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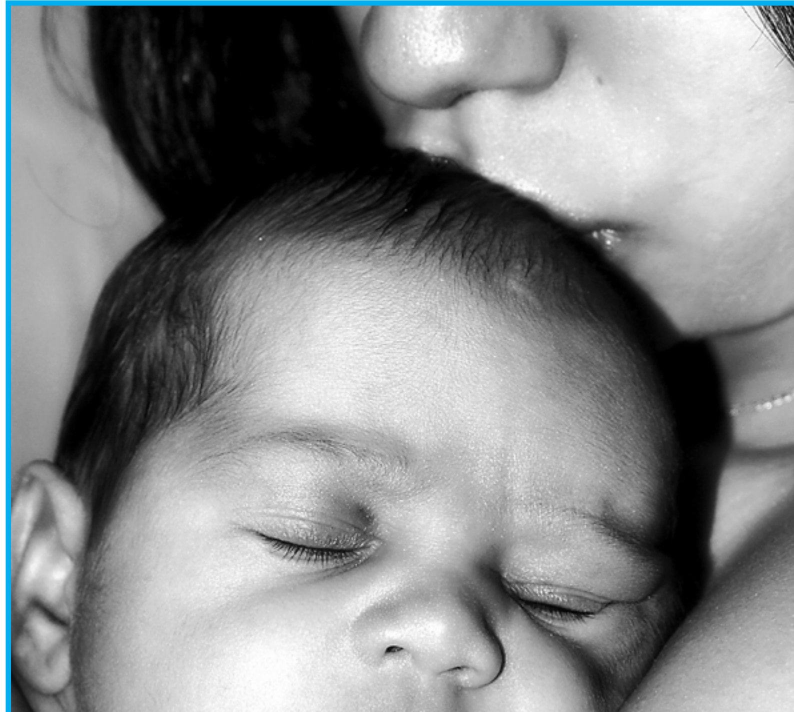

The power of love: breastfeeding and methadone

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Breastfeeding: The Power of Love

Rosemary Jambert-Gray of Wimbledon Quaker Meeting shares her experience

Prior to my redundancy, I worked as a mental health nurse. A specialist in substance misuse, I am interested in women who use drugs. The focus of my qualitative PhD study was four methadone-treated breastfeeding mothers. My being a Quaker influenced the project, with Equality the most influential of the Testimonies. If all are equal, who am I to regard as an unequal? Can I predetermine where the Light will arise? As drug-users often have low self-esteem, I saw my role as helping to reveal their Light.

For anxious readers I acknowledge concern for the baby. After all, it feels counter-intuitive to trust a breastfeeding mother knowing she has previously been addicted to heroin. With the addition of methadone, there are added anxieties this will harm the infant.

Methadone is a much-researched relatively safe, opiate replacement therapy used in the treatment of heroin addiction. Prescribed by a doctor and within a structured drug treatment programme, it helps stop illicit heroin use. When a woman discovers she is pregnant, heroin is replaced by methadone under medical supervision. As it is taken daily, the foetus is not exposed to fluctuating drug levels.

With breast-milk containing less than 3% maternal daily dosage of methadone, it remains the best for both of them. Keeping them physically close with cuddles, breast-milk also provides for an infant undergoing opiate withdrawal. The released oxytocin acts as a de-stressing 'love hormone' for the mother. Potentially, breastfeeding can be profound and potentially life-changing.

Previously documented evidence suggests that motherhood is an important time for change in drug-using behaviour, although breastfeeding is lacking in the research. I followed four mothers during the first 12 weeks of motherhood - each interviewed four times. The findings indicate mothers experience internal emotional turbulence. Whilst feeling profound love for their babies, they described feeling stereotyped as drug users. Portrayed as potential risks to their babies, they feared services taking away their babies.

As a Quaker, I was interested to see if becoming a mother incited some deep spiritual experience. To this end I describe the powerful story of one young mother I call Beth. Her life started to change the moment she started to love. She started to love the moment she started breastfeeding.

Beth was 19 years old, an unemployed hairdresser. Although she was still in contact with the father of her baby, she preferred to live alone. She described her local authority flat as unsuitable for habitation, devoid of furniture and destroyed by other drug users who stole all her belongings.

Beth discovered she was pregnant at three months. At the time she says she was spending a lot of time 'partying' - drinking and using a lot of different drugs. She used heroin as an antidepressant. Thinking she was dehydrated, she went to her doctor.

On discovering her pregnancy, Beth agreed to a hospital admission to transfer safely from heroin to methadone and stayed there until her delivery. A healthy baby girl was born on her expected delivery date, which was a Friday. Because Beth was a known opiate-user, it was hospital policy she be admitted to the neonatal unit (NNU) for monitoring of withdrawal symptoms. Beth remained on the postnatal ward. She said a midwife told her because she was a drug-user she did not deserve such a beautiful daughter.

Over the weekend Beth did not breastfeed. She describes how emotionally distant she felt.

"*You just go there [NNU] and look at her and think this baby's screaming like all the other babies. I didn't think she was mine … I just looked at her it was strange you come out of me and I don't feel that love*"

She breastfed for the first time on Monday and her baby latched onto the breast immediately. With the release of oxytocin, came the experience of love.

"*When I did [breastfeed] AW! [big sigh]…I actually cried that day….Felt guilty cos I didn't go down and see her for so long, how could I not care?*"

From that moment Beth described herself as a different woman. Her entire focus was on her baby.

As she was unknown to social services, she needed monitoring with her baby for six months. Beth was discharged from hospital to a residential parenting assessment unit. On arrival she chose to stop methadone because she did not want anything numbing her experience of love for her daughter.

She said her reactions shocked her, that this was the first time she has ever loved anybody else.

"*It's like my foot or my arm or part of me for some reason… cos I've never loved anyone else, let alone myself…. It's the first time I'm ever loving truly. You know to even recognise what love is, that's what she [baby] gave me cos I didn't know the meaning. Strong, strong feeling, you can't switch it off……… So that's what I got from it* [breastfeeding]."

Living in a parenting assessment unit was not easy. Beth describes a difficult emotional, explosive place where previous drug using behaviour, such as "stealing, lying, deceiving…bullying" continued. She noted that where previously she would have retaliated by fighting, she said she felt different. Her instincts had changed.

"*A* [baby] … *the one that's keeping me going, that's my main motivation really … Just the smiles she gives me…I never thought I could do it but I've done it. When it comes to not taking drugs and not actually getting the cravings as bad as when I see people in here… they go mad and they think about it all the time. I don't… I'm never stressed about being stoned or using.*"

If she had been unable to breastfeed, Beth admitted she would have returned to her previous drug taking lifestyle. She recognised this would have resulted in the removal of her baby from her. In that situation she remarked she 'wouldn't care'. Love generated from breastfeeding was starting to save her and her baby's lives.

What dost thou say, Friend?

We received this letter from David Barry of Hastings Quaker Meeting, offering his experience - and a question

Recently I had a telephone call claiming to be from a police officer. He asked if I had used my debit card in the Birmingham area in the last half hour. As he had contacted me on my landline in Hastings, it was obvious I hadn't. He then said an attempt had been made to withdraw a large sum in the Birmingham area from my account. As a retired fraud investigator my suspicions were aroused. The outcome was I got local police to intercept when I invited the caller (who was not a police officer at all) to send a courier to take my 'corrupted' debit card, and an arrest was made.

I concluded that I had been targeted as I live in a block of retirement flats. I realised that many of my fellow residents are trusting enough to have fallen for this scam, and with this in mind I arranged for a local home beat police officer to give a talk to my fellow-residents and alert them to the possible dangers. Unfortunately, the talk was postponed at short notice as the police had raided a local cannabis factory and they needed all their resources at the raided address.

My immediate thoughts were that somebody trying to drain a pensioner's bank account was a bigger concern than the local cannabis factory being closed down. Hastings, like many rundown seaside towns, has its fair share of drug problems. However, I believe that cannabis factories are generally low key establishments in either squatted or short-term rented basement flats or small industrial units. They generally move on leaving unpaid electricity bills after a short time. The organisers distance themselves from the day to day running and those convicted are low down on the production chain. Raids may be an inconvenience, but operators seem to be back in business pretty swiftly in alternative premises.

Apart from my thoughts that local police had their priorities skewed on this occasion I gave the matter little thought until I read in the national press that Mike Barton, Durham's Chief Constable, had been brave enough to say that given the financial cutbacks, his officers could not waste valuable time on prosecutions for cannabis possession where small amounts are involved. I have often thought at street level that this may take place in many forces, and felt Mr Barton was simply rubber-stamping an established custom in his force. I suspect other forces will follow his lead.

These two events led me to think more deeply about the cannabis situation. Several prominent MPs have put their hands up to having used it, usually during their student days. No doubt many other pillars of society have, in their youth, also done the same. Most users cease using after a few years. Alcohol harm is far more widespread. It seems unrealistic that folks should be obliged to declare a conviction when applying for employment, having had a moment of recklessness in their youth. Leaving people with the possibility of being refused travel to some countries because of a petty conviction seems needlessly punitive.

All of this would suggest consideration should be given to decriminalising personal use of cannabis. I then thought about the arguments against. Medical opinion is undecided about long-term effects. It can be a gateway drug with users being persuaded to try more addictive alternatives by unscrupulous dealers. Legalising anything because enforcement of prohibition is difficult is not a good reason for going down that road.

Despite normally being a decisive person, this has left me unable to make up my mind over decriminalisation. The arguments for are as persuasive as those against. I would be interested to know how others feel about this.

Pax et bonum

NEWS ROUND-UP NEWS ROUND-UP NEWS ROUND-UP

Alcohol consumption in Scotland

Alcohol sales have been falling in Scotland in recent years, but a recent Scottish Health report has shown that this downward trend is flattening. The change seems to be occurring mainly in 'off-trade' sales, where prices are generally lower. A recent report also showed an increase in alcohol-related mortality. The Health Minister stated that it underlines the need for Minimum Unit Pricing in Scotland. The law that enables MUP (which will be set at 50p per unit) is currently subject to legal challenge in the European court by the Scotch Whisky Association.

Benefit review involving people with addictions

The government's is conducting a review on 'the impact on employment outcomes of drug or alcohol addiction, and obesity' with a deadline of 11th September for consultation responses. It is looking at the treatment initiatives that help people with alcohol and drug problems get back to work – and is also considering the implications of linking benefit entitlements to take-up of appropriate treatment or support. While increased access to treatment would be welcome, concerns have been expressed about coerced intervention, including by the Conservative MP and General Practitioner, Sarah Woollaston.

Scotland considers Fixed Odds Betting Terminals

The Local Government and Regeneration Committee of the Scottish Parliament has been considering the issue of Fixed Odds Betting Terminals – the machines that are found in betting shops that have a maximum stake of £100. Under the Gambling Act of 2005, betting shops are entitled to have four machines. Groups including QAAD have been arguing for increased local powers to deal with numbers and for a reduction in stake size to £2.

There is a proposal under the Scotland Bill that the Scottish Parliament be given increased 'legislative competence' in relation to FOBTs, which would mean they have the powers to limit the numbers of machines in betting shops with stakes of more than £10. However, these powers would not be retrospective. The Scottish Government has put forward an alternative, proposing that the increased powers are not limited to newly granted licences, in order to address the proliferation that has already occurred.

The matter is still under review after a consultation process. The date for consideration of the Bill at report stage and third reading has not yet been announced.

Mitigation and change

Helena Chambers, QAAD's Director, gives some background on cannabis issues

David Barry's letter raises several significant points from the drug debate: many countries, including ours, have contended with them.

Decriminalisation has been adopted in Portugal, where there was a significant heroin problem prior to the change in the laws. Possession of small quantities of a drug is not criminally prosecuted (though supply is), and health-based interventions are offered. Another approach in Europe (particularly in countries with higher levels of cannabis use) has been to mitigate some negative effects of the criminal law on cannabis possession and to encourage treatment services, whilst retaining laws against both possession and supply. The UK is in the latter group.

What 'mitigation' has occurred?

One of the principal initiatives has been 'diversion from court' for possession of small quantities of cannabis. These have been adopted with the main aims of reducing police time and being less punitive for the user. In the UK, there are local variations by area and in relation to the discretion of the police officer, but in general, 'out of court' measures can be applied as long as the amount of cannabis is small, and there are no aggravating factors (for example, a minor being present). The graded system involves:

- First possession of cannabis - a cannabis warning
- Second – a penalty notice for disorder (a 'PND' which involves a fine of £90)
- Third – an arrest with consideration of a formal caution, a caution with conditions, or prosecution in court
- Subsequent offences - court proceedings to be expected.

When these measures were introduced, one of the effects was a rise in recorded drug offences – probably because warnings and penalty notices are easy to apply. Numbers peaked in around 2010-11, but have fallen since then. This may suggest that some police forces are rethinking their priorities, as David Barry suggests.

Further mitigation possibilities

If a person goes to court for cannabis possession and is convicted, it constitutes an offence and would therefore appear on a police check. Cannabis warnings and PNDs are also recorded, but they are not convictions, so would be unlikely to show up on a routine check. It is possible they could appear on an enhanced check, if they were deemed to be relevant by the Chief Police Officer – for example, to a particular kind of employment.

Within Europe, record systems vary, but Greece has a provision whereby possession of cannabis is not retained on file if it is not repeated within five years. In the UK, a House of Commons Committee in 2013 looked at penalties both in and out of court. It recommended that consideration be given to simple cannabis possession offences not appearing on a Disclosure check after they are 'spent' or after three years, whichever is the sooner. It also suggested that a cannabis warning could be treated as immediately 'spent.' These proposals could readily be adopted, even under existing legal frameworks.

Bringing a health focus to 'out of court' disposals

There is an important distinction between systems that simply prevent or reduce penalties, and those that provide health interventions aimed at the drug use itself. In Germany, for example, a programme initially provided for 14-18 year olds is called 'Early intervention in first-offence drug consumers.' Results were promising: two thirds of those attending expressed an intention to modify their drug use, and the scheme has now been extended to include young adults. Similar programmes, including some that involve motivational interviewing, are being developed in Norway and Malta.

In the UK, the 'PND' scheme already allows attendance at a course as an alternative to a fine, and there do seem to be some of these available. However, there is scope to develop them more fully. At present, those who show signs of a problem can already be referred to treatment by the police. However, interventions by drug professionals may engage with people in ways that are less likely to feel punitive. Courses aimed at the non-problematic user can encourage 'desistance' and offer information that may help prevent problem use developing. Such interventions are more expensive, but this can be balanced with reducing health costs to society and harm to the individual.

Medical issues and public health

Drugs data is collected separately in Scotland, but evidence from England and Wales indicates that roughly a quarter of people who take cannabis cease doing so within a year, and the average length of time for taking it is about 6 years, usually in young adulthood. [1]. One important question is whether or how the current legal status has an influence on this 'desistance', and also whether it affects frequency of use. Both duration and frequency have a relevance for health problems and dependency.

Although less addictive than Class A drugs like heroin or cocaine, cannabis is more widely used, and is the most frequently cited drug of dependence by young people seeking help in the UK. At a European level, cannabis is now the most common drug among 'first time' treatment entrants. The usual figure given for dependency rates on cannabis is 9%, and somewhat more for young people. Dependency rates and other health problems are significantly higher among frequent users (weekly or even more significantly, daily users).

Studies have also shown links between the incidence of mental health problems and frequent and/or early use of cannabis, particularly as regards vulnerable groups [2]. Depression, too, has been associated with early/frequent use.

These factors underline the importance of education about the risks of cannabis, particularly for young people, and the role of information and support when it occurs. Policing decisions may affect cannabis penalty and offence rates, but perhaps the central challenge is the further development of health-based responses. The Select Committee recommended a Royal Commission to look at these questions, and QAAD has supported this recommendation.

1. According to figures taken from a survey of 2011-12 'Drug Misuse Declared' Crime Survey for England and Wales

2. Tests of causal linkages between cannabis use and psychotic symptoms (2005) Fergusson DM, Horwood LJ and Ridder EM. Addiction, 100 (3).

Making a difference

The vastness of the problems of addiction seems overwhelming, but QAAD makes a difference by being an effective pressure group for tackling those problems.

We speak up on behalf of concerned Friends.

We support Friends working in the field of addiction, and local meetings who have members with related problems.

We depend for financial support on the giving of present and past members.

Your donation please should be made payable to QAAD and sent to: Ron Barden, Treasurer, 33 Booth Lane North, Northampton, NN3 6JQ.

Giving by individuals by cheque or cash can be enhanced by signing and enclosing the form below.

Gift Aid Declaration

I confirm that I have paid or will pay an amount of Income Tax and/or Capital Gains Tax for this tax year (6 April to 5 April) that is at least equal to the amount of tax that all the charities that I donate to will reclaim on my gifts for the current tax year. (Other taxes such as VAT and Council Tax do not qualify). I understand that the charity will reclaim 25p of tax on every £1 that I give.

Name ______________________________

Signature ___________________________

Date _______________________________

Address ____________________________

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A date for your diary:

The QAAD/Woodbrooke conference 2016

Dates: 29th – 31st July 2016

Title: Making A Difference

We hope to see old Friends and new at our biennial conference at Woodbrooke for reflection and sharing.

More news in the next edition of QAADRANT

Keep an eye on the QAAD website at

www.qaad.org

Work on the new QAAD website is progressing well, and we hope that it will be going live before the next edition of QAADRANT.

Letters and articles for QAADRANT are very welcome, and should be sent to Helena Chambers, 21 Church Street, Tewkesbury, Gloucestershire GL20 5PD. t: 01684 299247 e: helenaqaad@hotmail.com