3.2 Births affected by drugs

Improvement Project Title: Births affected by drugs

Executive Sponsor (Chair of Outcome Improvement Group or Locality Partnership):
Rob Polkinghorne

Project Lead:
Simon Rayner, Alcohol and Drugs Partnership Lead

Aim statement
Reduce the number of births affected by drugs by 0.6 %, by 2022.

Link to Local Outcome Improvement Plan:

Stretch Outcome 3. 95% of children (0-5 years) will reach their expected developmental milestones by the time of their child health reviews by 2026

Driver 3.2 Keeping young children safe.

Stretch Outcome- 12: Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026

12.3 Enhance early intervention and preventative treatment for those at greatest risk of harm from drugs and alcohol

Why is this important

Aberdeen is an outlier compared to other urban areas of Scotland in relation to the number of babies born to substance using mothers.

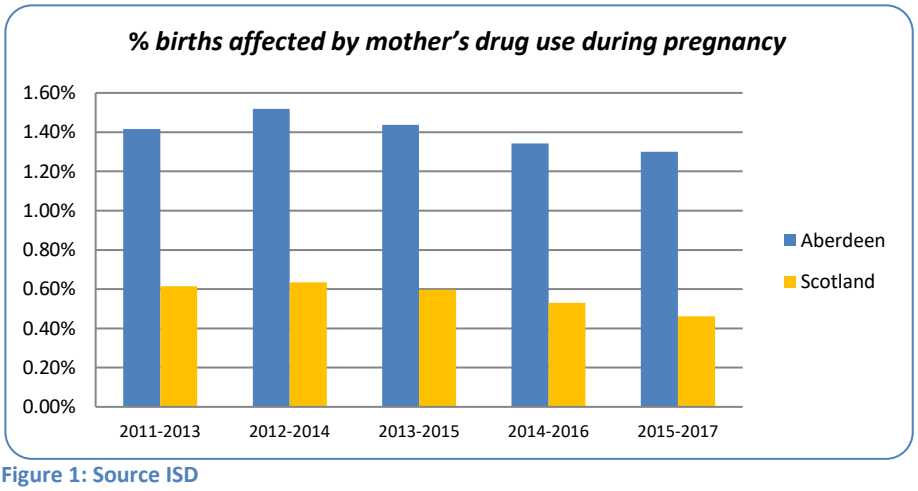


Figure 1: Source ISD

There is no definitive understanding as to why Aberdeen is an outlier compared to other areas and the reason is likely to be multi-faceted, for example it could be links to deprivation, the way services operate, general views about contraception, prevalence of drug use etc

Across Scotland deprivation can be seen as a significant factor in rates of harmful substance use and corresponding rates of babies born affected by maternal drug use. There are more births affected in

areas of higher deprivation as seen in Figure 2 Percentage of babies born affected by substance misuse per quintile.

Financial Years	Area / Deprivation Quintile									
	Aberdeen City					Scotland				
	1	2	3	4	5	1	2	3	4	5
2011-2013	2.81%	2.34%	1.86%	*	*	1.19%	0.74%	0.43%	0.21%	0.16%
2012-2014	3.09%	2.15%	2.11%	0.54%	0.35%	1.19%	0.70%	0.48%	0.29%	0.19%
2013-2015	2.60%	1.89%	2.33%	0.75%	0.43%	1.05%	0.69%	0.47%	0.30%	0.17%
2014-2016	2.94%	1.96%	1.36%	1.03%	0.37%	0.93%	0.63%	0.40%	0.30%	0.14%
2015-2017	3.03%	2.03%	1.36%	0.92%	0.23%	0.78%	0.62%	0.35%	0.24%	0.11%

Figure 2: Source ISD

Substance use whilst pregnant can cause a number of harms to the unborn child including physical and neurological impairments which can go onto to be disadvantages in later life. Depending on the substances used, babies can experience neonatal abstinence syndrome (NAS). This is primarily associated with use of opiod substances and can result in the child experiencing withdrawal symptoms at birth requiring support within the neo-natal unit.

At the ante-natal care / post-birth stage there is a lot of support provided to ensure that both baby and mother are safe and cared for.

We do not, however, have a comprehensive strategy to provide contraception and family planning support across this vulnerable population on a multi-agency / multi-disciplinary preventative basis to both men and women. Not every opportunity is made to count in relation to minimising the potential impact of substance use on pregnancy or ensure that women have the opportunity to make informed choices about contraception.

The NHS Grampian MCN for Sexual Health and Blood Borne Viruses Strategic Plan 2018 sets out the following requirements in relation to improving sexual health:

- Working alongside Community Planning Partnerships, who are expected to take an overall leadership role in implementing the Pregnancy and Parenthood in Young People Strategy (2016-2026)
- Timely access to information and counselling on contraception as well as contraceptive services, including within primary care will be a focus.
- An increase in LARC (Long Acting Reversible Contraception) uptake across Grampian in line with Health Improvement Scotland Standards, working specifically in areas or communities where uptake or provision is low and unplanned pregnancy rates are disproportionately high.
- We aim to engage key partners, who come into contact with individuals who are at risk of rapid repeat pregnancy to prioritise and pilot innovative solutions to improve access to services without delay. For example, in substance misuse services, maternity, abortion services, prison, community pharmacy, primary care and third sector partner organisations.

To “make every opportunity count” we need to ensure that reducing unplanned pregnancy for the most vulnerable people is part of all our work. What is required is a whole system, multidisciplinary approach to engaging on the issue.

Targeting opportunities for engagement

If we segment the target population as per figure 3 we can identify different opportunities for improvement (albeit figures are based on opiate / benzodiazepine use only)

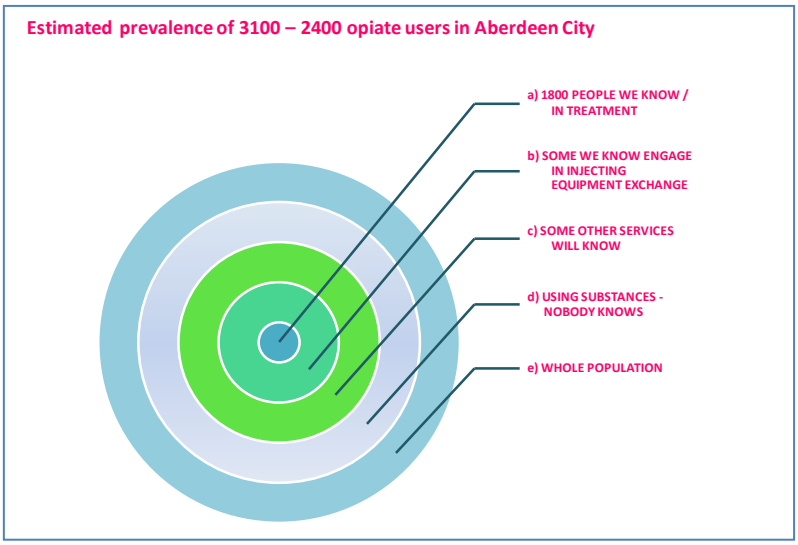


Figure 3

- Population A: People currently engaged in substance misuse treatment
- Population B: People with substance misuse issue engaging with low threshold / harm reduction services
- Population C: People not engaged in substance misuse treatment but accessing public services where the substance misuse issue is apparent
- Population D: People actively using substances where no one is aware
- Population E: The "whole population" may occasionally use substances but not aware of the impact on pregnancy e.g. alcohol, cannabis etc

Defining the opportunities

Population A: People currently engaged in substance misuse treatment
Substance use treatment may provide an opportunity to address the possibility of future pregnancies.

As access to treatment for drug issues increases, so does fertility for the most chaotic users and these opportunities are not being grasped. There are opportunities for increasing routine preventative work with people accessing substance misuse treatment.

For people within the specialist substance misuse service 35% are women and 65% male. The age distribution suggests 98% of the women are with an age where contraception is indicated: Figure 4

Age	Females	% of All Females
15-19	2	0.5%
20-24	18	4.2%
25-29	41	9.6%
30-34	88	20.7%
35-39	108	25.4%
40-44	94	22.1%
45-49	46	10.8%
50-54	21	4.9%
55-59	5	1.2%
60-64	2	0.5%
65+	0	0.0%
Total	**425**	**1.00%**

Figure 4

As an example examining data of patients seen within a single GP practice indicated that of 31 female patients 23 (74%) didn't have effective contraception.

Population C: People not engaged in substance misuse treatment but accessing public services where the substance misuse issue is apparent
Substance use is often a symptom of other underlying challenges, including, not exclusively domestic abuse, traumatic childhood experiences, homelessness, problematic mental health. It is very difficult to maintain heavy substance use without encountering other problems such as employment issues, benefits, housing, other health issues, family and child related issues and people will often pass through or engage with these wider services. Within this cohort there will be people where the substance use will be known or a factor in other support services being provided by other professionals in primary health care, secondary health care, housing and social care services and therefore opportunities to engage in preventive activity.

Population D: People actively using substances where no one is aware
There will be an unknown number of people using substances who are not known to any public services and we have an opportunity to raise awareness the impact of ante/post natal substances use across the whole population. This is especially true in relation to in particular alcohol use, smoking, cannabis use, cocaine and ecstasy type substances as well as benzodiazepine type substances non-benzodiazepine hypnotics and sedatives such as zopiclone.

The number of women engaging in substance misuse treatment continues to be lower than estimates would indicate should be the case. Some of this is due to stigma and potential fear and concern if there are already children in the house hold as well as other factors.

Population E: The "whole population" may occasionally use substances but not aware of the impact on pregnancy e.g. alcohol, cannabis etc
There continues to be a number of children born with foetal alcohol syndrome and anecdotal feedback about the lack of clarity on the impact of alcohol on pregnancy and a requirement to reinforce the Chief Medical Officer guidance. Other data is not currently available and improvement is required to identify and report this information.

Highly vulnerable women
Within all of the cohorts above there also continues to be a number of women who have multiple pregnancies that result in the child being removed due to the ongoing risks of having the child remain in the parental environment. It is thought that the trauma experienced of removal of a new born for protection reasons can also manifest itself through a number of rapid, subsequent repeat pregnancies in the number of subsequent repeat pregnancies. Adverse childhood events and trauma are one of the root causes of problematic substance use.

A potential improvement project is the PAUSE Programme, an intensive support and intervention programme delivered to a small cohort of women who are willing to commit to having a break in pregnancy for an 18month period, who have lost two or more children to local authority or kinship care. Currently Aberdeen City Council is working alongside PAUSE in a scoping exercise to determine Aberdeen's data in order to understand if this programme would be appropriate to initiate in the city. Scoping will aid scrutiny of data to evidence potential impact of such a programme not only for Integrated Children and Family Services, but also for ADP, NHS, Housing, Police Scotland etc and will offer a richer data set in relation to the charter.

There have been discussions through the Best Start In Life working group of the Integrated Children's Services Board.

Based on the driver diagram at Appendix 1 the five broad areas are identified for improvement.

1 Can increase the number of contraception reviews undertaken within substance misuse treatment services?

2 Can we increase number of women accessing IEP / Harm Reduction support and the number of contraception reviews for men and women?

3 Can we increase opportunities for a whole system approach where people are known to other services but not in addiction treatment?

4 Can we raise awareness of the impact of substance use and pregnancy across the whole population?

5 Can we reduce the incidence of repeat pregnancies with the most vulnerable women?

Measures: (How will we know if a change is an improvement?)

Outcome measures

- Reduce the number of maternities recording / affected by maternal substance / alcohol use
- Reduce the number of women with SMS issues with a repeat pregnancy / repeat removals identified

Process Measures

Increase the number of contraception reviews undertaken within substance misuse treatment services

- Number of women accessing substance misuse treatment services
- Number of contraception reviews in SMS / Primary Care / Prison HC

Increase number of women accessing IEP / Harm Reduction support and the number of contraception reviews for men and women

- Number of contraception reviews for men and women

Increase opportunities for a whole system approach where people are known to other services but not in addiction treatment

- Number of women presenting at maternity services not known to substance misuse services
- Number of staff signed up to contraception MEOC programme
- Number of people supported to sexual health
- Number of staff reporting feeling confident on knowledge of contraception / sexual health

Raise awareness of the impact of substance use and pregnancy across the whole population

- Number of people seeking further information
- Rate of campaign recognition

Reduce the incidence of repeat pregnancies with the most vulnerable women

- Number of pregnancies
- Number of removals

Balancing measures

There is no reduction in the number of women engaging in the services
There is no increase in late presentations of pregnancy where substance use is an issue

Change ideas

1 Can we increase the number of contraception reviews undertaken within substance misuse treatment services?

- Create fast track pathway for women for contraception to SHS/GP
- Use VISION to recall and review - increase the number of contraception review undertaken in primary care / Develop a sexual health checklist standard
- Training in contraceptive provision regarding FAST track training for PGD use including implant insertion
- Use Non Medical Prescribing for mini pill and contraception
- Make Modules 3, 4,10, ,8 Faculty of Sexual and Reproductive Health (FSRH) core for substance misuse staff /

2 Can we increase number of women accessing IEP / Harm Reduction support and the number of contraception reviews for men and women?

- Women's IEP / Harm Reduction drop-in service in priority locality

3 Can we increase opportunities where people known to other services but not in addiction treatment?

- Increase staff knowledge and confidence
    - Promote the "Ins and Outs" website and other resources
    - Improve use / distribution of promotional materials
    - Ensure staff are aware of the impacts of different substances on pregnancy
    - Make on line modules available to non-clinical staff to increase confidence / awareness
    - Promote Modules 3, 4, 10, 8 Faculty of Sexual and Reproductive Health (FSRH) for non-clinical staff?
- Make every opportunity count approach
    - Consider the population characteristics of people who are NOT routinely accessing services
    - Use case studies to share missed opportunities
    - Have condoms available at access points

d Can we raise awareness of the impact of substance use and pregnancy across the whole population?

- Support all public health staff to promote messages
- Support all public sector staff to promote message
- Promote APPA (Alcohol Pre-pregnancy and Pregnancy Advice) project adopted the Scottish Government'
- Run a promotion in locality areas

5 Can we reduce the incidence of repeat pregnancies with the most vulnerable women?

- Develop PAUSE programme
- Make every opportunity count approach across system

Potential risks and/or barriers to success & actions to address these

- Cost
- Staff time for training
- Culture of staff not taking a role regarding sexual health / pregnancy
- Risk of continued focus across the partnership when there is acknowledged to be a vulnerable unborn baby, rather than preventative, earlier stage.

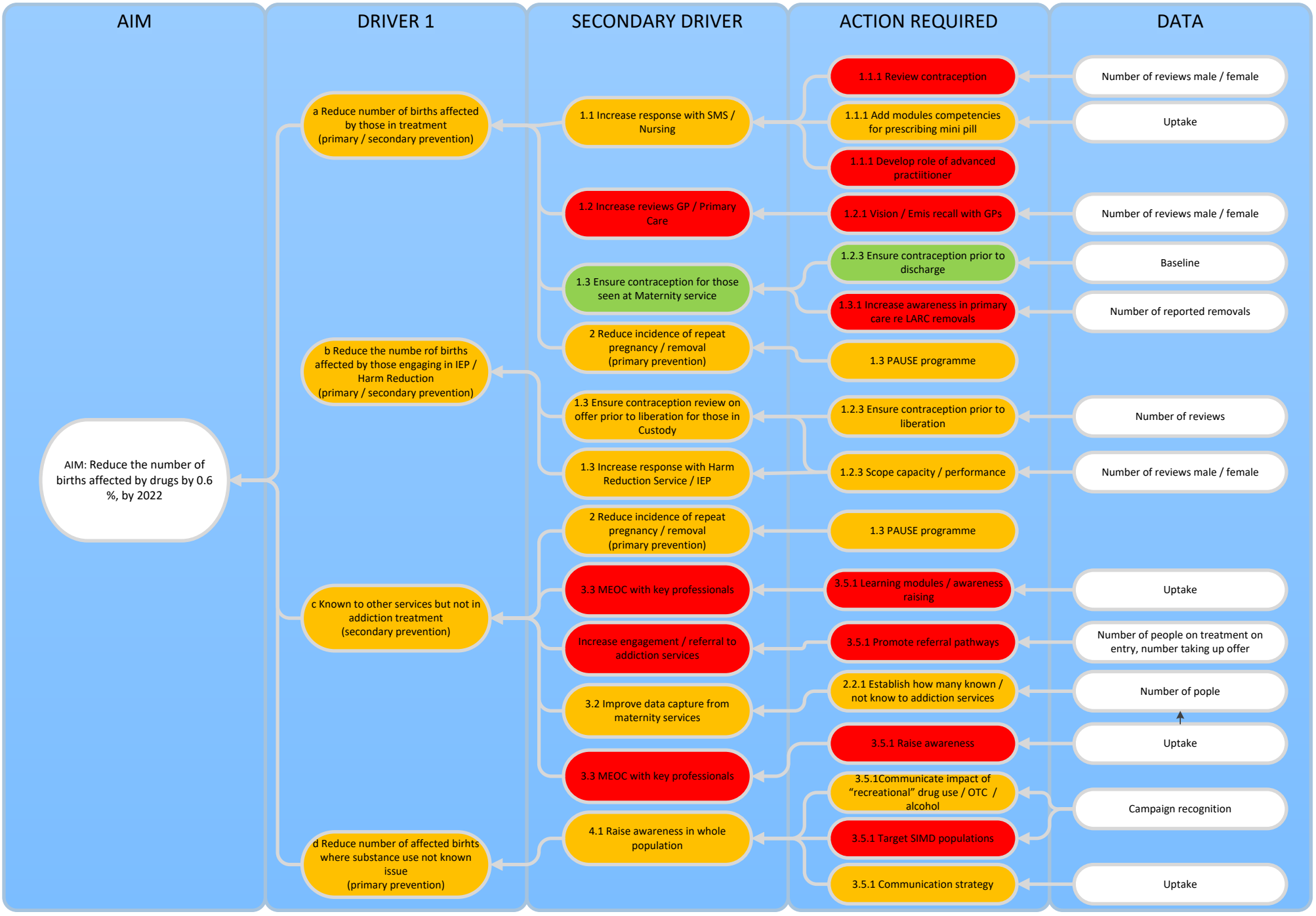
Project Team:
A project team hasn't been formed for this improvement but there has been discussion with:

- Best Start In Life Group
- Ali McAlpine Lead Service Manager (Acting) Integrated Children and Family Services
- Lisa Allerton, Manager, MCN Sexual Health and BBV
- Tracy Gerviase, (former) Chair of BSIL and Child Health Champion NHS Grampian
- Heather McRae, Chair of BSIL
- Emily Dobie, Business Development Co-coordinator
- Substance Misuse Service Staff and management team
- GPs involved in Vision / Substance misuse service
- Enhanced Service Group for GP contracts
- GP Clinical Lead for Aberdeen City

A project group will be formed as a side group of BSIL to take forward tests of change and in line with the four broad areas for improvement.

Outline Project Plan

Project Stage	**Actions**	**Timescale**
Getting Started (Project Score 1-3)	• Areas for improvement identified • Ideas for improvement generated Gather baseline data for project measures and put systems in place for any data not currently gathered Improve use of data and increase target activity Charter agreed	Completed July 19 July/ August 19 September 19
Designing and Testing Changes (Project Score 4-7)	Develop promotional materials First three improvements designed, staffing aligned and testing to run for 2 months then review	October – February
Implementing and sustaining changes that demonstrate improvement (Project Score 7-10)	Possible funding , resource redesign	June 2020
Spreading Changes (Project Score 9-10)	What actions are required to reach the full scale of the project? Possible funding , resource redesign	Sept 2020


AIM
DRIVER 1
SECONDARY DRIVER
ACTION REQUIRED
DATA
AIM: Reduce the number of births affected by drugs by 0.6 %, by 2022
a Reduce number of births affected by those in treatment (primary / secondary prevention)
b Reduce the numbe rof births affected by those engaging in IEP / Harm Reduction (primary / secondary prevention)
c Known to other services but not in addiction treatment (secondary prevention)
d Reduce number of affected birhts where substance use not known issue (primary prevention)
1.1 Increase response with SMS / Nursing
1.2 Increase reviews GP / Primary Care
1.3 Ensure contraception for those seen at Maternity service
2 Reduce incidence of repeat pregnancy / removal (primary prevention)
1.3 Ensure contraception review on offer prior to liberation for those in Custody
1.3 Increase response with Harm Reduction Service / IEP
2 Reduce incidence of repeat pregnancy / removal (primary prevention)
3.3 MEOC with key professionals
Increase engagement / referral to addiction services
3.2 Improve data capture from maternity services
3.3 MEOC with key professionals
4.1 Raise awareness in whole population
1.1.1 Review contraception
1.1.1 Add modules competencies for prescribing mini pill
1.1.1 Develop role of advanced practiitioner
1.2.1 Vision / Emis recall with GPs
1.2.3 Ensure contraception prior to discharge
1.3.1 Increase awareness in primary care re LARC removals
1.3 PAUSE programme
1.2.3 Ensure contraception prior to liberation
1.2.3 Scope capacity / performance
1.3 PAUSE programme
3.5.1 Learning modules / awareness raising
3.5.1 Promote referral pathways
2.2.1 Establish how many known / not know to addiction services
3.5.1 Raise awareness
3.5.1Communicate impact of “recreational” drug use / OTC / alcohol
3.5.1 Target SIMD populations
3.5.1 Communication strategy
Number of reviews male / female
Uptake
Number of reviews male / female
Baseline
Number of reported removals
Number of reviews
Number of reviews male / female
Uptake
Number of people on treatment on entry, number taking up offer
Number of pople
Uptake
Campaign recognition
Uptake