FACTORS THAT INFLUENCE WOMEN’S DISCLOSURES OF SUBSTANCE USE DURING PREGNANCY: A QUALITATIVE STUDY OF TEN MIDWIVES AND TEN PREGNANT WOMEN

Diane Phillips, Kristina Thomas, Helen Cox, Lina A. Ricciardelli, Jan Ogle, Veronica Love, Angela Steele

The present study was designed to examine the factors that motivate or act as barriers to disclosure of substance use by pregnant women. Participants included 10 midwives and 10 pregnant women who attended two ante-natal clinics at an Australian maternity hospital. One clinic specialized in women who were substance users and one clinic was specifically for young women (under 19 years of age). Midwives and pregnant women were interviewed in-depth about disclosure of substance use. Interview transcripts were analyzed, and the results revealed six main themes: practice style, assessment of substance use, practice environment and privacy, child protection issues, health of the baby, and continuity of care. The findings are discussed in relation to recommendations for best practice in midwifery care when working with pregnant women who use substances.

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The women who use drugs and alcohol are no different to other women; they have the same dreams and hopes as anyone else. She wants a supportive partner, a home, a dog in the back yard, the happy family. They are no different to anyone else; they just have a lot more barriers getting in the way of achieving that. (Midwife 6)

**INTRODUCTION**

The incidence of illicit drug use by pregnant women in Australia is between 8% and 17% (Australian Institute of Health and Welfare [AIHW], 2003). However, the incidence is likely to be underreported as many women do not disclose this information to professionals. The incidence of licit drug use, including tobacco and alcohol, is higher still. In one study, 61% of women reported smoking tobacco and 43% of women reported drinking alcohol at some point during their pregnancy (Clark, Dawson, & Martin, 1999).

It is known that drug use and misuse contributes to illness and disease, injury, workplace concerns, violence, crime, and breakdown in families in Australia (Commonwealth of Australia, 2005). Pregnant women who use substances are at risk of developing physical, mental, and social problems (Bradley, Badrinath, Bush, Bidywickizer, & Anawalt, 1998; Lewinsohn, Rohde, & Seeley, 1996; Sarigiani, Ryan, & Petersen, 1999; Stein & Cyr, 1997). Maternal health problems include risks of human immunodeficiency virus transmission (Andrulis & Hopkins, 2001), sexually transmitted diseases, hepatitis, spontaneous abortions, and malnutrition (Little et al., 2003). Further to physical health problems, women who engage in use of substances are also likely to be subjected to physical and sexual abuse and are also likely to suffer severe depression (Horrigan, Schroeder, & Schaffer, 2000).

The impact on the unborn/newborn infants of women who engage in use of substances is wide ranging (AIHW, 2003) and represents a major public and social health problem in Australia (Alcohol and other Drugs Council of Australia, 2000; Banwell, O’Brien, Hamilton, & Attewell, 1999). Potential health problems for the unborn/newborn infant include withdrawal effects of substances. Illicit substances in particular (AIHW, 2003) have an impact upon pregnancy through intra-uterine growth retardation, risk of vertical transmission of hepatitis C virus-positive, prematurity, low birth weight, placental abruption, congenital malformations, and the potential for fetal death (Miller, Cox, Harbison, & Campbell, 1994). The risk of fetal alcohol syndrome (Redding & Selleck, 1993) is a major concern when women continue to use alcohol during pregnancy, especially during embryonic and fetal development of early pregnancy.
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After birth, children of women who have used substances during pregnancy are at great risk of impaired cognitive development and behavioral problems (Kukko & Halmesmaki, 1999). The long-term effects of substance use on children also include ineffective parenting, (Buchi, Zone, Langheinrich, & Varner, 2003), child abuse, poverty, and neglect (Andrulis & Hopkins, 2001).

Through early identification of substance use during pregnancy, early implementation of treatment can reduce the harmful side effects. In turn, this can lead to improved maternal and infant health outcomes (Armstrong et al., 2000). Early recognition of substance use in pregnancy can also lead to improved outcomes for unborn/newborn infants such as a longer gestational period, heavier birth weights and better Apgar scores immediately following birth (Sweeney, Achwartz, Mattis, & Bohr, 2000).

However, early identification of substance abuse during pregnancy is difficult as women who use alcohol, tobacco and illicit drugs during pregnancy often have difficulty accessing traditional systems of healthcare and disclosing their use of substances to health professionals (Corrarino et al., 2000). Previous research has found that pregnant women who are using alcohol and illicit drugs are most concerned about the possibility of losing custody of their unborn infant or the custody of their other children as seeking health care may lead to detection of substance use (Jessup, Humphreys, Brindis, & Lee, 2003; Sword, Niccols, & Fan, 2004). Jessup et al. (2003) reported that 78% of their sample of pregnant women who were abusing substances highlighted fear of losing the custody of their unborn child or police involvement were barriers to seeking health care. Fears about being judged by health care professionals can also deter them from seeking prenatal health care (Jessup et al., 2003).

On the other hand, fear of losing custody has also been identified as a motivating factor for women to seek treatment for their substance use (Sword et al., 2004). Furthermore, women may also be motivated to enter treatment for their substance abuse or seek prenatal health care to ensure the health of their unborn baby (Corse & Smith, 1997).

Little research has examined the barriers and motivating factors to seeking health care and disclosing substance use for pregnant women. How to best obtain honest information regarding substance use while maintaining an ongoing relationship with the woman is a relevant issue for health care workers. One study found that health professionals who provide maternity services generally fail to ask women about their use of substances when performing their health assessments (Svikis et al., 1997). Further research has shown that training staff to use a structured screening tool can improve the percentage of women being screened for substance use (Kennedy, Finklestein, Hutchins, & Mahoney, 2004). In addition, using a screening tool that
includes more detailed questions about the frequency of use can improve disclosure rates in comparison to a yes/no check box of use (Clark et al., 1999). Clark and colleagues found that self-disclosure of alcoholism or drug abuse rose from 0% using a basic screen to 6% using the detailed screening tool for a general population of pregnant women.

Midwives are well positioned to obtain information from women related to their lifestyle that could place them and their unborn/newborn infants at risk (McLeod et al., 2003). The findings from an Australian study on antenatal risk assessment indicated that midwives played a key role in the identification of psychosocial issues for pregnant women (Willinck & Schubert, 2000). The midwives role in performing careful and thorough health assessments of women during pregnancy can identify whether or not women are using substances (Ettlinger, 2000). Corse and Smith (1997) found that certified nurse-midwives in one program provided effective and appropriate care of substance using women through comprehensive assessments, education, intervention, and referral care.

This study examines the factors that influence self-disclosure of substance use by pregnant women from the perspectives of both the midwife and of the pregnant woman. The midwives were specifically interviewed about their experiences of working with pregnant women, particularly in relation to screening for and working with substance abuse issues. The women were interviewed about their experiences seeking midwifery care, particularly in relation to substance use and disclosing substance use to midwives.

**METHOD**

**PARTICIPANTS**

Ten midwives from the Royal Women’s Hospital in Melbourne were informed of the study by poster information advertising it and recruited by the two on-site research project associates. The midwives were also informed of the study by the research assistant when she was at the hospital. Of the 10 midwives who participated, two midwives worked in the Women’s Alcohol and Drug Service (WADS), two midwives worked in the Young Women’s Clinic (YMC), two midwives worked in the Bookings office, and the remaining four midwives worked in two general antenatal practice settings within the hospital. All midwives cared for pregnant women who used or had used substances. As shown in Table 1, midwives had varying experience ranging from four to 36 years.

Ten pregnant women were also recruited from two services within the Royal Women’s Hospital via posters advertising the study and by the research assistant. The women were invited to participate if they met the criteria. The criteria was that the women had to be over 18, were able to speak English, were not deemed aggressive or substance affected on the day (as assessed by the clinic staff), and
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TABLE 1
DEMOGRAPHIC INFORMATION ABOUT MIDWIVES

<table>
<thead>
<tr>
<th>Clinic Where Currently Employed</th>
<th>Years of Midwifery Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife 1 General ante-natal</td>
<td>15</td>
</tr>
<tr>
<td>Midwife 2 Booking Clinic</td>
<td>32</td>
</tr>
<tr>
<td>Midwife 3 General ante-natal</td>
<td>20</td>
</tr>
<tr>
<td>Midwife 4 General ante-natal</td>
<td>9</td>
</tr>
<tr>
<td>Midwife 5 WADS</td>
<td>14</td>
</tr>
<tr>
<td>Midwife 6 WADS</td>
<td>22</td>
</tr>
<tr>
<td>Midwife 7 Bookings Clinic</td>
<td>20+</td>
</tr>
<tr>
<td>Midwife 8 YWC</td>
<td>4</td>
</tr>
<tr>
<td>Midwife 9 General ante-natal</td>
<td>12</td>
</tr>
<tr>
<td>Midwife 10 YWC</td>
<td>10</td>
</tr>
</tbody>
</table>

TABLE 2
DEMOGRAPHIC INFORMATION ABOUT PREGNANT WOMEN

<table>
<thead>
<tr>
<th>Clinic Attended</th>
<th>Number of Pregnancies</th>
<th>Stage of Pregnancy (Weeks)</th>
<th>Substance Use</th>
<th>Methadone Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman 1 WADS</td>
<td>2</td>
<td>36</td>
<td>Heroin, marijuana, tobacco</td>
<td>Yes</td>
</tr>
<tr>
<td>Woman 2 WADS</td>
<td>4</td>
<td>38</td>
<td>Amphetamines, tobacco</td>
<td>No</td>
</tr>
<tr>
<td>Woman 3 WADS</td>
<td>1</td>
<td>34</td>
<td>Heroin</td>
<td>Yes</td>
</tr>
<tr>
<td>Woman 4 WADS</td>
<td>2</td>
<td>38</td>
<td>Alcohol, tobacco, marijuana</td>
<td>No</td>
</tr>
<tr>
<td>Woman 5 WADS</td>
<td>1</td>
<td>29</td>
<td>Heroin</td>
<td>Yes</td>
</tr>
<tr>
<td>Woman 6 YWC</td>
<td>1</td>
<td>30</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Woman 7 YWC</td>
<td>2</td>
<td>24</td>
<td>Ceased tobacco</td>
<td>No</td>
</tr>
<tr>
<td>Woman 8 YWC</td>
<td>1</td>
<td>40</td>
<td>Ceased alcohol</td>
<td>No</td>
</tr>
<tr>
<td>Woman 9 YWC</td>
<td>1</td>
<td>28</td>
<td>Tobacco</td>
<td>No</td>
</tr>
<tr>
<td>Woman 10 YWC</td>
<td>1</td>
<td>17</td>
<td>Ceased tobacco</td>
<td>No</td>
</tr>
</tbody>
</table>

showed interest in finding out more about the study. Table 2 shows demographic information about the women.

Five of the 10 women who participated attended the Women’s Alcohol and Drug Service (WADS) for antenatal care. This service is specifically for pregnant women who have been identified as having substance use issues. All five of these women were using illicit drugs (including heroin, marijuana, and amphetamines) and four were using tobacco and/or alcohol. Three were on the methadone program.

The remaining five women who participated in the study were recruited from the Young Women’s Clinic (YWC), which was set up to support pregnant women...
aged 19 or under. While the women who attend the YWC do not necessarily have substance use issues, substance use among young women is common. Of the five women from the YWC, none reported using illicit substances, three reported using tobacco, and one reported using alcohol. All women were 18 years or older and were interviewed between 29 and 38 weeks of their pregnancy.

**Procedure**

Invitations to both midwives and women were posted in areas where this information would be noticed by them. The research assistant associated with this study approached potential participants, invited their interest, informed them of the study and then distributed a copy of the Plain Language Statement to those potential participants who demonstrated an interest in this project. Those who agreed to participate in the study were requested to complete the consent form, and arrangements for an interview with each potential participant were then made. All participants were advised that they could withdraw from the study at any time. The response rate for both midwives and pregnant women who were invited to participate and met the criteria was 100%. No one refused to participate and none of the participants withdrew their participation from this study.

A semi-structured interview schedule was designed and used to obtain information about midwives experiences and knowledge. A semi-structured interview schedule was also designed and used to obtain information about the women’s experience with substance use and their experience of how their midwives dealt with this issue. In both interviews, questions were asked about the assessment of substance use and factors that facilitated or were a barrier to self disclosure of substance use.

Interview questions were unstructured and designed to promote open-ended responses. Interviews with the midwives were between 45 minutes and an hour long. The interviews with the pregnant women were much shorter—20 to 30 minutes. Interviews were taped (with the consent of participant) and transcribed.

Transcripts were analyzed for main themes and then coded according to those themes using the Nueman (2000) three phase coding system. During the first phase of coding, the primary researcher performed an initial scan of the data, highlighting words or phrases used by the participants and locating initial themes. Members of the research team identified the core themes through a process of collaborative analysis and linked the core themes to the aims of the study. In the second phase, the researcher focused on connecting themes and finding links in the data. In the final phase, the primary researcher reread the data and assigned excerpts that illustrate the final themes. All coding was checked by another researcher to ensure it was coded accurately.
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RESULTS

The analysis of interviews with midwives and pregnant women revealed six main themes: practice style, assessment of substance use, environment and privacy issues, child custody, health of the baby, and continuity of care. A summary of the barrier and motivating factors to disclosure of substance use for pregnant women is presented in Table 3.

PRACTICE STYLE

Every midwife spoke of the importance of building rapport and a sense of trust with each woman in order to encourage disclosure of substance use. One of the main factors described by the midwives in building rapport was having a nonjudgemental approach towards substance use and other lifestyle factors.

I've got an attitude that is open with women ... It doesn’t really bother me whether they are on drugs or not, I won’t treat them any differently. I wouldn’t judge them. (Midwife 4)

One midwife reported that her nonjudgemental attitude was maintained by her belief that these women have disclosed their substance use, are attending WADS, and are seeking help and seeing it as a problem. She understands that people relapse, that abstinence is difficult, and that their lives are commonly very stressful. She says, “I don’t condone it but I understand it” (Midwife 5).

The midwives reported that it was also important to portray themselves as supportive and caring rather than confrontational and intimidating.

I've had the occasion where the woman's absolutely stoned... I mean she is falling asleep ... but like if you go off at her she’s not gonna come back again. (Midwife 2)

The pregnant women also highlighted that the practice style of their midwife was important. All of the women wanted, and in the main had, midwives who were nonjudgemental. One woman said that, “the midwives treated me with respect,” and another said “she [the midwife] talked to me, not down to me” (Woman 2).

She [the midwife] should be open minded, not judgemental, and try to put herself in the other person’s shoes. Yeah, just don’t make someone feel threatened ... that’s probably best. (Woman 3)
She was very open and easy to talk to. (Woman 2)

Another factor that was highlighted by the midwives as important in establishing rapport and building a trusting relationship was incorporating encouragement and praise.

Keep going, you are growing that baby nicely. (Midwife 1)

You’ve been taking heroin in the past and now you are on methadone … this a fantastic step to take because you’re not unstable anymore. You are trying to get off heroin, you’re pregnant and this is far better for your baby than having the highs and lows of shooting up. We commend you for coming to the clinic and being on the program. (Midwife 4)

**ASSESSMENT OF SUBSTANCE USE**

All 10 midwives reported that they asked about substance use at some point in the interview and most repeatedly asked at each visit as women may not be honest about their substance use initially. All of the midwives agreed that questions about substance use are received better by women if asked later in the interview after a rapport has been established.

What I do and I encourage other people to do, is put the drug use aside and to make a connection with the woman first and the rest will follow. If you don’t make the connection you don’t get the information.... I think that it is all up to me in terms of developing that rapport and making her feel comfortable and making her feel safe as to how much information I get. (Midwife 6)

I think it is really important to build up a rapport with them before you expect them to disclose something that personal. (Midwife 9)

All of the midwives reported using the prescribed structured assessment form and many find this helps them ask questions about substance use as the questions follow a holistic assessment of the women’s life circumstances.

One midwife also mentioned that she finds that the way the form is structured is helpful as it leads to all questions being asked. However, a detailed history is
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uncovered before questions about substance use are asked, so a great deal is already known and the women have relaxed a little.

When a woman has spoken of considerable stress, mental health issues, homelessness, domestic violence, it provides an opening for the midwife to ask about how they have coped with such difficult circumstances, have they taken anything to help them. (Midwife 5)

The midwives advocated for direct questions about drug use in order to get direct and detailed responses. They suggested that there needs to be clear differentiation between types of drugs and even how drugs are used.

Just ask them about drug use directly, don’t avoid the subject, because you can’t get an answer if you don’t ask them directly. (Midwife 10)

Do you smoke tobacco? Use marijuana? If so, how much? (Midwife 1)

Use normal language, ask them normal questions, don’t try to evade and be embarrassed and go around the questions. They’ll respect you more if you speak honestly and clearly to them. (Midwife 9)

The women also noted the advantages of direct questions:

Well I wouldn’t volunteer the information. If I’m asked a direct question I’ll give a direct answer. (Woman 2)

It’s good to ask straight out because I mean to ask a question about drug using, if you beat around the bush I think so will the patient. As a drug user you don’t really tell the truth anyway so it’s good, the more direct you are the more a person might realize they have to be honest to themselves. (Woman 5)

However, some midwives did report finding it difficult to ask about substance use and to differentiate between different types of drugs. Two midwives admitted that they were not consistent in the questions they asked about substance use and would
let the woman’s age or religion influence them. Another midwife admitted that in assessments she does not clarify smoking as “tobacco” or “marijuana” and she also admits that “she is not as good with alcohol” and does not ask about that either.

I suppose I’m really at fault, I don’t really ask much about alcohol ... I think too a lot of our clients are Turkish and Moslem and I don’t think alcohol figures a lot in their lifestyle. It’s a cultural thing. (Midwife 7)

On the other hand, three midwives highlighted how important it was not to make assumptions about who might use substances.

I have been in the business long enough to know that just because someone may not look like they are using drugs, they may in fact be using vast quantities. The questions need to be asked. (Midwife 6)

Similarly, the women expected to be asked about their drug use, particularly those who attended WADS:

I’d wonder what was wrong with them if they didn’t ask. (Woman 2)

I had the feeling they were prying, but to make sure everything is safe you have to tell them. (Woman 4)

THE ENVIRONMENT AND PRIVACY

Some of the midwives spoke about privacy as an issue that influenced disclosure:

The setting in which the interview is taking place, if the door is open or if there are just curtains portioning the various areas, they need to know that other people aren’t going to be listening to the conversation. (Midwife 6)

The issue of privacy was further complicated when partners or family members accompany the woman and stay with her when the assessment is being conducted. In this sample, most women did bring someone with them to the clinic visits. While
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this support can be very important and helpful, the midwives acknowledged that often the presence of the partner or family would inhibit disclosure of substance use, particularly if there was domestic violence in the relationship. Midwives understand this as an issue and develop strategies to manage this.

It will often be something they have kept from their family ... so I'll try and ask them without a partner or someone there, just them and I. (Midwife 9)

Two of the pregnant women also highlighted partner issues as a barrier to disclosure of substance use. One woman talked about how she feared making her partner angry and said, “I always thought about how it would affect him before I did answer…in a couple when there are drugs and things going on, you have to hide and lie about everything most of the time” (Woman 5). Another woman said, “I don’t think you can be honest with your partner in the room” (Woman 4).

CHILD PROTECTION ISSUES

One of the major barriers to pregnant women disclosing their substance use, as reported by midwives, was fear of having their child taken by child protection agencies. Three of the midwives noted that it was much easier to address this fear and work together if the woman presented early in the pregnancy. If it was later in the pregnancy, then women were less willing to disclose substance use due to the fear of child protection involvement.

They are not going to divulge any more than they want you to know, they are afraid of the consequences…maybe they have had dealings with community services or had their kids taken away in the past. (Midwife 2)

If women gave a history of say intravenous heroin using and they’ve presented at the first visit say 8 to 12 weeks, it’s unthreatening to talk about it compared to talking about it at 36 weeks. (Midwife 6)

In Australia, reporting to the Department of Human Services (DHS: child protection services) is mandatory for midwives if they fear for the child’s safety. One midwife talked about how she states this up front and then gets the woman to plan what needs to change in order for her to be able to keep the baby safe. About reporting, she said:
Quite often they will be resentful to us for a couple of weeks…but we keep supporting them, we keep advocating for their rights, for them as a mother. But we are really clear that safety is paramount. Often notification to child protection is not seen as a negative because they receive the intensive support they need to parent successfully. (Midwife 6)

The pregnant women also highlighted this as a real fear for them, and two of the women reported previous DHS involvement. The issues did affect disclosure and also the relationship with the midwife.

I was scared that if I came here they would dob me in and I would lose my child. I wasn’t sure how child welfare was involved and I was scared of that. (Woman 3)

However, another woman actually felt pleased that the Department of Human Services was involved as the agency put in place supports to help her.

**Health of the Baby**

A main theme that emerged as a motivating factor for women to seek health care and disclose substance use was the health of their unborn baby. As Woman 5 states, “I want more than anything to have a healthy baby and for the baby to be safe when it is born.” This woman had undergone treatment for her addiction and was committed to staying drug free because of her desire for a healthy baby.

“Holding [the information] doesn’t help your baby. If you say you are on 50ml of methadone and you are actually taking 90ml, you are not helping,” said Woman 1. The fact that both the women and midwives had the health of the baby as a goal was reassuring for the women and helped build a strong working relationship. This factor highly influenced their ongoing attendance at the clinic. “We’re sort of all working together now to just keep clean and keep the baby healthy,” said Woman 5.

**Continuity of Care**

Continuity of care was highlighted by women and midwives as an important factor. As discussed earlier, midwives reported that a good rapport and trusting relationship was often necessary for disclosure of substance use. However, it may take a number of visits to establish trust and rapport. For the women, continuity of care was viewed as essential and also meant that they did not need to keep retelling their story. The women at the WADS clinic did have the same caregiver, whereas the women at the YWC clinic did not. These women received care from
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midwives working in “team midwifery,” where the concept of continuity of care is promoted.

Yeah, I explained to her [the midwife] on the phone I’m not very good with change. I need consistency, and she’s made sure that I’ve had it.” (Woman 2, WADS)

If you see different people, different midwives each time you come to the clinic, then they are not going to disclose anything to you, if you see the same midwife each week then they’re more likely to disclose what they are using. (Midwife 4)

It’s a pain in the bum, having to go over it every time, cause I haven’t changed, but yeah if you have a different midwife every time how’s she supposed to know what you are on since last time, so she’s gotta go back over it all. (Woman 1, YWC)

DISCUSSION

Prior research has shown that using substances during pregnancy increases the risk of health problems for the unborn child. Through early identification of substance use during pregnancy, access to health care and substance use treatment can reduce harmful side effects and lead to improved maternal and infant health outcomes (Armstrong et al., 2000). Midwives are well positioned to obtain information on substance use during comprehensive health assessments (Ettlinger, 2000) and provide appropriate ongoing care and referral to substance using women during pregnancy (Corse & Smith, 1997).

Little research has been conducted to examine factors that motivate or act as barriers to disclosure of substance use or to ongoing attendance at maternal health clinics. The aim of this study was to interview midwives and pregnant women about their knowledge and experiences to examine the factors that facilitate or are barriers to disclosing substance use during pregnancy. Ten midwives and 10 pregnant women were interviewed in depth.

Six main themes were identified as important in facilitating disclosure of substance use during pregnancy. Table 3 provides an overview of the main themes in the context of how each theme can operate as a barrier or as a motivating factor to disclosing substance and receiving ongoing health care.

The practice style of the midwife is important in developing rapport and building trust. In particular, both the midwives and the pregnant women highlighted that disclosing substance use would only occur after a trusting relationship had been
# Table 3

## Barriers and Motivating Factors to Disclosure of Substance Use for Pregnant Women

<table>
<thead>
<tr>
<th>Barrier/Factor</th>
<th>As a Barrier</th>
<th>As a Motivator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice style</strong></td>
<td>Judgmental; intimidating and confrontational.</td>
<td>Nonjudgmental; supportive and caring; direct and honest; encouragement and praise.</td>
</tr>
<tr>
<td><strong>Assessment of substance use</strong></td>
<td>Relying on stereotypes — not asking; asking vague questions; ask too early — without a rapport; not differentiating between different substances; fail to ask at each interview.</td>
<td>Ask every woman about her substance use; use structured assessment tool; use direct questions; ask how much and how often; repeat at each interview and probe further as trust is built.</td>
</tr>
<tr>
<td><strong>Environment and privacy issues</strong></td>
<td>Lack of privacy; having another person in the room may prevent honest disclosure; domestic violence may prevent honest disclosure.</td>
<td>Ensure interview is conducted in a private setting; arrange time with the woman alone (be creative); be aware of the possibility of domestic violence.</td>
</tr>
<tr>
<td><strong>Child protection issues</strong></td>
<td>Woman may fear that seeking health care and disclosure of substance use will result in losing her child.</td>
<td>Be up front about mandatory reporting; encourage woman to be honest about substance use so that you can work together towards change.</td>
</tr>
<tr>
<td><strong>Health of the baby</strong></td>
<td>A main motivating factor in seeking health care is the ultimate health of the baby; encourage the woman to be honest about substance use so that you can maximize health of the baby; this should be a joint goal for the midwife and the woman to work towards — helps build rapport.</td>
<td></td>
</tr>
<tr>
<td><strong>Continuity of care</strong></td>
<td>Team midwifery that lacks continuity of care may lead to poor rapport, less disclosure, and increased frustration for the woman.</td>
<td>Continuity of care ensures a solid and trusting relationship develops between the woman and midwife; continuity of care increases disclosure and improves outcome.</td>
</tr>
<tr>
<td><strong>Referral to other services</strong></td>
<td>Woman may not receive access to substance abuse treatment, mental health treatment, financial assistance etc.</td>
<td>Midwives also need to acknowledge their limitations and have good links with relevant services to refer patients to for substance abuse treatment, mental health treatment, domestic violence counseling, financial assistance support etc.</td>
</tr>
</tbody>
</table>
established and that a nonjudgemental and supportive approach was the most effective way to establish trust. One explanation for this is that women fear being judged by health professionals (Jessup et al., 2003).

Midwives reported different ways of screening for substance use. However, the majority reported that using a screening tool and conducting a comprehensive assessment were both important. Screening tools with specific information prompts pertaining to substance use have been validated by prior research (Clark et al., 1999; Kennedy et al., 2004). It appears that a more precise substance use screening tool would guide midwives to ensure that women are questioned about their use or nonuse of substances throughout pregnancy.

In this study, the midwives took a holistic perspective of the women. They reported that many of the women they see who are using substances also report abuse, mental health difficulties, and financial concerns. Questions about how women coped and whether substance use was also part of their history followed on from assessments of the difficulties they had faced throughout their lives. Midwives advocated for questions about substances to be asked directly, which is consistent with the findings on asking women about their tobacco use (McLeod et al., 2003). They were also clear that stereotyping women and making assumptions about substance use was not helpful.

The practice environment was also shown to be important for disclosure of substance use and particularly privacy. In relation to partners attending the health consultations, there were two factors that may affect disclosure. Firstly, pregnant women may not have told their partners about their substance use or the severity of their substance use. Secondly, domestic violence was frequently reported within this population, which may also inhibit disclosure. Previous studies have also found that women who use substances are more likely to be subjected to physical and sexual abuse as well as family breakdown (Commonwealth of Australia, 2005; Horrigan et al., 2000).

The results of this study showed that the women’s main concern was the health and safety of their unborn child. In order to ensure the health of their child, the women were willing to seek prenatal health care and disclose their substance use history. This confirms the findings of previous studies that suggest pregnancy offers a motivation to seek treatment for substance use (Corse & Smith, 1997; Sword et al., 2004). The midwives also reported that this was important in order to identify a joint goal and to establish a good working relationship with the women.

On the other hand, the women’s desire for a healthy child was countered by their fear of losing custody of their child by disclosing their substance use. Previous studies have also found that fear of child protection involvement is a major barrier to accessing health care and disclosure of substance use (Jessup et al., 2003; Sword...
This fear is real as midwives have mandatory reporting responsibilities according to the *ACM Code of Practice for Midwives* (Australian College of Midwives Incorporated, 2001), which was adopted by the regulating authority, the Nurses Board of Victoria. The midwives in this study were able to manage this fear in a number of ways. Midwives reported it was important to be clear about the mandate up front, that it was more easily managed earlier in the pregnancy, and that they encouraged the women to come up with a plan of what needed to change in order for the child to remain safe (and therefore child protection would not need to be involved).

According to the midwives, continuity of care was also important in both building a trusting relationship and encouraging disclosure. The pregnant women also wanted continuity of care and did not want to have to repeat their story each visit. Continuity of care for women is generally viewed by midwives as a critical element of woman-centered care through the provision of a known and named midwife to provide care for women and their families (Mills, 2000). This is supported by an Australian study conducted by Yelland, Krastev, and Brown (1999), where it was concluded that having the same midwife was important for women during pregnancy and prior to birth as it improved women’s satisfaction with their care.

One factor that did not emerge from this study was the issue of referral for substance use treatment. Further research is needed to examine whether midwives are aware of other services that might be useful for women who use substances and feel competent to refer to those services. It is important for midwives to recognize the role and function of other health professionals and to engage in a referral when it is identified that care is becoming complex (Australian College of Midwives Incorporated, 2001).

The strength of this study was that the use of in-depth interviewing allowed for new themes to emerge in order to provide a more thorough understanding of the factors that affect disclosure of substance use for pregnant women, as well as how midwives are able to positively affect disclosure. One limitation of this study was that the sample of pregnant women relied upon two specialized clinics, one for women who had been identified as using substances during pregnancy, and the other a service for young pregnant women. Therefore, it may be that the results are not generalizable to a large proportion of pregnant women using substances who attend mainstream clinics. In addition, the small sample may limit the generalizability of the results, particularly in relation to ethnicity and social class, and therefore further research is needed that incorporates a larger and more diverse sample of pregnant women.

Overall, it is recommended that midwives working with pregnant women (of which a proportion will be using substances) need to be more aware of issues related...
to substance use during pregnancy. During every assessment, midwives should employ a caring, supportive, and nonjudgmental practice style, assess substance use by asking direct questions and using screening tools, ensure privacy during the assessment, promote the health of the baby as the main goal, address child protection issues early and honestly, and ensure continuity of care. Professional development training on these issues relating to substance use during pregnancy would assist midwives in providing appropriate and effective maternity services and improve health outcomes for women who use substances during pregnancy.

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