House of The Oireachtas,(2006) Joint Committee on Child Protection, Dublin, Stationery Office

awareness of attendant risks and reduce severity of N.A.S" (Coghlan et al 1999 : 232-236)

Child psychiatrists at the Mater Hospital, Dublin, suggest that the issue of multi-disciplinary work concerning the use of opiates in 'utero' is crucial to the post birth welfare of the child in 'utero'. Clarke & Fitzpatrick's (2005:123) findings assert that there is a need for better liaison between obstetrics, neonatal, addiction, social work, and child psychiatric services, to ensure early diagnosis and continuity of care'. A further study (Barry et al in 2007:18) found that the issue of alcohol harm in pregnancy requires 'collaboration of paediatricians, child psychiatrists and other health professionals'. Mc Millian et al (2007) writing in the *Irish Medical Journal,* commented on data which showed that 58% of a study group who used alcohol in pregnancy "did not and would not alter their consumption behaviour even after being informed of the risk by health professionals". The authors concluded that education and prevention services need to be delivered by all health care workers in order to address the social acceptance of such behaviours within Irish culture.

Equally, many commentators and research studies suggest that the real harm and concern for the unborn lies in economic and social disadvantage. The Institute of Public Health in Ireland (IPHI) suggest that "an exploration of the relationships between socio-economic status and congenital anomaly in Ireland would serve to improve our understanding of the social gradients observed in relation to mortality and low birth weight" (IPHI, 2006:4). A study by O' Connor, Stafford-Johnson & Kelly (1998) of forty-five opiate addicted mothers between 1984 and 1986 attending treatment, found significant evidence concerning the psychosocial backgrounds of the women. All were unemployed; all smoked and had left school at an average age of 14 years. There were high levels of family alcoholism, with over half of the group having fathers classed as alcoholics, and one third of the mothers suffering from depression (Farrell, 1999). This suggests that the psychosocial needs of pregnant drug and alcohol users are significant factors in assessing issues of concern or harm to the unborn.

The challenge of foetal rights and the rights of pregnant women is complex and difficult for all who operate within the field of medical, legal or social policy interventions. It is a contested area that needs much thought and sensitive understanding.

The needs of pregnant drug and alcohol users are complex and challenging for all who engage within this practice area. The consideration of social and sometimes multiple complex needs are significantly interwoven within the context of drug and alcohol using pregnant women (Enkin et al 2000). The impact of such factors on a woman's ability to maintain a healthy outlook for both herself and her unborn cannot be ignored in any examination of the issues. Their combined psychosocial needs throughout pregnancy, present many professionals with a challenge to manage what can be deemed 'complex needs'. Rankin and Regan (2004:1) define such complex needs as "a framework for understanding multiple interlocking needs that span health and social issues".

This qualitative study aims to explore contemporary thinking on the subject of harm to the unborn child. In doing so, it will explore participants' roles and practice experiences whilst providing services to women who use alcohol and drugs while pregnant. It will seek participants' views on whether they have a child protection concern in the course of their duties. The research does this by collecting data from four public health nurses, five social workers and five maternity hospital personnel.

This project aims to:

1. Explore practitioners' beliefs, views and experiences in relation to their role when working with pregnant women and the unborn.
2. Examine what causes professional concerns in relation to the unborn child.
3. Explore participants' professional response to pregnant women and the unborn child.
4. Explore what would enhance multi-disciplinary working in responding to pregnant women and their unborn children.

The study will explore these aims, from the perspective of frontline practitioners with a collective professional history of 212 years of service.

In seeking the views of 14 professionals from three key service areas, it will seek to determine where the concern exists, and how they can be addressed while balancing the rights of both mothers and their unborn children. In doing so, it acknowledges the medical, social and legal views on the competing rights of both the unborn and, the reproductive autonomy of women to choose how they manage their own pregnancy. The professionals involved within this study, have a valid standpoint from which to observe this complex and contentious emerging public health issue. Participants were chosen from three distinct areas of medicine and social services, as it is now generally accepted that multi-disciplinary practice is key to meeting the medical and psychosocial needs of drug and alcohol service users. The study aims to bring together medical and social models of understanding, in the hope of increasing knowledge of the complex needs of pregnant drug and alcohol users and their unborn children.

Lay out of Study

Chapter 1 **Introduction** - outlines the aims and objectives of the study and gives a rational for the reason for undertaking a study on this contested area of practice.

Chapter 2 **Agency Context** – presents the agency in which the author of this study is situated.

Chapter 3 **Literature Review** – outlines and discusses literature of relevance to the research, defining the "unborn", women, pregnancy and gender, ante-natal care, drugs in pregnancy, alcohol in pregnancy, services to pregnant women, law and social policy, child protection structures and the multi-agency response.

Chapter 4 **Methodology** – follows the methological framework adopted in this study.

Chapter 5 **Findings and Discussion** – details the findings of the study under five themes of services to women, multi-disciplinary working, policy and procedure, legislation and child protection.

Chapter 6 **Evaluation and Recommendations** – puts forward seven recommendations with evaluation of the five themes of the findings.

Chapter 2 – Agency Context

Introduction

This study took place within three service divisions of the Health Service Executive (HSE) Dublin North East, formerly known as the Northern Area Health Board. HSE Dublin North East encapsulates 7 Local Health offices covering Dublin North, Louth, Meath, Cavan and Monaghan. The study is set within three of these local health office areas - Dublin North, Dublin North Central and Dublin West (Appendix A).

The (HSE) (Appendix B) was established on the 1st of January 2005, charged with the management and delivery of health and personal social services in Ireland. The functions of all previous health boards under the management of the Health Boards Executive (HeBE) were then transferred to the HSE.

The purpose of the HSE is rooted in the Health Act 2004 and states that its functions are:
"To use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public" (Section 7 (1))

It has adopted both a vision and a mission statement as follows in order to meet the legislative requirement detailed above.

Vision "To consistently provide equitable services of the highest quality to the population we serve".
Mission "Our Mission for the future is to provide high-quality, integrated health and personal social services built around the needs of the individual and supported by effective team working" (HSE Corporate Plan 2005 - 2008).

Demographics

The 2002 Census indicates that HSE Dublin North East has a population of 486,305, a rise of 31,406 from the 1996 figures.

Local Health Office	Census 2002
Dublin West	160,571
Dublin North Central	122,423
Dublin North	203,934
Total	**486,934**

Source: Central Statistics Office Population Census 2002

The child population of the fore mentioned areas amounts to 116,565 which are broken down as follows;

Local Health Office Area	Child Population	Percentage of the Three Local Health Office
Dublin West	38,807	33
Dublin North Central	24,515	22
Dublin North	53,243	45

Source: Central Statistics Office Population census 2002

The delivery of services to children and families within the HSE Dublin North East is covered by three main areas of service. These include Family Support, Child Protection and Alternative Care Services. The net expenditure on services for children and families in 2004 was €94.5m. Recent figures published in the National Development Plan 2007 – 2013 allocates €12.3 billion to Children and Families divisions of the state over the six year period (NDP 2007). This figure contains an allocation of €3.4 billion specifically allocated to Child Welfare and Protection. Expenditure will be administered by the HSE. The delivery of health services in Ireland is currently of major political concern to Irish people. The issue of child abuse and neglect has gained considerable political and media attention over recent years (Buckley 2003:9).

The aim of Family Support Services is to assist families during times of need. The HSE Dublin North East sets out to achieve best practice in

family support by: “identifying children and families as early as possible who require support ….. appropriately balanced and preventative, early intervention and therapeutic options” (Review of Adequacy of Child and Family Services 2004:68). The family support strategy is firmly rooted in the Department of Health – Exploring Good Practice:

- Child Focused, accessible, integrated and attractive services.
- Services which are responsive to need and effective for clients.
- Collaborative and strengthening service option.
- Culturally competent services delivered by staff who are capable and interested in their work (Dept. of Health and Children 2004).

The child protection service is delivered primarily through a legislated mandatory requirement of the Child Care Act 1991. “It shall be the function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection” (Sect 3 (1)). The Department of Health and Children introduced Children First Guidelines in 1999. This has had a major impact on the way the child protection service is operated and delivered. Although, still delivered by local community care teams, the changing approach to protection of children has seen a major focus on multi- disciplinary work. This has been evident in the development of closer working between professions and agencies, through the operation of structures such as the Child Care Managers office, Liaison Management Teams, Local Child Protection Committees, and Regional Child Protection Committees. The HSE Dublin North Central sees child protection as best rooted in effective social policy that promotes healthy childhoods, the right to be protected and to be heard and have influence over matters which affect them (Review of Adequacy of Child and Family Services 2004:102).

The author of this study is based within the Child Care Training and Development Unit (CDTU), which provides training and advice to services within Local Health Office areas of Dublin West, Dublin North Central and Dublin North. The post carries specific remit for training and policy development in Local Health Office, Dublin North Central. The main focus of the work of the CDTU is the provision of Children First training at briefing and foundation level. In addition, the CDTU develops programmes of education in other subject areas. Its’ primary focus is the professional

development for all children and families staff within the HSE North East. The delivery of our education programmes ensures that multi-disciplinary and multi-agency values underpin all CTDU training. Our work is guided by the Transformation Programme 2007 – 2010. This sets out clear standards for HSE staff to incorporate into daily service delivery at every level of the organisation.

Our purpose incorporates:

- Provision of high quality easily accessible services.
- Simplification in service delivery.
- A decision making process aimed at optimum results in service delivery.
- Effective forward planning.
- Accountable and responsible service delivery.
- Goal setting with guaranteed follow up.
- Dedicated service.
- Incorporation of service user views.

  (Transformation Programme Section 8).

The central role of the CTDU is to promote best practice through education, training and policy support. The subject of this study the welfare of the unborn is currently not an identified training need for our users. However, it is the hope of the author that the findings of this study will lead to greater awareness and understanding in this emerging area of social policy. In my role as a training and development officer within the HSE, I hope to be able to disseminate best practice findings from the research data, which in turn could lead to better preventative, support and integrated services to women who use illicit drugs and alcohol while pregnant.

Chapter 3 - Literature Review

Introduction

This chapter will conduct a review of current literature of maternal drug and alcohol use in pregnancy. It will address and focus on four main areas within the literature:

- the definition of the unborn,
- the impact of illicit drugs on the unborn in 'utero',
- the impact of alcohol,
- the multi-disciplinary response to the welfare and protection of the unborn.

The literature aims to give a brief overview of contemporary relevant thinking which relates to the study. The complex nature of multi-agency working will be addressed, as will the focus of post-birth development and protection issues.

The literature review will examine the international developments in social policy and legislation in respect of the unborn. The author accepts that much of the literature focusing on the welfare of the unborn has been derived from a medical perspective on what constitutes harm. Where possible, texts derived from social writings which address factors such as poverty, socio-economic levels of deprivations and psychosocial issues will be considered. Legal perspectives of the issues will be considered.

It has to be acknowledged at the outset that this is a contested area of social policy. Ira Chasnoff (1991:6) cautions that maternal substance abuse is often only a symptom of other factors, such as environment and lifestyle, which need to be addressed if a child is to reach its full potential.

Historically, literature tended to focus on child development from infancy to adolescence. The thalidomide scandal in 1962 began a shift in people's thinking to the pre-birth developmental stage, and its possible impact on the newly born child. This scandal involving a legally prescribed anti-emetic drug to pregnant women from the late 1950s to 1962, resulted in thousands of viable healthy foetuses developing severe abnormalities and

deformities while in 'utero'. The scandal rocked the Western world, with the drug being removed from pharmacies in 1962. However, the damage was done and 45 years later the visible images of the thalidomide babies are still evident. As Benegbi states 'With 45 years of experience gathered from the thalidomide tragedy, what responsibilities have we assumed as a society towards the "cradle of humanity", that is to say pregnant women, with regards to toxic substances, medications or drugs to which they are exposed? (Benegbi 2006).

The use of illicit drugs and the consumption of alcohol among pregnant women continue to pose a level of growing concern in Irish Society. In the recently published study, Barry et al (2007:1) suggested that it is "time to investigate the extent of alcohol and other substances consumption in pregnancy in Ireland. A similar study by Daly et al (1992) found a worrying level of ignorance in pregnant women about the dangers of alcohol. Much consideration is now being giving to the issues of alcohol within Irish culture. A recent Oireachtas Report (2006) has recommended that alcohol should be included in the National Substance Misuse Drug Strategy.

The Committee states that the recommendation should be acted upon quickly, believing that to do so should " finally anchor this important policy issue within a well-established structure which guarantees ongoing policy work at the highest government level" (Oireachtas Report 2006:26). The new *National Drug Strategy 2008 – 2012* is currently in the consulting phase with state agencies and voluntary groups. Indications suggest that consideration will be given to alcohol consumption as a gateway to illicit drug use. Minister Pat Carey who was appointed on the 20th of June 2007 with special responsibility for the drugs strategy (Drugnet Issue 22:1), states that alcohol misuse is linked to illicit drugs use. He states that there is evidence suggesting that about 80% of people in treatment centres say their first experience with any kind of drug was with alcohol before moving on to use ecstasy, cannabis and heroin" (Sunday Times, July 22:2)

Women Pregnancy and Gender

The role of women in Irish society up until the mid-1970s was viewed within a patriarchal structure of two significant sources - the "Catholic

Church and the Constitution of the State" (Daly & Claver 2005). Women's roles were viewed as subservient, as homemakers and mothers, while men were viewed as the breadwinners and protectors of the family unit. The Constitution of Ireland 1937 constructed this role with Article 41 when it prescribed:

> *"In particular, the state recognizes that by her life within the home, woman gives to the state a support without which the common good cannot be achieved and the state shall, therefore, endeavour to insure mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties within the home" (Constitution of Ireland, 1937)*

The Constitution, through other key articles such as 41.1.2 (Family) and through Article 41.3.1(Marriage), ensured that the women are seen in the context of married family life, and that their rights as individuals flowed from this structure.

Women moved towards seeking an identity outside that of the patriarchal model of society from the beginning of the 1970s. Killian (1996), notes that in 1970 the first Irish Women's Liberation Group was formed. The goal was to collectively reject the 'patriarchal ideology' of rural Ireland. Called Irish Women's Liberation Movement (IWLM), it came into existence at a time when women's roles were beginning to emerge from the closed social policy directives of the previous decades (Stopper 2006).

Through the following decades the role of women within Irish social policy continued to make significant advances to achieving parity with their male counterparts. One such significant change was the repeal of the 'Marriage Bar' in 1973[3]. This legislated to remove a ban on the employment of married women in the civil service. Coupled with the developments of social justice legislation, arising from our membership of the European Union, Ireland has seen the role of women develop significantly over the last four decades. Women have exercised their right to seek employment, with women working outside the home increasing by a massive 60 per

[3] Government of Ireland (1973) Civil Service (Employment of Married Women) Act. The Stationery Office

cent in the decade from 1988 to 1998 (Daly, 2000). Women have made significant steps toward equality in the field of politics, with two women holding the office of presidency. Mary Robinson was installed in as President in 1990, being succeeded by Mary McAlesse in 1997.

Women's homemaking role has evolved successfully outside the home, gaining some degree of parity with their male counterparts within Irish society. However, the Irish Constitution through articles 41 and 42, still implies a social and legal duty on women to be mothers of the states' future economic security. Kiely writing on the subject of fathers suggests that it is still mothers and women who carry "the weight of responsibility with respect to the less glamorous tasks of child rearing and household chores" (Kiely, 1996). The legal requirement attributed to Article 41 of the Constitution could be interpreted as one which exploits women, in that it enshrines their role as one of unpaid labour within the home for the good of the state (O'Connor, 1998).

Kiely (1996: 154) concluded that "The mothers are clearly the managers. They keep the internal affairs of the family. They take care of the children, do the household tasks and make most of the decisions". The political and social forces which surround Irish women do so in order to maintain the role of mothering and reproduction, which is seen as paramount to any states' survival. In pregnancy, through the role of reproduction, women become regulated yet again (Woollett, 2000). The issue of the rights of the unborn as expressed in article 40.3.3, and those of the mother as expressed in article 41.2.1, ensure that a women's pregnancy is not solely her own. From the point of conception, women are subjected to external controls in legislation and social policy to ensure their role as mothers. Failure in this role attracts blame. The vast majority of Irish women learn their parenting responsibilities from their own personal experiences of being parented, outside of which there is no formal training. Pregnancy and parenting is described as an exciting time. In addition, it can be a time of uncertainty (One Family, 2005).

Definition of Unborn Child

National and international literature reflects the complexity of defining the unborn. In an Irish context, the debate about when life begins has had numerous hearings in the Irish courts over recent times. There are a number of constitutional clauses that focus on family rights and those of children. However, in the context of the unborn, the most important provision within the State's Constitution is that of article 40.3.3,
'the state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws defend and vindicate that right'.

This constitutional amendment was carried by a state referendum and was introduced as a pro-life statement of intent by the Irish state. In Attorney general (SPUC) v Open Door Counselling Ltd, Hamilton J. stated that the 'Offences Against the Person Act of 1861 protects the foetus in the womb, and that such protection dates from the point of conception.'[4] A countering argument is offered by the *Irish Family Planning Association (IFPA)* when it states that the definition of the unborn foetus should only be used when that foetus becomes viable through the ability to sustain independent life outside the womb. The IFPA estimates that this stage of development occurs at approximately twenty-two weeks. Recent case law in the Irish High Court suggests that the protection of the unborn within constitutional law is afforded from the point of conception (Cullen 2006).

In his ruling, Justice Brian McGovern asserted that frozen embryos outside of the womb could not be considered as part of Article 40.3.3 of the constitution. However, there still remains much uncertainty surrounding the constitutional amendment of 40.3.3. The amendment has not being interpreted into civil law by the Oireachtas. This has led to a number of high profile cases coming before the courts for judgments to interpret the constitutional statement of 40.3.3. The ruling by Justice Brian McGovern implies that the growing foetus from day one, through to its ability for independent life meets with the constitutional definition of 'unborn'. Furthermore, such views on the definition of the 'unborn' are held by the

[4] Attorney General (SPUC) v Open Door Counselling Ltd (1998) IR 593

Society for the Protection of Unborn Children (SPUC). Speaking on behalf of SPUC, Kathy Sinnott, MEP, at the launch of Amnesty for Babies Before Birth Campaign in June 2006 asserted that

"medical science has also shown beyond any doubt, from the moment of fertilisation, each newly formed human embryo has a unique, separate and distinct identity and is in fact a new human person in his or her earliest stages"(SPUC, 2006). Similarly, McCarthy, J, in his judgement in *Norris v The Attorney General* believed the constitution "… would appear to lean heavily against any view other than that the right to life of the unborn child is a sacred trust, to which all the organs of government must lend their support" [5].

The legal status of the unborn will always pose strong ethical and moral debates within future policy fields. In highlighting the contested nature of this area of practice, Schweppe talks of the moral and ethical dilemmas that the issue presents, by asking the questions "can a woman violate the rights of her unborn child by delivering drugs and alcohol to the child via the placenta? If so, what should the legal response be?" (Schweppe 2006: 19). Schweppe asserts that the current practice of the Irish legislator does not give clarity to the constitutional position of the unborn as stated in Article 40.3.3. Equally, future thinking will need to fully explore the constitutional rights of women, in an attempt to strike a balance between these two constitutional positions of the 'unborn' and motherhood.

Canada has, through the *New Brunswick Family Services Act and The Yukon Children's Act*[6]), legislated to define the unborn as a 'child', with applicability in child protection legislation within its states. The impact of such laws was noted by Bowen in an article concerning a pregnant woman arrested for credit card fraud in the town of Sarnia, Canada. In giving the woman a probation order, the judge instructed that the court must seek to look after the welfare of the defendant's unborn baby. The sanction of a probation order stated that the defendant must not consume drugs or alcohol and must seek counselling for substance abuse (Bowen 2007). This suggests that the legislation is being interpreted in a supportive manner for the welfare of the unborn child by the Canadian judiciary.

[5] (1984) I.R. 36. at 103.
[6] Department of Justice Canada. [online] http://laws.justice.gc.ca

However, feminist writers such as Dawson challenge such a position. Writing in the Canadian Journal of Family Law she "urges that society would be better served with a solution that better serves the common needs of the pregnant women and their foetus, rather than creating conflict between the rights of mothers and those of their unborn (Dawson 1991). However, Kennedy writing on British law suggests that the growing foetus does have rights and that these rights "must include the right of the foetus to be free from avoidable harm, and to be free from that which may destroy or damage its potential for being born whole" (Kennedy 1988: 375). Such medical, legal and feminist thinking will continue to challenge the definition of the unborn.

The Irish Family Planning paper *-Definition of the "Unborn" and its Implications,* concludes that conferring legal protection to an "unborn" in an Irish context will give rise to complex medical and legal dilemmas but, more importantly, they will cause extremely stressful situations for the women involved who will, no doubt, be more concerned about their own lives and their family circumstances than about legal niceties or medical or ethical conundrums" (IFPA 1998:7).

What is antenatal Care?

The importance of providing health promotion advice and general service information during pregnancy is noted in a Department of Health policy document when it states:

> *Information is an important component in the empowerment of women to take care of their own health and to interact with the appropriate health services. (Dept of Health 1995a)*

This message is repeated by the Maternity & Infant Care Scheme Group (Dept of Health, 1997; WHO 2002; 2006; Collins 2007), when they state that advice and reassurance to be primary aims in providing antenatal care. Antenatal care therefore, is to ensure the well-being of both mother and baby.

Geer (2003) identifies the following eight points as the cornerstones of antenatal care:

- treat minor problems you might encounter in pregnancy, e.g. heartburn,

- identify and treat any pre-existing medical conditions you may have, e.g. diabetes, epilepsy or heart disease,
- check whether you are at risk of complications in pregnancy and if possible prevent these complications; e.g. if you are at risk of anaemia, this can be prevented with iron and vitamin supplements,
- identify and treat any new problems you might develop in your pregnancy, e.g. pre-eclampsia,
- make a plan for your labour and delivery,
- provide information on infant feeding and care,
- offer family planning advice, if required, for after delivery,
- provide advice, reassurance, education and support for you and your family regarding all aspects of pregnancy (2003 p.107).

Several legislative provisions protect the right of women to antenatal and postnatal care during and after their pregnancies. These rights are protected in Irish law and social policy through the Maternity Protection Act, 1994[7], the Maternity Protection (Time off for ante-natal care and post-natal care) Regulations, 1995a[8], the Maternity Protection (Disputes and Appeals) Regulations, 1995b[9] and the Maternity Protection (Amendment) Act, 2004[10]. These legislative provisions ensure that the role of mothering and reproduction is protected by the state as laid down by constitutional law in article 41 & 42. As discussed earlier, it ensures the economic wellbeing of the state in producing healthy viable citizens of the future (Woollett 2000).

Blondel et al (1985) conducted a study within thirteen states of the European Union, and found that there was no single model of antenatal care amongst them. Similarly, no single national policy connects the delivery of antenatal care in an Irish setting. Currently antenatal care is

[7] Government of Ireland (1994) Maternity Protection Act. Dublin: The Stationery Office
[8] Government of Ireland (1995a) Maternity Protection (Time Off for Antenatal Care and Post-natal Care) regulations. Dublin: The stationery Office
[9] Government of Ireland (1995b) Maternity Protection (Disputes and Appeals) Regulations. Dublin: The Stationery Office.
[10] Government of Ireland (2004) Maternity Protection (Amendment) Act. Dublin: The Stationery Office

delivered through two main options. The first is the Maternity and Infant Child Scheme (The Combined Ante-natal Care Scheme). This provides for combined care between the women's General Practitioner and the Maternity Hospital or maternity unit. The second option of maternity care is offered through Hospital Based Care Only, where all antenatal and two postnatal care visits are offered directly by the hospital doctor and midwifery services (One Family, 2005). Both of these schemes are provided under the Health Act 1970 – The mother and Infant Care Scheme. This ensures that all pregnant women are entitled to free ante and post natal public health care in respect of their status as pregnant women.

It is generally accepted that 10 to 12 pre-natal visits is the optimum for successful monitoring of pregnancy (Geer 2003, Abbas 2007). The degree of risk in the pregnancy determines the number of ante-natal appointments required to monitor safety. High risk pregnancies are individualized and controlled by hospital protocols (Abbas 2007 p 56). Abbas suggests that Irish antenatal care strategies should follow the UK National Institute of Clinical Excellence (NICE) Guidelines (2003), until such time that Ireland implements its own module or guideline. The use of drugs and alcohol while pregnant has been well documented in numerous studies and journal articles as a factor constituting high risk of harm to the unborn while in 'utero' (Barry et al, 2007; Fagan & Keenan 2006; Hogan et al, 2006; Schweppe, 2006; Barker, 1997; Burns et al 1996; Kennedy, 1988). Such studies suggest that the first trimester is associated with the highest risk (Appendix C).

Early antenatal screening of drug and alcohol use in pregnancy is crucial in assessing the potential of harm to the growing foetus as well as in offering advice, education and services to pregnant women at the earliest possible opportunity. The first antenatal visit usually takes place between weeks 10 and 14 within the Irish health system. However, recent media coverage suggests that this option of early appointments is not available in some parts of the country. Two leading stories in the Irish Times newspaper recently stated that pregnant women wait up to twenty weeks for an initial appointment (Fallon, 26/03/2007; 20/03/2007). This contrasts sharply with two reports published by the World Health Organization

(WHO), which state that ideally the first visit should take place before week 12 of pregnancy (WHO 2002), and that maximum benefit requires early intervention (WHO 2006). The latter report suggests that concerns within pregnancy can be better addressed with early intervention. They highlight such concerns as:

- complications of pregnancy itself,
- diseases that may affect pregnant women and those that may be aggravated by pregnancy,
- negative effects of unhealthy lifestyles on the outcomes of pregnancies. (WHO 2006).

Clearly, this discrepancy between what is ideal in respect of first contact with antenatal services and that which is accounted for in the *Irish Times* reports, suggests that women who use drugs and alcohol may be at higher risk within the Irish antenatal care service. It appears that the three WHO objectives are being negated due to a weakness in service provision to pregnant women. Collins, in her Rotunda study, found that 'Information that women report receiving during their pregnancy fell far short of their actual expectation', and that the provision of information is provided in a 'haphazard way' or not at all (Collins 2007:64).

Collins' findings are concerning, given the identified need for careful and supportive advice to be offered to women in the early stages of pregnancy. The initial visit usually includes a risk plan in order to detect those at high-risk.

First visit information deals with:

- healthy diet,
- the importance of folic acid,
- weight checks,
- blood pressure,
- urinalysis,
- haemoglobin levels,
- blood group.

This first visit is seen as essential in detecting at risk pregnant women early (Abbas 2007:55). However, a further complexity in assessing the risk plan of pregnant drug and alcohol users is the physiological changes on the body which may in turn lead to a late pregnancy diagnosis. Chasnoff, 1991; 8 notes, “female addicts tend not to suspect their pregnancy early, sometimes not even until the pregnancy is in its second trimester”, a point also noted by Fagan & Keenan, 2006). Where health promotion advice is absent or haphazard in the first trimester, there may be a significantly increased risk of harm to mothers-to-be and their unborn children.

Drugs in Pregnancy

It is generally accepted that substance use and misuse is having a major impact on family life in the twenty-first century. Irish studies by McKeown and Fitzgerald 2006, Butler and Mayock 2005; Hogan and Higgins 2001; Butler 2002b; Woods 2000; Farrell 1999; Woods 1994; and Butler and Woods 1992, have played a significant role in placing the needs of women, drug use and parenting on the social agenda. The increased use of drugs in society, along with drugs and alcohol consumption in pregnancy, highlight significant concerns for the unborn (Barry et al 2007; Fagan and Keenan 2006). The use of drugs and alcohol in pregnancy is a complex and contested area of intellectual, social and moral debate, where the competing individual rights of both the pregnant woman and that of her unborn child take centre stage (Kennedy 1988:364-384). UK studies found that 90% of women drug users presenting to services were of child-bearing age (Clarke and Formby 2000).

Irish and overseas studies have shown a large increase in the numbers of newborns exposed in-’utero’ to drugs (Laudet & Magura 1996; Gomez 199;Thornton et al 1990;Barry et al 2007; Coghlan et al 1999; Fagan and Keenan 2006). A study undertaken in the US by Chasnoff et al 1989 found that eleven percent of newborns discharged from a study of 36 hospitals were exposed to illicit drugs in-’utero’. The explosion of cocaine use in Ireland over recent years has shifted public perception that drug abuse was a class issue reserved for less well off sections of society. With the emerging picture of middle and upper class members of the community developing addictions, it is accepted that no sector of society is immune

from illicit drug consumption **(**National Advisory Committee on Drugs (NACD) (2007). Special concerns have been raised regarding cocaine. NACD findings suggest that 'information about cocaine/crack and its harm should be disseminated to raise awareness among individual user groups' (p. 64).

Research on cocaine use in pregnancy has provided conflicting evidence within international fields of study. Some reports suggest that cocaine use in pregnancy is likely to have serious outcomes for children at birth. Difficulties such as changes in the nervous system (Dixon & Bejar 1989), growth deficits (Chasnoff, 1988; 1991) and behavioral difficulties (Chasnoff et al 1989) have been cited. Some international findings suggest that cocaine use will lead to low birth weight babies, with 250 gram deficits being reported with cocaine use (Shankaran et al 2002). However, although the use of cocaine has increased significantly in recent years, there is as of yet no conclusive evidence within Irish studies on the effects of cocaine on the unborn. Evidence is emerging that opiate users are identified as being at particular risk of delivering low birth weight babies, according to a recent report published by the Institute of Public Health in Ireland (2006). Furthermore, Fagan & Kennan (2006) suggest that cocaine has teratogenic effects on the foetus.

Dr. Desmond Corrigan, speaking at the "Drugs in Dublin" conference in 1997, highlighted what he considered to be the dangers of using drugs while pregnant:

> "If a pregnant woman is using drugs, the foetus in her womb will also be exposed to the drug at key vulnerable stages of its physical and mental development. The results can include babies born addicted to opiates, physical abnormalities related to cocaine and alcohol, retarded intrauterine growth and development due to exposure to alcohol, tobacco and cannabis "(Corrigan 1997:2)

The wider issue of drugs in the obstetric field is increasingly recognized as a cause for concern (Fischer, 2000; Fagan and Keenan 2006; Barry et al 2007). Barry et al 2007:18 demonstrated that illicit drug use in pregnancy results in low birth weight babies. This study found evidence of a broad

range of substances used by the women attending a Dublin based hospital.

The consumption of different drugs as reported by 447 women is broken down as follows:

Drug	**Numbers of Women Consuming**
Methadone Treatment	323
Cannabis	87
Heroin	64
Diazepam	51
Ecstasy	14
Cocaine	13

(Barry et al 2007:11)

The high use of methadone signifies a significant number of women accessing drug treatment. Methadone is an oral substitute drug which is given to opiate users under controlled medical protocols as part of a harm reduction treatment protocol. Oral substitution treatment is free. However, all who commence methadone treatment must be registered on the Central Treatment List (Scully et al 2004 p 27). As of January 2006, there were 7,933 registered to receive methadone treatment. Two thousand five hundred and forty of those registered were women. Statistics demonstrate that 190 children were born in Dublin hospitals to women on methadone maintained programmes (Fagan & Keenan 2006).

The Irish approach to using the treatment protocol was developed in the late 1990s, coming into effect on the 1st of October 1998 (Butler 2002d:311). Registered treatment systems were put in place to prevent the leakage of methadone to non-compliant opiate users (Barry 2002).Treatment provision for pregnant women was significantly enhanced with the introduction of the Drug Liaison Midwife service to the three Dublin maternity hospitals in 1999.This allows treatment services to refer pregnant drug users to a registered midwife, so that the pregnancy can be monitored and a care plan put in place. Although this service prioritized treatment for pregnant opiate users when launched in 1999, it is not a national service, being confined to the three main Dublin maternity

hospitals. Evidence suggests that pregnancy and motherhood are key motivators for women accessing treatment services (EMCDDA 2006: Selected issue 2: 36), a prime indicator for directing appropriate services within the treatment field. Others such as Schroedel suggest that any legal basis to treatment should aim to rehabilitate users rather than punish them (Schroedel, 2000: 101).

Morgan has shown that children of mothers in methadone treatment programmes have a greater chance of remaining in their mothers' care (Morgan, 1990). Evidence from such treatment programmes suggest that the stability gained as a result of methadone treatment aids the improvement of parenting skills. Such stability reduces the potential for prenatal children to be born with opiate withdrawal and is of considerable assistance to mothers. Children with opiate withdrawal at birth can present with low birth weight, irritability, jitteriness and poor feeding habits (Coghlan et al 1999).

A new born infant born to a mother who has a dependency on illicit drugs may develop drug withdrawal symptoms, which is clinically known as Neonatal Abstinence Syndrome (Murphy et al 1991; Coghlan et al 1999; Kelly et al 2000). There appears to be little research conducted in Ireland which could demonstrate the true extent of illicit drug use in pregnancy. As illicit drug use is implicitly an illegal activity, data from self-reporting users in pregnancy is likely to be inaccurate (Fagan & Keenan 2006). What we do know is that illicit drug use in the wider community is on the increase (Corr, 2004), and that patterns are changing, with a higher representation of female users (EMCDDA 2006). Clarke and Fitzpatrick (2005), in a study of children referred to the child and adolescent services at the Mater Hospital, Dublin, call for a cohort study of all children born to opiate dependent mothers in order that the risks can be fully identified.

Alcohol in Pregnancy

New advances in medical research and diagnostic tools are bringing the subject of maternal use of alcohol during pregnancy to new levels of public health concern (Royal College of Obstetricians and Gynecologists, (RCOG 2006). However, the subject of women drinking alcohol while pregnant is not reserved to modern day medicine and social policy. In 343 BC Aristotle

is quoted as saying 'foolish drunken and hair-brained women most often bring forth children like unto themselves, morose and languid' (Able 1999). In the 1720s the Royal College of Physicians reported that maternal alcohol consumption was a "cause of weak feeble and distempered children" (Warner 2003). During the 1950s and 60s, research studies contributed to a growing understanding of the fears associated with alcohol in pregnancy. It was not until 1973 that the first classification of harm to the unborn as a result of alcohol consumption was discovered. Research carried out at the Harbour Hospital in Seattle, USA by Dr David Smith and Dr Ken Jones and published in the *Lancet Medical Journal* introduced the term Fetal Alcohol Syndrome (FAS) as a medical diagnostic term for newborns suffering from alcohol exposure in the womb (Smith & Jones 1973). This was the first contribution to the current pool of literature on the effects of alcohol on the unborn.

FAS is a permanent condition which is considered to be a leading cause of non-genetic intellectual handicap. Other less severe effects associated within this area of fetal alcohol exposure are Fetal Alcohol Effects (FAE) or Alcohol Related Neurodevelopment Disorder (ARND) (O' Leary 2002). Collectively, these diagnostic terms are now referred to by some researchers as Fetal Alcohol Spectrum Disorder (Barry et al 2007), an umbrella term to include all suspected cases of fetal alcohol harm. This is not in itself a clinical diagnostic term.

Evidence clearly demonstrates that alcohol taken during pregnancy crosses the placenta undiluted into the unborn child's blood stream (Stratton et al 1996). The potential harmful effects are described by Stratton et al in two different outcomes:

(a) any type of physical malformation (e.g., alcohol exposure has been linked in cases of spina bifida, heart defects, and kidney defects).
(b) Learning and behavioral challenges (1996:6).

Alcohol in pregnancy is now studied extensively by both medical and social researchers here and abroad (Beattie et al 1983, Halliday et al 1982; Daly et al 1992; RCOG No 5, 2006; Barry, et al 2007; Mc Millian et al 2007). This last study, conducted in the Rotunda Hospital in summer of

2003, found that there was ‘considerable ignorance regarding the risk of alcohol in pregnancy’ with only 44% of women interviewed having awareness of the risks. A more worrying aspect of the research findings was that despite 28% (42) of the women surveyed receiving information about the risks of alcohol while pregnant, 71% (30/42) stated that this advice and guidance did not alter their behavior (Mc Millian et al 2007). It is clear that the study provides clear evidence for concern.

However, much research fails to acknowledge other factors consistently associated with poor outcomes for the newborn such as socio-economic and poverty issues. Observational Studies conducted by McLeod et al, 2004; Kwok et al, 1983; found that women who were socio-economically disadvantaged and who smoked, were likely to abstain from alcohol during pregnancy. Currently there is no representative data to suggest that alcohol abuse among Irish pregnant women is solely associated with socio-economic or poverty factors (Dept of Health 2006:60). It is interesting to note research conducted by the US Institute of Medicine (1998), which considers alcohol to cause more harm to the unborn than any other substance (including marijuana, heroin and cocaine). This is due to the teratogenic effects associated with alcohol use during pregnancy. The Oxford Medical Dictionary states “teratogen is any substance, agent or process that induces the formation of developmental abnormalities in a foetus” (p.650). Alcohol is freely distributed from a pregnant woman’s blood to the foetus. It crosses both the placenta and the foetus blood-brain barrier rapidly and easily (Julien, 1998:64). This is the primary factor which suggests that alcohol causes more harm to the unborn than other substances, as noted above.

The study by Barry et al 2007 conducted between 1987 and 2005 at a Dublin maternity hospital, using a sample size of 125, 945 women, have produced equally concerning data. This study found that the dangers of cigarette smoking were well understood - though not the dangers of alcohol. “Our data trends would suggest that the risks of alcohol related fetal harm in Ireland are high. Unfortunately, the risks in Ireland are unquantified and this is a public health matter that needs urgent attention” (p.17). A significant outcome in the data is the percentage of young

pregnant women consuming high levels of alcohol while pregnant as illustrated in the following table:

Age Bands	**No Alcohol**	**< 5 Units per Week**	**6 - 9 units per week**	**More than 10 units per week**	**N = 25,312**
14 - 17	34.6	59.2	4.4	1.8	451
18 - 24	23.7	66.4	6.5	3.4	5,178
25- 29	23.2	68.2	6.6	2.0	6,034
30 - 34	19.6	70.6	8.0	1.8	8,277
35 - 39	20.4	69.7	8.4	1.5	4,565
40 +	22.4	67.8	8.4	1.4	807

The table demonstrates that young women aged between 18 – 24 years consumed over 10 units per week (3.4 per cent). This highlighted a worrying trend and encourages public health efforts to be made with the cohort aged under 24 years (p.18).The report further suggests that "alcohol consumption patterns in pregnancy ….. point to the need for a much more proactive policy and set of actions to reduce intake in pregnancy, thus reducing harm to future cohorts of Irish born children" (Barry et al 2007:19

Introducing a public health harm reduction strategy to address the issue of alcohol in pregnancy is a difficult challenge. Some studies which have small data samples such as that by Mc Millian et al (2007) with a 151 respondents at the Rotunda, suggest that abstinence from alcohol is the only way to prevent harm to the unborn. This is juxtaposed with the advice from the *Royal College of Obstetricians* that one or two drinks per week are perfectly safe for consumption. The RCOG policy statement however in acknowledging the abstinence message suggests that "it remains the case that there is no evidence of harm from low levels of alcohol consumption defined as no more than one or two units of alcohol once or twice per week" (RCOG 2006 p.1). The RCOG guide highlights the varying levels of alcohol strengths and units contained in everyday drinks, which can be bought off the shelves of any convenience store. It highlights that the standard can of Budweiser beer contains 3 units of alcohol, as does

Stella, Strongbow and Kronenbourg (2006, p.3). Deirdre Murphy, obstetrician, speaking at the conference launch of the Barry et el study stated “you can’t undo the damage of fetal alcohol syndrome, but you can prevent it by not drinking at all during pregnancy” (Murphy 2007).

The contradictory guidance which states that up to four units is shown to do no harm and that one can of beer is the advised maximum intake, underlines the complexity of the educational challenge faced in delivering public health messages.

The current Strategic Task Force on Alcohol (STFA) (2004:39) report gives the following policy objectives relating to pregnancy:

- Encourage pregnant women and women who are planning to become pregnant to avoid alcohol consumption, especially during the critical first trimester of pregnancy.
- Require a health-warning label on all alcohol products and alcohol promotional materials.

Furthermore, the report, in its recommendations, strives to support ongoing research in order to monitor alcohol related problems. It states “Evaluate alcohol related attitudes and behaviour surrounding pregnancy” (STFA 2004:42). The Department of Health is seeking to understand what evidence of best practice and policy is needed in order to direct future government led strategies. However, what is equally concerning emerging from this document is that Ireland no longer uses the classification of ‘units’ per alcoholic drink , but now uses a new classification of Alcohol Bt Volume (ABV). This seems slightly at odds with current need for public health education. All contemporary research, both national and international considered within this study, has collectively presented diagnostic evidence from a ‘unit’ measure perspective. The most recent publication of the Barry et al study (2007) equally talks of ‘units’ of consumption.

The evidence gained from an assessment of the literature on the subject of drinking in pregnancy is that physicians and social researchers continue to emphasise the importance of education and health promotion regarding

the risks associated with alcohol. Although there is still no outright conclusive evidence of safe levels of alcohol taken when pregnant, most experts agree that abstinence during pregnancy is the safest approach to protect the unborn from the potential harm as detailed in this chapter. Daly et al (1992) concludes:

> *"The media and medical profession have been more successful in recent years in informing people about the adverse affects of smoking while pregnant. The same cannot be said regarding the dangers of alcohol. Alcohol remains a part of social life while nicotine use is frowned upon more and more and particularly so by the medical profession" (*Daly et al, 1992:157*).*

Problems in pregnancy due to alcohol use are noted by Cole (1995:11) as follows:

- Foetal Wastage,
- Facial dysmorphia,
- Persistent growth retardation,
- Central nervous system damage/intellectual deficits,
- Cardiac abnormalities,
- Neonatal withdrawal Syndrome,
- Failure to thrive,
- Vision and hearing problems,
- Long term effects.

It is important to remember that alcohol may have different effects on different people. Subsequently one cannot say with certainty what the outcomes will be for an unborn child whose mother consumes alcohol during pregnancy. This is noted by Cole (1995) who states that some children born with foetal alcohol effects (FASD) do not usually display difficulties throughout childhood. This highlights the contested nature of this area of social concern. It is important for GPs, obstetricians, midwives, public health nurses and social workers to devise ways of identifying women who may suffer from problem drinking, during or before any pregnancy. Brief interventions, repeated patiently have been show to help many services users to address the burdens of daily life (Quigley 2003, Ingersoll 2006) and in the wider family context (Butler 2002a).

It is evident from literature that there still remains considerable doubt as to whether infrequent and low levels of alcohol consumption during pregnancy convey any long-term harm, in particular after the first trimester of pregnancy. (RCOG No 5: 8)

Similar studies on the use of alcohol in pregnancy suggest that further research and data collection is necessary to fully understand the role of alcohol in pregnancy (Barry et al 2007). Further research is vital, as is the need for early supportive social care interventions to women who drink during pregnancy. Butler (2002a) encourages care specialists to move beyond the mystique of addiction in order to develop capacity to engage with the problems that alcohol presents. Early interventions by non-addiction specialists using psychosocial interventions, such as motivational interviewing, can have significant positive outcomes (Ingersoll 2006) for mothers and unborn children alike.

Approaches to Substance Use/ Misuse among Pregnant Women

From the early 1980s the issue of maternal substance abuse has gained considerable attention within the United States (Gomez, 1997). This was primarily fuelled by sensational and misleading stories within the media about punitive responses to “crack babies” (Gomez, 1997, Paltrow et al, 2000). By the mid -1980s American legislators began to introduce legislation in response to this social problem as highlighted by media reports. While many American states sought to criminalise the issue of maternal substance abuse during pregnancy, others sought to introduce amendments to civil child welfare laws. Such laws vary considerably within different states in the US federal system. In some states maternal substance abuse is seen as a trigger to evaluate maternal ability and the need to provide preventative services. Other states deem substance use in pregnancy to be a matter of neglect and poor parenting, justifying removal of parental rights (Paltrow et al, 2000).

By the early 1990’s researchers published a number of studies documenting the effects of maternal drug use on foetal health. Researchers linked the use of crack/cocaine and heroin with a number of

medical and neurobehavioral complications (Berger et al, Chasnoff et al 1989). The combination of media coverage and research studies left policy makers and legislators grappling with the issues of maternal substance abuse. Some favoured a punitive approach that would force expectant mothers into treatment to the point of incarceration, as a means to ensure infant and child health. Others, including reproductive rights activists, public health and medical personnel argued that such approaches are counter-productive. Critics argued that forced treatment only serves to alienate women, create obstacles to treatment and ultimately infringe women's rights at the expense of both the mothers' health and the health and welfare of the unborn (Kaiser & Figwort 1998).

What emerged during the late eighties was that the American media played a significant role in highlighting the debate between foetal rights and a mother's right to autonomy in her pregnancy. Media reports sought to sensationalise the issue and demonise pregnant women who used drugs or alcohol in pregnancy (Gomez 1997:.30 -31).

A second wave of studies in the early nineties began to urge caution against labelling pregnant addicts and punitive responses. Chasnoff and colleagues produced a follow-up longitudinal study of three-year-old children stating "Contrary to information in the popular media, not all substance-exposed children suffer the same poor prognosis. In fact, generalization about the fate of drug- exposed children must await additional research into the outcomes of the broader population of drug-exposed children, examining the roles of maternal and environmental factors" (Griffith, Azuma and Chasnoff, 1994).

During the late eighties / early nineties, little attention was paid to substance misusing pregnant women in Ireland. No such measures of punitive responses or forced treatment concepts have ever been discussed in respect of Irish drug using women. With the emergence of the HIV epidemic, services expanded in response to HIV drug users, to counteract the spread of HIV, utilising a model of Harm Reduction (Butler & Woods 1992). The early part of the 1990s saw considerable expansion of treatment services with the Irish government employing a harm reduction approach (Barry 2002). Statutory methadone and needle

exchange programmes were introduced from the late 1980s, responsibility devolving to health boards (Butler 2002c). In Dublin, access to treatment was prioritized for pregnant opioid women (Scully et al 2004). Arising from a concern for HIV pregnant women, the first gender specific treatment services were developed with the development of the Drug Liaising Midwife service. A number of Irish studies highlighted that the number of dependent drug users accessing treatment was on the increase (Moran et al 1997, Coghlan et el 1999, O'Brien et al 2000, Butler 2003).

As cited earlier, the favoured harm reduction strategy for opiate using pregnant women is methadone - a pharmacological substitute. Evidence from a study at the Rotunda Maternity Hospital suggests that maternal methadone doses of less than 20mg daily are associated with 'mild withdrawal' Coghlan et al (1999). Methadone treatment in pregnancy is the favoured treatment offered by addiction services on a pharmacological basis (Bell and Lau 1995). Fagan and Keenan 2006 believe methadone to be the best stabilising agent in pregnancy. However, they also suggest that methadone treatment needs to be supported by 'psychological, social and medical support'.

The view that psychological support and psychosocial interventions are necessary alongside pharmacological responses is a relatively new departure in the harm reduction model. Drug treatment services need to develop responses which address the unique needs of women drug users (Alperen and Paone 1998) and provide psychosocial interventions (NHS 2007).

Alperen and Paone (1998) suggest that current treatment services for women often lack:

- Services for children (e.g. day care, play therapy, child development monitoring and parental training),
- Comprehensive health care (e.g. prenatal, family planning, and HIV prevention),
- Appropriate staffing (e.g. female, non-confrontational, culturally and racially sensitive staff),
- Advocacy role (e.g. contact with child protection services, welfare).

The practice of need identification over and above a maintenance response is one that can greatly assist in meeting the complex needs of pregnant drug and alcohol users. Psychosocial interventions which aim to address root causes of addiction are seen as helpful in assisting the drug treatment process. These interventions are described by the National Institute for Clinical Excellence (NICE) 2007 as “any formal, structured psychological or social intervention with assessment, clearly defined treatment plans and treatment goals, and regular reviews”. A number of different approaches exist within these psychological interventions such as *Contingency management* (Griffith et al 2000), *Interpersonal therapy* (NICE 2007), *Therapeutic community* (Smith et al 2006), *Standard cognitive behavioural therapy* (Maude-Griffin, 1998) and *Behavioural Couples Therapy* (Fals-Stewart et al (2002). One such psychosocial intervention which is gaining considerable recognition with the drug treatment services is brief interventions/motivational interviewing within the science of cognitive behaviour therapy (NICE 2007:61). Motivational interviewing is an effective method for enhancing brief intervention approaches (Miller and Rollick, 1991).

Brief interventions are defined as those with a maximum duration of two sessions. The main aim of the intervention is to enhance the possibility of change in terms of abstinence or the reduction of harmful behaviours associated with drug use. The principles of brief interventions include expressing empathy with the service user, not opposing resistance and offering feedback, with a focus on reducing ambivalence (NICE:92). It is believed that such interventions can be offered to users who are not in formal treatment settings or as an adjunct to formal treatment structures (Ashton, 2005).

A recent study in the US by Ingersoll (2006) offers compelling evidence to support the use of motivational interviewing. In a pilot study with a group of ‘at high risk binge drinking women’, it found that after just four sessions of motivational interviews the candidates went from ‘high risk’ behaviour of alcohol consumption to ‘low risk’. The study “demonstrated that using motivational counselling can have a major impact, even on behaviours that are considered difficult to change, such as binge drinking” (Ingersoll 2006).

The development of non-medical therapies such as motivational interviewing is relatively small, due to what Lacroix (2002) refers to as the dominance of the disease model of addiction. The medical response to addiction developed rapidly during the US post war period. It was not until the 1980s that psychologists and counsellors began to understand the more complex needs of addiction. It is generally accepted that psychosocial treatments have not yet produced a body of evidence comparable with other branches of the medical/ health response model (Drugnet 2006 p. 25). Welte et al (1998) notes that successful implementation of early intervention models needs agency commitment along with staff training for those who encounter addiction in their duties. However, 73.8% of Irish practice nurses cited "insufficient time", as a major barrier to 'life style counselling' - an umbrella term for brief interventions (Lambe et al 2007).

A noteworthy recent study by Collins at the *Rotunda Hospital,* asked a cohort of 500 pregnant women about service provision. The research found that over one quarter (26.8%) of women who were current drinkers, did not receive any information concerning alcohol intake during their antenatal period (Collins, 2007). Given the value of providing health promotion advice in the antenatal period, it is concerning that this objective is being negated (Lambe (2007). Collins concluded by stating that the 'antenatal period is not currently capitalised on in respect of health promotion and education" (Collins, 2007:65).This can only add to the risk factors of drugs and alcohol, and needs to be taken into account when assessing the welfare of the unborn. Of equal importance are the concluding comments of Fagan and Keenan (2006:34) who state:

"Throughout this process, it must be remembered that most pregnant women remain stable in their drug use and, as mothers can care adequately for their children, especially if offered non-judgemental support"

Law and Social Policy National and International Perspectives

The contexts within which child protection services operate are difficult and complex areas of social practice. Intervention to protect the unborn child is fraught with even greater complexities. A multi-faceted area of practice

without guidelines or a legislative framework, it presents a challenging professional task for many practitioners on a regular basis (Barker 1997).The Child Care Act 1991 is the primary regulatory instrument in Irish law underpinning child protection services. In doing so it must give full regard to the family as the "natural primary and fundamental unit group of society, and as a moral institution possessing inalienable and imprescriptable rights, antecedent and superior to all positive law" (***Bunreacht na hÉireann 1937)*** More recently the state introduced the *Children First Guidelines 1999*, which further enhances and regulates the system of child protection. In the context of the protection of the unborn, neither of these two systems gives any direction or guidance in assessing the welfare of the unborn.

Yet Constitutional law, which would be interpreted by many as the foundation of law and practice in the Irish state since 1937, does give significant status to the unborn. In the eight amendment of 1983, the people of Ireland afforded protection to the unborn through a constitutional amendment (article 40.3.3). Despite this guiding law in respect of the unborn, there is a deficiency in Irish constitutional and domestic civil law. The *Child Care Act 1991* makes no reference to the unborn and considers all its application to be in respect of a live child. It is generally accepted that the enactment of Article 40.3.3 was primarily an anti-abortion response to protect the unborn. However, Schweppe (2005) writing in the *Irish Journal of Family Law* believes that Article 40.3.3 is framed in a protective language which encourages the state to "protect and vindicate" the right to life of the unborn child. She argues that there is "nothing prohibiting the legislature" from interpreting Article 40.3.3 in a broad approach. However such interpretations are currently absent resulting in situations where concerns for the welfare of the unborn remain un-assessed.

The comparable legislative instrument in the United Kingdom of the Children Act 1989 does not formally acknowledge the unborn. However, in their guidance publication *Working Together under the Children Act 1989* (1991) specific guidance can be found in respect of the unborn. The most recent data for pre-birth registrations in the UK gives a figure of 25,900 children on the child protection register (31st of March 2005), of which 310

registrations were for unborn children (Dept of Education and Skills, 2006). Therefore it is reasonable to interpret that legislation is being applied in the form of the Child Care Act 1989, legislation which directs the issues of case conference and registration of vulnerable children.

Child Protection System and Process

Ireland has undergone some considerable changes and development in its child welfare and protection services (Buckley, 2005). Towards the mid/late eighties the recognition of child sexual abuse as a problem emerged as a matter of social awareness and concern. Some took the view that prioritising sexual abuse was at the cost of other child welfare matters (Buckley, Skellill and O'Sullivan (1997). Abuse scandals such as the Kilkenny Incest, The West of Ireland Farmer case, the CC Case in court law, along with the emergence of paedophile and internet concerns have raised questions concerning our commitment to child protection. Such questioning help procure stronger and more robust systems of protection in an evolving world. A cost of this development is the high level of legal and social policy development that has impacted on the social work profession. McWilliams writing in *Irish Social Worker*, talks of social work becoming engulfed by child protection concerns and subsequent demands as a result of the change that is happening in the Irish Social Work profession (McWilliams, 2006: 20). This process of change is described by Ferguson as a societal change, which has seen the subject of child protection and welfare go from relative complacency to radicalisation (Ferguson 1996).

The recent decade has seen significant developments in knowledge and understanding of child welfare issues. Such progressions have aided the development of a child protection infrastructure which informs systems and services to vulnerable children (Fowler 2003:13, Buckley et al 1997). A further advance in child welfare and protection was the ratification of the *UN Rights of the Child 1992* by Ireland in1992. Article 19 of this legislation requires that the state put in place measures that protect children from any form of abuse whilst in the care of parents and any other person, and have systems in place to investigate and report on issues of child abuse (URC Article 19).

The application of Article 19 in domestic law is reflected through the administration of the Child Care Act 1991. The primary encompassing basis of the child welfare and protection system is the legislative instrument of the Child Care Act 1991, which requires the Health Service to:

> *"Take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area"*[11]

Sections 12 and 13 allow the state to intervene in emergency situations in order to uphold the protection of children from abuse.

Where a member of the Garda Siochana has reasonable grounds for believing that –

(a) there is immediate and serious risk to the health or welfare of a child, and

(b) it would not be sufficient for the protection of the child from such immediate and serious risk to await the making of an application for an emergency order by the Health service under Section 13, the member, accompanied by such other persons as may be necessary, may without warrant, enter (in need be by force) any house or other place and remove the child to safety.[12] In the event that such an emergency situation happens within office hours and there is no option for a voluntary agreement with the child's guardian the state may invoke Section 13 of the legislation which states:

"an emergency care order shall place the child in under the care of the health service of the area in which the child is for the time being for a period of eight days or such shorter period as may be specified in the order"[13].As cornerstones of the child protection legal process, Sections 12 and 13 serve to ensure the State's duty to protect.

[11] Sect 3 (a) Child Care Act 1991 Dublin, Stationery Office
[12] Sect 12, Child Care Act 1991 Dublin, Stationery Office
[13] Sect 12(2) Child Care Act 1991, Dublin Stationery Office

The subject of the unborn child is not addressed anywhere within this legislation or the UN Declaration on the Rights of the Child. The complex nature of attempts to afford legal protection to the unborn child is one which provides for significant moral, social and legal argument (Fortin, 1988). Legal argument is beginning to emerge asking that the chasm between Article 40.3.3 of the constitution and the child protection instruments in civil law be addressed. Schweppe (2005:26) argues:

> *"That a comprehensive piece of legislation is necessary, not only to provide for the circumstances in which abortion is permitted in this country, but also to provide for firm legal principles governing third party foetal assaults."*

Clearly such a law would be advantageous to other aspects of the child protection system in its attempts to protect the unborn, where maternal behaviour constitutes risk to the unborn. Equally, Charleton et al believe that Article 40.3.3 affords "equal treatment of unborn and born life is explicit in the constitution" (Charleton et al, 1999).

Two recent practice documents published within the Irish Child protection system make reference to the unborn child. *Children First National Guidelines for the Welfare and Protection of Children (1999)* when reprinted in 2004, with slight alterations, referred to the unborn in Appendix Nine. On the subject of children moving to Ireland from other jurisdictions such as England, Scotland or Wales, Children First directs that "where this information relates to an unborn child who would be considered to be at risk once born, the Assistant Chief Executive/Programme Manager in all health service areas must notify the relevant maternity hospital(s) immediately"(p.164 2.2). Clearly, this insertion in an Irish policy document derived from the child protection policies of other jurisdictions.

The Department of Health Child Alert System was set up to work with other jurisdictions on children who go missing. This structure allows for notification of unborn children to the Irish state. The UK child protection service list unborn children on their child protection registers in the same manner as born children. This system intervenes to protect unborn

children once they have passed twenty-four weeks gestation (Barker 1997). The UK based Child Protection legislation as presented in the Children's Act 1989, bears strong resemblance to the Irish Child Care Act 1991.

The second policy document to refer to the unborn appears in a local guidance document entitled *Child Protection Guidance - Local Health Office Dublin North Central in 2005.* This document gives practical guidance to professionals working at the frontline of service delivery, and directs that "pre-birth concerns should be handled with the utmost sensitivity and respect. The need for intervention must be considered at length and the method of intervention discussed fully in a strategy meeting before any inquiry/protection procedures are initiated" (LHO7: 55; 6.91).

These initiatives operate without a civil legislative framework other than Article 40.3.3. of the Constitution. The evidence implies that the current child protection system is developing pockets of practice whereby practitioners interpret Article 40.3.3 as a basis for using the law as cited in the Child Care Act 1991. International literature highlights that the challenge of protecting the unborn is fraught with complexity of competing rights, ethical dilemmas, and moral decisions. Article 40.3.3 alone is not sufficient to address such complexities.

The response to protecting the unborn child in the USA gained considerable attention in the 1980's, with consideration of the use of opiates (Azuma and Chasnoff, 1993; Phibbs et al 1991; Gomez, 1991; Chasnoff et al 1989). This concern developed through the 1990s, and has seen many federal states in America introduce punitive legislative measures, emanating from concerns expressed in the previous decade. These measures included mandatory treatment orders, including cases where failure to comply resulted in criminal prosecutions (Paone and Alperen, 1998). The Unborn Victims of Violence Act 2004 makes it a crime to cause the death or bodily injury of a 'child in 'utero' ' while committing certain crimes, and gives the unborn distinct rights independent of its mother. Currently the US Senate is debating the Unborn Child Pain Awareness Act 2006. This is aimed at women who seek abortion and their commitment to understanding the pain of the unborn (Minkoff and Paltrow,

2006).The authors of this paper suggest that although the legislation may have a central premise on abortion, the scope and potential of both the 2004 and 2006 Acts is to criminalize mothers who do not have abortions but may fail other state requirements (2006:26).

Similar advances on the issues of foetal rights and protection are taking place in Australia. The Seymour Report in Australia (1995) concluded that introduction of legislation is not necessarily the most coherent way to protect the unborn child or for regulating parental behavior. In particular the inquiry found that: "The law of torts has a very limited part to play in the regulation of family life and it follows that parents do not owe legally enforceable duties to their children. They do however “have a moral duty” (Lee Ann Marks, 1995). It was judged that the Seymour Report had attempted to steer ‘middle ground’ through the contentious issue surrounding the role of maternal and foetal relationships. The report argues that legal measures are inappropriate and suggest solutions that would ensure that pregnant women are well informed of risks and given appropriate assistance in relation to guidance and information on the needs of the unborn. However, currently both New South Wales and Queensland child protection legislation make it a ‘reportable action’ for a mother to put her unborn at risk (Ainsworth & Hansen, 2006). Cited in this article is the story of a third-time mother whom a medical consultant reported for seeking a natural birth and refusing a caesarean section. It was the consultant’s view that the action of the mother was placing the welfare of her unborn at risk.

What is evident from the assessment of international approaches is that there is controversy and uncertainty about what should be done to address this issue of harm to the health and welfare of unborn ‘in ‘utero’ ’. A recent study in Ireland by Barry et al (2007) suggests that the state is failing to properly ‘vindicate and protect ’the life of the unborn child. This study estimates that approximately six-hundred children per year are born in Ireland with Fetal Alcohol Syndrome (FAS). The syndrome can result in children having attention deficit, impulsive behavior, retarded growth, facial abnormalities, hyperactivity, and psychiatric disorders (Barry et al 2007:2).

If the current child protection system became aware of risk of significant harm to a born child arising from a parental action, the system would invoke Section 12 of the Child Care Act 1991 to prevent such harm occurring. No current studies are available to consider the numbers of unborn children who are affected by illicit drug use. This may suggest that the figure from the study carried out by Barry et al is significantly conservative in its finding.

The evidence of this recently published study poses serious questions for the Irish social policy. Some have called for a legislative response to this issue with Schweppe suggesting that if Article 40.3.3 "is seen in a more expansive role than initial traditional interpretation of anti-abortion, then it is clear that legislation is needed to provide for the gaping holes that run through the current statutory framework" (Schweppe 2005:26).

It is important to note however, that in the event of the welfare and protection of the unborn being given a statutory status, this would likely cause considerable difficulties to practicing doctors, social workers and public health nurses. As current systems and thinking stand there is considerable reluctance and confusion about the status of the unborn in law. For social work practitioners to exercise their statutory role under the Children Act 1991, or under any future legislative instrument, would be a considerable challenge to the ethos of working in partnership with pregnant drug and alcohol users. The social work profession, if mandated to protect the unborn, would have to reconcile many ethical and moral dilemmas upon which it is grounded. The profession is based on respect for the 'inherent worth and dignity of the people it serves (IASW Ethical Principle 4.1). The manner in which social workers uphold ethical values to both mothers and their unborn is fraught with complexity. With the exception of Barker (1997) little social work literature can be cited in any analysis of this complex challenge in protecting the unborn. What is evident, however, is that the Irish social work professional stance is still evolving in relation to parental substance abuse. Despite the growing evidence on the impact of drug and alcohol on Irish families, there still is little debate on how addiction should be best handled by the profession (Butler 2002a:45). Furthermore, a study by Woods exploring the needs of women, drug use and parenting, found that on the basis of data collected

from professionals in the drug treatment and social work fields the "scenario for women drug users appears bleak and grim" (Woods 2000:280)

This evidence suggests that social work must reach a greater understanding of adult addiction, to inform professional practice on the needs of the unborn. Equally, it is imperative that addiction counselors and specialists understand the needs of children. Butler (2002a:14) in his assessment of the impact of alcohol on Irish children, argues that where parental alcohol use raises a welfare concern, there should be parallel service provision from both child and addiction specialists. Any development in a system that mandated the protection and welfare of the unborn should simultaneously develop parallel responses to achieve effective outcomes for both mothers and children.

Considerable thought, policy, and practice guidance will need to be developed in order to assist such practice development. It is argued that "professionals undermine their working relationship with families if they are unclear or equivocal about the extent to which options are available" (DOH 1995:15). Current systems operate within a vacuum, and as such, are likely to cause uncertainty both for the pregnant women and for professionals attempting to intervene. Child protection services have to deal with situations where such sources of concern exist. However, the ethical, legal and practice issues that arise when considering the unborn are relatively unexplored within contemporary social work practice. Early intervention where concerns exist is shown to have positive outcomes for both maternal and fetal health, but the mechanisms for such interventions remain unclear and unregulated (Barker, 1997:222). However, early interventions such as psychosocial interventions could operate within the current structures if greater awareness and understanding of the complex needs of drug and alcohol using pregnant women were understood by services at early contact points. Irish studies by Clarke and Fitzpatrick, 2005; Barry et al 2007: Fagan and Keenan, 2006 and McMillan et al 2007, have all consistently called for early intervention within a context of multi-disciplinary/multi-agency collaboration at the post birth stage in order to ensure better outcomes for both mother and child.

Multi-Agency Response

The requirement for multi-agency and multi-disciplinary work in protecting children has gained considerable status over recent times. A wealth of academic and social research studies all conclude that the need to work together is imperative in order to protect and promote the welfare of children (Hallet and Birchall, 1992; Hallet, 1995; Butler 1996; Buckley, 2002; Harrison et al 2003; Murphy 2004).These studies have demonstrated the need for closer working relationships in the field of child protection from one of rhetoric to one of political and social policy directives from governments to achieve this goal. In Ireland and in the UK, both Governments have developed and published documents to support, enhance and develop the field of multi-agency working through policy directives.

In Ireland, the publication of the *Children First Guidelines* (1999) saw the introduction of the first significant multi-disciplinary policy document to address the growing social concerns of child protection and vulnerable children. In the UK, publications such as *Working together to Safeguard Children* (1999 updated in 2006), and the findings of the Lord Lamming (2003) inquiry into the death of Victoria Climbie have seen a considerable emphasis being placed on the need for joint work. This has culminated in the introduction of legislation (Children Act 2004) which in *Section 10* legislated for multi-agency co-operation and commitment to ensure local safeguards for vulnerable, abused and neglected children (Murphy 2004).

Such developments have enabled “significant advances” for agencies and professionals to break down barriers which have affected the task of joint working in the past (Buckley 2005). As the general framework of multi-agency working was established over recent years, the need to focus on specific areas of practice was identified. Practice in the area of drugs and alcohol and their effects on child welfare and protection issues in the preceding decade became an area of professional concern where contested views still exist (Buchanan and Corby 2005). It has been acknowledged is that the knowledge level within the area of drug use and child protection is ‘woefully inadequate’ (McKeganey et al 2002). In the UK, the Advisory Council on The Misuse of Drugs (ACMD), a body

established under the Misuse of Drugs Act 1971, which is required to make representations to government and to offer advice to Ministers on issues pertaining to drug use, published the *Hidden Harm* Report.

The main findings of Hidden Harm were as follows:

- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
- Effective parental treatment can have major benefits for the child.
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases (Hidden Harm 2003).

Alongside these key findings, the report made forty-eight policy and practice recommendations. One such recommendation (3) focussed on the needs of pregnant problem drug users. The recommendation stated:

- *Problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic and these data linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. This would enable epidemiological studies to be carried out to establish the relationship between maternal problem drug use and congenital and developmental abnormalities in the child (Hidden Harm 2003).*

The UK Government produced a response to Hidden Harm (DfES, 2005), in which it set strategic measurable goals against each of the forty-eight recommendations of the original report. It is interesting to note that recommendation (3) cited above was accepted by the Department of Health (p. 2). The government report declined six of the forty-eight recommendations, citing reasons such as that the need was being met by other strategies.

There is a lack of contemporary Irish studies which seek to combine both the medical and social models of care for pregnant drug and alcohol users. Equally, there is an apparent dearth of any contemporary studies which reflect medical concerns on the combined issues of child protection, and adult drug use. Within the Hidden Harm Report, eight recommendations (3, 4, 8, 18, 19, 20, 24. 25, and 46) of the total forty-eight, focused on the issues of maternal substances use and misuse. This suggests that our neighbouring jurisdiction considers this area to be one of a public health need within its social policy directives. Separate Irish studies have recently consistently called for the issues to be addressed within government social policy (Barry et al 2007) and on a multi-agency level by Clarke and Fitzpatrick,2005 ; Fagan and Keenan 2006; Mc Millian et el 2007).

The need for inter-agency work in the field of parental problem drug and alcohol use is well documented. Nonetheless, the translation of such documented findings into real action through effective policy, procedure and service delivery are ad-hoc and uncoordinated. Women continue to experience drug treatment services as gender biased and discriminatory to their needs (Powis et al. 1997; Becker and Duffy 2002; EMCDDA 2006). Studies by both Buchanan and Corby 2005 and Tunnard 2002; and Woods 1994; 2000, have highlighted the fears and worries of women in approaching services due to negative attitudes held by some professionals arising from a lack of training and awareness on drug and alcohol issues. This can lead mothers and pregnant women to a fear of being judged as unfit in their role as parents, and being reported to child protection and welfare services.

Evidence suggests that a need for conjoined thinking and working together are vital to meet the needs of the maternal problem drug and alcohol use and those of the children who are exposed to it. Such development cannot succeed without positive liaison between different disciplines and between adult and children's services (Tunnard 2002; Butler 2002a). The task of protecting the unborn child presents both adult and child services with a complex and difficult challenge.

Some of the possible professional difficulties in working with the welfare of the unborn may be:

- the perceived and actual consequences of making a wrong decision in high-profile, high concern cases.
- the consequences for professionals of deciding for the removal of children at birth – possibly lengthy and demanding legal proceedings.
- feeling bound by the conclusions or views of previous professionals to the extent that divergence may be perceived as disloyalty.
- the amount of factors for consideration in assessment that are outside the professionals' direct experiences.
- the emotive nature of such work, particularly when coupled with strong views about removing children at birth (Calder, 2003).

Clearly, these concerns outlines the extent of the complexity that professionals face when attempting to intervene to protect the welfare of the unborn. However, such a task cannot be the preserve of either the medical or social models of practice in isolation. Murphy states that the responsibility of facilitating positive collaboration can not remain with any one practice group or any one level of the professional government hierarchy (Murphy 2004). Fagan and Keenan assert that doctors and society have a duty of care to the pregnant substance misusing woman and her infant – this is best done with a multidisciplinary team approach that liaises effectively with the obstetric service (Fagan and Keenan 2006).

Conclusion

The literature overview provides an insight into contemporary views on the unborn child in relation to maternal drugs and alcohol consumption in pregnancy. It summarizes the nature of national and international professional practice. It draws on a large body of evidence in research and social policy which highlights the need for protecting, promoting and ensuring safe outcomes for the unborn. Drug and alcohol using pregnant women who access services often find that there are significant shortcomings in the services provided (Collins 2007:65). Negative attitudes

experienced by pregnant women who access the health service can lead to fears of them being judged as unfit mothers. This is coupled with their fear of being stigmatised by child protection services.

Poor level of multi-agency cooperation is seen as a significant barrier to achieving effective holistic preventive responses to pregnant drug and alcohol users. Many of these difficulties appear to have originated in the lack of clear policy and procedural approaches in addressing the complex needs of this area of service provision. In addition, the need for professionals to develop skills in addiction work and for addiction specialists to equip themselves with knowledge of pertinent childcare issues as discussed by Butler (2002a) is imperative to shared professional understanding.

This literature review demonstrates that the welfare of the unborn is contingent on close working relationships between adult service practitioners and child welfare services. It further suggests that the needs of the unborn cannot be met without focusing on the needs of the mother. The provision of psychosocial services, counselling and therapeutic inputs is imperative in order to address the complex factors which prevail in illicit drug use and alcohol in pregnancy.

The literature review reveals that current practice developments in the Irish context are disorganised and lacking in a central co-ordinated focus. Recent publications by Barry et al (2007); The Institute of Public Health (2006); Department of Health (2006); and Collins (2007), indicate significant pressing issues that need to be addressed within Irish medical and social models of service delivery. The current legal initiative seeking clarity on the interpretation of Article 40.3.3 by Schweppe (2005; 2006) is timely. Clarity on the legal status of the unborn would contribute to greater awareness of their needs and would provide a framework for professionals to delivery preventative and supportive services.

Evidence presented in this literature review suggests that consistency is the key to protecting the welfare of the unborn. Consistent educational messages on the dangers of alcohol and illicit drugs are imperative, as well as a standardised response from professionals to pregnant users who

seek help. As the greatest period of potential harm to the unborn from drugs and alcohol occurs in the first trimester of pregnancy, early education is vital to protect and promote their welfare. Given the growing concern in medical and social work practice about the threats to the unborn whose mothers use drugs and alcohol, it is desirable that the principles of multi-disciplinary working are developed and applied effectively to this domain.

The chapter to follow will outline the aims and objectives of the study and the methodological framework applied in carrying out the research.

Chapter 4 - Methodology

Having completed the literature review, this chapter describes the study's methodological perspective. It outlines the research aims and objectives, the underlying methodological perspective, the methods used and the overall research design underpinning the study. In research design, the issues of access and consent will be fully explored and explained. The concluding section offers assessment of the limitations of the study, and of the reflective learning generated by the data. The overall approach is known in research as a 'qualitative approach', which will be described further within the Methodological framework.

Aims and Objectives of Research

This study aims to explore the experiences Public Health Nurses, Social Workers, and Maternity Hospital personnel of working with child protection concerns for unborn children, where parental drug and alcohol use is suspected.

The aims can be further broken down into four distinct parts:

1. To explore practitioners' beliefs, views and experiences in relation to their role when working with pregnant women and the unborn.
2. To examine what causes professional concerns in relation to the unborn child.
3. To explore participants' professional response to pregnant women and the unborn child.
4. To explore what would enhance multi-disciplinary working in responding to pregnant women and their unborn children.

Methodological Framework

This methodology takes a 'qualitative approach'. Qualitative research techniques are described by Mason as:

> *"grounded in a philosophical position which is broadly 'interpretivist' in the sense that it is concerned with how the social world is interpreted, understood, experienced, produced or constituted …. based on methods of data generation which are both flexible and sensitive to the social*

context in which data are produced ….and based on methods of analysis, explanation and argument building which involve understandings of complexity, detail and context" (Mason, 2004:3).

The qualitative approach is chosen as the methodology best supports the study's objective. Judith Bell (1993) states 'methods are selected because they will provide the data you require'. The study is concerned with the multidisciplinary response to the use of illicit drug and alcohol during pregnancy, asking if this presents a child protection issue in conducting their duties. This will involve exploring the current beliefs, practices and actions of the participants as well as collecting data which will assist the research task. In adopting a qualitative interviewing approach, the researcher is seeking to elicit participants' views as described by Mason (2004) of 'knowledge, views, understandings, interpretations, experiences'.

The study sought to explore this area of undefined practice, with a view to enhancing further thinking in future social policy development within the HSE setting. The approach taken to elicit the views and experiences of participants is known as a constructivist theory approach. Constructivist researchers consider the task of research to understand the multiple constructions of meaning and knowledge.

Ezzy (2002:3) suggests that constructivism allows for meanings to constantly change and are produced and reproduced in each social situation depending on the variables of the setting and the context as a whole. Through this approach the researcher is able to assess the different possible meanings of the data, the context from which they are derived, prior to linking those interpretations to the research objective. This paradigm appears to be best suited to answering the study objective.

Sample

The sample in this study is taken from within three distinct professional areas of public health and social care. These are social work, public health nursing and the medical profession.

Social Workers were chosen due to their statutory role to protect children, despite the fact that their role in relation to the unborn is currently

undefined by practice legislation. The social work service has been and continues to be involved with service users where drug and alcohol consumption figures highly within their caseloads. Currently the service contains some practice areas where pre-birth meetings are held in order to plan care for the unborn once born.

Public Health Nurses were chosen due to their statutory role post birth in caring for new born babies. Currently there is no role or involvement requirement within the Irish public health nurse role. This contrasts sharply with their UK counterparts, i.e. Health Visitors, who have a statutory role in the antenatal care of the unborn. The researcher selected Public Health Nurses in order to elicit their views in respect of their role and to determine whether they had concerns about the antenatal period from which they are excluded in their designated role.

Maternity Hospital Personnel were chosen due to their unique role and position in the role of pregnancy and childbirth. This is a group of mixed professionals from the maternity hospital setting. In research conducted in Dublin on the issue of harm to the unborn, the focus was confined to the medical model of public education. The researcher was keen to explore medical and social work views in relation to the wider social concerns of drugs and alcohol in pregnancy, and their experience of how social and medical services responded to their expressed concerns.

Access and Consent

Access to data sources involved seeking permissions from two different sources, in that the three professional groups identified in the study were set within two different organisational structures. The first group of Public Health Nurses and Community Care Social Workers were attached to the researcher's place of employment, the HSE. Formal permission was sought from the line manager to apply to undertake the study within the Health Service Executive. Consent to approach these two groups was granted (Appendix D) on behalf of the Research and Ethics Committee of the LHO on November 16th 2006. Access to the maternity personnel was a more independent process, whereby a letter was sent to the Master of the

hospital (Appendix E) to seek initial permission to approach the hospital staff.

The researcher appeared before a twelve member Ethics and Research Committee of the hospital on December 14th 2006. In depth questioning addressed how the proposed research would be conducted and how the issues of confidentiality and anonymity would be guaranteed. This included a more detailed copy of the informed consent document (Appendix F), and a copy of the researcher's Curriculum Vitae. Permission to formally proceed with the study was granted on January 10th 2007 as well as the resource of a hospital liaison contact person for the purpose of the study. (Appendix G).

Letters were circulated to each discipline head of service and the hospital liaison person inviting participants to participate in the study. The letter was entitled 'Seeking Research Interview Candidates' (Appendix H). In this communication potentially interested participants were invited to contact the researcher by phone or email. The hospital liaison person was successful in recruiting the five interviewees very quickly, due to her long standing role within the service. As participants responded to the invitation to be involved in the study, they received a copy of the research proposal and a copy of the informed consent document, asking them to fully consider the study and their willingness to freely engage as interview participants. They were further informed that the researcher would make telephone contact about two weeks later to ascertain verbal confirmation of their willingness to commit to participation in the study. The hospital liaison contact was given five copies of the proposal and five copies of informed consent documents in late January. At this stage the researcher was given the names of those personnel who had agreed to take part in the study.

Fieldwork

The fieldwork aspect of this study was carried out during the month of February and March 2007. Pre-interview processes were carried out in January. This involved mailing all perspective interview candidates with a copy of the thesis proposal and a copy of the Informed Consent procedure of the study. All candidates were asked to take some time to consider the

information with particular emphasis on the Informed Consent procedure. After two weeks of this initial posting of these documents, the researcher contacted each interviewee with the view to arranging a time to meet. Before assuming commitment, their permission was sought again to be interviewed following their assessment of the material sent prior to the verbal contact. All intended participants remained committed to participation in the study at this stage.

Semi-structured interviews took place mainly in the workplace of the interviewee. In addition, the researcher secured a confidential room in the HSE. Two candidates availed of this opportunity to be interviewed away from their direct work environment. Each interview took in the region of forty-five minutes to complete. All interviews were digitally recorded, with full consent granted by the participants prior to interview. The process of using digital recording equipment ensured a higher level of confidentiality to participants, in that there were no audiotapes involved in the process. This significantly reduces the possibility of tapes becoming misplaced or lost and reducing the possibility of other people getting access to the recordings post interview. All interviews were carried out over a four-week period beginning on the 12th of February.

The researcher entered into the social world of the interviewee in conducting the fieldwork. This was particularly evident in the maternity setting. This forum yielded additional observational data. The researcher was privledged to observe neonates within the intensive care unit, a profound experience. Atkinson and Coffey (1996:97) see field work ‘as a chance, an opportunity, special, where you think and write, where you are independent’. Certainly the fieldwork aspect of this study allowed new learning from a variety of professional settings. It afforded opportunities for personal reflection on values and ethical learning gleaned from the study. It elucidated understanding of the ethical dilemmas faced by practitioners in their daily working lives.

Such dilemmas were addressed by Loewenberg & Dolgoff (1996) as the principles of:

- the protection of life,
- equality and inequality,

- autonomy and freedom,
- least harm,
- quality of life,
- privacy and confidentiality,
- truthfulness and full disclosure.

These principles figured highly within this study due to the complex and contested area of practice it addresses.

Insider Status

Consideration was given to the method of engaging participants due to the sensitive nature of the study subject and to relatively high profile of the researcher accruing from his professional role as trainer and educator within the services. As stated in the literature, this area of practice is a contested area of moral, ethical and legal conflicts. The researcher was careful to avoid being associated with any aspect of this contested conflict. Bateson cautions on the need to take responsibility for the method chosen method of participation.

"In every research project, in any set of circumstances, there are always choices of how to participate in the situation. Whenever I make a choice, I commit myself to a broader category that encompasses that choice. Every question I pose and every quote I transcribe involve decisions within the arena of ethics and aesthetics. Bateson cautioned us to take responsibility for our choices and the way we elect to participate in life" Bateson (1987:87). The questions I ask as a researcher are informed by certain premises and presuppose certain beliefs, and to an extent, shape the answers I find. If I am looking for certain things, it follows that I am marginalizing other things. My identity as the researcher is an important component of the method, and this identity should be shared to contextualize the research in much the same way as the literature review serves to contextualize the research question.

The researcher acknowledges 'insider' knowledge of the service structures from which participants were drawn, deriving from the role of Training and

Development officer of the HSE. Many of the respondents had been on previous training events delivered by the researcher, with around seventy-five per cent of them known previously. This facilitated greater confidence in gaining access to research participants. Such a method of gaining consent would be classed as overt by (Silverman, 1999), informing potential participants, gaining their agreement with the permission of the gate keeper. This point is developed further in the section dealing with 'Access and Consent'. It was important, however, that those respondents saw the researcher in the role defined for the study purpose as opposed to the previously known role to which they were more familiar.

The researcher worked at establishing a research identity with participants in order that any confusion in the process of data collection is addressed. Bilton et al (1981) speaks of the importance of acknowledging one's own identity in the research strategy:

'The way in which you approach people is very important. It is impossible to have a neutral identity; we should try in advance on the identity we wish to create for ourselves, one that will affect things the least'.

It is therefore important to acknowledge that the researcher's identity approaching the study has both positive and negative attributes. A 'positive' feature of pre- research identity was the high profile in the service due to experience of training and education role to health professionals. A 'negative' aspect was the fact that the researcher could be seen as an educator on the subject matter of the study.

Semi Structured Interview

In collecting data using semi-structured interviews and observational techniques, the aim was to develop an understanding of each profession's organisational and management structures, their roles, views, and experiences of working with drug and alcohol using pregnant women. The interview guide (Appendix I) which was developed from the literature review and pilot interview, allowed flexibility for each participant in accordance with their role and responsibilities. When researchers require more specific information, a semi-structured format is employed (Merton et

al 1990). The interview guide allowed for this semi- structured approach. It was important not to be too rigid in the style of questioning, giving the spread of different professions within the group of interviewees.

It was imperative that the researcher remained as natural as possible in the interview role with the different professional roles encountered within the study. The less structured method interview approach facilitated a greater sense of exploration with the respondents. As stated by Wilson and Sapsford (2006:119) “less structured methods minimize procedural reactivity and all the freer exploration of respondents’ meanings and beliefs”. Such a technique of semi-structured interviewing was important due to the data collection being conducted in both medical and social work arenas. Furthermore, the objectives of the study are to elicit the views, experiences and concerns of the respondents. Therefore it was important structure of the interview facilitated this goal as naturally as possible.

The pilot exercise revealed the need for a more relaxed fluid interview style. Consequently, the interview schedule was altered and a more introduced open style of questioning was introduced in subsequent interviews.

Each interview lasted in the region of thirty to forty-five minutes. No further interviews were conducted once the initial cohort of interviews was concluded.

Pilot

A pilot study was conducted two weeks before the start of the fieldwork data collection of the main study. The following description by Mason (2002:44) best summarises the rationale behind a pilot study when she argues that:
“In the scheduling of this you should allow enough time not only to design and execute it, but to analyse and review your findings and to make forward decisions about your study on the basis of this”.

As this research study is only using one research tool in the collection of data, it was only necessary to conduct one pilot activity of qualitative

interviewing using semi-structured interviews. This pilot interview was carried out in the first week of February at the researcher's work location. A colleague in Health Promotion Department served as the pilot interviewee. The interview was carried out in the manner intended for the full study interviews to follow. The pilot interview addressed the schedule of questions, digitally recorded the conversation, and electronically uploaded the data to the researcher's PC.

Following this interview, a number of key changes were introduced to the interview schedule, as the pilot interviewee observed that the interview felt a bit 'rigid'. This feedback was invaluable in helping focus more clearly on the objectives of the study. It emerged from the pilot feedback that the questioning style interrupted the natural flow of the interview. The interview was restructured to ensure a more free narrative account from the interviewee. This was done by breaking up the physical layout of the interview guide, and introducing more prompt phrases instead of formal questions. The pilot allowed for digital recording of interviews. The quality of the material collected was superb. The process of uploading the digital recording to PC was straightforward. This greatly relieved the researcher's anxiety, and indeed helped to boost confidence in the physical and practical aspects of the process.

Data Analysis

In considering the task of data analysis within this qualitative research study, a number of key texts on producing an analysis of the data were considered (Mason, 1996; Coffey and Atkinson 1996; Robson 2002). The chosen method of analysis i.e. template analysis, was most suited to the task of analysing the data generated from the semi-structured interviews.

Robson describes the steps of template analysis as follows:

- key codes are determined either on a priori basis (derived from the theory or research questions) or from an initial read of the data,
- these codes then serve as a template (or bins) for data analysis; the template may be changed as analysis continues,

- text segments which are empirical evidence for template categories are identified,
- typified by matrix analysis, where descriptive summaries of the text segments are supplemented by matrices, network maps, flow charts and diagrams. (Robson 2002:458).

As described by Robson the template is derived from assigning codes to the data either from the research questions or from an initial reading of the data transcripts. Coding helps to organize, manage and retrieve the most significant and meaningful pieces of data (Coffey and Atkinson 1996:26). This allows for the data collected in the interview process to be condensed into manageable sections of analysed data. It is worth noting that Coffey and Atkinson warn that coding is not the complete process of analysis and it should not be seen as a substitute. A similar process of cross-sectional and categorical indexing is proposed by Mason (1996:111). This form of analysis uses classificatory categories to establish the common index. Index categories are then applied systematically and consistently to the complete volume of data.

This method of analysis is suited to the process of assessing qualitative data in that semi-structured transcript data is likely to be much less ordered; “it may be disorganised, eclectic, incoherent in places, and may or may not take the form of sequential narrative” (Mason, 1996:10).

Given the semi-structured nature of the interview transcripts, this form of data indexing/coding offered the most coherent approach to the analysis. Having read through the individual transcript accounts of each respondent (a total of 192 pages of transcripts) and reviewed the initial research questions, five index categories of policy and procedure were established. These were legislation, professional roles, services to women and multi-disciplinary working. With this task completed, the transcripts were re-read in more depth and colour codes were applied to the assigned index categories.

At this initial stage of the analysis the researcher was conscious that the categories were assigned early in the process. Allowance was made for the possibility of changing or adding to the categories as the analysis

progressed towards a conclusion. However, Mason warns that standardisation of the categories is essential and the decision of when to finalise the categories needs to be constantly evaluated (1996:124). Throughout the analysis process attention was paid to the possible social explanations to be found within the data to support the overall aim of the study. The task of data analysis is not just about coding information and linking that information to categories. Seidel and Kelle (1995:52) describe codes that "represent the decisive link between the original 'raw data' that is, the textual material such as interview transcripts or field notes, on the one hand and the researcher's theoretical concepts on the other".

Do the data, research questions and study aims have a common thread? It was necessary to continue asking this question throughout, in order to focus on the recommendations that would flow from the findings within the data. As this study is examining a 'grey area' of Irish social policy, the researcher sought to develop a social explanation described by Mason (1996:137) as 'Comparing' which is a form of explanatory logic throughout the analysis stage. This allows comparative explanations of social phenomena, social processes, social locations and social meanings. Given that all transcripts came from three professional groups, working in similar settings of health, it was felt that this comparative action within the analysis, would lend itself to giving social explanations and meaning to the outcome of the study.

Respondents' identities were withheld in order to conform to the conditions as outlined in the 'consent to interview' procedure. The following table gives a breakdown of the referencing method used in the use of data provided by the respondents. Professional roles are denoted as follows: Social Work (SW), Public Health Nurse (PHN) Maternity Hospital personnel (MH)

Research Code	**Profession**	**Length of Service**	**Current Service Role**
SW 1	Social Worker	21 Years	Community field work
SW 2	Social Worker	3 years	Community field work

SW 3	Social Worker	20 years	Senior Social Worker-family addiction support service (Statutory)
SW 4	Social Worker	30 years	Service Manager Child Protection (Statutory)
SW 5	Social Worker	18 years	Service Manger Child Protection (Voluntary)
PHN 6	Public Health Nurse	17 years	Community field work
PHN 7	Public Health Nurse	9 Years	Community field work
PHN 8	Public Health Nurse	30 years	Community field work
PHN 9	Public Heath Nurse	12 years	Community field work
MH 10	Consultant	19 years	Neonatal Paediatrician
MH 11	Registrar	6 years	Gynaecologist
MH 12	Social Worker	7 years	Team Leader
MH 13	Midwife	14 Years	Infectious Disease Service
MH 14	Midwife	12 years	Drug Liaison Service

Ethical Concerns

It became evident from the very outset of this study that the challenge of ethics and ethical decision would figure highly throughout all stages of the research. The researcher became familiar with and used professional guidelines prescribed from two sources. The first source was from the *Irish Association of Social Workers*, membership of which served as a source of guidance in times of professional uncertainty. The social work ethical code requires upholding the rights and dignity of the entire client group. In principles 4.1 of the organisations *Ethical Code* states

“Social work is based on respect for the inherent worth and dignity of all people, and the rights that follow from this. Social workers should uphold

and defend each person's physical, psychological, emotional and spiritual integrity and well-being" (p.4). However, professional ethical standards needed to be transferable to the professional research role. To this effect, the guidelines published by the Sociological Association of Ireland in 2005 were consulted. The guidelines offer three main areas of consideration for the social researcher: Relationship, Responsibility and Anonymity.

(1) Relations to Research participants: Sociologists, when they carry out research, enter into personal relationships with those they study. There is a responsibility to ensure that the welfare of the research participants is not adversely affected by their research activities.

(2) Responsibility: As far as possible, sociological research should be based on participants' freely given informed consent. This implies a responsibility on the researcher to ensure to explain as fully as possible, and in terms meaningful to the participants, what the research is about, who is undertaking and financing it, why it is being undertaken, and how it is be promoted. Cooperation should be negotiated, not assumed.

(3) Anonymity, Privacy and Confidentiality: Researchers have a responsibility to ensure that personal information of the participants is kept confidential. Commitments of confidentiality and anonymity must be honoured, unless there are exceptional, clear and overriding reasons to do otherwise.

Professional organisations codes of ethical standards and those of the Sociological Association of Ireland were employed throughout all aspects of preparing and undertaking this study. All participants were given a copy of the research proposal, along with a copy of the informed consent at the initial first contact when they expressed an interested in taking part.

Abbot and Sapsford (2006:265) state that nothing should be done to participants "without their agreement, and that this agreement should be based on adequate knowledge, supplied if necessary by the researcher, of what is implied by consenting". Furthermore, Gribich (1999) states that respondents should be told 'explicitly' of the manner in which confidentiality and anonymity will be maintained. Care was taken to give

participants as much knowledge as possible about the proposed research, given the sensitive nature of the research topic.

On second contact, all participants were asked formally if they wished to proceed having now read the two aforementioned documents. All participants gave consent voluntarily at this stage of the research activity. Anonymity was assured at the point of interview, where participants gave just a first name and professional title at the time of recording. All participants were offered a copy of the study on completion post submission and evaluation. Participants were informed that they would be informed of any future publication arising from the study.

One ethical dilemma that arose related to one of the interviewees whose role suggested possible easy identification within the study. This matter was discussed with the participant prior to interview. Another ethical issue to arise in the fieldwork data collection was the issue of the recording of interviews. Participants seemed confused / unsure by the use of a digital recorder machine rather than a tape. Interviewees were provided with a full explanation of the recording method in order to allay any fears they had. Silverman (2005: 258) urges us to take account that initial consent may not suffice by saying “however, initial consent may not be enough, particularly where you are making a recording. In such cases it often is proper to obtain further consent to how the data may be used

This was borne out in the interview situation. However, participants seemed more relieved and secure about the process once the digital method was explained. Participants were assured that the lack of tapes increased confidentiality, as a possibility of tapes becoming mislaid or lost was not a factor.

A further ethical concern was to truly and fairly represent the views and experiences of the cross professional group of participants. The nature of the research lent itself to emotional expression in the field work data collection. This feature demanded that the researcher should remain objective, independent and reflective within the data collection process. Hall and Hall (1996:176) talk about the need to reflect when they assert that researchers:

"Should therefore reflect upon what is happening in terms of the process taking place. This leads to greater sensitivity about the issues and topics being discussed and whether these are central to the concerns of the informants or not". This presented a significant challenge throughout the process, especially in the fieldwork stage of the project.

Limitations

This explorative study has to be considered a small study in that the number of interviews was limited to fifteen. Such small numbers cannot accurately represent a finding in respect of thousands working in the multi-disciplinary field of drugs, alcohol and pregnancy. This view is highlighted in Blaxter et al (2001:15 when they state
'No research project can realistically aspire to do more than advance our understanding in some way'.

The researcher acknowledges that the subject of child protection for the unborn is still a grey area within Irish social policy. It is hoped that the study can advance this area of practice in 'some way'. It therefore follows that the study is set within a limitation of the wider social policy of the state.

No case files were sourced or client information sought for the study. The absence of pregnant women and their views on the professional services they encountered during their pregnancy is one significant limitation of this study. The absence of drug and alcohol treatment service providers is a further study limitation.

Reflection

During the process of carrying out this research a number of personal issues arose for the researcher. Firstly, the subject of the unborn is a sensitive topic with which to engage conversation with respondents. Enquiring into pregnancy which is an exclusively female experience required a significant amount of reflection for a male researcher. Eighty per cent of respondents in this research study were female. Clearly, the written interview schedule proved to be invaluable in times of self consciousness.

The researcher's gender did not impact on the data collection either negatively or positively. Whether it influenced those who responded to the request for interviewees is unknown. Blaxter et al (2006:57) encourage reflection as "perhaps the most researcherly, it has to do with the ability to stand back from, and think carefully about, what you have done or are doing". After each interview the researcher used reflection in order to assimilate the information obtained and to question the impact of his role during the interview process.

Reflection on this study and the interactions with the respondents imbued the researcher with a sense of responsibility. This responsibility is measured by the commitment to complete this study, develop findings and disseminate those findings to increase awareness of the difficulties some participants were experiencing in their supportive role with the unborn. Outside the role as researcher and reverting back to being a social worker helped in the process of reflection. As a practitioner the researcher always operated within a framework of professional and personal reflection on interventions with service users.

Conclusion

This chapter outlined the nature of how this research study was undertaken. Firstly, it must be acknowledged that the research study in question has a number of features that requires careful consideration throughout the life of the study preparation, fieldwork, data analysis and writing up. The subject matter deals with a sensitive area of social policy and practice. The subject can be an emotive one, which evokes personal issues for those involved. This study is seeking to understand a complex social and moral area of this social work, nursing and medical practice. The subject matter is a much contested area of policy and law, which has been highlighted in the literature review. However, it is hoped that the study can shed light on an area of practice that is gaining a lot of attention in international jurisdictions and one which is causing some professionals a degree of anxiety within this jurisdiction.

Chapter 5 - Presentation and Discussion of Findings

Introduction

The last chapter will outline the findings from the qualitative fieldwork carried out with fourteen professionals, using semi-structured interviews. It will consider the qualitative findings alongside other research evidence in the literature, which supports the overall aims of the study. The findings are discussed in five main categories, as discussed in the methodology. These five key categories or themes are:

- Services to women,
- Multi-disciplinary working,
- Policy and Procedure,
- Legislation,
- Child Protection or Not?

The findings from respondents will be discussed in the light of the empirical research literature and theoretical findings as reviewed in Chapter 3. The findings are reported from the perspective set out in the study's aim of exploring the experiences of Public Health Nurses, Social Workers and Maternity Hospital personnel in their work with child protection concerns in relation to the unborn, where maternal drug and alcohol use is suspected. It will detail and explore the findings within each theme, offering evaluation of the findings within each of the five selected areas.

In the first theme discussed, respondents spoke of the difficulties that pregnant women face when interacting with services within an Irish setting.

Services to Pregnant Women

One of the key themes to emerge from the professionals who engaged in the study was the issue of services to drug and alcohol using pregnant women. This is consistent with Becker and Duffy 2002; EMCDDA 2006, who suggested that current structures veer heavily in favour of male drug and alcohol users, suggesting that services are patriarchal. Pregnant and parenting women who use drugs or alcohol face particular societal condemnation, which can often lead to women failing to access services or accessing services too late (Woods 1994; 2000; Farrell 1999; United Nations 2004) or, when accessing services may be confronted by professionals who wish to side-step the issues of addiction and refer on (Butler 2002a). The fear of being judged as unfit mothers, figures highly in the challenges services experience trying to engage women in treatment and education supports. In the executive summary of the UN (2004:1) report, it states the "women encounter significant systemic, structural, social, cultural and personal barriers in accessing substance abuse treatment". Coupled with the evidence from literature, the barriers within drug and alcohol treatment services, and the current structures and services of ante-natal care programmes (Abbas, 20007; Irish Times, 2007; WHO 2006, Collins 2007), suggest that pregnant women accessing services may encounter multiple difficulties within the very services assigned to help them.

Several respondents reflected that societal and practical living conditions were significant concerns for women affected by this issue. The manner in which drug and alcohol services are structured was seen by a number of respondents as problematic for women accessing help and education. When asked how we might reach the women who are pregnant and using drugs and alcohol, a public health nurse expressed the view that ante-natal care needed to be more accessible. Women whose drugs or alcohol use is chaotic, tend to be less structured and focused in accessing structured health services. As women usually keep their drug treatment appointments, it was felt that a holistic approach to the treatment and pregnancy could be best managed with the community drug treatment setting as opposed to the medical setting of hospital.

I would imagine you know, having services that are more meaningful to women as in maybe having ante-natal care delivered in drug clinics……. I would think more sort of like locally based services. (PHN 7)

In another case the Senior Social Worker talked of having family friendly services where women who are already parents, can access services which will cater for their children while they receive treatment.

"One thing that's been evident is that there's a need for such a facility, a sort of facility which combines childcare with support around addiction you know in a safe environment". (SW3)

When asked if we were doing enough to educate on the dangers of alcohol and drugs in pregnancy, one of the medical personnel stated:

"*Probably not because a lot of the people that have this problem are of lower social economic status, they usually have poor education and, poor link to the relevant people that may be able to teach them, so maybe a better outreach programme might be of benefit to target certain people" (MH 11)*

Such findings reflect previous Irish research carried out by Farrell (1999) which concluded that the 'lack of childcare facilities and the fear of being cast as an 'unfit mother' were significant barriers which prevented women coming forward to access treatment services' (2001:173). Similarly, the research conducted by Butler and Woods (1992) found that women suffering from HIV, a significant factor within addiction histories, were less likely to access services due to a fear of being cast as unfit mothers and having their children taken into care by the state. Copeland (1997:186) talks of the 'double deviant' stereotyping that is attributed to women users because they are often viewed as being sexually promiscuous due to their drug and alcohol behavior. She goes on to explain that the double deviance is born out of the traditional place that women have occupied within society. As the literature explored, this traditional place for Irish women is held very strongly within Irish social policy (Kiely, 1996; Stopper 2006). One interviewee suggested that due to this societal pressure, women were often their own harshest critics:

I think if society would see a woman who is using drugs while they're pregnant as the lowest of the low and the women who are using drugs when they're pregnant are completely aware of that and would also feel that, you know not feel that they're the lowest of the low but feel very acutely a kind of the you know, judgment that was out there, but equally would judge themselves quite harshly as well.(MH12)

A key sub-theme which emerged in the data was the concern of respondents that a significant number of the women who engaged with their services (public health, social work and maternity) were from lower socio economic groupings. A recent publication by the *Institute of Public Health in Ireland* suggest that babies born to opiate using mothers are "at the lowest end of the socio-economic scale and the risks experienced by these babies are exceptionally high" (2006:52), a view echoed by Fagan and Keenan (2006). Clearly, as discussed by MH 11, those women at the lower end of socio economic status are currently identified as hard to engage, and the current system structures may not be sufficient in addressing the needs of either the babies or their mothers who are deemed to be at "exceptionally high risk". Such high risk factors were seen by many of the interviewees as being twofold, firstly the level of substance abuse, but secondly the environmental factors both before and after birth. A hospital based social worker spoke of the difficulty of maintaining women in structured ante-natal care:

"Some of them will drop out of their drugs treatment programme, they could be living in a car, they can see, you know, ante-natal visits are really low on their priority list". (MH12)

Additionally, the simple fact of ante-natal appointments being offered at the wrong time and on the wrong day posed a significant challenge to this hospital service.

"And we discovered two things, Wednesday was before pay day and they didn't have the bus fare to come in and the other thing was eh, literacy or illiteracy, they knew the letter, they knew the letterhead was the == but

they couldn't figure out either the day or the date or the time, now we changed the clinic to a Monday" (MH14).

This evidence suggests that services are trying to do their best in engaging women with drug and alcohol use. *MH 11,* in her role as a drug liaison midwife, has made significant inroads in working with this client group in the north Dublin region. However, currently there are only three drug liaison midwives within the whole country who serve only the three main maternity hospitals in the Dublin region. The current liaison midwife at the hospital in this study has over eighty cases of babies born to methadone maintained parents (MH14). There are no such services to women who live outside the Dublin region.

"If you go outside of Dublin it's very, it's more pocketed (drug use) and all of that then makes it more difficult for the women to access services".
(MH 14).

The development of the Drug Liaison post within the Dublin region arose out of a need for a specialist post for women suffering from the HIV virus in late 1990's. It was in working with this group of pregnant women that the disclosure of drug use prompted the development of the current role, with the first liaison midwife role being appointed in 1999. This role is seen as pivotal to engaging women who are using/misusing while pregnant (EMCDDA, 2006:35; Scully et al 2004). Clearly, the development of a national policy on the provision of drug liaison midwife services, which engages all maternity hospitals, should be a matter of priority for the Health Service Executive.

The development of the service in Dublin is highly regarded by the professionals working in the three areas of service in this study (MH 10, 12. 13, 14, PHN 6 & 7 & SW 1, 2 and 3). This suggests that there is at least some development in challenging the old patriarchal structures of drug treatment. However, many obstacles remain in order to develop a system whereby women can access services without stigma and blockages (Butler and Woods 1992; Woods 2000; Becker and Duffy 2002; EMCDDA 2006). The development of women/mother friendly services is imperative in order to promote early access to prevention and education

services. The noted success attributed by interviewees to the drug liaison midwife role suggests that it is possible to build effective working relationships with pregnant substance using women. However, a consistent theme which emerged in the data is the lack of joint working and the provision of wrap-around services to women who are identified as being in need of specialist services during pregnancy. The data suggest that there is a lack of consistency amongst the different services. This can have a negative impact consistent with the findings of the UK study *Hidden Harm* (2003) which found that effective treatment of parents can have major benefits for the welfare needs of the child. One of the difficulties of the drug liaison role is the lack of effective consistency when she engages with other services:

I feel passionate that the women do deserve more consistency and I mean through that I would think there would be some more clarity for them and potentially better outcomes for baby. MH14.

There was evidence that individual professionals working to the same aim of providing and supporting women substance misuse, felt isolated in the task and without any sense of collective support.

"*I think you know that it will be very useful to actually see what, what other people are saying because sometimes you can seem like a voice in a church, you know, sort of speaking to yourself." (SW3).*

Summary

This section sought to examine the level and provision of services to women who use drugs and alcohol while pregnant. It found that service provision is still structured in ways that does not encourage the development of seamless services. The development of the Drug Liaison Midwife role in 1999 has made significant advances in meeting needs of women referred from drug clinics. The research finds the fast tracking of pregnant drug users into treatment services by the statutory addiction services is a significant positive outcome in meeting the needs of women.

Furthermore, the study finds that the development of support services to women while in treatment is very weak and disjointed. Respondents gave an impression of feeling isolated and overburdened with the challenges they face in trying to secure the wellbeing of pregnant women and achieving better outcomes for the unborn. The study noted a genuine sense of commitment from professionals, who felt isolated and misunderstood within the wider social network, to enhance opportunities for women.

A difficulty in engaging with other services substantially affects the services that are available to women. The study suggests that in order to properly focus, deliver and coordinate services, there needs to be a designated role with responsibility to provide integrated case management when pregnant women present for services. The current system of treatment needs to be developed into that which the EMMCDA (2006) calls 'integrated quality care'. This would ensure that there is a holistic response to pregnant addicted women, which recognizes their social, emotional and psychological needs. Collins (2007:65) suggests that Irish pregnant women are receptive to information during pregnancy. Such findings should motivate professionals to do more to promote health and harm reduction strategies.

Multi-disciplinary work

One of the prominent themes to emerge in the review of literature was the current poor status of multi-agency/multi-discipline working relationships in working with women who have drug and alcohol addiction needs (Buchanan and Corby 2005; McKeganey et al 2002). Such is the growing level of awareness and concern of the impact that addiction has on the family, that the UK Government funded the Hidden Harm report in 2003. One of its key finding suggests the reasoning behind why personnel need to work more closely together. "By working together services can take many practical steps to protect and improve the health and well being of affected children". (Hidden Harm, 2003).

Such findings concur with some local medical studies which have made similar recommendations in an Irish context (Barry et al 2007; Mc Millian et al 2007; Clarke, Fagan and Keenan 2006; Clarke and Fitzpatrick, 2005) as well as with academic studies by Woods 2000, Butler 2002a, 2002b, Butler and Woods 1992. Although such findings call for closer working with the issue of substance and women, there exists the complex reality that the work of ensuring the welfare of the unborn is emotionally challenging for some professionals documented by Calder (2003). The challenges of working collaboratively to deliver services are peppered with mistrust and unrealistic expectations according to Buchanan and Corby (2005).

The findings from this study suggest that there are some significant difficulties and barriers within and between professional groups working in the area of addiction, child welfare and maternity services. Clearly, when considering the issues of the welfare of the unborn, professionals can struggle to engage others with their concerns.

"This mother has two children in care as a direct result of her drug misuse but because she's moved areas then two community care areas are playing a tennis match, nobody's taking responsibility, there's no accountability, really confusing". (MH 13).

This experience of not being listened to and having concerns taken seriously was a common theme within the sample interviewed. Tunnard (2003) speaks of positive liaison between different disciplines as being essential to the task of protecting and promoting the welfare of children exposed to maternal drug and alcohol use. What is concerning about this finding is that the history of the case did not seem to signify the genuine need for intervention to support this mother and her unborn child. Such situations may ultimately lead to unwarranted intervention at birth, the new born being admitted into care and the parent/ child bond being damaged.

"I used to put money on she'll deliver now on Friday of a bank holiday weekend and there'll be you know high drama, section 12s, like unnecessary stuff you know because of bad management." (MH 13).

Barker (1997:226) noted that different responses from professionals were likely to arise as a result of the policies and practices of the child protection agencies and workers attached to those services. Similarly, the view that personality rather than policy was a significant factor pervading within the Irish child welfare services was noted:

"I think that social services in Ireland tend to be a mixed bag of people with their own personal and professional view, and I don't think that anybody is seriously addressing a lot of issues that are child protection let alone this area of the unborn. (SW5).

The Public Health Nurses within the sample portrayed a sense of grievance about the way they were involved with high risk drug and alcohol cases. Notifications came from the hospital after the birth. PHNs would often be told at this stage that concerns have existed from early stages in pregnancy, and that various meetings had taken place. This led to a feeling of mistrust developing between the professions.

"Such and such a one is coming home, she's hepatitis or something else or the child's on withdrawal symptoms, won't be discharged for three weeks and then the child is dumped out on the district so where do you go to?" (PHN 9).

A public health nurse expressed how angry she was, at being left out of the loop when asked to engage with a mother who had been seen by the addiction services and the drug liaison midwife in the ante-natal stage.

"Because I was very angry at that you know finding out there's a meeting tomorrow and I made phone calls and I asked people you know, why wasn't I involved? And I was told that it wasn't anything to do with me, it wasn't my remit, it wasn't you know, you know I was just the public health nurse, it wasn't up to them to involve me, it wasn't their role to involve me and they had dealt with it sufficiently and you know that was it".(PHN 6).

Clearly this feeling of being excluded could derive from poor communication. Lack of communication aids the development of a

mistrust, which ultimately creates difficult working relationships. Buckley (2000) talks of the need for professionals to develop a child centered approach which can transcend hostilities and tensions between professionals. Similarly, Butler (1996) found that some agencies were perceived as doing nice bits of practice, while others are left with the difficult practice decisions. Butler further observed that non-social work practitioners were unwilling to take on a social policing role. This was not a finding of this study in that individually, all respondents acknowledged their responsibility for the issues. Another participant talked of the lack of communication between the different disciplines as being a primary factor in the frustrations she experienced in working with drug and alcohol 'baby cases'.

"I often think because it's a contradiction in terms, I mean I think as Irish people we're so good at talking and all the rest and yet we're dreadful communicators a lot of the time you know." (PH8)

The art of communication is essential in any partnership role that endeavours to protect and promote the welfare of others. Murphy argues that " good communication can help to secure greater involvement by making individuals feel included and confident that they are sufficiently well informed to make useful contributions" (2004:35).

"I keep coming back to that, but I suppose it does just make you much more aware of you know, when you're in the picture, the bigger picture and more of the potential problems that might occur". (PHN 9).

"That they could have known about? Yeah I have to say I think probably public health nurses in there at the beginning would be quite a good idea, sometimes we forget them". (MH13).

A clear finding from the data is that all the maternity personnel spoke highly of their internal working-together strategies. Clear multi-disciplinary meetings take place each week. Cases where issues of risk as a result of alcohol or drug use are given considerable status and response by all the concerned professionals. This ensures careful management of the cases, and sets down clear care plans in respect of the pregnant women.

"Working internally here it's quite good yeah, quite well balanced and quite well organized." (MH 11).

"We will usually be together and there are multidisciplinary meetings, monthly and then make a plan for her so, it is working quite well so far we do discuss cases like this patient is at risk, what we need to do and try to". (MH12).

All five maternity personnel within the study had some level of difficulty when liaising with external agencies – particularly the HSE. External requests might for a family support worker to be provided to maintain the care package that had been started within the maternity hospital.

"I mean you know we would hope that in that planning process for example if it's home help she needs, or a family support worker, you know, and this used to completely upset me that at 28 weeks we'd be talking about family support worker, baby would be born, spend four weeks in the NICU having a neonatal withdrawal and still no family support worker, like where's the planning involved in that you know so I would see that as a huge problem." (MH 14).

The need for close working relationships between disciplines in respect of child welfare and protection has been well documented in the literature review (Hallet and Birchall 1995; Hallet, 1995; Butler 1996; Buckley 2002; Harrison et al 2003; Murphy 2004). The specifics of close working relationships in the field of drug and alcohol services has been discussed by Butler 2002a 2002b 2002c; Woods 1994; 2000; Buchanan and Corby 2005; Butler and Mayock 2005; Tunnard 2003; Calder 2003, and in medical assessments of pregnancy by Barry et al 2007; Coghlan et al 199; Clarke and Fitzpatrick 2005; Fagan and Keenan 2006; McMillan 2007; Collins 2007). Although this represents a significant contribution to the call for working together from medical, social and academic fields, there still exists a chasm between the models of care offered within different service structures.

When asked what they would like to see in place for pregnant substance users in terms of an integrated case management system, one respondent highlighted the difference between social and medical models of care as potential difficulties in achieving an integrated system of shared care.

"I think there's probably a slight disconnection between the social work services and the medical services you know". (MH 10).

Combined with the isolation of PHNs, and the difficulty in engaging social work services, a picture of disjointed services and non-cooperative practices emerges. The UN report of 2004 clearly states that appropriate interventions must include a collaboration between substance abuse treatment sectors and prenatal and child care services. Evidence from this study concerning joint working and multi-disciplinary liaison suggests that current structures are not meeting effective best practices treatment and intervention **(**Buchanan and Corby 2005). The concern about inadequate mechanisms for working together was shared by the social work services.

"I'm pretty you know irritated by the way the health board operates anyway, I would have had a much greater sense of working in Scotland and other areas of proper multidisciplinary and multi-agency working you know." (SW 5).

Summary

A recurring theme gleaned from the data analysis was that in working together in this field, professionals experienced communication barriers which prevented holistic care planning for mother and baby. These included a lack of understanding of roles and services which led to frustrations in achieving best practice outcomes. The breakdown in communications figured highly between maternity services, public health nursing and social work. One positive note to emerge from data analysis was the success of the drug liaison midwife role since its inception in 1999. This has created a fluid working relationship between the addiction and maternity services.

"Liaison midwife would get referrals from the addiction service obviously pregnant, would also get referrals from the maternity service on a methadone programme or maybe smoking heroin, injecting heroin, not on treatment so by merging the two services, the communication became quite good". (MH 14).

The success of this model has significantly reduced some risks to unborn/newborn children of drug and alcohol using mothers. Available data suggests that much work needs to be done to achieve integrated case management and co-ordinated child welfare assessments where drug and alcohol pose risks to both mother and baby. The working model offered by the drug liaising midwife has demonstrated success in bringing two agencies together. The development of this model in a multi-professional structure, encompassing social work, public health nursing, dietician, community welfare etc. could have a positive effect on meeting the holistic and somewhat complex needs of pregnant drug and alcohol users.

Policy and Procedure

The research found that there was no policy or procedure in operation for multi-disciplinary working within the field of drug and alcohol use in pregnancy. Currently there is no assessment framework or guidance to assess risks or needs in relation to the welfare of the unborn/newborn child. Barker (1997) talks of lack of professional clarity and of confusion with regards to the unborn child. The safeguarding of the unborn was a significant concern of all interviewees of the study. However, translating these concerns to practice principles was a difficult transition for some. It further emerged that there was more awareness of the dangers of drug use than alcohol use during pregnancy. Some argued that the introduction of clear policy and practice procedures would be an aid to addressing this issue.

"I do think it's a fault of the health system authority that we tend not to focus too much on alcohol abusers, to the extent as we would drug users, right." (MH13).

The feeling of not having any guidance and not knowing what do was expressed.

"I think if you had a framework and people are aware of what they, you know, what is expected of them and what they ought to do, you know". (PHN 7)

"It's sad to think that we might need a protocol how to communicate but maybe policy and procedure does again, stipulate certain things that has to be done". (PHN 9)

"I would like to see is a consistent approach in terms of policy or guidelines". (MH11)

One Local Health Office in the region has published guidance to professionals in respect of concerns for the unborn.

"If the social worker is satisfied that there are serious concerns, we convene a child protection, a pre-birth child protection conference, we invite parents as appropriate in the same way as you invite parents under the same guidance as we would if the child were born". (SW4)

This exposes lack of standardised practice within statutory social work services, in that another social worker in another local health office area, talked of needing a mechanism to be put in place in order to have proper multi-disciplinary case conferences.

"Where the hospital would have serious concerns around the level of alcohol or drug misuse you know, and the associated problems that often come with that, that eh, that there should be some mechanism for establishing a pre-birth conference." (SW3)

Clearly these discrepancies within social work services will cause much frustration and difficulty for other professionals in seeking to have concerns for the welfare of the unborn and new born addressed in a preventative way with parents at the early stages of pregnancy. Farrell's overview (1999) stated that assurance needed to be given to female drug users

seeking treatment, that such action would not jeopardize their role as mothers. It would be difficult to see how such assurance could be given judging by the apparent discrepancies and inconsistencies evident in current procedures and practices. Another social work practitioner when asked if policy and procedure could help her in her practice stated:

"Definitely yeah, because I think again without protocol or procedure every case is dealt with differently you know, and sometimes that doesn't work at times, but I think that if everyone is very clear about what's going on and the importance of working with an expectant mother you know, some people would see it as important, some people wouldn't, but if there's a protocol and a procedure there, these people have to be worked with, you know." (SW2)

Another response from a public health nursing perspective demonstrated that preventative and supportive practices were not on the agenda, due to lack of protocols for addressing the service needs of pregnant women who use drugs or alcohol.

"*You see there's no really protocol for us only you try and advise them, and if they're going to the GP, it's up to the GP to do something about it or if they're going to the hospital, but nobody seems to be doing anything, everybody's kind of passing the buck from one to the other. That's what's happening. I mean I'm being honest about it, it's not, there are no real protocols unless very bad drug addicts where the child is taken away and put into care." (PHN 9)*

There are some major concerns within the different professional groupings about how to work effectively and supportively with pregnant drug and alcohol users. This concern for professional guidance and practice direction has been highlighted by a number of locally based research studies over recent times. Barry et al in their study at the Coombe Women's hospital, called for collaboration of pediatrics, child psychiatrist and other health professionals in order to tackle the issues of drug and alcohol use in pregnancy (Barry et al 2007). Equally, Clarke and Fitzpatrick (2005:123) suggest "better liaison between all disciplines in order to ensure early diagnosis of problems and ensure continuity of care".

Although some positive policy initiatives have taken place in Ireland over recent years, such as the drug liaison midwife role, there is no clear auditing or evaluation of current service provision to drug or alcohol misusing women. This has led to the Department of Health (2006:68) describing current services being developed 'on an ad hoc basis rather than in a strategic national focus'. This study, focusing on the issues of low birth weight within high risk pregnant women, concluded that there is a lack of information on the 'success of multi-intervention initiatives. This belief about an 'ad hoc' nature of service was stated on a number of occasions within data collection:

"It's all a bit ad hoc. There is and again it comes back to what I feel is eh, lack of guidelines or procedures in place and depending who the team leader is, principal social worker, it depends on the response." (MH14).

"Would have a drugs liaison midwife to liaise with the local health offices and the care teams but her experience would be a very disjointed, ad hoc response, some very positive experiences but very, very negative experiences". (PHN 8)

"We have lots of policies but we never get the procedures written so everything is not uniform, a bit ad hoc. Now I would also say that it shouldn't just be for drugs and alcohol because domestic violence should be in there as well because usually that is when the physical violence will start, either when she falls pregnant or if she chooses to leave him, so you know". (SW 1)

The issues of domestic violence when considering the welfare of the unborn, is considered in number of international studies (Gilliland et al 1998; Jasinski, J. L. 2001; Humphreys and Stanley 2006). The correlation between domestic violence and drug and alcohol use is considered as a significant factor in protecting the welfare of a pregnant woman and that of her unborn child. Foetal harm and possible death have gained considerable attention, leading Schweppe (2005) to call on Irish legislators to revisit the constitution amendment of 40.3.3 in respect of domestic violence and the unborn. The study acknowledges the validity of SW1's

calls for policy and procedure to consider this area of practice in any future developments addressing the unborn.

In the event that there were coherent multi-disciplinary procedures for the assessment of risk and welfare in operation, then it is believed that such issues of domestic violence could be addressed within the myriad of issues that may affect women in pregnancy. A sample policy is included in Appendix J, demonstrating what a coherent multi-disciplinary policy might look like. This procedural document by Gloucestershire NHS (2004) is just one of many per-birth assessment tools that exist within the UK health structures.

Such procedural guidance would assist in creating a less ad hoc system, and give professionals the confidence to work in what is described as a complex area of practice (Barker 1997; Calder 2003). Continuity of response would greatly assist in giving pregnant women a consistent and less threatening service (Tunnard 2002). Clearly defined procedural practice guidelines could greatly assist in dispelling some of the fears pregnant women have as discussed in the literature by Powis et al. 1996; Becker and Duffy, Woods 2000; 2002; EMCDDA 2006; Fagan and Keenan 2006; Collins 2007.

Some main points that policy and procedure could assist which emerged from this study are as follows:

- the wide variation in knowledge between professions and within professions as to what constituted risk or welfare issues for pregnant women;
- the different professional roles with some having responsibility to adults and some to children;
- the lack of guidance and shared understanding between professions on acceptable behaviors in parenting;
- concerns that mothers may not be able to care for their newborns without community based supports;
- concerns amongst designated child protection officers over what
- constituted making a child protection referral.

Summary

As stated in the section on multi-disciplinary working, the research found that there is considerable misunderstanding between professionals in working with pregnant drug and alcohol users, which creates barriers to effective joint working and fluid practices across the different professional boundaries. The development of carefully crafted procedures and policy between the HSE and maternity hospitals could greatly diminish the problems of confused and ad hoc services. Where HSE social work and public health nursing services can engage early with the maternity and addiction services, then the full weight of supportive practices can be put in place.

"I suppose it concerns me at times in fact that it's very late in the pregnancy that the requests are made to me, maybe at 35 weeks and yes I would prefer to, for those concerns to be looked at an early stage".(SW4)

"We should really link in with each other the whole time, because it just makes, it's better practice you know". (SW2)

The data suggests that professionals do want to work proactively together in order to assist with better outcomes for both mother and baby. The lack of procedural guidelines is creating professional anxiety, which in turn contributes to professional barriers and misunderstanding. This ultimately leads to poor practice in our service response where concerns exist for both the welfare of the mother and her unborn.

Legislation

Study participants were asked to consider their understanding of the legislation in respect of working with concerns for the unborn. Did they feel they had a role designated in law which supported their objectives of protecting and supporting the welfare of the unborn and her mother? How did they view the constitutional status of the unborn and what, if any, implications this had on their practice? The views ranged from clear accountability to the unborn, with the unborn being treated in a similar

manner as the born child, to views that there is nothing that can be done until the child is born. This confusion is replicated within the literature and is consistent with the views expressed by both Schweppe 2005, 2006; Charleton et al 1999. Interestingly, what did emerge in the findings is the belief by some that the Child Care Act 1991 does have a mandate to intervene, while others felt it did not. One Local Health Office Manager who has direct management responsibility of the Child Welfare System stated:

"I would have the similar child protection functions as I have for children who are born where risks are identified, during the pregnancy to a child who, as yet unborn and, we proceed accordingly". (SW4)

This view contrasted sharply with other professionals within the study who felt that responses to concerns by the statutory services were very 'ad hoc'. The literature explored the subject of law and its application in the UK Structures. Here it found that although the Child Care Act 1989 does not specifically recognise the unborn within its legislative frame work, it does however instruct professional guidance in the form of " Working Together under the Child Care Act 1989", that intervention should take place where there is concern for the unborn (Barker 1997). This instruction issued by the UK Department of Health, has seen child protection registrations for the unborn in the UK since the first year of this guidance in 1992 (145 registrations), to the last year of the UK Child Protection register in 2005 at 310 pre birth registrations (Dept Of Education and Skills, 2006). This suggests that perhaps that the Child Care Act 1989 (a very comparable piece of legislation to our Child Care Act 1991), is being interpreted to take account of the welfare of the unborn as with the born child. This research was unable to find any notifications and registration of any unborn child in the geographical study area.

Professionals talked of having their 'hands tied' when attempting to intervene where they had concerns for the unborn:

"Yeah and again it's just, I would feel that our hands are tied in that there is nothing I can do". (SW2)

One respondent talked of the need for a mental/cultural shift in people's thinking about how we address the needs of the unborn. This would be consistent with the developments that are taking place internationally in respect of revisiting the welfare of the unborn.

"I would have these worries so in other words, in my view, personal view, the child protection system should operate, for the unborn as it does for the born child, and that, so that maybe, a mental and cultural shift that we need to make to be more systematic, in how we consider risks for unborn children". (SW4)

Such developments of cultural shifts have been evident for some time in other jurisdictions, most notably the United States of America child welfare system, which incorporates punitive responses and child welfare responses, where maternal behaviour poses risk to the unborn. Alperen and Paone (1998) talk of the problematic nature of punitive approaches that have taken place within the US Child Welfare system. Punitive measures can have the negative effect of preventing women coming forward for help. There was no call for punitive measures from any of the respondents to this study. Indeed respondents were more in favour of developing services to women rather than penalising them, a view that would be consistent with Fortin, who suggests that statutory coercion by way of criminal sanction is unlikely to persuade pregnant women to have more thought for their unborn (Fortin, 1988:76). Criminal sanctions deter women from seeking prenatal and substance misuse treatment (Berrien, 1990:340; Paone and Alperen 1998:103).

"Absolutely, yes, yeah, the punitive approach isn't really going to work, women need support not damnation by the courts". (PHN 9)

"I suppose it's both actually, it's not just child protection. It's the maternal protection in the first place." (MH11)

However, professionals did see the possibility of holding Child Protection Case Conferences, under the guidance which was issued in *Children First 199: 8.19.1,* as a possible positive step to engaging parents who fail to engage with supportive services. The view expressed was that such a

vehicle could enhance professional cooperation and regularise the services offered to women, where concerns persisted during pregnancy. It is important to note that some professionals considered the *Child Protection Case Conference to* be a statutory instrument under the law of the Child Care Act, 1991. This is not the case in Irish child protection processes at present; however the similar process in the UK model operates under legislation in the *Children Act 2004* (Murphy 2004). Confusion around this particular piece of practice may be caused by the inward flow of professionals from the UK Child protection system in recent years. Five respondents had previously worked within the UK system. The following quote is representative of a number of contributions on the issue of using the child protection case conference model to engage at risk drug and alcohol using pregnant women:

"I visited a few sites in the UK and eh I certainly, what impressed me most was there was really proactive multidisciplinary team working, now their system is a little bit different because they have greater communities supports in the UK than we do here from a maternity perspective and they certainly do seem to have more structures but I would definitely think that's the way we need to move forward". (MH14)

The professional interpretation of the constitutional statement of 40.3.3 varied from individual to individual in the study. Some viewed it as having no role in day to day practice of working with maternal behavior that may harm the unborn, while others felt quite strongly that we were failing to uphold the constitutional right of the unborn. The Constitution of Ireland specifically protects the right to life of the unborn, while at the same time ensuring the equal right to life of the mother (Article 40.3.3).

"And it's you know, until the child is born those rights don't appear to come into play". (MH14)

"I suppose there's a conflict in rights there and generally I think the situations always go in favor of the parents in that situation in my experience". (MH10)

There was general acceptance that the current system could not intervene, where professionals might have grave concerns for the welfare of the unborn in serious cases of drug and alcohol use. However, one professional talked of the inequalities that she perceived in the law. She had experience of being involved in a pre-birth case where the court had ordered a mother to undergo medical direction in order to safeguard the welfare of the unborn. These cases have taken place where it was necessary to give certain medications in order to protect the welfare of the unborn 'in 'utero'.

"You see part of me in my total cynical way right, thinks it is so much easier for, you know, super medics to go to a judge and it's sort of a sexier story for want of a better expression, right". (MH13)

What became clear in discussions on the subject of law and competing rights is that these 'rights' cannot be viewed independently of each other, but that some form of compromised intervention is needed. It was generally accepted that respondents felt a sense of unease and frustration in trying to meet the needs of both mother and unborn where concerns were expressed. Respondents wanted structured services which could safely negate the difficult waters of competing constitutional rights. The concept of a public health approach with a legislative basis, which would incorporate education, further research and a coherent holistic harm reduction treatment option, was the main finding to emerge in discussing the legislative base for addressing the problem. This concurs with literature produced by Butler 2002a; 2002b; 2002c; Tunnard, 2002 Woods, 2002; Schroeder 2000; EMCCDA, 2006; Barry et al 2007, all of whom advocate strongly that accessible non-judgemental services are the key to successful outcomes for children of drug and alcohol misusing parents.

"It probably would be a maternal issue and if you can help the mother to help herself then the baby should be fairly safe after the baby is born". (MH11)

Summary

There is a need to review some of the current systems and structures, whether based on policy or legislation. The upholding of the constitutional status of the unborn, in supporting and enabling the mother to achieve a best outcome for her new born, is collectively held as the best way forward. The difficulties and complexities of weighing up the competing demands in these cases have been documented by Barker (1997) and Calder (2003). Professionals need to be given strong leadership in order to safely negotiate these complexities.

Concerns exist within the professional groupings of Public Health, Maternity and Social Work. These can be addressed, given clarity and direction. Where cases present as serious risk either to maternity or GP services, the child care services need to respond in a systematic, proactive fashion. The legislative debates regarding the unborn will continue to challenge and change within Irish society in the years to come. This does not alter the current need for service planners and social policy writers to develop services that currently exist in law. Respondents in this study believe that there are sufficient current structures both in law and policy, which if properly administered, could greatly enhance service delivery to pregnant women in need of support. There is however, a need for the legislature to clarify if Article 40.3.3 of the Constitution can be interpreted in a more expansive manner, which could aid the understanding of prevention and support services.

Child Protection or Not?

Health care providers who participated in this study sometimes face the difficult responsibility of making decisions that affect their duty of caring for pregnant women in a non-judgemental way. Consideration of the welfare of the unborn, whilst attempting to engage a mother exhibiting behaviours which endanger the child, is loaded with moral, ethical and social responsibility. The absence of clear guidelines to help professionals caught between their responsibility to the mother and their responsibility to the unborn -leave workers without a suitable response that can ease their concerns. In cases where the behaviour is continuously repeated,

professionals face a dilemma in order to minimise the perceived risk, while maintaining continuity of care.

Fieldwork research for this study exposed similar ethical struggles as those described by Loewenberg and Dolgoff (1996). The subject of child protection for the unborn is complex bringing with it, as it does, the difficulty of balancing the rights and wrongs of professional practice.

"We proceed in practice faced with those ethical dilemmas usually, most usually one is faced with a parent who is seeking assistance and there are times where parents are not seeking assistance". (MH11)

The data demonstrates that respondents were unanimous in their view that drug and alcohol abuse can harm the outcome of the unborn 'in utero'. Many expressed the view that this harm is more likely in the first trimester of pregnancy (Appendix C), which poses a serious challenge, in that many women might not be even aware of their pregnancy at this stage. It was therefore believed that retrospective responses are of little use in preventing the short or long term effects drug and alcohol misuse in pregnancy. This finding suggests that the most effective protections given to the unborn are maternal protection and coherent education within wider Department of Health social policy directives. Sadly, current social policy and education on the issues of harm to the unborn is not deemed to be universally effective.

The *Strategic Task Force on Alcohol (Second Report 2004)* attempts to redress this situation through recommendations 6.11 and 6.12. These recommendations have not yet been implemented. The research could not find any comparable strategic recommendations in respect of drug use in pregnancy. A search of the states' Health Promotion Unit web page inserting the words "drugs and pregnancy" yielded no results. On a further search of the National Drugs Strategy 2001 – 2008, the author assessed the 108 actions of the strategy and found that none of the actions were related to pregnancy or pregnant women and drug use. There are however some recommendations' relating to children and child care.

No respondents sought punitive actions to be taken against women who continued to use drugs and alcohol in pregnancy. Respondents were asked if they considered the use of alcohol and drugs in pregnancy as a child protection issues. The following is a sample of the response given.

"Personally I think absolutely". (SW5)

"Where one human being's actions or inactions directly impact in a negative way on another human being and that human being is under 18 or pre-birth then it becomes a child protection issue, so yes it is a child protection issue". (PHN 9)

"Child protection has a huge role right, eh, it's a role that should be there throughout the entire pregnancy and not just when the child is born". (MH13)

"I definitely would consider it to be child protection yeah because I think it should be seen as that in the beginning." (PHN6)

"I would say yes there are child protection issues right, you know just to be the level and I think the early intervention could be the stuff that you know, …….even if you're reducing the amount of drugs or alcohol would have been consumed during the pregnancy you should be helping the foetus". (SW2)

"*Yes it is child protection". (MH14)*

The impact of alcohol consumption and illicit drug use during pregnancy on the developmental outcomes for newborn babies has been fully explored within this text. This exploration suggests that the protection of the unborn is a significant social issue, which has to be confronted and addressed in a coherent manner. Women need to be encouraged to book ante-natal care as soon as possible in pregnancy in order to ensure that they get adequate advice on the issues of alcohol and drugs in pregnancy.

However, Collins (2007:64) reveals concerning evidence that such services are being offered in a haphazard manner. Department of Health statistics state that 22.2 per cent of pregnant women wait until the second trimester of pregnancy before presenting for antenatal care, while 7.9 percent do not present until the third trimester (2006:248). The application of current antenatal strategies in line with those called for by the WHO report 2006 and outlined in this study could play a significant part in promoting the welfare of the unborn.

Where concerns persist following ante-natal assessment and advice, practitioners felt there was a need for more formal assessment structure that combined the medical and social philosophies of protection and welfare. Respondents were informed that the UK child protection system had 310 pre-birth registrations in 2005 (DES, 2006), and asked if they felt that this was useful tool in intervention.

"I think that should happen here." (SW5)

"I could yeah, I think it would be useful, you know there maybe previous child protection issues, or even where the hospital would have serious concerns around the level of alcohol or drug misuse you know, and the associated problems that often come with that, that, that there should be some mechanism for establishing a pre-birth conference". (SW3)

However, respondents referred to the current ad hoc responses from community care social work services, as a major stumbling block to effective intervention, whereby social work services were feared rather than perceived as supportive or preventative in their practice. It was clear from several accounts that this 'ad hoc' service sent mixed messages to parents, parents who '*all knew each other, and shared their stories of the social work service' (MH14).* This account is consistent with the findings of Woods 2000; Corby (2003), who reported that child protection services are ambivalent in their delivery of supportive practice when working with drug and alcohol abuse in families, while remaining vigilant in their need to offer protection from abuse. Clearly, concerns exist in some cases where parents willfully continue to abuse substances during pregnancy. These situations require a forum for assessment and protective response.

It is interesting to note that the subject of the unborn was first referred to in the reprinted version of *Children First (1999)*. In a memo sent to all Chief Executives by the Child Care Policy Unit of the Department of Health in May 2004, concern was expressed that notifications from other jurisdictions were not being acted upon or being acted upon too late. The memo cited cases demonstrating that pregnant women who had fled other jurisdictions, had had their babies and left the maternity hospital before notifications were passed down (Child Care Policy Unit, 2004). The memo closes by emphasizing the importance of such information being passed to maternity hospitals without delay.

This clarity on procedure and guidance from the Child Care Policy Unit of the Department of Health, in respect of children conceived outside this jurisdiction is in stark contrast to the guidance given internally for children conceived and born in Ireland.

Summary

This section explored an issue which is complex and full of ethical and moral dilemmas. In starting with the ethical principles, the study acknowledges that the challenge of offering protection to the unborn is fraught with difficulties and anomalies. What does emerge from the findings is that professionals consider the issue of drugs and alcohol during pregnancy as a child protection concern which creates difficult professional decisions and inter-disciplinary modes of working. In addressing the topic of protection for the unborn, it is clear that procedural guidance and co-ordinated seamless services are vital in providing for their protection. The findings of the previous sections in relation to services to women, legislation, multi-disciplinary working and policy and procedure cannot be ignored if we are to offer genuine services of protection and welfare. In the absence of clarity on the issue of whether the Child Care Act 1991 has any pertinent authority, it is obvious that provision of preventative and support services to mothers would afford optimum protection to the unborn. In the words of MH11 ‘maternal protection is child protection’.

Overall Conclusion

A number of key points emerge from the findings as follows:

- The respondents highlighted the need for drug and alcohol services for pregnant women to be more women friendly and accessible. The need for maternity and ante-natal services to be more accessible is further highlighted.
- More liaisons between the services of adult, child and maternity professionals.
- Maternal protection is good child protection.
- Services need to be supportive and caring rather than being coercive and controlling.
- The need for procedural guidance to assist professionals in this complex area of practice.
- Less legally driven and more social services provision with effective supports.
- Services are currently delivered in an ‘ad hoc’ manner. This causes frustration to the professionals working in this field.
- Alcohol and illicit drug use in pregnancy is a child protection concern which needs to be addressed.

Chapter 6 - Evaluation and Recommendations

Introduction

This study set out to explore professional concerns of public health nurses, social workers and maternity hospital personnel of working with pregnant women who consume illicit drugs and alcohol during pregnancy. The study asked if they consider the issue of illicit drugs and alcohol in pregnancy to be a child protection issue. In particular, the study sought answers to the following research questions:

1. To explore practitioners' beliefs, views and experiences in relation to their role when working with pregnant women and the unborn.
2. To examine what causes professional concerns in relation to the unborn child
3. To explore participants' professional response to pregnant women and the unborn child.
4. To explore how to enhance multi-disciplinary working in responding to pregnant women and their unborn children.

The findings suggest a great variation among professionals in responding to the needs of unborn children and their mothers. The study considered five key areas of professional practice, seeking to understand how these five areas impacted on their ability to work with illicit drug and alcohol using pregnant women:

- Services to women,
- Multi-disciplinary working,
- Policy and procedure,
- Legislation,
- Child protection or not?

Services to Women

A particularly strong finding of the study is that the current provision of services to pregnant women using illicit drug and alcohol, are un-structured and ad hoc in their delivery. Such a situation for women is described by Woods as 'bleak and grim' (Woods 2000:280). The challenge of promoting the welfare of the unborn is impacted upon by drug treatment structures which are perceived by pregnant women and professionals as patriarchal, with serious delays and haphazard information provision in the health system in respect of ante-natal care (Collins, 2007). As stated in the literature review, the optimum first ante-natal check needs to happen in the first trimester at around 10 to 12 weeks. However, current health system structures are delaying that first assessment until the 20th week of pregnancy.

Professionals spoke positively about the development of the *Drug Liaison Midwife* role and how this improved the access routes for pregnant women into treatment. However, the findings also suggest that this service suffers from a lack of holistic strategies to encompass the psychosocial needs of the women who access treatment. There is a dedicated focus on treatment options, but very little on education and prevention. Recent studies by Lambe (2007) and Collins (2007) found the 'time' constraints were offered as mitigating circumstances by professionals, for not offering holistic services of advice, information and guidance to women in antenatal care.

Professionals within the three disciplines talked of needing a coherent, holistic approach to meeting the needs of illicit drug and alcohol pregnant users. The need for parent-friendly policy responses was seen by most respondents as the most effective measure in ensuring the best outcome for the newborn child. The study found that there is a significant void within the social model of care offered to illicit drug and alcohol using pregnant women. There is a clear need for the development of specific services to encompass the psychosocial needs of advice and counselling in order to identify the social and emotional needs of pregnant women while accessing treatment services. However, the studies and findings by Collins (2007) and Lambe (2007) cannot be ignored in the provision of such services.

Multi-Disciplinary Working

The study reviewed a number of international texts in respect of working together where issues of illicit drugs and alcohol use in pregnancy were a concern (Barker 1997; Calder 2003; EMCDDA 2006; United Nations 2004). The findings of this study show that inter-agency/multi-disciplinary working needs to vastly improve, if the longer term and more complex needs of illicit drug and alcohol use in pregnancy are to be addressed.

The study found some isolated pockets of good practices, where individual professionals had some successes due to their personal commitment to achieving best practice in working with pregnant illicit drug and alcohol users (MH 11). For these isolated pockets to become the norm, it is essential that the responsibilities and roles of the agencies involved in providing services to pregnant women be clearly articulated and supported by policy, procedure and training in the models of health and social care. Barker (1997) noted that the subject of protection of welfare of the unborn is fraught with complexity. This study concurs with Barker, in its finding that professionals suffered from professional isolation when endeavouring to address their concerns about the welfare of the unborn.

The issues of communication figured highly for many of the respondents, who believed that an improvement in communication could produce a corresponding improvement in services. Respondents did not express a view that services were under funded though they stressed that the lack of communication and working together was the biggest concern of those interviewed (PH8, PHN 6, MH 13, SW 5 MH 10). The findings concur with those of Buchanan and Corby (2005); Tunnard (2003); Calder (2003); Butler 2000a, all of whom called for greater links and closer working relationships between the adult health and the child welfare systems of service delivery.

The study revealed a lack of understanding of each others' roles and responsibilities between professionals, with some being excluded from vital aspects of case management of pregnant women where risks were identified (MH 13; PHN 6). Findings suggest that professionals need clarity on their own roles and responsibilities, with regard to pregnant illicit drug

and alcohol users. This clarity needs to come from organisational ownership and delivery of health promotion and harm reduction polices and procedure, to adequately support the welfare of both pregnant women and their unborn children.

Policy and Procedure

The study looked at the issue of policy and procedure when working in the area drugs and alcohol use in pregnancy. The findings suggest an absence of a coherent holistic approach in policy or procedure. They show the existence of one effective treatment model in the number of pregnant women who are fast tracked to treatment with the drug liaison midwife. However, as noted by MH 13, the linking of 'needs' to a model of social care on issues such as housing, child care, and family support were extremely ad hoc and in-accessible to many pregnant women. The absence of policy and procedure was disadvantageous to professionals engaging with the women. Inconsistent service delivery created a fear in pregnant women of being judged harshly. This finding concurs with those of Farrell 1999; Woods 2000, suggesting that assurances are required for pregnant women to trust the system wishing to engage them.

The findings are consistent with the acknowledgment by the Department of Health (2006), that current services are developed on an' ad hoc basis' with no overall strategic plan or vision being in operation. Coupled with no single ante-natal care strategy (Abbas 2007), together they signify a significant weakness in meeting the complex needs of pregnant women who use illicit drugs and alcohol. The findings of the study suggest that where care and treatment are combined, comprehensive educational supports can be delivered on the dangers of the medical and social consequence of drugs and alcohol in pregnancy. This was the case were one local health office social work intake team was working proactively with its maternity colleagues. Where multi-disciplinary pre-birth meetings took place, the outcomes were generally more favourable to both mother and new born child. This team operated within a Local Policy Guide issued in 2005, which included a section on the issue of pre-birth assessment. As stated by the EMCDDA 2006; Fagan and Kennan 2006, pregnancy is a key motivator for women to enter drug treatment services. Although the

Irish treatment services have some positive gender specific approaches to pregnant women, these are not borne out in any coherent psychosocial approach to meet the wider services needs of pregnant women entering treatment.

It was the wish of many of the respondents that some form of joint protocol/procedure could be implemented with the three main strands of service provision of social care, addiction treatment and maternity care. It is hoped that such a development would aid the focus of best practice and ensure a more needs-led service for illicit drug and alcohol using pregnant women. This would ensure that there was a system in place to respond to professional concerns for the welfare of the unborn with clear and accountable communication between agencies.

Legislation

This study evolved from seeking to understand the constitutional rights bestowed on the unborn in Article 40.3.3, asking if these 'rights' presented a challenge to the professionals working with illicit drug and alcohol using in pregnant women. The study acknowledged that Article 40.3.3 is primarily a legal instrument to uphold the right of the unborn in preventing abortion in the Irish state. However, the latter part of the constitutional statement states that it will "*by its laws to defend and vindicate that right*".

The Penguin English Dictionary defines the word 'Vindicate' as "to *maintain the existence of; to uphold".* From this we can infer that the Irish legislature intends to maintain and uphold the right to life of the unborn. The study does not seek to offer judgement or opinion on the act of pregnant women seeking to have an abortion. It does, however, seek to offer opinion on the duty of the state to uphold the rights of unborn, by not having their lives impaired due to illicit drug and alcohol during this most vulnerable, delicate stage of life in 'utero'. The Constitutional statement by its very nature, applies a legal precedent to grant the same status to the life of the unborn as to a born child.

The research findings suggest that there is a real and palpable level of concern on this topic existing within the medical, legal and social work

arenas. Modern medical advances have informed our understanding and knowledge from those first clinical findings of Smith and Jones (1973) on the developmental effects of alcohol on the unborn, and findings from Margura and Laudet (1996); Chasnoff, (1988, 1991) on the harm caused by illicit drugs. Barry et al (2007) offer further knowledge when they state that in the region of six-hundred children per year are born within the Irish state, with some level of harm under the umbrella term of Foetal Alcohol Spectrum Disorder.

During the data collection for this study, an interesting point was made by MH13, when she talked about the 'sexier end' of protecting the unborn. In this comment the respondent felt there was an unequal application of the rights of the unborn by the Irish legislature. Since this interview the issue of the unborn has reached our courts yet again in the case known as Miss D. This case concerns the right of Miss D. to travel to the UK to seek an abortion of her four week foetus who suffered from anencephaly, a condition resulting in the absence of a major part of the brain, skull and scalp. An interesting note from this case was the appointment of a Senior Counsel on the 2nd of May 2007, to represent the interests of the rights of the unborn (Irish Times 2/5/'07). Here we see the states' obligation to protect and vindicate the life of the unborn as per the constitutional statement of 40.3.3, and to give the unborn an equal status within the legal proceedings of this case.

The study does not argue for punitive or draconian measures to be taken on pregnant women who use illicit drugs and alcohol in pregnancy. However, it clearly suggests that there is a need for a mid-way point between the constitutional statement and the day to day practice in maternity, addiction and social work services. It is suggested by some respondents that the Child Care Act 1991, should be unequivocal in its role to protect and promote the rights of the unborn in the same manner as it acts on the part of born children. Given our unique position of having a constitutional statement on the rights for the unborn, it therefore should follow that the Child care Act, 1991 could and should act in a supportive manner to protect the welfare of the unborn from potential harm where concerns exist.

Child Protection or Not?

This study sought to explore this difficult question through the words and experiences of three separate professional groups. The findings suggest an unequivocal positive answer to this question. However, they further suggest that respondents did not view their concerns of harm for the unborn as wilful acts by its pregnant mother, but more as a matter of circumstantial factors of poor education, high socio-economic barriers and ad hoc poor delivery of state services in the prevention of such harm. The study reflects poor inter-professional liaison, which is primarily a result of state failure to give adequate guidance, protocol or procedure on this complex area of practice.

This has resulted in misunderstandings, poor communication, professional anxiety and a feeling of helplessness on the part of professionals to protect and promote the welfare of the unborn. Such views are consistent with the work of (Barker 1997; Calder 2003), who advises us of the complexity in addressing the competing rights which abound in these cases. What is evident from this study and that of Barry et al (2007) is that the subject of harm to the unborn is not necessarily a wilful act on the part of most pregnant women, but one which needs to be acted upon by the state in order to address the factors of health promotion, harm reduction strategies and socio-economic exclusion.

What is evident in the data and in consulted literature is that a more proactive social policy is needed. This policy needs to educate, support and guide women on the dangers and to minimise the effects of illicit drug and alcohol intake during pregnancy, if there is to be a reduction in harm to future cohorts of Irish children. The helplessness felt by a number of respondents (SW 2, PHN 9 PHN 6, and MH 13) needs to be addressed if it is truly the case that the Irish constitution gives equal rights to the born the unborn. The feeling of having their 'hands tied' would not be a factor in responding to a born child where similar factors of harm were evident. As stated under the legislation analysis, clarity needs to be brought to the *Child Care Act 1991*, in order to give some benchmark from which practice can develop in this area. The vast majority of child protection and welfare cases coming before the HSE receive support, resources and assistance to families in need. The author believes such services can and should be

delivered to pregnant users of illicit drugs and alcohol, in a multidisciplinary, coherent, and co-ordinated manner, in order to promote the best possible outcome for mother and child.

The study makes the following seven recommendations based on the emergent findings of the five themes addressed.

Recommendation 1 Service to Women

- All agencies working with pregnant drug and alcohol users should recognize that they have a responsibility towards dependent children and the unborn. Services should consider whether they could improve the effectiveness of their interventions by adopting a holistic, needs-led, women centered approach.

Recommendation 2 Services to Women

- The current Drug Liaison Midwife Role should be extended so that all national drug treatment services can have access to the most appropriate guidance, supports and maternity links. The study suggests that the appointment of a national Consultant status Drug Liaison Midwife be put in place, to guide the current system and to campaign for better co-ordinated services to pregnant women.

Recommendation 3 Multi-Disciplinary Working

- That the HSE, in conjunction with the maternity services, develop multi-disciplinary training programmes on Pre-Birth Risk Assessment. This would facilitate the bringing together of professionals from the different professional groupings to work on effective, preventive interventions where concerns exist.

Recommendation 4 Multi-Disciplinary Working

- That the Department of Health consider setting up a national advisory group with regional representation to advise and inform on

the development of services for pregnant women who use drugs and alcohol during pregnancy. Suggested membership includes GP, Public Health Nurse, Social Work, Drug Liaison Midwife, Consultant Gynaecologist, and Community Welfare Officer, Drug Treatment Professionals.

Recommendation 5 Policy and Procedure

- That the HSE, in partnership with the maternity hospitals, develops a joint procedure to detail the working relationships and mandatory procedures for dealing with high risk pregnancies due to illicit drugs and alcohol consumption, where there is a concern for the welfare of the unborn. A sample protocol is contained in the appendix (J).

Recommendation 6 Legislation

- That guidance is issued under the *Child Care Act 1991*, for appropriate and sensitive measures to protect and promote the welfare of the unborn. That such guidance is universal and consistent in its application.

Recommendation 7 Child Protection or Not?

- HSE Health Promotions Service develop programmes and advertising to educate women who are thinking of becoming pregnant concerning the use of substance use and alcohol during pregnancy. The current HSE promotion on the issues of folic acid in pregnancy is an example of the promotional scale needed on the subject of illicit drugs and alcohol in pregnancy.

The Final Word

This study set out to explore what was termed a 'grey area' within Irish social and legal policy. In doing so it sought the views, experiences and concerns of fourteen professionals from different walks of life within Irish public services. The study discovered that although this area might be 'grey', it is one that holds serious concerns and anxieties for those professionals.

These findings suggest that there is a real and pressing issue to be addressed within our future social policy direction. The need for women/parent friendly services are vital in any attempt to protect and promote the welfare and post-birth outcome of children born to illicit drug and alcohol users. Respondents spoke passionately about mother protection as the best form of protection the services could offer to the unborn. It is apparent in the services structures, that there are major concerns from different professionals about poorly structured services, lack of shared values, and structural blocks to communication and cooperation. The study found that current ad hoc service structures need to be reviewed in the light of both medical and social recent advances concerning the welfare and treatment of pregnant women. The development of greater social awareness that could aid the development of fluid, interlinked health and social services is an imperative, in order to promote the welfare of the unborn in 'utero'.

In order to achieve this goal, collaboration is required at all levels within the structures, as has been well documented by Irish academic, legal, medical and social researchers. Evidence from this study suggests that professionals are aware of and committed to the principles of multi-disciplinary working. However, the lack of guidance in this area is deemed to be a major hindrance to their efforts. The results suggest that services need to address the issue of maternal alcohol and substance use in pregnancy. This can only be done through a strategy of multidisciplinary ownership of this complex challenge. Bridge building between addiction services, child welfare services, health promotion specialists and obstetrics is essential if we are to truly believe in the old adage – prevention is better than cure.

Bibliography

Abbas, M., (2007) Antenatal Care in Low Risk Pregnant Women: Modern Medicine, The Irish Journal of clinical Medicine, Vol. 37 (1) p 52- 55

Abel, E., (1999) Was The Fetal Alcohol Syndrome recognised by The Greeks and Romans? Alcohol & Alcoholism, Vol. 34 (6) 868-872

Ainsworth F., Hansen, P. (2006) Five tumultuous years in Australian child protection: little progress: Child & Family Social Work 11 (1), 33–41.

Alperen, J., Paone, D., (1998) Pregnancy Policing: Policy of harm. The International Journal of Drug Policy, Volume 9 (2) pp 101-108

Ashton, M. (2005) The Motivational hallo. Drug and Alcohol Findings. 13, 23-30

Atkinson, P. & Coffey, M. (1996) Making sense of Qualitative Data: Complementary Research Strategies. London: SAGE Publications

Azuma S., Chasnoff, IJ., (1993 "Outcomes of Children Prenatally Exposed to Cocaine and other Drugs: A path of Analysis of Three- year Data", Pediatrics 92: 396-402

Barker, R. (1997) Unborn Children and Child Protection – Legal, Policy and practice Issues: The Liverpool Law Review Vol. X1X (2)

Barry, J., (2002) Policy response to opiate misuse in Dublin. Journal of Epidemiology and Community Health, 56, 7-8.

Barry, S., Kearney, A., Lawlor E, McNamme and Barry, J., (2007) The Coombe Women's Hospital study of alcohol, smoking and illicit drug use 1998 -2005. Department of Health & Children. Dublin: The Stationery Office.

Bateson, G. (1987). Conventions of communication: Where validity depends upon belief. In J. Ruesch & G. Bateson, Communication: The social matrix of psychiatry (pp. 212-227). New York: Norton.

Becker, J,. and Duffy, C. (2002) Women Drug Users and Drug Services Provision: service level responses to engagement and retention. Home Office Drug Strategy Unit. London HM Stationery Office

Bell, J., (1993) Doing Your Research Project. Buckingham: Open University Press,

Bell, Gl., Lau, K. (1995) Perinatal and neonatal issues of substance abuse. Paediatric Journal of North America. 42: 261-270

Berrine, J. (1990) "Pregnancy and drug use: the dangerous and unequal use of punitive measures". Yale Journal of Law and Feminism (2) 239-250

Berger, C, Sorenson, l., Gendlet. B., (1990) Cocaine and policy: a challenge for health care providers. Health and Social Work. 15 (4): 310-314

Benegbi, M. (2006) 45 Years later…. where do we stand! Motherisk Update Conference 2006, Toronto. [online] http://www.thalidomide.ca/en/information/45%20years%20later.html (accessed 29 /01/ 2007)

Bilton. T., Bonnett, K. et al (1981) Introductory Sociology. London. Macmillan

Blaxter, L. Hughes, C and Tight, M. (2001) How to Research (2nd Edition) Buckingham: Open University Press

Blaxter, L. Hughes, C and Tight, M. (2006) How to Research (3rd Edition) Buckingham: Open University Press

Blondel, B., Pusch, D., Schmidt, E, (1985) Some characteristics of antenatal care in 13 European countries. An International Journal of Obstetrics and Gynaecology 92 (6), 565 -
568

Bowen, N. (2007) Jude aims to protect woman's unborn child. The Sarnia Observer, April 5th. [online] www.theobserver.ca Accessed 23/04/2007

Buchanan J & Corby B (2005) 'Drug Misuse and Safeguarding Children: A Multi agency Approach', pp 163-179 in R Carnwell & J Buchanan Effective Practice in Health & Social Care: A Partnership Approach Open University Press, Maidenhead

Buckley, H., (2000) 'Interagency Co-operation in Irish Child Protection Work', Journal of Child Centred Practice, (6) 9-17

Buckley, H., (2003) Child Protection Work: Beyond the Rhetoric. London: Jessica Kingsley Publishers.

Buckley, H., (2005) Review of Children First: Some Considerations. Irish Journal of Family Law. 3. pp 2 – 7.

Buckley, H., Skehill. C, and O'Sullivan (1997) Child Protection Practices in Ireland – a case study. Dublin: Oak Tree Press

Bunreacht na hEireann (1937) Constitution of Ireland. Dublin: stationery Office

Burns, E., O'Driscoll, M., Watson, G.(1996) The Health and Development of Children Whose Mothers are on Methadone Maintenance. Child Abuse Review Vol. 5: 113-122

Butler, S (1996) 'Child protection or professional self-preservation by the baby nurse? Public health nurses and child protection in Ireland'. Social Science and Medicine 43, 303 -314.

Butler, S. (2002a), 'Addiction Problems, Addiction Services, and Social Work in the Republic of Ireland', Journal of Social Work Practice in the Addictions, 2. 3/4: 31-48.

Butler, S (2002b) Alcohol Consumption and Its Negative Impact on Irish Children and Young People. Cited in- Under the Influence, Dublin: Barnardos.

Butler, S. (2002c). Alcohol, Drugs and Health Promotion in Modern Ireland. Dublin: Institute of Public Administration.

Butler, S. (2002d) The making of the Methadone Protocol: the Irish system?. Drugs: education, prevention and policy. Vol. 9, No 4, 311-324

Butler, S. (2003) Paying the Price for Extended Opening Hours: a comment from Ireland. Drugs: education, prevention and policy. Vol. 10, No 4, 293-296

Butler, S. & Mayock, P. (2005) 'An Irish Solution to and Irish Problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, 16, 415-422.

Butler, S., & Woods, M. (1992) Drugs, HIV and Ireland: Responses to women in Dublin. In Dorn, N., Henderson, S,. & South, N. (eds) AIDS: women, drugs and social care. London: Falmer Press.

Calder, M, (2003) Unborn Children: A framework for Assessment and Intervention. Cited in Eds Calder M.C. and Hackett s. Assessment in Child Care Work: Using and Developing Frameworks for Practice. London, Russell House Publishing

Charleton, McDermott, Bolger (1999) Criminal Law. Dublin: Butterworth's

Chasnoff, I. J. (1988) Drugs, Alcohol, Pregnancy and Parenting. Kluwer Academic Publishers,. The Netherlands

Chasnoff, I. J., Hunt, C., Kletter, R., Kaplan, D (1989) Prenatal Cocaine exposure is associated with respiratory pattern abnormalities. American Journal of Disabled Children, (7) 1556-15561.

Chasnoff, I., (1989) Cocaine, pregnancy, and the neonate. Women and Health. Vol. 15 23-35

Child Care Policy Unit (2004) Memo to Chief Executives of Each Health Board Region.
Dora Hennessy, Principal. Dublin, May 2004

Clarke, C. & Fitzpatrick, C., (2005) Psychiatric problems of children exposed to opiates in 'utero' – a descriptive study. Irish Journal of Psych Medicine 22(4) 121 – 123

Coghlan, D., Milner, M., Clarke, I., et al (1999) Neonatal Abstinence Syndrome. Irish Medical Journal. Vol. 92, No1, pp 232-236

Coghlan, D, et al (1999). Neonatal Abstinence Syndrome: Irish Medical Journal Vol.
92 No. 1, pp 232-236

Coles C. D (1995) Children of parents' who abuse drugs and alcohol. In Smith, GH, Coles, C.D, Poulsen, M.K. and Cole, C.K. (eds) Children, Families and Substance abuse: Challenges for changing education and social outcomes. Baltimore: Paul H Brookes Publishing Company (p 3 -23)

Collins, C. (2007) The discrepancy between the information pregnant women expect and receive in Ireland and the lost opportunity for health promotion and education. International Journal of Health Promotion & Education. Vol. 45 (2) 61-66

Corrigan, D. (1997) Drugs in Dublin Conference, Dublin Castle 7/02/97 (Conference Paper)

Corby, B. (2003) Supporting families and protecting children – assisting child care professionals in initial decision-making and review of cases. Journal of social Work, 3(2): 195-210

Coffey, A., and Atkinson, P., (1996) Making Sense of Qualitative Data: Complementary Research strategies. London, Sage Publications

Copeland, J, (1997) "Barriers to formal treatment among women who self-manage change in addictive behaviours. Journal of Substance Abuse Treatment. 14: no. 2 pages 183 -190.

Corr C (2004) 'Engaging the hard-to-reach: an evaluation of an outreach service'. In Pieces of the jigsaw. Dublin: Merchants Quay Ireland.

CREATE Foundation (2003) Do No Harm. Towards good practice in Protecting Children and Young People in Out-of-home Care from Abuse and Neglect. Sydney. [Online] http//www.create.org.au (accessed 26 November 2006)

Cullen, P., (2006) Fertility treatment Law likely to face delay. Irish Times: November 16th p.1

Daly, S., F., Kiely J., Clarke, T. A. (1992) Alcohol and cigarette use in a pregnant Irish population. Irish Medical Journal. Volume 85, NO 4 pp 156-157

Daly, M,. & Clavero, S., (2005) Contemporary Family Policy in Ireland and Europe. School of Sociology and Social Policy, Queens University, Belfast. [online http://www.welfare.ie/publications/familypolicy/cfpreport.pdf accessed 19/01/07

Daly, M. (2000) A fine balance- women's labor market participation in international comparison, in Scharpf, F. W. and Schmidt, V. A. (eds) *Welfare and Work in the Open Economy*, Oxford, Oxford University Press, 2000 (vol. 2), 467-510.

Dawson, T. B., (1991) A Feminist Response to Unborn Child Abuse: Contemporary legal Solutions. Canadian Journal of Family Law: Volume 9. No 2.

Department of Health (1997) Report of the Maternity and Infant Care Scheme Review Group. Dublin: The Stationary office

Department of Health (UK) (1995) The Challenge of partnership in Child protection: Practice Guide. London: HMSO

Department for Education and Skills (DfES) (2006) Working Together to safeguard Children: A guide to Inter-agency working to safeguard and promote the welfare of Children. London. HMSO

Department of Education and Skills (DfES) (2006) Statistics of Education: Referrals, Assessments and Children and Young People on Child protection Registers: Year ending 31st March 2005: London, HMSO

Department of Education and Skills (DfES) (2005) Government Response to Hidden Harm: the report of an Inquiry by the Advisory Council on the Misuse of Drugs. London. HMSO

Department Of Health and Children (2005) Health Statistics 2005 _Section E. Children in Care and Child Abuse Cases. Dublin. The Stationery Office

Department of Health and Children (1999) Children First: national guidelines for the protection and welfare of children. Dublin: The stationery Office

Department of Health UK (1999) Working Together under the Children Act 1989. London: HMSO

Department of Community, Rural and Gaeltacht Affairs (2001) National Drugs Strategy 2001 -2008. Dublin: The Stationery Office

Department Of Health and Children (2004) Strategic Task Force on Alcohol: Second Report. Health Promotion Unit. [online] www.healthpromotion.ie accessed 17/01/2007

Department of Health and Children (1991) Child Care Act, Dublin: The Stationery Office

Department of Health and Children (2006) State of the Nation's Children, Ireland 2006. Dublin: The Stationery Office

Dixon S, Bejar R. (1989) Echoencephalographic findings in neonates associated with maternal cocaine and methamphetamine use: Incidence and correlates. Journal of Pediatrics. 115:770–778.

Drugnet (2006) The National Documentation Centre on Drug Use. Issue 18, 25-26

Enkin, M., Keirse MJNC, Neilson, J., et al (2004). A Guide to Effective Care in Pregnancy and Childbirth, 3rd edition. Oxford, UK: Oxford University Press

European Monitoring Centre for Drugs and Drug addiction (2006), National Report to the EMCDDA: Ireland; new developments, trends and in-depth information on selected issues. [Online] http://www.ndc.hrb.ie/attached/3029-3227.pdf accessed 22/01/07

European Monitoring Centre for Drugs and Drug addiction (2006) Selected Issues: a gender perspective on drug use and responding to drug problems.
[online] http://issues06.emcdda.europa.eu/download/sel2006-en.pdfaccessed 22/01/07

Ezzy, D. (2002) Qualitative Analysis Practice and Innovation, London: Routledge

Fagan, J & Keenan, E (2006) Treatment for pregnant drug users. [online] www.dap.ie

Fallon, J., (20/03/2007) Women wait until start of fifth month of pregnancy for first antenatal appointment. Irish Times

Fallon, J., (26/03/2007) Pregnancy scan delay confirmed in Galway. Irish Times,

Farrell, E. (2001) Women, Children and Drug Use, (In), Moran, R., Dillon, L., O'Brien, M., Moyock, P., & Farrell, E. with Pike, B. (eds) A collection of Papers on Drug Issues in Ireland. Dublin: Health Research Board

Fals-Stewart, W., Kashdan, T.B., O'Farrell, T.J., *et al.* (2002) Behavioural couples therapy for drug abusing patients: effects on partner violence. *Journal of Substance Abuse Treatment, 22,* 87-96.

Ferguson, H. (1996) 'Protecting Irish Children in time. Child abuse as a social problem and the development of the child protection system in the Republic of Ireland. In H. Ferguson and T. McNamara (eds) *Protecting Irish Children: Investigation, Protection* and *Welfare*. Dublin: Institute of Public Administration.

Fischer, G., (2002) Treatment of opioid dependence in pregnant women. Addiction 95 1141 – 1144

Fortin, J. E., (1988) Legal Protection for the Unborn Child. The Modern Law Review, Vol. 51, No1 pp 54 – 83

Gomez, L. E., (1991) Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure Philadelphia: Temple University Press,

Greer, I. (2003) Pregnancy The Inside Guide: A Complete guide to fertility, pregnancy and labour, London: Harper Collins

Griffith, D. R., Scoot, D., Azuma and Ira J Chasnoff (1994) "Three-year out-come of Children Exposed Prenatally to Drugs". Journal of the American Academy of Child and adolescent Psychiatry. 33: 20 -34

Griffith, J. D., Rowan-Szal, G. A., Roark, R. R., *et al.* (2000) Contingency management in outpatient methadone treatment: a meta-analysis. *Drug and Alcohol Dependence, 58,* 55–66.

Gribich, C., (1999) Qualitative Research in Health. London, Sage

Hall, D., Hall, I., (1996) Practical Social Research. Basingstoke, Macmillian

Hallett, C. (1995) Interagency Coordination in Child Protection. London: HMSO

Hallet, C. Birchall, E., (1992) Coordination and Child protection. London. HMSO

Halliday, HL., Reid, MM., MaLure, G., (1982) Results of heavy drinking in pregnancy. British Journal of Obstetrics and Gynecology. (89) 893- 895 [online]

Harrison, R et al (2003) Partnerships made painless: A joined-up guide to working together. London .Russell House Publishing

Health Service Executive (2005) Child Protection Guidance, Local Health Office 7, Child Care Managers Office, Ballymun.

Health Service Executive (2005) HSE Corporate Plan 2005 – 2008. [online] www.hse.ie accessed 21/01/2007

Health Research Board (2000) Making Knowledge Work for Health: Towards a strategy for research and Innovation for health. Dublin: The Health research Board

Hidden Harm (2003). The report of the Inquiry. The Advisory Council on the Misuse of Drugs. UK Home Office, London. [online] http://www.drugs.gov.uk/publications-search Accessed 15/12/06

Hidden Harm (2006) Three years on: Realities, Challenges and Opportunities. Advisory Council on the Misuse of Drugs. UK Home Office, London. [online] http://www.drugs.gov.uk/publications-search Accessed 15/12/06

Hogan T. M., Myers, B., and Elswick, R.K., (2006) Child abuse among mothers of substance –exposed and none-exposed infants and toddlers, Child Abuse & Neglect
30: 145 – 156.

Hogan, D., & Higgins L., (2001) When Parent's Use Drugs. Dublin: The Children's Research Centre.

Home Office, (1991) DOH, DES, Welsh Office. Working Together Under the Children Act 1989. London: HMSO

Home Office (2002) Women Drug Users and Drug Service Provision: service level responses to engagement and retention: [online at] http://drugs.homeoffice.gov.uk/publication-search/diversity/women-drug-users accessed 28/02/07

House of the Oireachtas Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (2006) Ninth Report: The inclusion of alcohol in a national substance misuse strategy. Dublin: Stationery Office.

Humphreys, C., Stanley, N. (2006) Domestic Violence and Child Protection: Directions for Practice .London. Jessica Kingsley Publishers.

Ingersoll, K., (2006). Interviewing Technique Reduces Risks for Binge Drinking and Unplanned Pregnancies. [Online] www.healthsystem.virginia.edu (accessed 5/08/07)

International Federation of Social Workers et al (2004) Ethics in Social Work, Statement of Principles. Adelaide, Australia. [Online} Accessed: http//www.iasw.ie/index.cfm/loc/2-2/article. Accessed 10/02/07

Institute Of Medicine (1998) Fetal Alcohol Syndrome Diagnosis, Epidemiology, and Treatment. National Academy Press, Washington, DC

Institute of Public Health in Ireland (2006) Unequal at birth – inequalities in the occurrence of low birth weight babies in Ireland. Dublin: The Stationery Office

Irish Family Planning Association (1998) Facing up to Reality – The definition of the "unborn" and its implications, Dublin. Accessed http://ifpa.ie/abortion/facing5.html 25/09/2006

Irish Independent (2007) Cork survey shows one in five young people in the city use cocaine: Independent newspapers. 15/02/07

Jasinski, J. L. (2001). Pregnancy and violence against women. Journal of Interpersonal Violence, 16 (7), 712-733.

Julien, R.M.A., (1998) A primer of Drug Action, A Concise, Non-technical Guide to the Actions, Uses and Side Effects of Psychoactive Drugs, eight ed. Freeman and Company, New York pp. 64-78

Kaeser, L., Figdor, E. (1998) The Guttmacher Report on Public policy: Concerns Mount over Punitive Approaches to Substance Abuse among Pregnant Women. Volume 1. No 5 [online] www.guttmacher.org Accessed 31/07/07

Kennedy, I., (1988) Treat Me Right: Essays in Medical Law and Ethics. Oxford University Press.

Kelly J.J, Davis P.G, Henschke P.N (2000). The drug epidemic: effects on newborn infants and health resource consumption at a tertiary perinatal centre. Journal Pediatric Child Health 36:262-4.

Kiely, G., (1996) 'Fathers in Families', Cited in McCarthy ed. Irish Family Studies, selected papers, University College Dublin

King, P, A., (1991) Helping Women Helping Children: drug Policy and future Generations. The Milbank Quarterly, Vol. 69 No 4 pp 595 -621

Kwok, P., Correy, JF., et al (1983) Smoking and alcohol consumption during pregnancy: an epidemiological study in Tasmania. Medical Journal of Australia, 1 (5) pp.220-223

Lambe, B., Connolly, C., McEvoy, R. (2007) The determinants of lifestyle counselling among practices nurses in Ireland. Irish College of General Practitioners. [Unpublished]

Laudet, A., Margura, and S. (1996) Parental Substance Abuse and Child Maltreatment: Review and Implications for Intervention: Children and Youth Services Review, Vol.18. No 3, pp. 193 -220

Loewenberg, F. M., & Dolgoff, R. (1996) Ethical decisions for Social Work Practice. Itasca, IL. F. E. Peacock

Marks, L. A., (1995) The "Seymour Report" on Fetal Welfare and The Law in Australia. Murdoch University Electronic Journal of Law. Volume 2 (3) [Online] www.murdoch.edu.au/elaw/issues accessed 21/01/2007

Mason, J (1996) Qualitative Researching. London. Sage Publications

Mason, J., (2002) Qualitative Researching 2nd Ed. London. Sage Publications

Mason, J., (2004) Qualitative Researching. Sage Publications. London

Maude-Griffin, P.M., Hohenstein, J.M., Humfleet, G.L., *et al.* (1998). Superior efficacy of cognitive-behavioural therapy for urban crack cocaine abusers: main and matching effects. Journal of Consulting and Clinical Psychology, 66, 832–837.

Merton, R.K., Fiske, M., Kendall, P.L., (1990) The Focused interview: A Manual of Problems and Procedures, 2nd ed. London. Collier Macmillian

McKegany, N., Barnard, M., and McIntosh, J., (2002) Paying the Price for their parents' Drug use: The Impact of Parental Drug Use on Children. Drug Education, Prevention and Policy. 3 233-246

McWilliams, A., (2006) Supporting New Social Workers in Community Care. Social Worker: Back to the Future. Dublin: Winter 2006

Miller, W. R., Rollnick, S., (1991) Motivational Interviewing: Preparing people to change addictive behaviors. New York: Guilford Press.

Minkoff, H., and Paltrow, LM., (2006) The Rights of "Unborn Children" and the Value of Pregnant Women. Hasting Centre Report 36, No 2: 26-28[online]
http://advocatesforpregnantwomen.org/TheValueofPregnantWomen.pdf
Accessed 14/12/06

McKeown, K. & Fitzgerald, G. 2006. Impact of Drugs on family Well – Being, Ballyfermot Star, Dublin

Mc Millian, H., Smaarani, S., Walsh, T. et al (2007) Smoking and Alcohol in Pregnancy. Survey in the immediate post-partum period. Irish Medical Journal. Vol. 100 (1)

McLeod, D., Pullon, S., et al (2002) Factors influencing alcohol consumption during pregnancy and after giving birth. New Zealand Medical Journal, 93 (9) pp. 264-268

Murphy, D., (2007) How should we advise women about alcohol and pregnancy? Professor of Obstetrics & Gynecology, Trinity College Dublin & Coombe Women's Hospital; Presentation at Alcohol And Pregnancy, Friday March 2nd, Coombe Hospital

Murphy, M., (2004) Developing collaborative relationships in interagency child protection work. London. Russell House Publishing

Murphy JM., Jellinek M., Quinn D., (1991). Substance abuse and serious maltreatment: prevalence, risk and outcome in a court sample. Child Abuse Neglect 15:197-211.

Morgan, J., (1990) Clinical Management. Cited in H. Ghodse and D. Maxwell (Eds), Substance Abuse and Dependency. Macmillan, London, pp 98- 130

Moran, R., O'Brien, M., & Duff, P. (1997) National Drug Treatment Reporting System. National Report 1996. Dublin: The Health research Board.

NHS National Institute for Clinical Excellence (2003): Antenatal Care – Routine care for the Healthy Pregnant Woman. London: Clinical Guideline, No 6. [online]:http://www.nice.org.uk/pdf/CG6_ANC_NICEguideline.pdf accessed 28/02/2007

NHS National Institute for Clinical Excellence (2007) Drug Misuse: psychosocial intervention. London: Clinical Guideline No.51. [online] www.nice.org.uk/CG051

National Development Plan (2007 – 2013) Transforming Ireland: A Better Quality of Life for All. Dublin The Stationery Office. [Online at] http://www.ndp.ie/viewdoc.asp (accessed 29/01/07)

National Advisory Committee on Drugs (2007) An overview of Cocaine use in Ireland: II, Dublin, The Stationery Office. [online] http://www.nacd.ie/publications/Overview_Cocaine_Use_2.pdf accessed 9/03/07

National Child Protection Clearinghouse (2005) Child abuse Prevention Resource Sheet No3 Mandatory reporting of child abuse, [online]http://www.aifs.gov.au/nch/sheets/rs3.pdf accessed 28/02/07

O'Brien, M., Moran, R., Keller, T., & Cahill, P. (2000) National Drug Treatment Report System. Statistical Bulletin 1997 and 1998.National Data and data by Health Board Area. Dublin: The Health Research Board.

O' Connor, P. (1998) Emerging Voices: Women in Contemporary Irish Society. Dublin: Institute of Public Administration.

O'Connor, J.J., Stafford-Johnson, S., & Kelly, M.G. (1998) A review of the characteristics and treatment progress of 45 pregnant opiate addicts attending a National Drug Advisory and Treatment Centre over a two-year period. Irish Journal of Medical Science, 157 (5), 146 -149.

O'Leary, C., (2002) Fetal Alcohol Syndrome, A Literature Review. National Drug Strategy, Australia. [online] http://www.fasdconnections.ca/id93.htm accessed 18/11//06

One Family (2005) 'becoming a parent' [online] www.onefamiliy.ie accessed 12/01/07

Oxford Medical Dictionary (1998) Concise Colour Medical Dictionary: Oxford University Press. Oxford

Paltrow, L., et al (2000) Government response to Pregnant Women Who Use Alcohol or Other Drugs. Women's Law Project [online] www.drugpolicy.org/libary

Panoe, D., & Alperen, J. (1998) Pregnancy policing: Policy of Harm. International Journal of drug Policy (9) pp 101-108.

Phibbs, C., Bateman, D., Schwartz, R., (1991) "The Neonatal costs of Maternal Cocaine use", Journal of the American Medical Association 266: 1521 – 1526

Powis, B., Griffiths, P., Gossop, M., and Strong, J., (1997) The difference between male and female drug users: Community samples of Heroin and Cocaine Users compared. Substance Use and Misuse 31 (5) 529 - 543

Quigley, P. (2003) Hard Cases in Hard Places: Challenges of Community addictions work in Dublin. Drugs: education, prevention and policy. Vol. 10 (3) 211-221

Review of Adequacy of Child and family Services (2004) Northern Area Health Board, Dublin: Swords

Rawaf, J., (1998) Public Health and addiction. Current opinion in Psychiatry, 11(3) 273- 278

Robson, C. (2002) Real World Research 2nd Ed. Oxford: Blackwell

Royal College of Obstetricians and Gynaecologists (2006) Alcohol Consumption and the Outcomes of Pregnancy. Statement No. 5 [online] www.rcog.org.uk accessed 21/07/2007

Schroedel, J. R., et al (2000) "Women's rights and fetal personhood in criminal law" Duke Journal of Gender Law & Policy (7) 89-103

Schweppe, J., (2006) Pregnant Women and Unborn Children – In 'utero' Drug Exposure. Irish Journal of family Law. (1) pp19-24

Schweppe, J., (2005) Revisiting Article 40.3.3. Part One: Third-Party Feotal Assault. Irish Journal of Family Law (4) pp 19-27

Scully, M., Geoghegan, N. et al (2004) Specialized drug liaison midwife services for pregnant opioid dependent women in Dublin, Ireland. Journal of Substance Abuse Treatment 26: 27-33

Seidel, J., & Kelle, u. (1995). Different Functions of Coding in the analysis of textual data. In u. Kelle (Ed), Computer-aided qualitative data analysis: Theory, methods and practice (pp. 113 – 128). London: Sage

Shankaran S, Fanaroff AA, Wright LL, Stevenson DK, Donovan et al (2002). Risk factors for early death among extremely low-birth-weight infants. American Journal ObstetGynecol; 186:796-802

Silverman, D. (1999) Doing Qualitative Research: A Practical Handbook. London: Sage

Silverman, D. (2005) Doing Qualitative Research (second edition) **London: Sage**

Smith, D. W., Jones, K. I., (1973) Recognition of the fetal alcohol syndrome in early infancy. Lancet (2) 7839, 999-1001

Smith, L.A., Gates, S. & Foxcroft, D. (2006) Therapeutic communities for substance related disorder. Cochrane Database of Systematic Reviews, 1, CD005338

Society for the Protection of Unborn Children (2006) Speech by Ms Kathy Sinnott, MEP, Geneva, 28 June. [online]http://www.spuc.org.uk/lobbying/amnestyforbabies/sinnott Accessed 15/10/2006

Sociological Association of Ireland (2007) Research Ethical Guidelines. Dublin: University College Dublin. [online] www.ucd.ie accessed 21'01/2007

Stopper, A,. (2006) Monday's at Gaj's: The story of the Irish Women's Liberation Movement. Dublin, The Liffey Press.

Stratton, K., Howe. Battaglia, F., (1996) Fetal Alcohol Syndrome: Epidemiology, Prevention, and Treatment. Washington, National Academy Press

Strategic Task Force on Alcohol (2004) second report. Dublin: Department of Health and Children. Dublin. Stationery Office

Sunday Times (2007) Drug Plan to Focus on Drink. July 22nd, p2.

Tunnard, J. (2002) Parental Drug Misuse: a review of impact and intervention studies. Research in Practice. [online] http://www.rip.org.uk accessed 15/10/2006

United Nations Office on Drugs and Crime (2004) Substance abuse treatment and care for women: Case studies and lessons learned. New York: United Nations

U.S. General Accounting Office. (1990) Drug-exposed infants: A generation at risk. Washington, DC: U.S. Government Printing Office

Warner, J. (2003) 'Ask the Physician: modern relevance of 18th century public health crisis. Addiction 98 (2) 139 – 140

Welte, J.W., Perry, P., Longabaugh, H., (1998) An outcome evaluation of a hospital based early intervention service. Addiction 93, 573-581

WHO (2002) WHO Antenatal Care Randomized Trial: Manual for the Implementation of the New Model. Copenhagen: World Health Organization

WHO (2006) The World Health Report 2006 – Working Together for Health. Copenhagen: World Health Organization

Woods, M., (1994) Drug Using Parents and their Children. The Experiences of a Voluntary/Non-Statutory Project. Dublin: The Irish Social worker, 12 (2) 10

Woods, M., (2000). The Value of the Strengths Perspective in understanding and responding to alcohol and drugs Problems. Dublin: Irish Social Worker 18 (1) 20-22

Woods, M., (2000) Women, Drug Use and parenting in Dublin: The Views of Professional Workers in the Drug Treatment and Social Work Fields in Illicit Drugs: *Patterns of Use-Patterns of Response*, Proceedings of the 10th Annual ESSD Conference on Drug Use and Policy in Europe, Innsbruck: Studienverlag, edited by A. Springer and A. Uhl. Pp 275-289

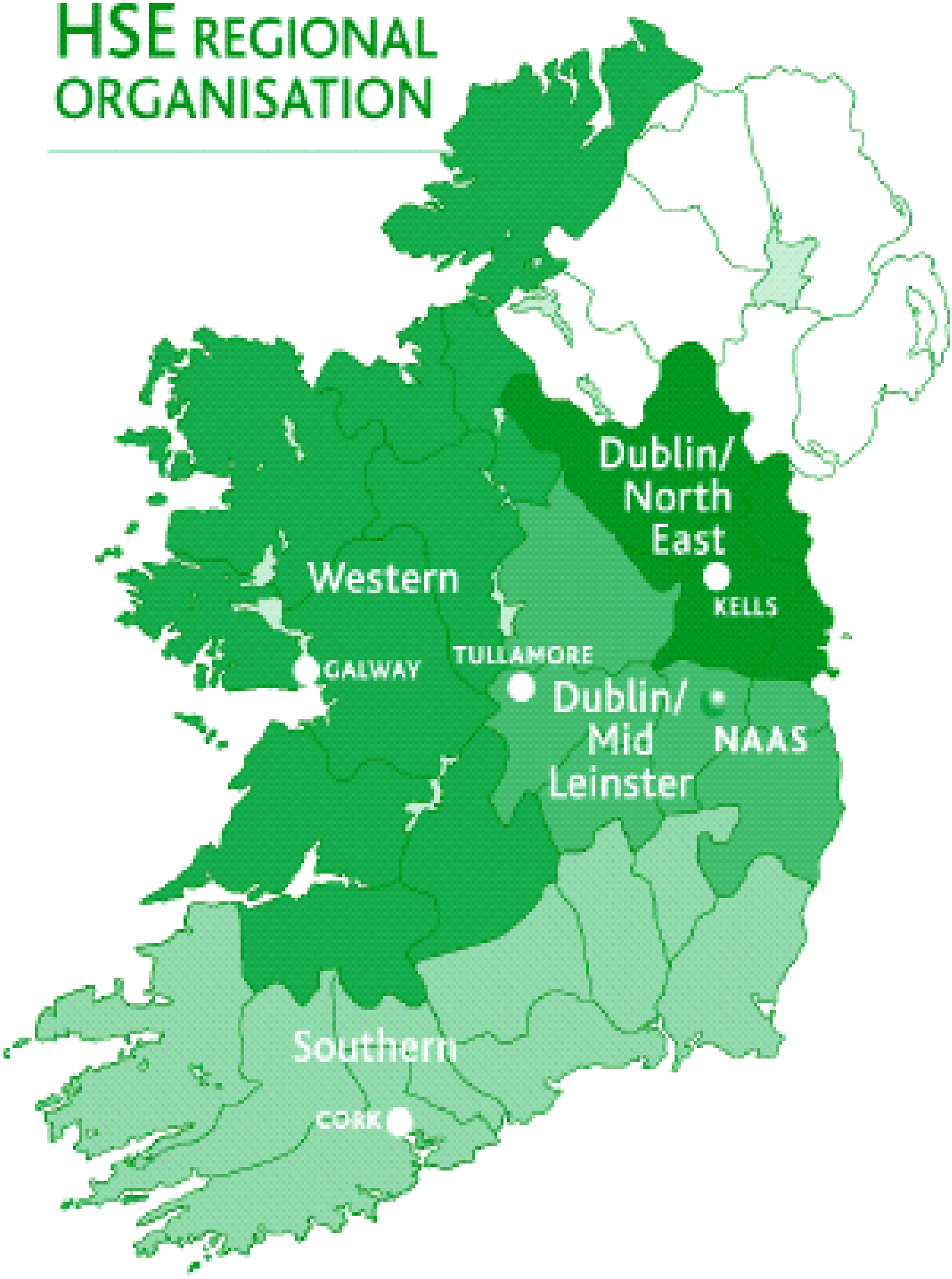
Woollett, A., (2000) Fit to Reproduce? The Regulative Role of Pregnancy Texts. Feminism & Psychology, Vol. 10, No 3, 351-366

APPENDICES

Appendix A

Primary, Community and Continuing Care (PCCC)
Dublin Local Health Managers

HSE REGIONAL ORGANISATION



Appendix C


Ist Trimester
Week 1-12
Month 1, 2 ,3
2nd Trimester
Week 13-26
Month 4, 5 ,6
Baby's head, eyes, eyelids, fingers and toes -fully formed
Ribs and spine are hardening into bone
Baby's length is approx 6.5 cms.
Weight 14 grams approx.
Mother- bulge above pelvis
Uterus –size of a grapefruit
Baby teeth buds are formed
Hair is growing
Skin and hair covered with Vernix –a greasy substance-a protective barrier
Length of baby 25cms Approx.
Weight 595gr (Approx)
Baby's eyes are open
Mother-From 18 weeks – baby movement can be felt
From 32 weeks baby fully formed
Period of rapid growth
Vernix and downy hair disappearing
Baby approx 55 cms.
Weight 3.4 Kgs approx
Mother- Feels more hungry
3rd Trimester
Week 27-40
Months 7,8,9,

Appendix D

Childcare Training and Development Unit
Local Health Office – North Dublin
Primary, Community and Continuing Care Directorat
HSE Dublin North East
3rd Floor, Park House
North Circular Road
Dublin 7
Tel (01) 8823433/8823447
Fax (01) 8823491
dympna.odonnell@mailc.hse.ie
philip.gibson@mailc.hse.ie

To Whom It May Concern:

Re: Mr. Liam Curran, Training Officer, CTDU – M.Sc. Research Project

---

Mr Liam Curran, Training Officer assigned to the Child Care Training and Development Unit of HSE Dublin North East, is currently studying for the M.Sc in Child Welfare and Protection in TCD. As part of this course, Liam is conducting a research study into ***'Multi-disciplinary Concerns for the Welfare of the Unborn Child in respect of illicit drug use and alcohol'.***

Liam will require the support of HSE personnel and services in his pursuit of this research. I would be grateful for the cooperation of you and your staff with Liam when he makes contact with you for statistics or access to staff for interview etc.

This research proposal has been approved by me on behalf of the Research & Ethnics Committee of the HSE Dublin North East. I have every confidence that Liam will conduct this research in a professional manner as per the procedures laid down in his proposal and the consent form. If you have any queries, please contact me at the above address.

Regards,

Manager CTDU
paul.fitzgibbon@mailc.hse.ie

Appendix E

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Childcare Training and Development Unit
Local Health Office – North Dublin
Primary, Community and Continuing Care Directorat
Health Service Executive
3rd Floor, Park House
North Circular Road
Dublin 7
Tel (01) 8823433/8823447
Fax (01) 8823491
Mobile 087 290 9563
liam.curran@mailc.hse.ie

Chairman
Research Ethics Committee

January 02/01/07

RE: **Permissions for Research within the ******** Hospital**

Dear **********

Thank you for your letter of December 15th, which I received today. I am enclosing a copy of my Curriculum Vitae and a copy of the Informed consent document for prospective participants. You will note that this document asks for the participant to agree to the study having read and understood the nature of the research.

I wish to recruit a cross section of staff within the hospital, using the guidance of the head Medical Social Worker.
In principal I would be seeking to interview in following professional fields:

Neonatal Nursing
Social Work
Drug Liaison Midwife
SHO/Registrar
Senior Midwife – Lille Suite
Obstetrician /Gynaecologist

As stated at the committee meeting on the 14th of December, I have not made any overt contacts to hospital personnel at this stage, as I wish to observe proper protocol of establishing an approval to proceed from the committee first.

I hope you find the enclosed information sufficient, and that you may be able to give approval for me to continue.

Yours Sincerely

_____

Liam Curran

Appendix F

MSc Consent to Participation in Study

You have agreed to participate in the research study as outlined below. You are being sent this document prior to interview, following agreement of a formal date for the meeting to take place. Please take some time to consider the points raised within this paper. If you have any questions on any aspects of the paper, then please don't hesitate to contact me on the details provide. I will bring a fresh copy of this consent form to our formal meeting, where I will ask you to sign it.

This study aims to explore the views, experiences and practices of participants' role, in providing services to women who use alcohol and drugs while pregnant, seeking views on whether they have a child protection concern in the course of their duties. Specific objectives being:

To explore if they believe they have a role in relation to the unborn child

To examine what raises their concerns in relation to the unborn child

To explore participants professional response to the unborn child

To consider what conditions are required to substantiate actions they wish to take.

The project is supported by the Childcare Training & Development Unit of the Health Service Executive Dublin North East. Permission was granted by the line manager of the above service. Permission has also been granted by a large urban maternity hospital research and ethics committee, in respect of the maternity hospital personnel taken part in this study.

I would like to thank you most sincerely for agreeing to take part in the study. I would like to clarify points regarding our commitment to each other in relation to you participation in the study.

As a participant

1. Your participation is entirely voluntary
2. Your consent to this study is without any duress or pressure from external forces.
3. Your are free to withdraw from the process at any time
4. You may refuse to answer any questions you feel uncomfortable with.
5. You may request a completed copy of the study on its completion.

As a Researcher

1. I agree to maintain you anonymity at all times before, during and after this study is completed
2. I agree to offering a copy of the finished study following its assessment by Trinity in the autumn of 2007
3. I agree to respect and represent honestly the views offered by you within this interview process.

Confidentiality

Participation in this study is confidential and all information will be written in a manner that does not identify you in any form. Both your first and last name will be given a pseudonym in the transcriptions of the study. Procedures to protect your identity will adhered to throughout the transcription process any in any future reports or publications from this work. Information gained from my time with you in interview, will be used solely for the purpose of my research as part of my MSc in Child Protection and Welfare. All audio tapes concerned with the interview will be erased following transcription.

Information collected with this study will be used solely for the study. In the event of direct quotes being used, you anonymity will be honoured and maintained at all times as stated earlier.

Transcripts of the interviews will be professionally transcribed by a third party. This third party is professionally committed to the principle of

confidentiality, and has agreed to honour totally the requirements of the study.

Service Area

The identity of the service which you work for will be kept will not be identified by the researcher in any aspects of the study.

Procedure

I wish to seek your permission to audio record our discussions within the structure of the interview time. The discussions will take place in a place which is mutually beneficial.

Please sign this form to indicate you understanding and acceptance of you role with this study.

Signed

Print

Date

Appendix G

This letter of permission has been re-drafted by the researcher in order to maintain the confidentiality of the hospital. All text used here is original to the master copy of the hospital ethics committee.

Mr Liam Curran
Childcare Training and Development Unit
Local health Office – North Dublin
3rd Floor, Park House
North Circular road
Dublin 7.

Re. 'Working Together' Multi-disciplinary Concerns for the Welfare of the Unborn Child in Respect of Illicit Drug and Alcohol. Child Protection or Not?

Dear Mr. Curran
Thank you for forwarding me your CV and other documentation in relation to the above study. This all seems to be in order and I am happy that your research may be conducted at the _____ Hospital. I note you will be liaising with the principal social worker in relation to the recruitment of interview candidates.

I wish you well with your project

Yours Sincerely,

Chairman
Research Ethics Committee

10th of January, 2007

Appendix H

Childcare Training and Development Unit
Local Health Office – North Dublin
Primary, Community and Continuing Care Directorat
Health Service Executive
3rd Floor, Park House
North Circular Road
Dublin 7
Tel (01) 8823433/8823447
Fax (01) 8823491
Mobile 087 290 9563
liam.curran@mailc.hse.ie

Principal Social Worker
HSE, Dublin North
Coolock Health Centre
Coolock
Dublin 5

RE: **SEEKING RESEARCH INTERVIEW CANDIDATES**

Dear

I am writing to request that you share with your staff a request for practitioners to take part in a research study I am currently undertaking at Trinity College under the direction of Prof Robbie Gilligan as part of a M.Sc. in Child Protection and Welfare. The details of the study are as follows:

Research Study Title:

Multi-disciplinary Concerns for the Welfare of the Unborn Child in respect of illicit drug use and alcohol.
Child Protection Or Not?

Research Aim:

To explore Public Health Nurses, Social Workers, and Maternity Hospital Personnel experiences of working with child protection concerns in relation to the unborn child where parental drug and alcohol use is suspected. I anticipate undertaking the fieldwork aspect of this research in January/ February 2007. I wish to ask if you could circulate my request within your social work teams in order to seek candidates who would be happy to take part in the study. The only criteria to apply to perspective candidates are that they hold or held a case where pregnancy was a feature of their involvement over the past twenty-four months. I would be grateful if any members of your staff group who would like to take part, contact me on either my email address or through my mobile no as detailed above.

The total number of interviews to be carried out within this project will be in the region of 15 using qualitative interview techniques, although only five will come from the social work profession.

If you require any further information, please do not hesitate to contact me.

Yours Sincerely

_____

Liam Curran
Training & Development Officer
CTDU
Dublin North East

Appendix I

Interview Guide

Date:

Participant ID

Sex:

Professional Qualification:

Length of Professional Service:

Study Aim

To explore the views, experiences and practices of participant's role, which provide services to women who use alcohol and drugs while pregnant, seeking views on whether they have a child protection concern in the course of their duties.

Specific objectives being:

To explore if they believe they have a role in relation to the unborn child
To examine what raises their concerns in relation to the unborn child
To explore participants professional response to the unborn child
To consider what conditions are required to substantiate actions they wish to take.

I'd just like to reiterate that everything you say in the interview is confidential to me and my supervisors at Trinity College, Dublin. The interview will use open-ended questions which have and allow for fairly broad responses. There aren't any right or wrong answers – I am simply interested in your views, experiences and practices in relation to the working with pregnant women. The first part of the interview is about you

and your general role in the social system that surrounds pregnant women. The interview will then progress to area of the unborn child and concludes with some questions on the subject of working together.

To explore if they believe they have a role in relation to the unborn child

WHATS THEIR ROLE

Can you tell me a bit about yourself?

What is your role in relation to the unborn?

How would you describe your role in relation to the unborn? Does it involve other professions?

What is good antennal care?

Mothers Right vs. the rights of the unborn – what do you think?

Has your personal view changed in relation to the unborn?

How would you rate joint working when dealing with pregnant substance misuses?

Risk and pregnancy (what is you view)

Does alcohol and drug factors incur risk in your assessment? (Can you tell me a bit more about ……

I wish to read to you sec 3, sub – s 3 of Article 40 of our constitution

"The state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its law to respect, and, as far as practicable, by its law to defend and vindicate that right thereby acknowledging the right to life of the unborn"

Dose this statement influence your current role in working with pregnant women?

Does your role allow you to fulfill this constitutional clause?

Does this statement present a challenge in respect of Drugs and Alcohol in pregnancy?

To examine what raises their concerns in relation to the unborn child

CONCERNS

Can you tell me a bit about what might cause you a concern in relation to the unborn?
What are these concerns?
What behaviors of the mother to be raise concerns?
Do you ever have concerns that the fathers behavior may impact on the mothers' ability to care for the child post birth?
How do you currently deal with theses issues?
Would you consider your concern to be a child protection matter **(pre-birth/post-birth)??**

What protocols do you follow when presented with your concerns?

Are your concerns shared by the social world you operate in?

How would you like your **concerns addressed within** your profession?

Do you think your concerns are **fairly typical of society?**

If yes, why?

If not, Why?

To explore participants professional response to the unborn child

Protocols, legislation, policy

What is **your response** to drug use in pregnancy?

What is your response to alcohol use in pregnancy?

Does drug and alcohol **harm the unborn** child in your view?

Early coordination and planning

Does your response follow any **child protection protocol in respect of the unborn?**

Would you like to respond differently? What level of care planning/prevention is offered by you service (Integrated case management (physician, midwife. SW, drug liaison midwife, CW0)

Community based resources. How can the **medical and social model** of system best support the drug alcohol patient/mother?)

How would you rate the current level of **joint working** in the area of substance misusing pregnant women?

What is the role of fathers?

Does your agency have a **written policy or protocol** for addressing the needs of pregnant drug users?

Does your agency offer any **specialist training** in the **assessment** and **management** of cases of families where there are **substance misuse issues**?

Who should be signed up to multi-disciplinary protocols? (**Integrated case management**)

Are you aware of current child protection definitions of harm? (Physical, Sexual, Neglect, Emotional,)

Is the unborn child represented in any **current child welfare procedure**?

Should they be?

To consider what conditions are required to substantiate actions they wish to take.

Multi-disciplinary working - what works, does it work, how should it work?

Are you happy with the **current response** to the unborn where drugs and alcohol are a feature of the parental behavior?

What would you like to see in place that **might improve** the outcomes for mother and baby?

What would be **good multidisciplinary** working in this area of practice?

Is there a need for **multi-professional response** to needs of the unborn where drugs and alcohol is a factor?

What is your view on current '**working together strategies'** in this area of practice?

What would you consider as **optimal Care** for mother and baby?

What **prevents** this happening?

Child protection of not? What's your View?

Have you anything else you would like to say before we close this interview?

Thank you for sharing your views and experiences in relation to your area of professional practice. I will seek to analyses the data you have given me, and produce a research finding linked to this study.

Appendix J

Gloucestershire

WORKING WITH MOTHERS AND THEIR UNBORN BABIES WHERE THERE ARE CONCERNS FOR THE WELFARE OF THE UNBORN CHILD

Joint Protocol agreed between Gloucestershire Social Services, Gloucestershire Hospitals NHS Foundation Trust and Cotswold and Vale PCT

Sue Butcher
Fieldwork Services Manager
September 2004

Working with Mothers and their Unborn Babies where there are Concerns for the Welfare of the Unborn Child

Working with Mothers and their Unborn Babies where there are Concerns for the Welfare of the Unborn Child

Joint Protocol agreed between Gloucestershire Social Services, Gloucestershire Hospitals NHS Foundation Trust and Cotswold and Vale PCT

Purpose:

The purpose of this joint protocol is to ensure that a clear system is in place to respond to concerns for the welfare of an unborn child and to maintain clear and regular communication.

Scope:

This joint protocol applies to Social Services staff and to hospital and community midwives.

Definitions:

Concerns for the welfare of an unborn child include (in this context):

- Concerns that the mother's current behaviour poses a threat the unborn baby
- Concerns that the mother may not be able to care for the baby to an acceptable standard
- Concerns that the behaviour of the father (or any other person) poses a threat to the unborn baby
- Concerns that the behaviour of the father (or any other person) will impact on the ability of the mother to care for the baby to an acceptable standard.

These concerns may relate to questions of mental health, mental capacity, learning or physical disability, substance misuse, previous parenting behaviour, offending behaviour or domestic violence. However, the presence of one of these factors does not automatically require referral.

Mandatory Procedures:

NB The timescales noted below refer to the duration of the pregnancy.

1. At 10 -12 weeks

- Where they have cause for concern, midwives will refer pregnant mothers to the Social Services Department following their 'booking-in' appointment that takes place at approximately 10-12 weeks of pregnancy.

- The referral will be made to Social Services' Customer Service Officers (CSOs) on 01452 426565. The referring midwife must confirm the referral in writing, either by letter or fax, within 48 hours.

- The CSOs will pass the referral to the Access Service, who must complete an Initial Assessment within seven working days. Urgent cases will be prioritised for completion at the discretion of the Access Manager.

- When concerns are raised, at any time, by someone other than the midwife, then the Social Services worker involved must bring them to the attention of the named community midwife, if known, or the child protection lead midwife.

2. By Week 18

- The Initial Assessment must be completed.

- If child protection concerns are ongoing, a 'Strategy Discussion' will be held with the police to include the child protection lead midwife and the named community midwife. An agreement will be made and recorded about the next step.

- A copy of the Initial Assessment will be sent to the child protection lead midwife and the named community midwife.

- If there are no child protection concerns, the referral can be closed at this point. The referral will stay open if other support needs are being assessed. The closure of this referral must be communicated to the named community midwife or the child protection lead midwife.

3. By Week 20

- The case will have been transferred to the appropriate Children in Need (CiN) Team.

- The CiN team manager will contact the named community midwife to advise on allocation. If the case is not allocated it will be brought to the attention of the fieldwork service manager leading on child protection matters.

- The allocated worker will consult with the Social Services Child Protection Unit and book a provisional date for a Case Conference.

- A Core Assessment, which will be co-coordinated by Social Services, must be started on allocation to the Social Services worker. When completed a further Strategy Discussion will be held to include the child protection lead midwife and the named community midwife. An agreement will be made and recorded by the social worker about the next step.

- A copy of the Core Assessment will be sent be sent to the child protection lead midwife and the named community midwife.

4. At Week 26

- The Case Conference will be confirmed or cancelled dependent on the outcome of the Core Assessment.

- The confirmation or cancellation will be communicated to the child protection lead midwife and the named community midwife.

5. At Week 30

- The Conference will be held or a 'Child in Need' Plan service plan completed. The latter can be shared with the child protection lead midwife and the named community midwife with the permission of the service user.

- The Plan for the time of the birth **must be explicit** and communicated to the service user and all professionals involved in the delivery and immediate after-care of mother and baby.

- The Plan will need to take account of the evidence that suggests, whilst most births take place at around 38 weeks, in mothers where there are concerns for the unborn baby, births tend to occur earlier.

6. Substance Misuse

Where there is alcohol or substance misuse, current agreed guidelines require 'Substance Misuse' meetings, led by health, to take place around week 20 and between 28-34 weeks of pregnancy. The allocated worker or other representative of the CiN team must attend, as a minimum, the latter of these two meetings. It may be appropriate to link these meetings with the Child in Need service plan review meetings.

Practice Guidance:

- Although this protocol does not explicitly mention fathers and extended family members they must be included as appropriate in the casework with the mother and unborn child.

- If another worker in Social Services knows the mother (e.g. a 'Care Leaving' Worker) that worker will work with the mother in a

supportive capacity alongside the Social Worker allocated to the unborn baby.

Implementation:

Within Social Services: This protocol will be added to the Social Services Policies and Procedures pages on the County Council website and all staff informed through “This Week”. CSO staff, the Access Service and CiN teams will be informed through team meetings.

Within Health: This policy will need to be accepted by the policy groups in both the Gloucestershire Hospitals NHS Foundation Trust and Cotswold and Vale PCT.
It will then be added to the ‘Current Guidelines’ folders within the maternity and paediatric services and will be distributed to all community midwives. Staff will also be advised about it through meetings.

Monitoring and Review:

The protocol will be reviewed after 12 months by a Social Services Fieldwork Services Manager (or their representative) and a senior midwife. This review will include auditing a sample of cases to confirm that the protocol was followed.