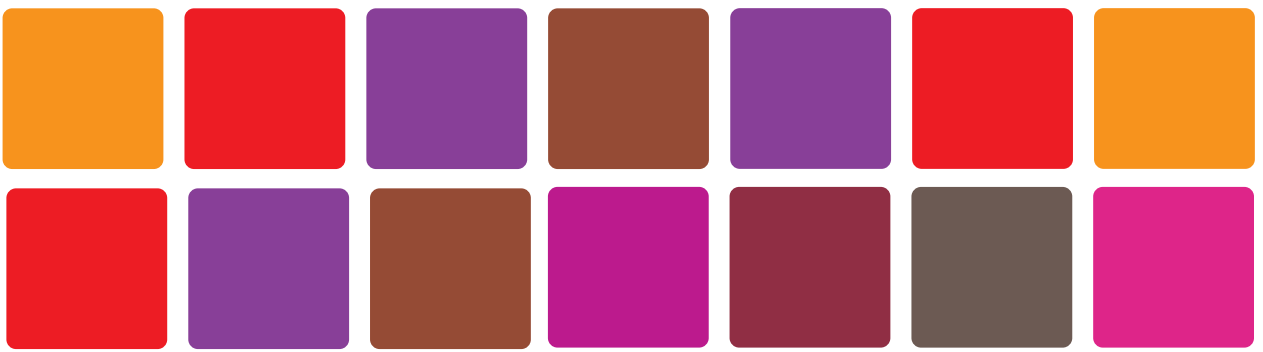
Guidelines

for Health Professionals working in Maternity Settings on the Care of Women with Concealed Pregnancy

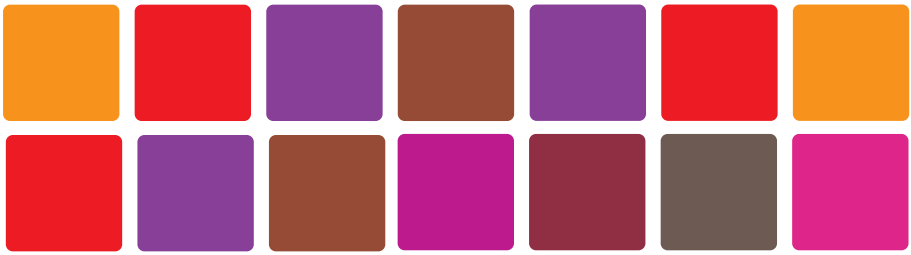


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

crisispregnancyagency
Formulating & Implementing a National Strategy

Guidelines

for Health Professionals working in Maternity Settings on the Care of Women with Concealed Pregnancy



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

crisispregnancyagency
Formulating & Implementing a National Strategy

ABOUT THE AUTHOR

Catherine Conlon graduated with an MA in Women's Studies from University College Dublin in 1994 and has since worked as a social researcher both within the university sector at the Department of Sociology, Trinity College Dublin and WERRC, University College Dublin, as well as in the public sector as Research Officer at the National Council on Ageing and Older People. Among other publications, she is co-author of Women and Crisis Pregnancy (1998) with Evelyn Mahon and Lucy Dillon and author of Mixed Methods Research of Crisis Pregnancy Counselling and Support Services (2005) and Concealed Pregnancy: A case-study approach from an Irish setting (2006). She is currently pursuing a PhD on the topic of Concealed Pregnancy for which she was awarded an Ad Astra Scholarship from UCD and a Crisis Pregnancy Agency Doctoral Scholarship.

ACKNOWLEDGEMENTS

The preparation of these guidelines was greatly assisted by the input of the following professionals who generously gave of their time and expertise to give us valuable feedback at draft stages:

- Dr. Meabh Ni Bhuinneain and Dr. Ulrick Bartels, Consultant Obstetricians at Mayo General Hospital
- Dr. Anne Flood, Director, Centre for Nurse/Midwifery Education, St. Conal's Hospital, Letterkenny
- Rosemary Grant, Principal Medical Social Worker, Coombe Women's Hospital
- Geraldine Keohane, Director of Midwifery, and her team at Cork University Maternity Hospital
- Loretto Reilly, Head Medical Social Worker, National Maternity Hospital, Holles St.
- Ann Marie Staunton, Assistant Director of Nursing and Midwifery, and her team at Mayo General Hospital.

Thanks also to participants of the Forum convened in Ballinasloe in April 2008 for valuable input into the drafting stages of the Guidelines. Catherine Conlon extends her thanks to the Research and Policy Sub-committee of the Crisis Pregnancy Agency, to the Agency's research staff – Dr. Stephanie O'Keefe, Dr. Patricia Moriarty and Sarah Murphy and to the Social Workers from HSE West, Ann Doherty, Marie Finn and Maeve Tonge, for their collaboration and support in carrying out this work.

CONTENTS

SCOPE OF CARE PATHWAY

This Care Pathway is intended to provide a protocol for health-care staff working in maternity settings, to improve their capacity to recognise, respond appropriately to and have understanding of and empathy for women who present concealing pregnancy.

The protocol is aimed at multidisciplinary professionals attached to hospital-based maternity services in antenatal outpatients, and prenatal, labour, postnatal and gynaecological wards.

The document is tailored for maternity settings where there is an on-site Medical Social Work presence.[1]

[1] The Crisis Pregnancy Agency is aware that further versions of this document are necessary to cover maternity-care settings that do not have an on-site social-work presence; as well as other hospital departments, and other hospitals without maternity departments where women concealing pregnancy may present complaining of another condition.

NOTES

UNDERSTANDING CONCEALED PREGNANCY

INTRODUCTION AND BACKGROUND INFORMATION

DEFINITION OF CONCEALED PREGNANCY

Concealed pregnancy may be defined as where a woman who presents for antenatal care past 20 weeks' gestation has neither:

- availed of antenatal care *nor*
- disclosed the pregnancy to her social network.

A woman may stop concealing the pregnancy at any point before delivery, may continue to conceal until delivery or may even conceal long after giving birth by placing the baby into the care of another, e.g. through adoption.

INCIDENCE OF CONCEALED PREGNANCY TODAY

Concealed pregnancy continues to be a feature of Irish society. Statistically, it is relatively rare, but it may end in an unassisted birth, with all the attendant risks including serious illness/trauma or even the death of the child and/or mother, or the newborn infant may be abandoned. This makes it an issue of critical importance for health-care services.

Conlon (2006) noted an incidence during 2004-2005 of:

- one concealed pregnancy in every 403 births in a rural Irish hospital
- one concealed pregnancy in every 625 births in a Dublin hospital.

This suggests a higher incidence in rural settings. In the international context, a study from Wessel et al. (2002) estimated an incidence in Germany of one in every 475 births.

PROFILE OF WOMEN CONCEALING PREGNANCY

Women of all ages conceal pregnancy but younger women, aged 16 to 24, predominate in studies. Most women are single but some are married or separated. Concealment of pregnancy has been observed among women of all social classes, levels of education and employment and professional status. A woman may repeat concealment on a second or third pregnancy.

FORMS A CONCEALED PREGNANCY MAY TAKE

Research has highlighted three forms or typologies that a concealed pregnancy may take:

- **An undetected pregnancy.** A woman whose pregnancy is undetected until advanced pregnancy or even labour

conceals the pregnancy without even being aware of it herself.

- **A detected pregnancy** that a woman actively denies. A woman consciously denies her pregnancy when she recognises she is pregnant but denies this to herself and others, and does not display emotions usually associated with pregnancy.

- **A detected pregnancy** that a woman acknowledges but conceals. A woman consciously acknowledges the pregnancy, and in some cases even welcomes it, but does not disclose it. Such women may engage in a process of adapting to the pregnancy and the prospect of motherhood, such as displaying emotions associated with pregnancy, engaging with the foetus or making preparations to care for the baby after delivery.

Since, in all these typologies, the pregnancy is concealed, the term concealed pregnancy is used throughout the Care Pathway to refer to any of these situations.

There are subtle differences in a woman's concealed pregnancy experience and the course of her pregnancy according to which of these typologies she adheres. Care responses always need, therefore, to be tailored to the specifics of each woman's pregnancy.

REASONS WHY A WOMAN MAY CONCEAL PREGNANCY

Physiological factors can contribute to a pregnancy being under-pronounced or not showing the usual or expected symptoms of pregnancy. For example, there may be continued periods/bleeding, no morning sickness, or specific anomalies that make detection difficult.

The principal **social/cultural factor** noted in the research literature relates to women viewing themselves as in the 'wrong' social circumstances for pregnancy, e.g. being unmarried or without a partner. Other social/cultural factors include threats to their life chances in terms of education, work and relationships; anticipating condemnation or even abandonment by parents or family, and risk to the stability of their existing family. Research suggests that families may be complicit in their daughter's concealment of pregnancy either because they do not accept it or because they respect her decision not to disclose.

Women may conceal a pregnancy so as to retain control of the pregnancy.

They may want to take the time to decide on their preferred outcome on their own and avoid pressure towards another outcome, where they anticipate opposition from parents or partners. For example, a woman with a disability may conceal in order to avoid pressure from others who do not support her choice to become a parent. Also, women who have had contact with child-protection services may conceal a pregnancy so that the baby does not come to the attention of the services. Women also conceal pregnancy because they perceive a threat to their safety or that of the baby, e.g. from a violent partner.

Psychological processes include women believing that pregnancy is inconsistent with their self-image to the extent that they cast from their mind the possibility that any of the symptoms they note could be caused by pregnancy. This usually means denial of the pregnancy.

Where a woman with a mental-health condition or a learning disability becomes pregnant, these conditions may hinder her capacity to identify that she is pregnant or cope with the pregnancy. The same applies where the woman has a drug or alcohol addiction.

HOW WOMEN CONCEAL PREGNANCY

The process of denying and concealing pregnancy takes a range of forms. The woman may believe that the pregnancy will never become established or may end in miscarriage. This means that she does not contemplate or anticipate the prospect of motherhood. Instead, the delivery is seen as the end in itself and plans are made to place the baby into the care of others, either through arranging adoption or anonymously leaving the baby in a place where it may be found and taken into the care of others.

Another strategy is to block out thoughts of pregnancy, using a range of means including:

- keeping busy physically and mentally
- explaining symptoms away (e.g. missed periods are attributed to recent stress or ill-health)
- drinking or misusing substances in order to forget.

Concealing a pregnancy from others involves a fine balance between taking action so as to hide the pregnancy, while at the same time not appearing to look or act any

differently. This can include:

- wearing concealing or constricting clothing
- isolating oneself (e.g. by provoking arguments with family/partners)
- trying to contain the development of the pregnancy by exercising and dieting
- hiding the signs of labour.

IMPLICATIONS OF CONCEALMENT

There is no conclusive evidence that concealing pregnancy during gestation in itself leads to adverse foetal outcomes or obstetric complications (Wessel et al. 2003; Treacy et al. 2002; Sable & Wilkinson, 2000; Geary et al. 1997). Women who conceal pregnancy usually do not participate in the full range of antenatal care set down by current practices in the medical management of pregnancy. This can cause difficulties in determining the estimated date of delivery or in detecting complications. As noted earlier, there are high risks if a woman gives birth without preparation or midwifery or obstetric assistance.
Denying pregnancy means that a woman does not adjust her lifestyle or adapt mentally to the prospect of birth and motherhood. As a result she feels unprepared for these life-changing events when labour begins. She may also engage in behaviours that are not advised during pregnancy and even put herself and/or the baby at risk.

Concealing pregnancy places an inordinate emotional burden on a woman. She may experience isolation and loneliness; fear; confusion, feeling scared and panicked; disbelief and shock; loss and grief; feeling trapped; anger; guilt and shame; feeling judged; embarrassment. These wide-ranging emotions are often acutely felt by the woman, with each compounding the other so that they deeply affect her and have enduring consequences.

In the aftermath of concealment, women may feel that professional caregivers, their family, significant others and the wider community disapprove of them for concealing the pregnancy. Within the hospital setting, those caring for her are most often not judgemental but rather express only good will towards her. However a clumsy, inappropriate comment from one individual within the hospital can resonate strongly with a woman whose sensitivities are heightened.

There are also consequences for the woman's personal relationships. Misgivings and recriminations may arise among partners, parents, siblings and friends in whom the woman did not place confidence.

CONCLUSION

Women often report that when they do disclose the pregnancy, a positive outcome most often ensues, and that aid and support from professionals can help greatly to heal damaged relationships. However, the fears that gave rise to a woman concealing her pregnancy may be realised so that, when she does disclose, she is rejected by her family or partner – which means that she has further need for support.

GUIDELINES FOR RESPONDING TO WOMEN CONCEALING PREGNANCY

A woman concealing her pregnancy may present to a hospital at any of the following stages:

1. **In advanced gestation** (late booker): at least past 20 weeks but frequently much later, without having disclosed to anyone or attended any antenatal care to date.

2. **In labour** (unbooked): without having attended for any antenatal care at either the hospital to which she is now presenting or at any other hospital or GP.

3. **Postnatally** (unbooked), where the baby has been born before arrival and both the mother and the baby need assessment and care. Serious issues may arise for the woman and the baby, in particular, if delivered without medical assistance.

Research on concealed pregnancy highlights how the situation for every woman concealing her pregnancy is unique and requires a **tailored response.**

In the hospital setting, an **integrated multidisciplinary approach** to providing for her and the baby's care is important. Midwives, nurses, doctors, social workers, counsellors, antenatal educators and administrative staff need to be made aware of the specificities of each woman's case and the care issues that these raise.

In responding to the woman, it is particularly important to:

a) sensitively engage with her, particularly on her first presentation

b) strive for continuity of care at each visit and to maintain a sensitivity to her situation at all times

c) ensure that the multidisciplinary teams under whose care the woman comes communicate about her specific situation and needs

d) support the woman in disclosing the pregnancy while respecting her wish to maintain the concealment and her confidentiality while in the hospital.

KEY COMPONENTS OF THE CARE PATHWAY

The key components of the care pathway for responding to women concealing pregnancy are:

1. **Principles** to guide how the professional responds to the presentation of a woman

concealing pregnancy.

2. A **Letter of Intent**, drafted jointly by the woman and a Midwife/Social Worker, that is placed on the woman's chart. It outlines her situation and wishes throughout the pregnancy, birth and postnatal care, to inform all members of the multidisciplinary team with whom she comes into contact.

3. A **Confidential Patient Policy** to supplement existing hospital patient confidentiality policies, with specific safeguards for women concealing pregnancy.

4. **Special procedures** in the Notification to the Registrar of Births, General Practitioners and Public Health Nurses.

1. THE PRINCIPLES GUIDING THE RESPONSE ...

... if a woman concealing pregnancy discloses to you

If you are the first person to whom a woman discloses her pregnancy, your immediate response is crucial in reassuring her and influencing her to engage with services, thereby accessing further supports. Try to be guided by the following principles:

- **Reassure** the woman that you understand she is going through a crisis and that you will support her through it. Let her know that you have met other women in this situation before who have coped and got through that crisis. Assure her that concealing a pregnancy can be a strategy women use to deal with a very difficult time in their lives.

- **Offer confidentiality** by outlining the hospital's general patient confidentiality policy. Establish a contact number/address at which the woman is happy to have staff from the hospital contact her about the pregnancy.

- **Offer every support** to enable her to disclose the pregnancy. However, if she maintains her wish to keep the pregnancy concealed from her social network, outline the specific provisions available to safeguard the confidentiality of women concealing pregnancy.

- **Be non-judgemental.** Research has shown that women usually have very good reasons for concealing their pregnancy. Acknowledge her crisis and accept that she feels she has good reasons for concealment. Reassure her that hospital staff will respect her decision and that she can be supported. Even in a situation where her behaviour

gives rise to risks of harm for herself or the baby, avoid judging her or attributing blame to her.

- **Be non-directive** in your approach and accept where the woman 'is at' in her pregnancy at the time. Allow her to consider what option is right for her at this stage in her pregnancy. **Inform her of specialist support** available to help her consider the options and, where appropriate, refer her to that support.

- **Acknowledge** the important step she has taken in presenting, whatever stage she may be at. Reassure her that a tailored package of care can be put in place to meet her specific needs as much as possible regarding the pregnancy and her desire for confidentiality at every stage – pregnancy, delivery and afterwards. Where the woman presents for antenatal care, highlight the importance of her continuing to attend throughout the pregnancy.

- **Outline the support services available to her,** including:

- medical care from midwives and doctors
- support, counselling, and help in considering options from social workers and counsellors
- additional support from antenatal educators
- links with other support agencies such as HSE social workers, crisis pregnancy counselling services, parent support groups, adoption societies etc.

- **Refer** the woman to a Midwife and/or Social Worker as early as possible.

2. LETTER OF INTENT

Given the specific needs and vulnerabilities that often arise when a woman is concealing pregnancy, communication regarding her particular situation and related needs is vital among all multidisciplinary professionals involved in her care.

The woman's chart is the key medium for communication with the multidisciplinary teams. A Letter of Intent, drafted jointly and co-signed by the woman and her Social Worker, should be placed on the woman's chart to communicate her situation and wishes. A copy of the letter should be offered to the patient for her own records, if she wishes to take it.

- The content of the letter should include:
  - A contact address and/or telephone number that hospital staff can use to

communicate with the woman during her pregnancy and after delivery.
- A statement of the woman's wishes regarding care during delivery, contact with the baby, rooming-in, and placement into care or parenting of the baby.
- A statement of the woman's wishes regarding notification to next of kin.
- A statement of the woman's wishes about disclosure and contact with her family or partner.
- Any directions about notifications to the HSE Births Notification Office for notification to the Public Health Nurse and the Registrar of Births as well as to GPs at the postnatal stage.
- If applicable, a statement that the women has elected to be a 'Confidential Patient'.

- The letter should be drafted in terms such as: 'At this point it is the woman's intention to …'. This allows for her changing her position at any time.

- The letter should acknowledge that the woman can change her mind on any matter discussed in it. The reader should be directed to respect her autonomy.

- The letter should be inserted on the woman's chart in an envelope addressed to the Clinical Midwife Manager of the antenatal, delivery and postnatal departments.

- The letter should be marked with the woman's patient number in case it becomes detached from the chart. Use of a coloured sheet/envelope may help to highlight the letter in the patient's chart. The letter can be formally updated on a regular basis if changes are required. The woman should be advised that she can now say to any staff member with whom she comes in contact that they may refer to the letter on her chart to understand her situation and specific needs. She should feel confident that this letter will explain these clearly. She should also be informed that she can change her mind regarding her status at any time which will result in reversal of procedures.

Where a woman presents in labour or with baby born before arrival

Where a woman presents to the hospital while in labour or if the baby is born before her arrival, this creates an emergency for midwifery, obstetric and paediatric staff and allows no time for advance

consultation with a Social Worker. A referral to the Social Worker needs to be made immediately and the timing of the involvement of the Social Worker depends on the patient's needs.

In such a case, the Midwife caring for the woman should try to outline, in a Letter of Intent placed on the woman's chart, the following:

- The woman's wishes about contact with the baby, rooming-in and placement into care or parenting of the baby.
- Her wishes about disclosure and contact with her family or partner.
- Her wishes about contacting next of kin if an emergency arises.
- Any directions about notifications to the HSE Births Notification Office for notification to the Public Health Nurse and the Registrar of Births as well as to GPs at the postnatal stage.
- A contact address and/or telephone number that hospital staff can use to communicate with the woman after discharge.
- If applicable, a statement that she has elected to be a 'confidential patient'.

The note should be drafted in terms such as: 'At this point it is the woman's intention to ...' to allow for the woman changing her position at any time. The reader should be asked to respect the woman's autonomy in the event that she does change her mind.

The woman should be advised that she can now say to any staff member with whom she comes in contact that they can refer to the note on her chart which explains her situation and specific needs.

3. 'CONFIDENTIAL PATIENT' POLICY

Observance of hospital confidential policy

Confidentiality is often a key concern for a woman concealing pregnancy. It will be reassuring for her to be told that it is general hospital policy that all patient information is treated with absolute confidentiality at all times.

The usual hospital policy and procedures for patient confidentiality should be meticulously observed for a woman concealing pregnancy. In particular, it is imperative that:

- All medical and social assessments be conducted in appropriate private spaces

- Patient details or issues are never discussed among staff members within audible range of other patients or members of the public.

Specific 'confidential patient' arrangements for women concealing pregnancy

Where a woman presents concealing pregnancy, the Social Worker or Midwife will discuss with her how she can be supported in disclosing the pregnancy to significant others. To encourage disclosure, it may be stressed that:

- Support from significant others is important for any woman going through pregnancy.

- It is important that children know the identity of both parents.

- It is likely that the woman will encounter a positive reaction from significant others.

In a small number of cases, the woman may decide to maintain concealment throughout gestation, delivery and placing the baby for adoption, these Guidelines propose specific arrangements to facilitate a woman who so decides).

The specific 'Confidential Patient' Policy is intended to optimise confidentiality for women concealing pregnancy. It seeks to ensure that no acknowledgement of a woman's presence in the hospital will be made in response to enquiries from the public, particularly those presenting as family or friends, as to the well-being of an in-patient or their location in the hospital.

'Confidential patient' arrangements

The elements of a 'confidential patient' policy for women concealing pregnancy are:

1. If the woman, following discussions about the supports for and benefits of disclosure, says she wishes to continue concealing her pregnancy, the Midwife or Social Worker will outline the special arrangements available in the hospital to safeguard her confidentiality in line with her wishes. **A Confidential Patient form** is co-signed by the woman and a Midwife/Social Worker (see example in Appendix 1). This form is placed at the front of the woman's hospital chart so all who consult this can see she is a 'confidential patient'. Printing the form on coloured paper or keeping in a coloured envelope may aid visibility of the form.

2. The hospital's Patient

Information System is configured so that a patient's record can be marked: **'Confidential Patient: no information to be given out'**. This will be seen by all midwifery, medical, social-work and administrative staff consulting her record. They will know not to acknowledge the presence of or disclose any information about the woman either personally or by telephone to any visitor/enquirer.

3. The hospital's Patient Information System is configured so that a **patient's record does not appear on the enquiry list or in the computers operated by reception staff** who deal with enquiries from the public, either by telephone or in person. This means that if an enquiry about a named woman is made to reception staff, their computer will not retrieve information about her and they will inform the enquirer that no-one of that name is a patient of the hospital.

4. Where ward noticeboards listing the names of in-patients are in use, a **Confidential Patient's entry will be listed as 'Occupied'** rather than using the woman's name.

Limits to Confidential Patient policy

Women should be fully apprised of the implications of being marked a Confidential Patient, as follows:

- Should anyone ask for the woman at the hospital reception, they will be told that no-one of that name is in the hospital. If the woman has disclosed her pregnancy to particular people who she wishes to visit her in hospital, she should advise her confidantes that the reception or ward staff will not acknowledge that she is an in-patient when they visit.

- Due to the nature of the hospital environment and the inability to control who the woman may encounter while in public spaces, the hospital cannot assure complete confidentiality. She should be advised to be careful about circulating in public spaces in the hospital, e.g. shop or smoking areas, in the interest of maintaining her confidentiality.

- Where it is the professional judgement of a member of hospital staff that there is a risk to the well-being of the woman and/or her child, they may – in the interests of their protection and safety – have to liaise with other professionals.

- The age of the woman may also create a limit to how far the hospital can adhere to her wish for confidentiality.

Procedures for implementing the Confidential Patient policy
For a woman presenting for antenatal care

The Social Worker will:

- Explain the procedures available for being designated a 'confidential patient' and discuss the implications of this fully with the woman.

- Establish early in the woman's care in the hospital her preference on whether to be deemed a 'confidential patient' or not.

- Take the lead on implementation, that is: co-sign the form and place it on the woman's chart, and alter her Patient Information System (PIS) record to read 'Confidential Patient', and remove it from the reception computer.

For a woman presenting in labour or with a baby born before arrival

The Midwife caring for the woman, or the Social Worker if the timing is appropriate, when taking the woman's history will:

- Outline the procedures for being designated a 'confidential patient' and the implications of this.

- Establish the woman'spreference on whether to elect to be a 'confidential patient' or not.

- Take the woman through the Confidential Patient form, co-sign it and place it on her chart.

- Instruct Admissions to alter her PIS record to mark 'Confidential Patient' and remove it from the reception computer.

- Ensure that she is listed as 'Occupied' rather than by name on the ward noticeboard of the labour and/or postnatal departments.

- Notify the Medical Social Work department that a woman has been admitted and has requested Confidential Patient status.

4. SPECIAL PROCEDURES FOR NOTIFICATION OF BIRTH

If a woman wishes to keep the birth of her baby concealed, the routine communications made to notify outside agencies of a birth may need to be modified according to her need and preferences. Time constraints

and deadlines for notifications need to be communicated.

To the Registrar of Births

The standard notification form to the Registrar of Births includes the option to mark the case as 'Sensitive'. If the woman is placing the baby in alternative care, this option can be taken to alert the Registrar so that:

1. The Registrar does not write to her address.
2. No notification is forwarded to the Child Benefit Section of the Department of Social and Family Affairs.

If there is a change of mind on the part of the mother, the above can be disregarded.

To the Births Notifications Office

If the mother is considering placing the baby for adoption, the Births Notifications Officer of the Health Service Executive (HSE) should be contacted directly and asked to withhold the birth notification from the local **Public Health Nurse**. This allows for the wishes of the mother to be clarified and the destination of the baby to be determined. Hospital staff should familiarise themselves with how births are notified to the HSE in their particular hospital or unit e.g. manually or electronically. In particular, hospital staff need to be aware of the timing of the Birth Notification as it may be necessary to act speedily for information to be blocked.

When the woman and/or baby is discharged, the Births Notifications Officer should be contacted again to advise of any of the following:

- The baby is being placed in alternative care and a Public Health Nurse (PHN) should visit at the baby's place of residence. The mother does not wish to receive a PHN visit, her identity remains confidential and no referral for the mother is made.

- The baby is placed in alternative care and a PHN is to visit the baby there. The mother does wish to be visited by a PHN for postnatal care and her place of residence is given (this may differ from her usual address). The notification regarding the mother will indicate that the pregnancy was concealed and the baby has been placed in alternative care so that the PHN will not expect to see a baby on the visit.

To the General Practitioner

Hospital staff need to be aware of

any letters generated automatically by the birth of the baby and the speed with which these are sent out (e.g. manually/electronically).

The Midwife or Social Worker should:

- Ask the woman if she wishes to have a letter sent to her GP or not.

- Offer to give her a referral letter that she can hand to any GP she might wish to attend for postnatal care.

To relevant hospital administrative departments

At the time of discharge, the Midwife or Social Worker should:

- Establish what usual follow-up letters may be sent from the hospital (e.g. invoices).

- Contact the relevant department to advise of an appropriate address to which post can be sent safely to the woman.

NOTES

DETAILED GUIDELINES FOR EACH PROFESSIONAL GROUP

GUIDELINES FOR EACH PROFESSIONAL GROUP CARING FOR A WOMAN CONCEALING PREGNANCY IN A MATERNITY HOSPITAL OR DEPARTMENT ARE SET OUT BELOW. THEY ARE ORGANISED ACCORDING TO EACH DISCIPLINE.

These guidelines cover more detailed issues specific to each profession and its role in caring for a woman during pregnancy. They supplement the overall care pathway and tailor it to each professional group.

Where appropriate, the guidelines are separated according to:

- antenatal department
- delivery/birthing department
- postnatal department

SECTION ONE

MIDWIFERY

MIDWIFERY TEAM

KEY ELEMENTS OF RESPONSE

1. Be guided by the following principles in responding to a woman concealing pregnancy:

   Reassure her that you will support her through this crisis

   Offer confidentiality and outline the special arrangement for concealed pregnancies

   Be non-judgemental: women usually have very good reasons for concealing their pregnancy

   Be non-directive: accept where she 'is at' in her pregnancy at the time

   Acknowledge the important step she has taken in presenting for care

   Outline the supports: medical, social, counselling, both hospital and community-based

   Refer her to a Social Worker as early as possible.

2. Explain the Letter of Intent to be drafted jointly by her and a Midwife/Social Worker and place it on her chart. It outlines her situation and wishes – throughout the pregnancy, birth and postnatal care – for all multidisciplinary teams with whom she comes into contact. Implement this in conjunction with a Social Worker or alone, as applicable.

3. Explain the Confidential Patient policy. If the woman opts to be a 'confidential patient', take the lead on implementing the policy in conjunction with a Social Worker or alone, as applicable.

4. Determine whether any special procedures are necessary in relation to notifications to the HSE Births Notification Office for notification to the Public Health Nurse and the Registrar of Births as well as to GPs at the postnatal stage. Do this in conjunction with a Social Worker or alone, as applicable.

FIRST PRESENTATION OF A WOMAN CONCEALING PREGNANCY

In addition to the usual midwifery functions:

- Confirm that the woman fits within the Concealed Pregnancy definition.
- When taking her history, be sensitive to her reticence or inability to give complete information.
- Discuss with the woman the supports available for and the benefits of disclosing her pregnancy to significant others. Where she wishes to maintain concealment, inform her of the Confidential Patient policy. If she opts for this, take the lead in putting the arrangements in place where time or the woman's wishes do not allow for Social Worker involvement.
- Emphasise the importance of continued contact with the hospital and note down her contact details so that she can be reached during her pregnancy and postnatally.
- Encourage the woman to confide in a trusted other.
- Establish her preferences about contacting next of kin (NOK) in an emergency.
- Outline the role of the Medical Social Worker (MSW) and, following discussion with the woman, and within the maternity unit, make a referral in a timely manner. Liaise directly with the MSW. Advise the Obstetrician under whose care the woman is placed of her situation.
- While the woman is an in-patient, try to offer her a choice of ward type, where possible. Ideally, this should be a private room or group ward, depending on what is available.
- Where any complications or adverse outcomes for the woman or baby arise, the situation needs to be handled sensitively, in liaison with the Obstetrician and/or paediatrician. Even if the woman's behaviour in concealing the pregnancy gave rise to risks of harm for herself and/or the baby, it is important to avoid judging her or attributing blame to her. Women should be reassured that the Midwife and doctors are concerned for her well-being and that they understand that concealing a pregnancy is a very traumatic event that can lead to tragic outcomes the woman never intended.

SPECIFIC INFORMATION FOR ANTENATAL DEPARTMENT MIDWIFE CARING FOR A WOMAN CONCEALING PREGNANCY

- Discuss the usual chart handling procedure, particularly where women are generally offered the option of taking the chart home. Make special arrangements if necessary.
- Discuss and encourage the woman to link with antenatal education, refer the woman if she wishes and liaise directly where necessary.
- Discussing how a care plan can be tailored for her, taking account of the stage of pregnancy at which she has presented.
- Where a woman plans to give birth in another hospital, strongly advise that she take a copy of her antenatal chart to the Maternity Department of that hospital.

SPECIFIC INFORMATION FOR LABOUR WARD MIDWIFE CARING FOR A WOMAN CONCEALING PREGNANCY

Women presenting unbooked or with baby born before arrival

- Note that the attending Midwife(s) will be under pressure to catch up on some of the usual preparations for childbirth and paediatric care – i.e. to take the woman's history and administer tests usually administered during antenatal care.
- Be aware that the woman has had no preparation for labour. She is unlikely to have a birthing partner and will require much emotional support.
- Establish her wishes about contact with the baby, rooming-in and feeding the baby.
- A note of her wishes about the baby and about informing next of kin in an emergency should be made on her chart, instead of in a Letter of Intent.
- If necessary, provide basic provisions such as personal care items and nightdresses for the woman and/or clothing for the baby.

- If the woman decides to disclose to someone that she is in hospital giving birth, she should be offered any facility possible – e.g. a phone and/or a private area from which she can contact someone as she wishes.
- The woman may need to contact family or friends to explain her absence, to facilitate concealment where she had not expected to be admitted to hospital. Any facility possible – e.g. a phone and/or a private area – should be made available. Note that she needs to call from an area where background noise would not reveal where she is (e.g. pagers going off).

- Women who conceal a pregnancy and have made no mental preparations for the delivery can find the experience traumatic and overwhelming. Research has shown that some women may not engage with the birthing experience and find it therapeutic if their attending Midwife can debrief on the birth at some later time.

- The Medical Social Work department should be informed of the woman's admission and, in a sensitive and timely manner, following discussion with the woman, be involved in the case.

Women who attended for antenatal care

- When the woman is admitted in labour, check her Letter of Intent to establish her wishes regarding:
  - a birthing plan
  - postnatal accommodation
  - references on the in-patient noticeboard
  - rooming-in
  - contact with the baby
  - feeding the baby

- Check with her if the wishes she expressed in the letter still hold and allow her the autonomy to change them at this point should she wish.

- Inform her Social Worker as soon as you can that she has been admitted in labour.

Issues for both groups

If the woman has opted to be a 'Confidential Patient', ensure that her name is not listed on any noticeboard. Instead list her entry as 'Occupied'.

SPECIFIC INFORMATION FOR POSTNATAL WARD MIDWIFE CARING FOR A WOMAN CONCEALING PREGNANCY

- The woman may go through emotional turmoil after the birth and the act of concealing is exhausting. This can represent an enormous release and watershed at the end of very difficult months throughout the process of concealment. It may coincide with the disclosure of the pregnancy to family and/or a partner, who may or may not be supportive. The woman may need extra emotional support.

- Contact between the woman and her baby is an event that women concealing pregnancy are often unprepared for. Some women may opt not to have any contact with the baby. Midwives can gently encourage the woman to explore this option further, suggesting, for example, that she visit the baby just to see it, hold it, or gradually become involved in caring for it. There is consensus that, even where a woman places a baby into alternative care directly after birth, contact with the baby can be therapeutic for her as she comes to terms with this difficult time in her life during the months and years ahead.

- Where ward noticeboards listing the names of in-patients are in use, a Confidential Patient entry should be listed as 'Occupied' rather than the woman's name being used.

- If the woman is considering placing the baby in alternative care, the Midwife should liaise with the clerk handling notification of births to the Registrar of Births to ensure that the form giving notice of this birth is marked 'Sensitive' and to ensure that the woman's wishes regarding notification to the HSE Births Notification Office for notification to the Public Health Nurse and the Registrar of Births as well as to her GP at the postnatal stage are followed through.

- The standard procedures regarding Notification to General Practitioners may need to be modified. Both following delivery and at the point of discharge, the Midwife should consult the letter on the woman's chart to see what her stated preference at the time of writing was regarding the sending of a letter to her GP outlining medical details in relation to the pregnancy, birth and baby. S/he should discuss with the woman whether this is still her preference and withhold the letter if she requests this.

NOTES

SECTION TWO

SOCIAL WORK

SOCIAL WORK TEAM

KEY ELEMENTS OF RESPONSE

1. Be guided by the following principles in responding to a woman concealing pregnancy:

   Reassure her that you will support her through this crisis

   Offer confidentiality and outline the special arrangement for concealed pregnancies

   Be non-judgemental: women usually have very good reasons for concealing their pregnancy

   Be non-directive: accept where she 'is at' in her pregnancy at the time

   Acknowledge the important step she has taken in presenting for care

   Outline the supports: medical, social, counselling, both hospital and community-based

   Refer the woman to a Midwife as early as possible. If the Social Worker is the first point of contact for the woman, s/he should refer the woman to a Midwife or doctor as soon as possible.

2. Explain the concept of the Letter of Intent, to be drafted jointly by the woman and a Social Worker/Midwife and placed on her chart. It outlines her situation and wishes – throughout the pregnancy, birth and postnatal care – for the information of the multidisciplinary team with whom she comes into contact. Implement this in conjunction with the Midwife or alone, as applicable.

3. Explain the Confidential Patient policy. If the woman opts for this, take the lead in implementing it in conjunction with a Midwife or alone, as applicable.

4. Determine whether any special procedures are necessary in notifications to the HSE Births Notification Office for notification to the Public Health Nurse and the Registrar of Births as well as to GPs at the postnatal stage, in relation to this case. Do this in conjunction with a Social Worker or alone, as applicable. The Social Worker needs to ascertain the next of kin situation.

ASSIGNMENT OF CASE

When a concealed pregnancy referral is received by the Social Work department, the Principal/Senior Social Worker should assign it to a member of staff who is likely to be available to provide continuity of care to the woman throughout her pregnancy. The Social Worker should provide a one-to-one session as early as possible. The more advanced in gestation a woman is at first presentation, the more important it is to do this.

FIRST PRESENTATION OF A WOMAN CONCEALING PREGNANCY

A Social Worker's first meeting with a woman concealing pregnancy can be at any stage: advanced gestation, in labour or on admittance after her baby was born before arrival.
At the first meeting, the Social Worker should:

- Learn as much as is possible about the woman's situation, including her living situation, employment, education, family and relationship status and any pregnancy-related issues.

- Explain the role of a Social Worker. It is particularly important to:
  - give the woman accurate information about all the options available to her
  - explain the resources available to support her consideration of her options
  - clarify the role of the medical Social Worker as a link between the woman, her baby and the medical teams and agencies outside of the hospital.

- Discuss with the woman the supports available for and the benefits of disclosing her pregnancy to significant others. Where she wishes to maintain concealment, tell her about the Confidential Patient Policy and, if she opts for this, take the lead in putting the arrangements in place.

- Emphasise to the woman the importance of continued contact with the hospital. Note down her contact details so that she can be reached by the hospital during her pregnancy and postnatally.

- Where a woman has presented through Accident and Emergency or another hospital department, staff there should be briefed on the woman's wishes about how they should respond to requests for information from people who enquire about her.

- Prepare the Letter of Intent with the woman (as outlined above) and place it on her chart.

SPECIFIC ISSUES FOR SOCIAL WORK TEAM CARING FOR A WOMAN CONCEALING PREGNANCY

- Discuss the woman's options regarding the pregnancy. Outline the supports available to her, as appropriate, including:
  - The crisis pregnancy counselling and support service, where the woman wishes to explore her options further
    and/or
  - The adoption agencies and HSE Social Workers, where the woman is considering placing her baby in alternative care.

  Explain the procedures for referral to appropriate agencies where available, including the provision of letters of introduction as required.

- Encourage the woman to confide in a trusted person. Outline the importance of the support that any woman going through pregnancy and birth needs, as well as the need for us all to be supported through a crisis.

- Particular consideration needs to be given to informing and involving the father of the baby. In general, women are encouraged to name the father of the child in registration documents and to involve him to some extent in the life of the child. This is considered to be in the child's best interests, to help ensure the forming of a positive identity and to make available full information on hereditary health conditions. Relevant legal and policy issues also need to be explained clearly – for example, the legal requirements regarding the role of fathers when a baby is being placed for adoption and the duty to pursue partners for maintenance support where a woman submits a claim for social-welfare supports.

- Where necessary, in addition to the Letter of Intent, the Social Worker should liaise with the Managers/Consultants of all relevant departments/teams and brief them on specific issues concerning the woman's situation that will improve their capacity to be empathetic and reassuring to the woman throughout her care in the hospital. These Managers/Consultants include:

  - The Administration Manager
  - The Clinical Midwife Manager

of the Antenatal,Labour and Postnatal Departments
- The Antenatal/Parentcraft Education Department Manager
- The Obstetrician and Paediatrician.

- Where the woman indicates an interest in adoption, outline the procedures for arranging this and the support services available. Make appropriate referral to HSE Social Workers or adoption agency Social Workers. (See the 'Adoption' section in 'Responding to Crisis Pregnancy: Information and Service Directory for Community and Health Professionals' on the Crisis Pregnancy Agency website:

  http://www.crisispregnancy.ie/KC_Westwebversion.pdf.)

- Where a woman plans to parent her baby, inform her of locally available support services. Highlight community-based services to support mothers, such as young mothers' groups or community mothers' schemes. (See 'After Childbirth/Parenting Support' in Section One of 'Responding to Crisis Pregnancy: Information and Service Directory for Community and Health Professionals' on the Crisis Pregnancy Agency website:

  http://www.crisispregnancy.ie/KC_Westwebversion.pdf

Contact with a woman concealing pregnancy during antenatal care

- Arrange to have contact with the woman at each antenatal visit or at agreed intervals during her care.
- Ensure that the Letter of Intent, drafted jointly by the woman and her Social Worker and which explains her situation and specific needs, is continually updated.
- Where a woman has arranged to give birth in another hospital, discuss whether she wishes you to liaise with the Social Work Department there to apprise them of her situation.

Contact with a woman concealing pregnancy during postnatal care

In addition to the usual functions, the following additional steps should be undertaken:

- Where necessary, the Social Worker should liaise with the Clerk handling notification of births to ensure that the form giving notice of this birth is marked 'Sensitive' to ensure that

the woman's wishes regarding HSE Births Notification Office for notification to the Public Health Nurse and the Registrar of Births as well as to GPs at the postnatal stage, are followed through.

- Assess the woman's continuing needs for emotional, social and practical support after she is discharged from the hospital. Women should be offered postnatal counselling to address issues such as grief over placement of the baby for adoption or feelings of guilt about concealment of the pregnancy.

- Where possible, women should be offered the option of being 'debriefed' about the birth of the baby. The concealment process can affect the experience of childbirth in specific ways; for example, the woman's capacity to recall the birth may be diminished. For a debrief, the Social Worker would, ideally, convene a meeting at which the woman, her attending Midwife and the Social Worker would talk her through her birthing experience.

NOTES

SECTION THREE

OBSTETRICS

OBSTETRIC TEAM

A woman concealing a pregnancy may particularly benefit from transferring to another hospital. Staff should ensure that the unit the woman presented to is the correct one to attend for an increased sense of confidentiality.

PRINCIPLES GUIDING RESPONSE

Be guided by the following principles in responding to a woman concealing pregnancy:

Reassure her that you will support her through this crisis

Offer confidentiality, outlining the special arrangement for concealed pregnancies

Be non-judgemental: women usually have very good reasons for concealing their pregnancy

Be non-directive: accept where the woman 'is at' in her pregnancy at the time

Acknowledge the important step she has taken in presenting for care

Outline the supports available: medical, social, counselling, both hospital and community-based **Refer** the woman to a Social Worker as early as possible.

SPECIFIC ISSUES FOR OBSTETRIC TEAM CARING FOR A WOMAN CONCEALING PREGNANCY

From the perspective of the obstetric team, the difficulties that arise where a woman presents late in pregnancy (after 20 weeks) include:

- The likelihood of gaps in the medical history available.
- No established estimated date of delivery.
- Difficulty in managing conditions (e.g. blood pressure) or establishing the severity of their impact.
- The risk of unassisted birth.

The later in pregnancy a woman presents, the greater the significance of these issues.

- Where a woman concealing pregnancy is attending for antenatal care, a Letter of Intent (drafted jointly by herself and her

Social Worker) may be inserted on her chart. This provides a briefing on her situation and any specific needs she has.

- If she has opted to be a 'confidential patient', a signed Confidential Patient form is placed at the front of her chart.

- Where women present in labour, they will usually have made no plans or preparation for labour. Because of the stress of concealing pregnancy, the woman may be in a distressed state. However, the obstetric and paediatric team will not have available to them the information and results arising from the standard tests and checks usually administered during antenatal care.

- The Obstetrician may be willing to see a woman concealing her pregnancy in an alternative Clinic from the usual Antenatal clinic e.g. a Gynaecological Clinic or at a different time to allow for a greater sense of confidentiality.

- Where there is any adverse outcome for the woman and/or her baby, this needs to be handled sensitively in liaison with the Midwife. Even if the woman's behaviour in concealing the pregnancy gave rise to risks of harm for herself and/or the baby, it is important to avoid judging or blaming her. Try to reassure her that you are concerned for her well-being and the baby's. Understand that concealing a pregnancy is a very traumatic process that can lead to tragic outcomes that the woman never intended.

- Where an emergency arises which would usually require calling next of kin, note that this is not possible where a woman is concealing the pregnancy from her family and does not wish for contact to be made. Given that research has shown that women usually have good reasons for concealing pregnancy, every effort should be made to respect their wishes in this regard. In a medical emergency, a doctor can intervene on the grounds of the health and safety of the woman and her child. Thus there is no need to breach confidentiality by contacting her next of kin.

- Specific concerns arise in the case of a young woman under the age of medical consent (16 years), particularly in relation to her capacity to consent for non-life-saving but medically indicated procedures. In this situation, the decision will be governed by:

- in the first instance, the hospital's policies and guidelines on the treatment of people under 16 years

- secondly, the guidelines on managing pregnancy among women under 17 adopted by each hospital according to the provisions of the statutory document 'Children First'.

While working within these guidelines, however, Obstetricians should take into account the heightened wish for confidentiality of a young woman concealing pregnancy.

NOTES

SECTION FOUR

PAEDIATRICS

PAEDIATRIC TEAM

PRINCIPLES GUIDING RESPONSE

Be guided by the following principles in responding to a woman concealing pregnancy:

Reassure her that you will support her through this crisis

Offer confidentiality, outlining the special arrangement for the continued concealment of her pregnancy

Be non-judgemental: women usually have very good reasons for concealing their pregnancy

Be non-directive: accept where the woman 'is at' in her pregnancy at the time

Acknowledge the important step she has taken in presenting for care

Outline the supports available: medical, social, counselling, both hospital and community-based

Refer the woman to a Social Worker as early as possible or liaise with the Social Worker if one is already involved.

SPECIFIC ISSUES FOR PAEDIATRICIANS CARING FOR A WOMAN CONCEALING PREGNANCY

Research suggests that a woman concealing pregnancy can engage in behaviour that women are usually advised to avoid during pregnancy – for example; smoking, drinking, lifting heavy objects, working long hours. In addition, women concealing pregnancy attend antenatal care later or not at all so that routine opportunities to detect foetal abnormalities are often missed. These factors work against the particular concern of paediatricians – the well-being of the baby. However, research shows that women conceal pregnancy for very good reasons, in dealing with a woman in such a situation, a Paediatrician should have regard to this.

- Where a woman concealing pregnancy has attended a Social Worker during antenatal care, a Letter of Intent, drafted jointly by herself and her Social Worker, is inserted on her chart. It provides a briefing on her situation and any specific needs she has. Where women present in labour,

this should be drafted with a Midwife where time allows.

- If a woman has opted to be a 'Confidential Patient', this is indicated on her chart by the presence of a signed Confidential Patient form.

- Note that, where a woman presented in labour, the paediatric team may not have available to them the information and results arising from the standard tests and checks usually administered during antenatal care.

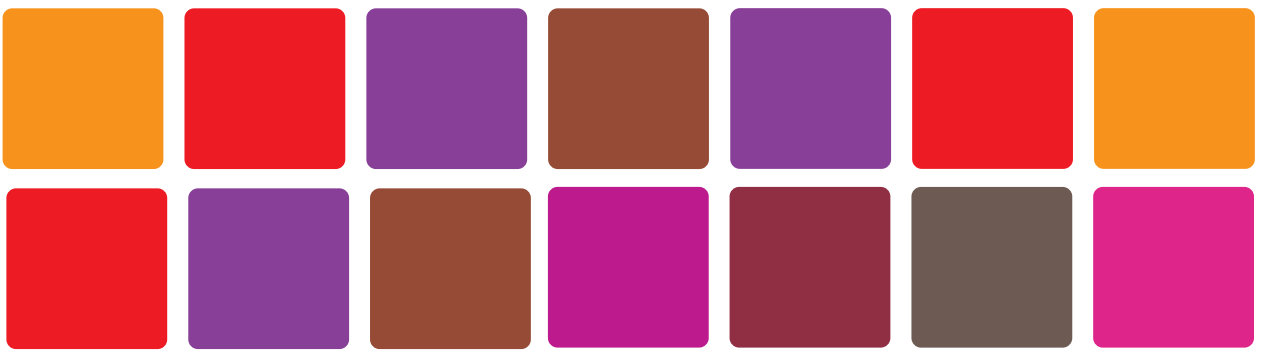
- The Paediatrician may need to make special follow-up arrangements for care of the baby or for adoption.

- Where there is any adverse outcome for the baby, this needs to be handled sensitively in liaison with the Midwife and with the Social Worker.

Even if the woman's behaviour in concealing the pregnancy gave rise to risks or harm for herself and/or the baby, it is important to avoid judging or blaming her. Women should be reassured that the Midwife and doctors are concerned for her well-being and understand that concealing a pregnancy is a very traumatic process that can lead to tragic outcomes that the woman never intended.

Guidelines

for Health Professionals working in Maternity Settings on the Care of Women with Concealed Pregnancy



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

crisispregnancyagency
Formulating & Implementing a National Strategy

SECTION FIVE

ANTENATAL/PARENTCRAFT

ANTENATAL/PARENTCRAFT EDUCATION TEAM

PRINCIPLES GUIDING RESPONSE

Be guided by the following principles in responding to a woman concealing pregnancy:

Reassure her that you will support her through this crisis

Offer confidentiality, outlining the special arrangement for the continued concealment of her pregnancy

Be non-judgemental: women usually have very good reasons for concealing their pregnancy

Be non-directive: accept where the woman 'is at' in her pregnancy at the time

Acknowledge the important step she has taken in presenting for care

Outline the supports available: medical, social, counselling, both hospital and community-based

Refer the woman to a Social Worker as early as possible.

SPECIFIC ISSUES FOR ANTENATAL/PARENTCRAFT EDUCATION TEAM CARING FOR A WOMAN CONCEALING PREGNANCY

- A woman concealing pregnancy may present at any stage between 20 weeks' pregnancy and labour, or may present after giving birth. Where she is attending antenatal care and under the care of a Social Worker, a Letter of Intent outlining her situation will be placed on her chart to brief all staff with whom she comes into contact about her specific situation and needs. In addition, a Midwife or Social Worker under whose care she has come may supplement this, if appropriate, with a dedicated briefing to the Antenatal/Parentcraft Education Team.

- A woman concealing pregnancy may need a tailored package of care from the Antenatal/ Parentcraft Education Team, either because she is presenting later than the point at which this intervention is usually offered or because of the social, emotional,

confidential or other issues associated with the concealment, or for both of these reasons.

- Some elements of the antenatal education programme may need to be handled sensitively, in recognition of the fact that women concealing pregnancy may have been in denial of the pregnancy until very recently, and may still feel unprepared for labour, meeting their baby and motherhood.

- Where a woman is concealing pregnancy, her needs from this department are best determined in discussion with her. The following should be considered:

  - The option of one-to-one or group antenatal education sessions.
  - Her capacity to attend a number of sessions, or whether one session is most appropriate (if, for example, she wants to minimise her attendance at hospital).
  - An antenatal education programme tailored to her situation and needs, taking particularly into account the stage of gestation reached – this may be very advanced and require an accelerated programme.
  - The woman should be assessed for her need for specific interventions to prepare her for first contact with her baby.
  - Whether providing a parenting education programme is in accordance with her decision about parenting or placing the baby in alternative care.

ADMINISTRATION TEAM

PRINCIPLES GUIDING RESPONSE

Be guided by the following principles in responding to a woman concealing pregnancy:

Reassure her that you will support her through this crisis

Offer confidentiality, outlining the special arrangement for concealed pregnancies

Be non-judgemental: women usually have very good reasons for concealing their pregnancy

Be non-directive: accept where the woman 'is at' in her pregnancy at the time

Acknowledge the important step she has taken in presenting for care

Outline the supports available: medical, social, counselling, both hospital and community-based

Refer the woman to a Midwife or Social Worker as early as possible.

SPECIFIC ISSUES FOR ADMINISTRATION TEAM IN ANTENATAL DEPARTMENT

Where a woman presents late in pregnancy and displays any reticence about imparting information, she should be immediately referred to a Midwife.

The Midwife can later be approached to confirm whether the woman will be attending the hospital for maternity care and to relay the information necessary to enter the woman on to the hospital system.

SPECIFIC ISSUES FOR BIRTH NOTIFICATION CLERK

The form for notifying the **Registrar of Births** includes the option to mark a case as 'Sensitive'. In the context of concealment, this option can be taken to alert the registrar to relevant issues, as follows:

- The pregnancy was concealed and the woman has requested that the Registrar does not write to her address.

- The baby is being placed in alternative care; notification should not be forwarded to the **Child Benefit Section** of the Department of Social and Family Affairs.

- The baby is being placed in alternative care; the appropriate **Public Health Nurse** (PHN) needs to be notified of the baby's place of residence and visits the baby there. Arrangements need to be made at a local level for the appropriate HSE staff to be notified of the possibility that a baby is to be placed in alternative care.

- If the mother does not want a visit from the PHN, her identity remains confidential, and no referral for her is made. The possibility of returning to the hospital for follow-up care should be outlined to her.

- The mother does wish to be visited by the PHN for postnatal care and her given place of residence may differ from her usual address. Where the baby has been placed in alternative care, the PHN is informed so that s/he will not expect to see a baby on the visit.

ALL DEPARTMENTS: THE CONFIDENTIAL PATIENT POLICY

The Confidential Patient Policy is a key feature of the care pathway. If a woman opts to be a Confidential Patient:

- Her name is excluded from the enquiry list/computer in reception.

- Her record in the Patient Information System is marked 'Confidential Patient: no information to be given out'.

- If someone enquires after her by phone or in person to the hospital reception staff, staff will retrieve no record of her when they enter her name into the computer.

- If someone enquires after her by phone or in person to the ward she is in, they will be told that no-one of that name is on the ward.

- All staff need to regularly review how cases of concealed pregnancy are dealt with and adopt protocols to new information.

COMMUNITY-BASED RESOURCES

THE SOCIAL WORKER SHOULD DRAW ON COMMUNITY RESOURCES AVAILABLE TO SUPPORT WOMEN WITH A CRISIS PREGNANCY.

The Crisis Pregnancy Agency has produced a **Key Contact** resource pack 'Responding to Crisis Pregnancy: Information and Service Directory for Community and Health Professionals', in conjunction with four HSE areas (to date):

- Information and Service Directory for Community and Health Care Professionals, developed in conjunction with the HSE Dublin North City and County/HSE North-Eastern Area.

- Information and Service Directory for Community and Health Professionals, developed in conjunction with the HSE West.

- Information and Service Directory for Community and Health Professionals, developed in conjunction with the HSE Southern Area (only available in hard copy).

In addition, there is a dedicated resource pack on Supported Accommodation and Reproductive Health Information aimed at Migrant women.

- Directory of Supported Accommodation for Women Experiencing a Crisis Pregnancy.

- Reproductive Health Information for Migrant Women: Pregnancy Prevention, Crisis Pregnancy Options, Related Health Matters. This document is available in a number of languages: Arabic, Chinese, English, French, Polish, Romanian and Russian.

  All the above publications can be accessed at the following link: **www.crisispregnancy.ie/about_support.html**

Treoir, the National Federation of Services for Unmarried Parents and their Children, has also produced an 'Information Pack for Parents who are not married to each other' which gives details on rights and entitlements.

This publication can be accessed at the following link: **www.treoir.ie/publications.html**

REFERENCES

Conlon, C. (2006). *Concealed Pregnancy: A Case Study Approach from an Irish Setting.* Crisis Pregnancy Agency Report No.15, Dublin. http://www.crisispregnancy.ie/pub/conceal.pdf

Craig, M. (1997). 'Perinatal risk factors for neonaticide and infant homicide: can we identify those at risk?', *Journal of the Royal Society of Medicine*, Vol. 97, 57-61.

Drescher-Burke, K., Krall, J. and Penick, A. (2004). Discarded Infants and Neonaticide. *A review of the literature.* Berkeley, CA: National Abandoned Infants Assistance Resource Centre, School of Social Welfare, University of California at Berkeley.

Finnegan, P., McKinstry, E. and Erlick Robinson, G. (1982). 'Denial of Pregnancy and Childbirth'. *Canadian Journal of Psychiatry*. Vol. 27, December 1982, 672-674.

Foster, J. E. and Jenkins, M. (1987). 'A Schoolgirl with Onset of Anorexia Nervosa during a Concealed Pregnancy', *British Journal of Psychiatry*, Vol. 150, 551-553.

Geary, M. (1997). 'Comparison of Liveborn and Stillborn Low Birth Weight Babies & Analysis of Aetiological Factors', *Irish Medical Journal*, Vol. 90 (7).

Green, C.M. and Manohar, S.V. (1990). 'Neonaticide and Hysterical Denial of Pregnancy', *British Journal of Psychiatry*, Vol. 156, 121-123.

Sable, M. and Wilkinson, D. (2000).'Impact of Perceived Stress, Major Life Events and Pregnancy Attitudes on Low Birth Weight', *Family Planning Perspectives*, Vol. 32 (6), 288-294.

Spielvogel, A. and Hohener, H. (1995). 'Denial of Pregnancy: A Review and Case Reports', *Birth, Vol.* 22 (4), 220-246.

Spillane, H., Khalil, G. and Turner, M (1996) .'Babies Born Before Arrival at the Coombe Women's Hospital, Dublin', *Irish Medical Journa*l, 89(2), 58-9.

Spinelli, M. (2001). 'A Systematic Investigation of 16 Cases of Neonaticide', *American Journal of Psychiatry*, Vol. 158, 811-813.

Treacy, A., Byrne, P.J. and O'Donovan, M. (2002). 'Perinatal Outcome in Unbooked Women at the Rotunda Hospital', *Irish Medical Journal*, Vol. 95(2).

Vallone, D. and Hoffman, L. (2003). 'Preventing the Tragedy of Neonaticide', *Holistic Nursing Practice*, Vol. 17(5), 223-230.

Wessel, J. and Buscher, U. (2002b). 'Denial of pregnancy: population-based study'. *British Medical Journal*. Vol. 324, 458.

Wessel, J., Endrikat, J. and Buscher, U. (2002a). 'Frequency of denial of pregnancy: results and epidemiological significance of a 1-year prospective study in Berlin'. *Acta Obstetrica and Gynecologica Scandinavica*. Vol. 81, 1021-1027.

Wessel, J., Endrikat, J. and Buscher, U. (2003). 'Elevated risk for neonatal outcome following denial of pregnancy: results of a one-year prospective study compared with control groups'. *Journal of Perinatal Medicine*. Vol. 31, 29-35.

APPENDIX ONE

CONFIDENTIAL PATIENT FORM: EXAMPLE

Sometimes, for personal reasons, a woman may wish to keep totally confidential the fact of her pregnancy, delivery and presence in the hospital.

If you wish to do this we will help you by:

1. excluding your name from the enquiry list/computer in reception
2. trying to ensure that no member of staff will provide any information about you, either by phone or face-to-face, to any enquirer or visitor

This means that, if you are a Confidential Patient, no-one from outside the hospital will be given any information about you.

- If someone arrives at hospital reception and enquires about you, they will be told that no-one of your name is in the hospital.
- If someone arrives on the ward where you are a patient and enquires about you, they will be told that no-one of your name is on the ward.

If you wish certain people to know the details of your baby's birth, therefore, it is up to you to inform them of your location within the hospital. Your chosen visitors should not enquire about you by phone or in person as they will be told that you are not a patient in the hospital.

Staff will do all that they can to honour your wish for this degree of confidentiality. However, since hospitals are public places, we cannot control the situation totally. It is important to minimise your visits to public parts of the hospital e.g. shop or smoking area.

I understand the above and wish to avail of the Confidential Patient arrangements.

Signed:

Date:

Witnessed by: (Midwife or Social Worker)

If at any stage your circumstances change and you no longer wish for this degree of confidentiality while in the hospital, please inform a hospital Midwife or Social Worker.

I no longer wish to avail of this degree of confidentiality.

Signed:

Date:

Witnessed by: (Midwife or Social Worker)

HEALTH SERVICE EXECUTIVE

Dr. Steevens' Hospital
Dublin 8

www.hse.ie

T +353 1 6352000
F +353 1 6352823

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CRISIS PREGNANCY AGENCY

4th Floor
89 – 94 Capel Street
Dublin 1

www.crisispregnancy.ie

T +353 1 814 6292
F +353 1 814 6282

crisispregnancyagency
Formulating & Implementing a National Strategy