

**Substance Use Guideline 3
GENERAL CLINICAL MANAGEMENT OF
PREGNANT SUBSTANCE USING WOMEN**

INTRODUCTION

This guideline is a general management approach for any drug exposure that occurs during pregnancy. In addition, please see the specific guidelines for the substance of concern. A collaborative team approach to prenatal and postpartum care is crucial to meet the complex medical and social needs of the substance using woman and her fetus. The team may include the mother and her support person (or people), registered midwife, physicians (family medicine / GP, addiction medicine, obstetrics, pediatrics, psychiatry, and infectious disease as appropriate), nurses (antepartum, labour & delivery, postpartum, neonatal, community health), social workers (hospital, community), child protection workers, mental health workers, support workers, the Ministry of Children and Families (MCF), Aboriginal Child Welfare Agencies (ACWA), and a pharmacist.

The functions of the team are to:

- 1) Identify the “Case Manager”.
- 2) Medically manage health issues.
- 3) Review tasks and roles.
- 4) Clarify consistency of approach with mother.
- 5) Assess and assist mother and family support systems.
- 6) Help remove barriers to care.
- 7) Address possible child protection issues.
- 8) Begin discharge planning.

It is important to remember that the interventions that seem to make the most difference (prenatal care and drug rehabilitation programs) require the woman to feel welcomed, cared for, accepted, and encouraged in order to stay engaged. A trusting nonjudgmental environment is crucial. Part of a harm reduction approach is to stay supportive of the woman even if she continues to use drugs. By staying engaged and offering her aspects of help she may be ready to receive, like housing or food, some of her risks may be reduced and she may later choose to decrease her substance use. Ensuring access to clean needles / syringes and condoms is also part of a comprehensive harm reduction strategy.

***GENERAL CLINICAL MANAGEMENT RECOMMENDATIONS FOR PRENATAL CARE
WHEN ANY SUBSTANCE EXPOSURE OCCURED***

When dealing with substance using women, it is important to have a comprehensive care model that includes the following:

- 1) Prenatal Care
- 2) Drug Rehabilitation Training
- 3) Nutritional Support
- 4) Social Services Support
- 5) Prenatal and parenting classes
- 6) HIV/STD Prevention Strategies
- 7) Well Baby Care

I GENERAL CLINICAL MANAGEMENT RECOMMENDATIONS

All women should have a BCRCP Antenatal Record completed. In addition, a specialized admission history, a physical, and investigations for substance using women as outlined below (and summarized in Table I) should be completed.

A. History

1) Addiction Assessment

- Drug type – alcohol (use T-ACE Questionnaire on reverse side of the Antenatal Record), opiates, cocaine, benzos, nicotine...
- Frequency and amount
- Route – inhaled, injected (sites), swallowed, snorted
- Needle or equipment sharing, tattoos, piercing
- When used in pregnancy –including date of last use
- Using and withdrawal effects – blackouts, seizures, overdoses
- Use / abuse / dependence (See DSM-V)
- Consequences of substance use - health, psychological, social
- Social context of use, identify relapse triggers
- What does substance provide – advantages of use
- Other addictive behavior - eating, sex, gambling, spending
- Alcohol and drug treatment attended, when and where
- Longest time substance free, what circumstances
- Stage of change, her desires and practical options
- Supports for changing lifestyle and behavior

2) Current Obstetrical History

See Antenatal Record for details and specifically assess the following:

- Nutrition, vitamins, nausea and vomiting, weight gain
- Contact with or symptoms of HIV, hepatitis B or C, STDs
- Evidence of preterm labour, antepartum hemorrhage, rupture of membranes
- Fetal assessment including growth parameters
- Withdrawal symptoms, including seizures during pregnancy
- Her desire for this pregnancy, explore options

- Partner involvement - view of pregnancy, substance use
 - Home stability, safety, and supports
- 3) Past Obstetrical/Gynecological History
See Antenatal Record for details and specifically assess the following:
- Drug use in previous pregnancies
 - Previous neonatal outcomes – FAS, NAS, HIV
 - Previous MCF involvement, children with mother vs. in care
 - Follow-up medical care for children
 - Childcare supports
- 4) Past Medical/Surgical History
- Blood born infections and last tests for HIV, blood tests for Hepatitis A,B,C and syphilis
 - STDs – gonorrhea, chlamydia, trichomonas, herpes, warts
 - Other vaginal infections – yeast, GB strep, bacterial vaginosis
 - Other chest infections – TB (last test), pneumonia, bronchitis
 - Other infections – endocarditis, cellulitis
 - Overdoses – (un) intentional
 - Seizures – during substance use, during withdrawal
- 5) Psychiatric History
- Previous psychiatric diagnosis
 - Depression, anxiety, mania – with use, when drug free
 - Hallucinations, paranoia – with use, when drug free
 - Suicide attempts – age, drug use involved
 - Abuse – physical, sexual, psychological
 - Previous psychiatric treatment
 - Mental status exam
- 6) Medications
- Include those prescribed, street purchased, herbal, and vitamins
- 7) Nutrition (See Appendix A)
- Access to food, types of food, eating patterns, eating disorders
- 8) Allergies
- Medications, street drugs, foods,
 - Medical alert bracelet, epinephrine
- 9) Family History
- Substance use
 - Medical, including genetic disorders

- **Family relationships**
- **Cultural considerations**
- Psychiatric
- Social stability and availability for this pregnancy

10) Social History

- Housing
- Safety
- Food supply
- Street work
- Home with friends / partner / family attitudes, drug use
- Education, options
- Parenting skills

11) Legal History

- Convictions, incarcerations, or outstanding charges

B. Physical Exam

Perform a complete physical exam as per the Antenatal Record with specific attention to the following:

1) Head & Neck

- Pupil size, nasal septum erosions, dentition, lymph, thyroid, lacrimation, salivation, sweating

2) Chest

- Lung fields, cardiac sounds – murmurs, breast exam

3) Abdomen

- Scars, organomegaly, tenderness, navel ring (remove)

4) Neurological

- Reflexes, tremor, ataxia

5) Skin

- Track marks, injection sites, abscesses, piercings, tattoos, branding, slash marks, other scars, rashes, infestations

C. Investigations (As appropriate)

- 1) PAP smear and swabs for chlamydia, gonorrhea, gram stain cultures, Group B strep

- 2) CBC, Group and screen, Rubella, RPR, triple screen, Anti-HBsAg, Anti-HBsAb, Anti-HbcAb, HCV, HAV, consider HIV qualitative PCR, if HIV + then do CD4 count, viral load, toxoplasmosis, CMV (See Obstetrical Guideline 15 – HIV in Pregnancy).
- 3) **Retest Group B Strep at 36 weeks, and HIV, HBV, and HCV in the third trimester**
- 4) Triple Screen
- 5) TB skin test
- 6) Urine drug screen – informed consent is needed
- 7) Ultrasounds:
 - early for dating
 - 18 – 20 weeks for detailed anatomy
 - serial growth measurements if needed
 - biophysical profile or other assessment of fetal well being: AFV, cord doppler
- 8) Amniocentesis if > 35 years, Triple Screen positive, or U/S abnormal (providing HIV and HCV negative)
- 9) Non Stress Test

D. Management

Each specific substance used needs to be managed differently. Management recommendations for opioids and cocaine are provided in subsequent guidelines. In the future, guidelines will be developed to outline management for other substances such as alcohol, benzodiazepines, tobacco, inhalants, etc. Some general management recommendations that apply to women detoxifying from **any** substance are listed below:

- 1) Encouraging and compassionate staff attitudes are essential (educational and emotional support for staff may be necessary).
- 2) A calm environment with low stimuli is helpful.
- 3) Warm baths, hot and cold compresses are useful.
- 4) Gentle walking or use of a rocking chair can ease joint pain.
- 5) Therapeutic Touch can provide pain relief, relaxation and decreased anxiety (Heidt, 1981; Bzdek & Keller, 1986).
- 6) Double food trays and access to snacks during stabilization is often needed.
- 7) From a licensed acupuncturist, acupuncture may be of assistance for withdrawal (Bullock, Cilliton, Olander, 1989; Ackerman, 1995; Brewington, Smith, Lipton, 1994). The National Acupuncture Detox Association (NADA) protocol for chemically dependent pregnant women consists of inserting 5 acupuncture needles in the external ear. These sites include Shen-men, Sympathetic, Kidney, Liver, and Lung. The client is treated while sitting for 30 minutes. This time can be used to relax, read, or meditate and the treatment ideally takes place in a group setting. Alternatively, black radish seeds taped to the external ear points can be used for acupressure and may be done by a trained lay person.

Table I – ANTENATAL ASSESSMENT SUMMARY

A. HISTORY

- Substance type, amount, route, frequency, last use
- Complications and consequences of use, overdoses, seizures
- Past detoxes and drug treatment, stage of change
- Viral infections, STD's, endocarditis, TB contact
- Psychiatric history, supports, abuse
- Stability of housing and food supply, nutrition
- Whereabouts of children, parenting skills, past pregnancy outcomes re: substance use
- Education, job skills, street work, legal history
- Substance use history of family and partner

B. PHYSICAL

- BP, HR, RR, temperature, weight, level of consciousness
- Pupils, sweating, rhinorrhea, yawning, piloerection
- Tattoos, piercing, scars, track marks, abscesses, phlebitis, infestations, lesions
- Nasal erosions, cardiac murmurs, respiratory wheezes, renal tenderness, liver edge
- Mental status exam
- Usual obstetrical/gynecological exam with attention to fetal heart sounds

C. INVESTIGATIONS (As appropriate)

- Usual blood work **plus**, HCV, HAV, Anti-HBsAb, Anti-HBcAb, AST, ALT, GGT
- HIV (consent) \pm PCR, if HIV + do CD4 count, viral load, toxoplasmosis, CMV, Vermicella
- If viral tests negative or if risk behavior continues, repeat in each trimester
- Usual PAP and swabs for culture and chlamydia, HSV, gram stain, wet preparation for trichomonas
- Tb skin test, urine drug screen (consent), urine culture, urinalysis
- Obstetrical ultrasounds for dating/anatomy/fetal wellbeing (e.g. biophysical profile), repeat in 2 weeks for growth, then as needed
- NST's q 1-2 days if >26 weeks during acute stabilization from substance use

REFERENCES

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Bzdek, V., and Keller, E. (1986). Effects of Therapeutic Touch on tension headache pain. Nursing Research(35), 101-106.

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APPENDIX A

NUTRITION DURING PREGNANCY FOR WOMEN USING SUBSTANCES

Often when women are using substances their diet is less than optimal. They often have altered their ability to obtain food, have altered appetites, and have altered metabolic requirements. This is doubly true in the case of pregnant women who are using substances. Simply providing an adequate diet to pregnant women, even if they do not change their substance use, will improve the fetal outcome since some of the damage of drugs and alcohol are related to nutritional needs not being met. Please do your best to offer pregnant women resources for information about nutrition and access to foodbanks and meal programs in your community. High risk women may have challenges buying nutritious foods, so food vouchers should be available.

I NUTRITIONAL RISKS & STRATEGIES FOR PREGNANT WOMEN USING SUBSTANCES

- 1) Heroin and alcohol use alter glucose tolerance & metabolism. Hyperglycaemia is followed by elevated levels of insulin, cortisol, glucagon, and epinephrine, causing a catabolic response. Therefore, to promote repletion and to minimise blood sugar swings, the diet should provide adequate protein and calories distributed in evenly spaced intervals throughout the day.
- 2) Substance substitution is common during recovery. When abuse of sugar, caffeine or nicotine replace a drug of choice, behavioural aspects of substance use can be perpetuated. Heroin decreases endogenous production of opioids whereas sugar increases its production.
- 3) Drug withdrawal increases physical stress and may cause symptoms of nausea, vomiting and diarrhea. However, many women experience a significant increase in appetite at this time. This occurs most frequently when appetite suppressing drugs such as cocaine, amphetamines or heroin, have been used. It is important to tailor the diet to satisfy appetite and maximise tolerance i.e. offer less nutrient-dense foods when nauseated.
- 4) Eating disorders are common with women who use substances. With detoxification, the eating disorder may resurface. Transfer of use of substances to an eating disorder is associated with an increased risk of relapse. Women who misuse cocaine, in particular, show an increased incidence of eating disorders. Reinforce good nutrition for the health of the baby if the woman is not interested in eating for herself.
- 5) Provide teaching on nutrition, baby food preparation, and cooking.