

TIP 2: Pregnant, Substance–Using Women

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Pregnant, Substance–Using Women *Treatment Improvement Protocol (TIP) Series 2*

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What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state–of–the–art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These experts include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal Resource Panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal Panel are then transmitted to the members of a second group, which

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consists of non–Federal experts who are intimately familiar with the topic. This group, known as a non–Federal Consensus Panel, meets for about 3 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Chair for the Panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP on guidelines for the treatment of pregnant, substance–using women is the second published by CSAT since a treatment improvement initiative began. It represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

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Foreword

One of the best opportunities we have to approach and intervene with the substance–using woman is when she is pregnant. The child's birth may give her a powerful motive to seek treatment for her addiction. Early intervention efforts during the prenatal period increase the likelihood that she will successfully recover from alcohol and other drug abuse.

It is equally important to provide the pregnant, substance–using woman with optimal, comprehensive obstetrical care. The results of prenatal drug exposure are well documented and can include intrauterine growth retardation, prematurity and low birth weight, central nervous system damage, and congenital physical malformations, among

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others.

A continuum of followup services is a third critical element for an improved quality of life for the substance–using woman and her family. She often lives in a stressful environment that may include physical and sexual abuse, single parenthood, and limited financial and social support. Interventions during the postnatal period are needed to help her successfully parent her child, abstain from the use of alcohol and other drugs, and address complex social needs.

The Center for Substance Abuse Treatment (CSAT) is keenly aware that pregnant, substance–using women and their children suffer from the adverse effects of addiction and is dedicated to enhancing and mobilizing the health and human services that they need. With this commitment, CSAT sought the advice and direction of a Federal Resource Panel. Based on their guidance, a national Consensus Panel of experts was convened. The medical care, alcohol and other drug treatment, and legal and ethical guidelines presented in this document are the result of their efforts.

On behalf of the Substance Abuse and Mental Health Services Administration and CSAT, we wish to express our grateful appreciation to the Consensus Panel Chair, Dr. Janet Mitchell, and to the many dedicated individuals who participated in the development of this Treatment Improvement Protocol.

These guidelines are intended to stimulate a wide variety of service providers to participate in crafting a full continuum of family–oriented services for pregnant, substance–using women and their children. The guidance offered by these protocols is the result of research knowledge and the clinical experience, careful deliberation, and heartfelt concern of Panel members. We invite you to use and adapt these models of care to strengthen your delivery of services to this at–risk population.

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Introduction

Despite decades of progress, individuals from all walks of life, in urban, suburban, and rural communities, continue to use and abuse legal and illegal drugs. This report focuses on the drug treatment, medical care, and followup services needed by one special population — pregnant, substance–using women.¹

Because this Treatment Improvement Protocol is particularly designed to assist drug treatment programs that receive Block Grant funding through their State substance abuse agencies, the emphasis here is on women served in the publicly funded drug treatment system. Such women are often poor and suffering from multiple socioeconomic problems. This emphasis should in no way obscure the fact that many affluent women also experience alcohol and drug problems. Those women who receive medical care through their private providers also need treatment for alcohol and other drug abuse. These guidelines are relevant to these women as well.

Our knowledge has increased dramatically about the dangers for the fetus of maternal use of alcohol and other drugs during pregnancy. These adverse effects are a source of mounting concern for many communities. Evidence continues to accumulate that children exposed to drugs in utero are at risk for long–term developmental problems.²

Environmental risk factors may interact with substance abuse to impact women and their families. For example, some women may suffer from poor nutrition and lack access to prenatal care. Women and their families may experience unstable home environments and homelessness.³ Frequently, pregnant, substance–using women have experienced

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sexual, physical, and emotional abuse that has gone unnoticed and untreated. Many women are victims of poor parenting.⁴

The pregnant, substance–using women who are targeted by these guidelines are often familiar with publicly funded medical, legal, and social service delivery systems. These women may receive welfare support, hospital emergency room care, publicly supported housing, and food supplements. They may involuntarily surface through the court system. Other women may be prevented from seeking the help and care they need due to cultural prohibitions and earlier negative experiences.

Some communities prosecute and jail women who abuse alcohol and other drugs while pregnant. These women may be legally separated from their children as well. More common, however, is the neglect they experience from health care and service delivery systems. The painful repercussions of the prosecution and neglect of pregnant, substance–using women and their children can be seen in shelters for battered women, among homeless populations, and in foster homes and child welfare institutions across the country.

Intervention for the Woman and Her Family

Early intervention during the prenatal period is highly desirable for the health of the woman, the fetus, and her infant after birth and for the initiation of alcohol and other drug treatment for the mother. The following guidelines emphasize a continuum of care, that is, long–term, perhaps indefinite, provision of services in support of the woman and her family. The woman who is linked to appropriate resources can be effectively supported to recover and to manage her multiple roles. This concept reflects the comprehensive approach to care that is needed and that is intended by these guidelines.

Guidelines for Comprehensive Care

The Center for Substance Abuse Treatment (CSAT) has sponsored the development of this Treatment Improvement Protocol (TIP) to provide guidance for those who care for pregnant, substance–using women and their families. The TIP development process was modeled on similar efforts undertaken by the Federal Government to address complex health and social service delivery issues. The consensus model that was used to develop these guidelines drew on the experience and expertise of representative specialists from across the Nation.

The process began with CSAT's appointment of a Federal Resource Panel of medical personnel, alcohol and other drug treatment experts, social service providers, and representatives of national organizations (for Federal Panel members, see [Appendix G](#)). The subsequent Consensus Panel of experts worked together in teams to prepare these treatment and service guidelines (for Consensus Panel members, see page vii). The draft guidelines were reviewed by over 35 additional field specialists (for field reviewers, see [Appendix H](#)). The final recommendations of the Consensus Panel reflect the diversity of experience and, most importantly, the agreement of many of the Nation's foremost experts regarding the basic principles and guidelines for programs to use to provide supportive, comprehensive care needed by pregnant, substance–using women.

Guidelines Focus on Patient Needs

The Consensus Panel strongly supports the view that the use of alcohol and other drugs by women during pregnancy is a public health issue, not a legal problem. The guidelines are intended to offer direction for the many disciplines involved in caregiving, including physicians, nurses, social workers, psychologists, counselors, and others. They are designed to be used in a variety of settings, such as hospitals, alcohol and other drug treatment programs, and clinics.

The Consensus Panel also supports these key recommendations:

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- ◆ The Panel does not support the criminal prosecution of pregnant, substance–using women. Furthermore, there is no evidence that punitive approaches work.
- ◆ Alcohol and other drug treatment programs must provide services to pregnant women and not deny these services based solely on the fact that a woman is pregnant.
- ◆ Service providers need to be sensitive to the feelings and the cultural background of pregnant, substance–using women and offer care in an environment that is supportive, nurturing, and nonjudgmental.
- ◆ Early intervention during the prenatal period is encouraged to improve the health of mothers and fetuses and to ensure that alcohol and other drug treatment is initiated.
- ◆ Comprehensive medical care and treatment for alcohol and other drug addiction is essential to start substance–using women on the road to recovery. This approach, it is hoped, will result in more productive adults, stronger families, and healthier children.
- ◆ A continuum of care — that is, the long–term provision of services — is vital to the well–being of pregnant, substance–using women. The continuum of care concept requires the collaboration and cooperation of many community–based services, ranging from agencies that offer safe housing to programs that stress parenting education and address the issues of domestic violence, abuse, and victimization.
- ◆ Case management services are needed to ensure that a comprehensive and optimal level of care is available to and accessed by pregnant, substance–using women and their families.

The Consensus Panel encourages service providers to review these guidelines and to use them to identify and coordinate their roles in the care of pregnant women and their families.

Finding What You Need in the TIP

The information in this TIP is intended to guide and instruct a broad spectrum of service providers who care for pregnant, substance–using women and their families. Some of the guidelines provide information for specific disciplines, such as obstetricians. Other guidelines, such as those on legal and ethical issues, are pertinent to all service providers caring for patients. A review of the entire TIP will help providers create and maintain the continuum of care that is vital to the well–being and recovery of their patients.

This report is organized into three chapters.

- ◆ [Chapter 1](#) provides alcohol and other drug treatment guidelines. These guidelines describe the comprehensive array of treatment and case management services needed by patients. The guidelines also make it clear that women function as part of larger family groups and must not be treated in a vacuum.
- ◆ [Chapter 2](#) presents standard obstetrical procedures for the care of substance–using women. Equally important, these guidelines identify additional medically relevant factors that may result from a woman's substance–using lifestyle.
- ◆ [Chapter 3](#) presents legal and ethical guidelines for the care of women and their children. Issues concerning confidentiality, reporting, and child protection are addressed.

This report also includes endnotes and several appendixes.

- ◆ The endnotes provide references for specific statements of fact made in the TIP. The vast majority of information presented in this report is not referenced, however, since it was developed through a consensus process and is the unique product of the experience and expertise of panel members.
- ◆ [Appendix A](#) consists of guidelines for training staff.
- ◆ [Appendix B](#) presents information about a selected group of standard instruments; some are examples of instruments that have been adapted to the special needs of particular programs. These instruments are used by professionals to assess a patient's alcohol and other drug use, and psychosocial and mental health functioning.
- ◆ [Appendix C](#) contains a model program, sample budget, and list of Medicaid reimbursement rates for selected

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medical procedures.

- ◆ [Appendix D](#) provides a discussion of quality assurance.
- ◆ [Appendix E](#) offers a glossary of terms used in the TIP.
- ◆ [Appendix F](#) consists of a bibliography and a resource list of selected national organizations that can provide information and assistance to service providers.
- ◆ [Appendix G](#) lists the members of the Federal Resource Panel on Pregnant, Substance–Using Women.
- ◆ [Appendix H](#) lists other contributors to the TIP, including programs from which relevant materials were obtained, and the names and affiliations of experts from the field who reviewed the document.
- ◆ [Appendix I](#) provides two comprehensive care flow charts for pregnant, substance–using women, depending on whether the point of entry to treatment is through alcohol and other drug treatment or through prenatal care. The charts are perforated for easy removal.

Chapter 1 -- Alcohol and Other Drug Treatment Guidelines for Pregnant, Substance–Using Women

Overview

Traditionally, alcohol and other drug treatment programs served adult males, and few women received the treatment they needed. The scarcity of treatment services for women continues today. It is imperative that programs include services designed specifically for women, particularly pregnant women.

Many alcohol and other drug treatment programs do not accept pregnant women because of liability issues or a lack of knowledge about pregnancy. Furthermore, programs have not had access to standardized guidelines for treatment, case management, and followup services. The information that follows offers such guidance and is intended to encourage programs to broaden and strengthen their services to pregnant, substance–using women.

Profile of the Women Being Served

Reliable national estimates of the prevalence of alcohol and other drug use by pregnant women are not available. Several factors limit the accuracy and usefulness of current estimates, including differences in the populations studied, the lack of representativeness of samples used, and differences in the methods employed to determine drug use. Results of specific studies, such as those reported below, illustrate to some degree the nature and extent of the problem.

- ◆ Data from one study of 36 hospitals, mainly in urban areas, were extrapolated to arrive at an estimate of 375,000 infants exposed in utero to illegal drugs each year, or 11 percent of all births.⁵
- ◆ A study conducted in Pinellas County, Florida, of urine samples from more than 700 women enrolling in prenatal care during a 1–month period in 1989 found little difference in the prevalence of drug and alcohol use between women seen at public clinics (16.3 percent) and those seen at private offices (13.1 percent), as well as similar rates of substance abuse among white women (15.4 percent) and black women (14.1 percent).⁶
- ◆ A study based on a review of medical records in eight hospitals in Philadelphia in 1989 found that 16.3 percent of women had used cocaine while pregnant.⁷
- ◆ A study that assessed drug use, utilizing urine samples obtained at admission for delivery in all seven hospitals in Rhode Island, showed that 3 percent of women used marijuana.⁸
- ◆ Fifty–nine percent of the women in a Boston City Hospital study acknowledged that they had consumed alcohol during their pregnancies.⁹

To meet the need for estimates of the prevalence of alcohol and other drug use by pregnant women that are generalizable to the Nation, the National Institute on Drug Abuse has recently sponsored a national, hospital–based

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study known as the National Pregnancy and Health Survey. Until these and other data become available, service providers should be alert to patterns of alcohol and other drug use occurring locally among women of all socioeconomic and ethnic groups.

Those with clinical experience in treating substance–using women have found that the therapeutic needs of women, especially those with children, are markedly different from the needs of men. Substance–using women come from every ethnic and socioeconomic group and have a multitude of needs. Moreover, a substantial portion of the women who seek publicly supported treatment for their addictions share a core group of problems that reflect problems of the communities in which they live. Unless these core problems are addressed, women will be unable to take full advantage of the therapeutic process.

Many women who seek treatment for their alcohol and other drug problems through publicly funded programs share the following characteristics:

- ◆ Function as single parents and receive little or no financial support from the birth fathers
- ◆ Lack employment skills and education and are unemployed or underemployed
- ◆ Live in unstable or unsafe environments, including households where others use alcohol and other drugs. Many women are at risk of being homeless and some are homeless.
- ◆ Lack transportation and face extreme difficulty getting to and from a variety of appointments, including treatment
- ◆ Lack child care and baby–sitting options and are unable to enroll in treatment
- ◆ Experience special therapeutic needs, including problems with codependency, incest, abuse, victimization, sexuality, and relationships involving significant others
- ◆ Experience special medical needs, including gynecological problems

Gender–Specific Alcohol and Other Drug Treatment

Alcohol and other drug treatment providers need to understand and address the specific problems pregnant, substance–using women face in accessing and participating in treatment. Treatment programs may lack linkages to medical services, especially prenatal care. Similarly, providers of prenatal care have a poor understanding of addiction and treatment issues and may not have appropriate linkages with alcohol and other drug treatment providers. Both prenatal and drug treatment providers have a poor understanding of treatment issues specific to women.

It is recommended that treatment programs serving pregnant, substance–using women include the following services, or support active outreach to and linkage with appropriate service resources already available in the community:

- ◆ Comprehensive inpatient and outpatient treatment on demand
- ◆ Comprehensive medical services
- ◆ Gender–specific services that are also ethnically and culturally sensitive. These services must respond to women's needs regarding reproductive health, sexuality, relationships, and all forms of victimization. Services should be offered in a nonjudgmental manner and in a supportive environment.
- ◆ Transportation services, including cab vouchers, bus tokens, and alternatives for women who live in communities where public transportation is cumbersome, unreliable, or unsafe
- ◆ Child care, baby–sitting, and therapeutic day care services for children
- ◆ Counseling services, including individual, group, and family therapy
- ◆ Vocational and educational services leading to training for meaningful employment, the General Equivalency Diploma (GED), and higher education
- ◆ Drug–free, safe housing
- ◆ Financial support services
- ◆ Case management services
- ◆ Pediatric followup and early intervention services

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- ◆ Services that recognize the unique needs of pregnant, adolescent substance–users

In addition to the delivery of direct services, there is a need for continuing collaborative efforts by maternal and child health programs, primary health care agencies, mental health agencies, and alcohol and other drug programs. Such collaboration can be useful in conducting needs assessments, designing interdisciplinary strategies, and establishing linkages through memoranda of understanding and interagency agreements.

Ongoing technical assistance and training is recommended for all health care, alcohol and other drug treatment, and other social service providers. Such efforts must involve administrative staff as well as direct service personnel to ensure that supportive, appropriate, and comprehensive care is offered to pregnant, substance–using women.

Preconception Counseling

All women who receive alcohol and other drug treatment services should receive counseling on the full range of reproductive options, including preconception counseling. Issues that should be thoroughly discussed include

- ◆ The various methods of contraception and the attitudes of the woman, her significant others, and her community regarding their use
- ◆ The impact on the woman and the fetus of alcohol and other drug use during pregnancy
- ◆ The teratogenic impact of prescribed medications, such as Antabuse and various anticonvulsants
- ◆ Alternative medications with reduced or no teratogenic potential for such common problems as seizure disorder. An obstetrician or geneticist can recommend such medications.

For patients who temporarily require medications such as Antabuse, or for those who choose to postpone childbearing, an effective, reversible form of contraception should be recommended. Substance–using women who have a history of irregular menses and involuntary infertility should be warned that sobriety or the successful initiation of a recovery program may result in a resumption of ovulation and an increased risk for unplanned pregnancy.

Access to Services

Pregnant, substance–using women may access health care services from a variety of sites, including emergency rooms, pregnancy testing sites, clinics treating sexually transmitted diseases, community health centers, and clinics of the Special Supplemental Food Program for Women, Infants, and Children (WIC). Occasionally, alcohol and other drug treatment program staff are the first to notice that a woman is pregnant. Regardless of where she accesses care, appropriate referrals for prenatal care should be provided, and she should be assisted to follow through on these referrals. The two perforated charts that accompany this TIP as [Appendix I](#) illustrate the components of comprehensive health care, depending on whether the woman's point of entry into the treatment system is alcohol and other drug treatment or prenatal care.

Access to care must be simplified for a woman when she enters the system. She should receive whatever support is needed — whether it is financial assistance, help in setting up appointments, or transportation and child care services. Whenever possible, a case manager should schedule a specific prenatal appointment for the woman and initiate other needed services. In addition, a psychiatric assessment should be done to identify cases of alcohol and other drug use and psychiatric illness.

It may be difficult to convince a pregnant, substance–using woman to seek prenatal care. The concept of preventive health care, as opposed to emergency–necessitated health care, may be a foreign concept to her. More importantly, she may have a basic distrust or dislike of the health care system in general, and doctors in particular. Her feelings of fear and guilt, and possible negative past experiences, may cause her to expect poor treatment. Sometimes she provokes a hostile interchange with health care professionals.

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Women need to receive health care services in an environment that is nonjudgmental, nonpunitive, nurturing, and culturally and linguistically sensitive. It is essential for all members of the health care team, from the clerical staff to the physicians, to recognize the importance of providing prenatal, postnatal, and pediatric services in a caring way. Staff must avoid comments designed to make the patient feel guilty or ashamed, such as the use of pejorative words like "wino" or "junkie." Each health care visit is an opportunity to provide positive reinforcement to the substance–using patient.

Scope of the Guidelines

These alcohol and other drug treatment guidelines discuss the continuum of care and the central role of case management that are essential for the delivery of comprehensive services to pregnant, substance–using women and their families. Medical stabilization and withdrawal guidelines establish a basis for alcohol and other drug treatment. Specific guidelines cover alcohol, opioids, cocaine, and sedative–hypnotic drugs. A review of mental health considerations in treating pregnant, substance–using women completes the chapter.

Guideline 1 -- Continuum of Care

The pregnant, substance–using woman requires a continuum of care that includes a broad range of support services provided over an extended period of time. This continuum of care should reflect the complexity of her multiple roles as a person in recovery, parent, partner, and frequently, single head of a household. Ideally, support services should be provided as long as the woman and her family need and can benefit from them, potentially until her last child reaches adulthood. In reality, support services may be available for a period of a few months to several years.

The case management function is essential for the recovery and well–being of the substance–using woman and her family. Virtually any agency can provide case management services, although the lead agency typically assigns an appropriate staff person to this role, such as a social worker or nurse. The case manager assists the patient in accessing services, and monitors her participation and progress in using health care, alcohol and other drug treatment, and other social services.

The multiple services coordinated by the case manager are generally provided by a variety of agencies. Many of these services are initiated during or even prior to pregnancy and should continue after delivery for as long as they are appropriate. The consortium of service providers may change over time, depending on the family's individual circumstances and resources.

The case manager should be aware that differences in philosophies may exist between health and social service agencies and the alcohol and other drug treatment field. Behaviors that health and social service agencies view as helping and supportive are often viewed as codependent behaviors by the treatment field. As agencies work together on behalf of patients, they too must recognize and handle complex and legitimate differences in philosophies and practices.

Case Management

Case management is a vital function that helps to ensure that patients receive and appropriately utilize a variety of services necessary for their improved functioning. Case management should be initiated prenatally and continue throughout the postpartum period for all substance–using women. Services should be provided and maintained as appropriate for the individual woman and her family. The case manager should support and guide the patient to address issues concerning her recovery from alcohol and other drug abuse, develop psychosocial and parenting skills, and meet her survival needs. Key case management functions include

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1 A review and assessment covering

- ◆ Physical and mental health history
- ◆ Psychosocial status, including family history, parenting skills and knowledge, and potential parenting problems (e.g., a history of sexual abuse)
- ◆ Alcohol and other drug use, treatment, and recovery status
- ◆ Support systems available to and used by the family, including sources of primary and emergency care
- ◆ Nutritional status of the mother and fetus
- ◆ Status of any unresolved legal issues, including outstanding warrants, domestic violence, child custody, adoption, foster care, and divorce
- ◆ Environmental circumstances, including financial status and needs, condition of housing, and availability of transportation
- ◆ Educational and vocational competencies
- ◆ Involvement with other social service agencies

2 An individual care plan prepared in conjunction with the patient and other service providers. This plan should address, at a minimum, the areas listed above. It may also cover arrangements for infant case management, either directly or through referral.

3 Discussion of the plan with the patient and other members of her health care and service delivery team. After agreement is reached on the individual plan, the case manager should schedule the needed services.

4 Referrals to other agencies, groups, or institutions as needed. These referral linkages should be made in conjunction with plans for ongoing communication about the patient's status.

5 Monitoring of the patient's progress in the programs in which she is enrolled, with followup contacts made if she fails to participate as planned and scheduled.

6 Ongoing case management support at regularly scheduled intervals, with termination ideally agreed upon by the patient and the case manager. Standards of success should be determined on an individual basis, but should allow a period of time for the patient to become adjusted to her drug–free status, to achieve self–sufficiency, and to feel confident about her parenting skills.

7 A review of the patient's individual care plan with revisions as needed during the recovery process

Comprehensive Service Delivery

The delivery of comprehensive services to substance–using women and their families should continue postpartum. The greatest success is achieved by and for these women when a continuum of care is available to address their special needs as women, mothers, spouses, and heads of households. The following services are often needed: **1 Health**

Care Services

- ◆ Comprehensive, high–risk obstetrical care
- ◆ HIV antibody counseling and testing

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- ◆ Routine checkups and immunizations for all children through a well–baby clinic, care by a pediatrician or other physician for specific health concerns as long as needed, and referral to early intervention programs
- ◆ Postpartum medical and dental checkups for the mother as long as needed
- ◆ Family planning, including contraceptive counseling and contraceptives
- ◆ Counseling for postpartum depression and for guilt about the effects of prenatal drug use on the infant, as needed
- ◆ Health care for other family members

2 Alcohol and Other Drug Treatment Services

- ◆ Medical withdrawal,¹⁰ as needed, in collaboration with prenatal care providers
- ◆ Ongoing alcohol and other drug treatment through a program of methadone maintenance, outpatient treatment, day treatment, or intensive outpatient care; or through intermediate or long–term residential care that provides services to a patient's children during the inpatient period
- ◆ Alcohol and other drug treatment in gender–specific programs that are ethnically and culturally sensitive, whenever possible
- ◆ Continuing support and relapse prevention through accessible community groups, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Adult Children of Alcoholics (ACoA), Talking Circles, and community and church support groups, with the understanding that relapse *should not* exclude women from treatment
- ◆ Group and individual counseling, focusing on such areas as codependency, self–esteem, and issues of sexuality, parenting, and relapse prevention

3 Survival–Related Services

- ◆ Housing assistance to find drug–free, affordable family housing, emergency shelters, safe homes
- ◆ Financial assistance through Medicaid and Aid to Families with Dependent Children (AFDC), as well as food from programs such as the Special Supplemental Food Program for Women, Infants, and Children (WIC), if eligible
- ◆ Vocational and job skills training with child care and/or transportation services
- ◆ Child care that is affordable and appropriate for the safety and well–being of the child. Programs should encourage the creation of and access to therapeutic and developmental child care centers onsite and in the community.
- ◆ Transportation for medical care, alcohol and other drug treatment, and for child care, and for vocational, parenting, homemaking, and recreational activities
- ◆ Home management training to develop nutrition, budgeting, time management, and food preparation skills
- ◆ Legal services for such issues as domestic violence, child custody, adoption, and divorce

4 Psychosocial Services

- ◆ Training in stress management and reduction; assertiveness; issues of sexism, racism, and class bias; and anger management
- ◆ Group, individual, and family counseling concerning sexual and physical abuse and their prevention
- ◆ Relationship and interpersonal skill building
- ◆ Personal care, issues of sexuality, and image enhancement
- ◆ Psychiatric and other mental health services, as needed by the woman, her children, and other family members

5 Parenting and Family Services

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- ◆ Planning and counseling for reunification with the patient's other children
- ◆ Counseling for women who wish to breastfeed regarding the risks to the infant of maternal drug use and from possible transmission of HIV; training in breastfeeding procedures, as appropriate
- ◆ Education about child and adult nutritional needs, food purchasing and preparation, and weight management
- ◆ Education about and training in child growth and development patterns
- ◆ Training in and support for nonpunitive child–rearing practices
- ◆ Assistance with and counseling about maternal and child bonding; participation in parental support groups
- ◆ Counseling for couples or significant others in communication, money management, crisis management, and parenting
- ◆ Counseling and intervention concerning child abuse and neglect, as needed
- ◆ Education about family systems, including information about cultures, traditions, and heritage
- ◆ Family therapy, as needed

Guideline 2 -- Medical Stabilization and Withdrawal

The initial stabilization as well as the medical withdrawal of pregnant women from their drug(s) of abuse are recognized means of reducing the acute illness associated with the use of alcohol and other drugs. The initial stabilization of the patient should be accomplished within 10 days of first contact or earlier if medically necessary. The goals listed on next two pages may be attained by one agency or a collaboration of agencies within the community. The latter option requires appropriate cross–training between agencies.

During the period of stabilization, caregivers need to monitor the mother and fetus for adverse signs of drug withdrawal, establish a basis for ongoing alcohol and other drug treatment and recovery, and initiate a relationship between the mother and available supportive services within the community. The lead agency is generally responsible for assigning an appropriate staff person to undertake case management functions. The role of the case manager is to monitor and promote completion of this initial phase.

The procedures to be completed for the initial stabilization of pregnant, substance–using women are presented on the following two pages. They also apply to all of the specific medical withdrawal guidelines that follow.

Medical and Obstetrical Assessment

- 1 Follow universal precautions for blood and body fluids and Occupational Safety and Health Administration (OSHA) standards. Staff in health care facilities, especially those working with patients with histories of alcohol and other drug use, should be well versed in the appropriate application of the precautions and standards.
- 2 Obtain a detailed history and comprehensive physical examination that includes an obstetrical evaluation.
- 3 Conduct a laboratory evaluation, including but not limited to, complete blood count (CBC), sequential multichannel autoanalyzer (SMA) 18, serological test for syphilis, and urine analysis. Obtain results from the prenatal panel if they are available. If the woman is admitted before an initial prenatal examination has been performed, all prenatal laboratory tests should be done (see Guideline 8–Prenatal Intake).
- 4 Discuss HIV and document the discussion on the chart.
- 5 Obtain urine toxicologies or blood alcohol level tests as necessary (see Guideline 15–Urine Toxicology Considerations).
- 6 Perform fetal assessment, including a baseline sonogram, Non–Stress Tests (NSTs), or biophysical profiles appropriate for gestational age, as necessary.

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7 Make other referrals as necessary.

Alcohol and Other Drug Use Assessment

- 1 Obtain a history of alcohol and other drug use, covering legal and illegal drugs (prescription drugs, over–the–counter drugs, alcohol, cigarettes), that includes
 - Duration of use, including age of first use
 - Frequency, type, amount, and periods of abstinence
 - Routes of administration
 - Social context of use (when, where, and with whom the patient uses)
 - Past treatment history
 - Support group involvement
- 2 Determine the consequences of alcohol and other drug use for the patient (self–perceived and objective).
- 3 Identify relapse factors for the patient.
- 4 Obtain a family history of alcohol and other drug use.
- 5 Assess the patient's motivation for treatment, including self–perceived and objective difficulties in entering treatment.
- 6 Assess the patient's motivation for continued use of alcohol and other drugs.
- 7 Obtain urine and/or blood toxicologies as needed (see Guideline 15–Urine Toxicology Considerations).

Psychosocial Assessment

- 1 Assess the patient's support systems, including her role in family and neighborhood support systems, and the stresses created by these systems.
- 2 Assess the patient's perception of her pregnancy and pregnancy options.
- 3 Assess the patient's educational level.
- 4 Assess the patient's employment skills.
- 5 Assess abuse and neglect experienced by the patient as an adult and as a child, including
 - Sexual abuse
 - Physical abuse and neglect
 - Emotional abuse
- 6 Assess legal considerations and problems.
- 7 Assess current crises.
- 8 Assess the patient's current life and environmental situation, including

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- Housing
- Transportation
- Child care
- Monetary support and assistance

9 Assess the patient's relationship to her other children.

Mental Health Assessment

1 Conduct a mental health evaluation that includes

- Mental status examination
- Psychiatric symptomatology
- Past psychiatric history and treatment
- Suicide risk
- Family psychiatric history
- DSM–III–R diagnosis
- Treatment recommendations

2 Use standardized psychiatric evaluation tools in diagnosis and followup.

3 Maintain liaison and ongoing contact with other members of the assessment and treatment team.

Alcohol and Other Drug Treatment Planning

1 Prepare a treatment plan with input from the patient and representatives from all participating health care and service agencies, that includes

- Appropriate alcohol and other drug treatment
- Medical and obstetrical care
- Followup services

2 Facilitate the introduction of the patient into alcohol and other drug treatment by contacting the patient at any point of entry for service or place of evaluation.

Guideline 3 -- Medical Withdrawal From Alcohol ¹¹

It should be assumed that pregnant women who consume over 8 ounces of [absolute] alcohol (1 pint of liquor) daily have developed tolerance.¹² However, tolerance may develop at lower levels of consumption in some women and in women using multiple drugs.

The sudden cessation of drinking can result in withdrawal symptoms, some of which may be threatening to the mother and the fetus. It is imperative that medical withdrawal of an alcohol–dependent, pregnant woman be conducted in an inpatient setting and under medical supervision that includes collaboration with an obstetrician. These conditions will ensure

- ◆ Close observation and monitoring of maternal alcohol withdrawal status

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◆ Continual monitoring of fetal well–being

Most programs choose to treat the pregnant, alcohol–dependent woman with short–acting barbiturates or benzodiazepines. Chlordiazepoxide (Librium) and other benzodiazepines, such as diazepam (Valium) and barbiturates (Phenobarbital, Seconal), are valuable for symptomatic treatment during medical withdrawal from alcohol. They are also potentially teratogenic. Some clinicians, therefore, recommend avoiding their use if at all possible. The risks versus the possible benefits of their use need to be assessed.

Disulfiram (Antabuse) is contraindicated during pregnancy. Its use has been associated with clubfoot, VACTERL syndrome (a pattern of congenital anomalies), and phocomelia of the lower extremities.¹³ The woman who conceives while taking this drug should receive counseling before deciding to continue the pregnancy.

Symptoms of Alcohol Withdrawal

Early symptoms of alcohol withdrawal generally appear 6 to 48 hours after drinking has stopped but can occur up to 10 days after the last drink. Withdrawal symptoms may include

- Restlessness
- Tachycardia
- Irritability
- Hypertension
- Anorexia
- Insomnia
- Nausea
- Nightmares
- Vomiting
- Impaired concentration
- Sweating
- Impaired memory
- Tremor
- Elevated vital signs

More severe symptoms of alcohol withdrawal may include

- Increased tremulousness
- Increased agitation
- Increased sweating
- Delirium (with confusion, disorientation, impaired memory and judgment)
- Hallucinations (auditory, visual, or tactile)
- Delusions (usually paranoid)
- Grand mal seizures

Note: Withdrawal symptoms do not necessarily progress from mild to severe. In some individuals, a grand mal seizure may be the first sign of withdrawal. Seizures usually occur 12 to 24 hours after cessation or reduction of drinking. One–third of all patients who have seizures develop delirium tremens.

Maternal and Fetal Effects of Alcohol

Alcohol use during pregnancy may be associated with a variety of serious health consequences for the woman, the fetus, and the subsequent infant.

1 Possible maternal complications of excessive alcohol consumption:

- ◆ Nutritional deficiencies
- ◆ Pancreatitis
- ◆ Alcoholic ketoacidosis
- ◆ Precipitate labor
- ◆ Alcoholic hepatitis
- ◆ Deficient milk ejection
- ◆ Cirrhosis

2 Possible effects on the fetus:

- ◆ Fetal Alcohol Syndrome (FAS)
 - ◆ prenatal/postnatal growth retardation
 - ◆ central nervous system deficits, including developmental delay and neurological/intellectual impairments
 - ◆ facial feature anomalies, including microcephaly
- ◆ Fetal Alcohol Effects (FAE)
 - ◆ cardiac abnormalities
 - ◆ neonatal irritability and hypotonia
 - ◆ hyperactivity
 - ◆ genitourinary abnormalities
 - ◆ skeletal and muscular abnormalities
 - ◆ ocular problems
 - ◆ hemangiomas
- ◆ No effect

Guidelines for Medical Withdrawal From Alcohol

Procedures at the Time of Admission

1 Obtain a detailed health history, including alcohol and other drug use and arrangements for prenatal care.

2 Conduct a comprehensive physical examination, including weight, vital signs, and an obstetrical evaluation.

3 Obtain laboratory tests, including: a) Initial blood workup that includes, but is not limited to

- ◆ Blood group, Rh factor determination, and antibody screen
- ◆ Serological test for syphilis
- ◆ Hepatitis B and C screens
- ◆ Complete blood count with indices

b) Other initial laboratory tests that include, but are not limited to

- ◆ Cervical cytology smear (Pap smear), unless the provider has results of a test performed within the past 3 months
- ◆ Cervical culture for gonorrhea

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- ◆ Urine screen for urinary tract infection, kidney disease, protein, and glucose
- ◆ Chlamydia screen

4 Obtain purified protein derivative of tuberculin (PPD) test with antigen panel.

5 Obtain urine and/or blood toxicologies (see Urine Toxicology Considerations).

6 Provide for HIV antibody counseling and testing.

7 Obtain baseline sonogram if appropriate.

Dosing Strategy

1 Evaluate the pattern, frequency, and amount of alcohol and other drug use.

2 Obtain a detailed history of alcohol and other drug use within the past 24 hours and of any previous alcohol withdrawal reaction.

3 Begin initial treatment with thiamine, folic acid, and prenatal iron and vitamins. Obtain laboratory tests listed above, including CBC, electrolytes, and magnesium level and, when indicated, obtain an electrocardiogram (EKG).

4 Obtain an initial blood alcohol level to determine

- ◆ Extent of intoxication at admission
- ◆ Safe time to begin medication
- ◆ Expected time for full withdrawal to begin. The usual rate of elimination of alcohol from a healthy alcohol dependent person is 30 mg/dl/hr. This rate may be increased during pregnancy.

5 Provide for nonpharmacological interventions designed to

- ◆ Reduce stimuli
- ◆ Maintain hydration
- ◆ Maintain reality orientation
- ◆ Provide reassurance and positive reinforcement
- ◆ Provide nutritional support
- ◆ Maintain physical comfort
- ◆ Maintain body temperature
- ◆ Encourage sleep and rest

6 Follow withdrawal schedule. Programs use different drugs to withdraw patients from alcohol. Drugs used include chlordiazepoxide, phenobarbital, and diazepam.

- ◆ Typical withdrawal schedules using chlordiaze–poxide include 25 to 50 mg 4 times a day for the first 2 days,

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decreasing gradually to 10 mg 4 times a day for days 8 through 10.

- ◆ Typical withdrawal schedules using phenobarbital include 15 to 60 mg by mouth every 4 to 6 hours as needed for the first 2 days, decreasing gradually to 15 mg by the 4th day.
- ◆ Typical withdrawal schedules using diazepam include 10 mg 4 times a day; 10 mg every 2 hours as needed for withdrawal symptoms with a maximum of 150 mg/24 hours; decreasing gradually at a rate of 20 to 25 percent over approximately 5 days.
- ◆ The loading dose protocol with diazepam is accomplished with doses given according to withdrawal symptomatology. When withdrawal symptoms are stabilized, the long half–life of diazepam alleviates the need for further medication in most cases.

7 Monitor for signs and symptoms of alcohol withdrawal syndrome (AWS). The use of withdrawal assessment scales can be valuable in determining the need for further medication. Monitor for the following:

- ◆ Vital signs (temperature, blood pressure, pulse)
- ◆ Delirium (orientation)
- ◆ Wernicke's encephalopathy (nystagmus)
- ◆ Psychosis (hallucinations, inappropriate thinking)
- ◆ Irritability (tremors, increased reflexes)
- ◆ Increased autonomic reflexes (goosebumps, sweating)
- ◆ Fetal well–being (fetal heart tones, sonograms, or Non–Stress Test) as appropriate for gestational age

8 Reduce medication dose if the patient shows signs of oversedation.

9 Provide for positive social support for the patient to help manage stress.

10 Discharge the patient after medical withdrawal to the care of a case manager for continuing treatment and prenatal care.

Guideline 4 -- Opioid Stabilization [14](#)

The following approaches are used to manage the pregnant, opioid–addicted woman. The first approach is methadone maintenance combined with psychosocial counseling. This is a well–documented approach to improve outcomes for both the woman and her fetus.

The second approach is slow medical withdrawal with methadone. The safety of this second approach has not been documented.

Opioid Withdrawal Signs and Symptoms
<p>Mild withdrawal signs and symptoms include</p> <ul style="list-style-type: none">• Generalized anxiety• Opioid craving• Restlessness• Slight aching of muscles, joints, and bones• Lower back pain

Mild to moderate withdrawal signs and symptoms include

- Tension
- Yen sleep (mild insomnia)
- Mydriasis (pupils dilated)
- Lethargy
- Diaphoresis (increased perspiration)

Moderate withdrawal signs and symptoms include

- Chills alternating with flushing and diaphoresis (sweating)
- Nausea and/or stomach cramps
- Rhinorrhea (runny nose)
- Moderate aching of muscles, joints, and bones
- Lower back pain
- Anorexia
- Nausea and/or stomach cramps
- Yawning
- Lacrimation (tearing)
- Goose flesh (earlier if client is in a cold, drafty room)
- Elevated pulse and blood pressure

Moderate to severe withdrawal signs and symptoms include

- Diarrhea
- Vomiting
- Tremors
- Tachycardia (pulse over 100 BPM)
- Increased respiratory rate and depth

Severe withdrawal signs and symptoms include

- Doubling over with stomach cramps
- Kicking movements
- Elevated temperature (usually low grade, less than 100° F)

Note: Withdrawal signs and symptoms differ in their order of appearance from one individual to another. Some individuals may not exhibit certain withdrawal signs and symptoms. Signs may also include uterine irritability, increased fetal activity, or rarely, hypotension.

Symptoms of Opioid Withdrawal Syndrome

Despite its dramatic appearance, the opioid withdrawal syndrome is rarely life–threatening or permanently disabling to an adult. However, there is good evidence that the fetus may be more susceptible to withdrawal symptoms than the mother. In the mother, the initial signs of opioid withdrawal progress to increasingly painful physical symptoms. In addition to these signs, patients show compelling psychological cravings for drugs, as well as drug–seeking behavior.

Methadone substitution is the standard treatment for heroin addiction. Methadone treatment alternatives consist of (1) high–dose blockage; (2) low–dose maintenance; and (3) medical withdrawal.

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Medical withdrawal of the opioid–dependent woman is not recommended in pregnancy because of the increased risk to the fetus of intrauterine death. Methadone maintenance is the treatment of choice. In addition to methadone maintenance, a comprehensive approach is needed that will provide the patient with counseling and other services.

The administration of methadone, combined with any opioid agonist/antagonist such as pentazocine (Talwin), will precipitate withdrawal.¹⁵ Any pregnant woman receiving methadone should be advised against taking opioid agonist/antagonists under all circumstances.

Neonatal abstinence syndrome (NAS) may or may not be related to maternal dose of methadone; NAS may also be related to fetal gestational age and infant weight. However, studies in both pregnant women and other adults have shown that larger doses of methadone result in a decreased use of other drugs.

Maternal and Fetal Effects of Opioids

These effects may be the result of concomitant maternal lifestyle factors rather than the direct result of drug use.

1 Possible effects on the pregnancy:

- ◆ Toxemia
- ◆ Intrauterine growth retardation
- ◆ Miscarriage
- ◆ Premature rupture of membranes
- ◆ Infections
- ◆ Breech presentation (abnormal presentation due to premature delivery)
- ◆ Preterm labor
- ◆ No effect

2 Possible effects on the mother:

- ◆ Poor nourishment, with vitamin deficiencies, iron deficiency anemia, and folic acid deficiency anemia
- ◆ Medical complications from frequent use of dirty needles (abscesses, ulcers, thrombophlebitis, bacterial endocarditis, hepatitis, and urinary tract infection)
- ◆ Sexually transmitted diseases (gonorrhea, chlamydia, syphilis, herpes, and HIV infection)
- ◆ Hypertensive disorder
- ◆ No effect

3 Possible effects on the fetus and newborn infant:

- ◆ Low birth weight
- ◆ Prematurity
- ◆ Neonatal abstinence syndrome
- ◆ Stillbirth
- ◆ Sudden infant death syndrome
- ◆ No effect

Opioid Conversion and Methadone Stabilization

The goal of the methadone strategy is to stabilize the patient without producing any indication of opioid abstinence syndrome.

Procedures at the Time of Admission

- 1 Obtain a detailed health history, including alcohol and other drug use and arrangements for prenatal care.
- 2 Conduct a comprehensive physical examination, including weight, vital signs, and an obstetrical evaluation.
- 3 Obtain laboratory tests, including
 - a) Initial blood workup that includes, but is not limited to
 - ◆ Blood group, Rh factor determination, and antibody screen
 - ◆ Serological test for syphilis
 - ◆ Hepatitis B and C screens
 - ◆ Complete blood count with indices
 - b) Other initial laboratory tests that include, but are not limited to
 - ◆ Cervical cytology smear (Pap smear), unless the provider has results of a test performed within the past 3 months
 - ◆ Cervical culture for gonorrhea
 - ◆ Urine screen for urinary tract infection, kidney disease, protein, and glucose
 - ◆ Chlamydia screen
- 4 Obtain purified protein derivative of tuberculin (PPD) test with antigen panel.
- 5 Obtain urine and/or blood toxicologies (see [Guideline 15](#) -- *Urine Toxicology Considerations*).
- 6 Provide for HIV antibody counseling and testing.
- 7 Obtain baseline sonogram if appropriate.

Methadone Dosing Strategy

Determine the amount of drug being used and follow the dosing strategy listed below.

- 1 Evaluate the pattern of drug use, route of administration, and frequency and amount of drug use. Know something about the purity of the street product and the other substances, such as quinine or Valium, with which the product may be cut or diluted.

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- 2 Obtain a detailed history of drug use within the past 24 hours.
- 3 Give an initial oral methadone dose of 10 to 40 mg. Because it is imperative to reverse any opioid abstinence symptoms as quickly as possible, an additional dose of methadone may be required in the range of 5 to 10 mg if objective signs of withdrawal persist after 3 to 4 hours (time to allow the methadone to reach a peak blood level). This 5– to 10–mg dose can be repeated at 3 to 4 hour intervals until objective signs of withdrawal are no longer present.
- 4 Adjust the dosage by 5 to 10 mg daily based on physical signs and symptoms of opioid withdrawal (see [table](#)) and patient comfort. Even minimal symptoms in the mother may indicate stress in the fetus.
- 5 After the stabilization dose has been established, keep the patient at this level for several days.
- 6 If there is simultaneous dependence on other drugs such as alcohol, cocaine, and sedatives, methadone induction should proceed as outlined in items 1 through 5, while concurrent medical withdrawal procedures are initiated. The other drug withdrawals can be managed as usual against the background of methadone maintenance. Ideally, this is an inpatient procedure.

Important Warning: NARCAN (or any narcotic antagonist) should never be given to a pregnant, substance–using woman except as a last resort to reverse severe narcotic overdose. Administration of a narcotic antagonist to a pregnant, substance–using woman could result in spontaneous abortion, premature labor, and/or stillbirth.¹⁶

Guidelines for Methadone Maintenance

Methadone maintenance is strongly encouraged for all pregnant, opioid–dependent women. It provides the following advantages:

- ◆ Reduces illegal opioid use as well as use of other drugs
- ◆ Helps to remove the opioid–dependent woman from the drug–seeking environment and eliminates the necessary illegal behavior
- ◆ Prevents fluctuations of the maternal drug level that may occur throughout the day
- ◆ Improves maternal nutrition, increasing the weight of the newborn
- ◆ Improves the woman's ability to participate in prenatal care and other rehabilitation efforts
- ◆ Enhances the woman's ability to prepare for the birth of the infant and begin homemaking
- ◆ Reduces obstetrical complications

There are no specific guidelines established for methadone dosages for pregnant women. In general, the clinical trend is toward use of an individually determined, most effective dose that is adequate to prevent withdrawal symptoms.

The following guidelines have been used for pregnant and nonpregnant substance users:

- 1 The high–dose methadone blockage dosage is between 50 and 150 mg per day.
- 2 The low–dosage methadone maintenance dosage is less than 60 mg per day.

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Based on current and emerging research, the National Institute on Drug Abuse (NIDA) suggests that maintenance doses below 60 mg are not effective and hence not appropriate.¹⁷ Arbitrary low–dose policies for pregnant and nonpregnant patients is often associated with increased drug use as well as reduced program retention. Based on current informed consensus, the most prudent course is to rely on individually determined methadone dosing that is measured by the absence of subjective and objective abstinence symptoms and the reduction of drug hunger.

An increased methadone dosage may be needed in later stages of pregnancy to prevent withdrawal. (The greater plasma volume and renal blood flow of pregnancy can contribute to a reduced level of methadone in the blood. As a result, the woman's maintenance dose may be insufficient to prevent cravings.) Either administer methadone twice a day to give a more even blood level throughout the day or raise the single daily dose.

Guidelines for Medical Withdrawal From Methadone

Medical withdrawal of the pregnant, opioid–dependent woman from methadone is not indicated or recommended. Few women will have the motivation or the psychosocial supports to accomplish and maintain total abstinence. The goal, therefore, is to achieve the best therapeutic dose possible with which the woman feels comfortable. The neonatal abstinence syndrome can be treated with minimal complications.

Despite the above caution, at times, medical withdrawal may need to be considered due to logistical or geographic barriers. In these cases, the decision to undertake such a program must be a joint decision between the obstetrician, the woman, and her counselor, with the understanding that few women will be appropriate candidates for this approach.

The woman should understand that she must prove she is a candidate for medical withdrawal by complying with prenatal and therapy appointments and supplying clean urines. If at any time the woman is unable to comply with these requirements, no further decrease in dosage of methadone should be ordered.

1 Timing of withdrawal. There are no research data that suggest withdrawal in one trimester is worse than in others. Some clinical practitioners indicate concerns regarding methadone withdrawal prior to 14 weeks or after 32 weeks. These concerns are based on the theoretical possibility of an increased incidence of spontaneous abortion and premature labor. Other clinicians believe that withdrawal can be performed in all trimesters.

Patients should be allowed to discontinue withdrawal at any time, for any reason, without feelings of guilt. They should then be placed into a methadone maintenance program at a therapeutically sound dose. Clinicians need to be particularly aware that a decrease in methadone dosage could precipitate a relapse to drug use. Patients in continuous treatment who return to illegal drug use should be placed back on methadone. Methadone is preferable to the use of illegal street drugs.

2 Withdrawal schedule. Medical withdrawal from methadone is usually done in decrements of 2 to 2 1/2 mg every 7 to 10 days. This procedure should only be done in conjunction with an obstetrician who can monitor the effects on the fetus. Intrauterine demise (death of the fetus in utero) has been documented as a complication of medical withdrawal even when done under optimal conditions, such as hospitalization and close fetal monitoring.

Note: At the time of publication, there was no protocol for medical withdrawal from methadone that had been evaluated in an appropriate number of women with suitable scientific and medical rigor.

Opioid Withdrawal Using Clonidine

The long–term effects of the use of clonidine in pregnancy are still unknown. Although clonidine hydrochloride has been used safely and effectively for rapid medical withdrawal in the management of opioid withdrawal in

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nonpregnant, opioid–dependent individuals,¹⁸ there are no data concerning its safety in pregnancy. Further research in this area needs to be performed before this technique can be recommended as a standard of care for pregnant women.

Guideline 5 -- Cocaine Withdrawal

There are no well–documented studies regarding the safety or efficacy of using drugs to medically withdraw pregnant, cocaine–using women. The evidence is extremely limited for all methods of medical withdrawal. Inpatient treatment is the ideal whenever possible, although these facilities may not always be available. Medical withdrawal is just the first step in the continuum of care for pregnant, cocaine–dependent women. Referral to ongoing alcohol and other drug treatment and relapse prevention services is essential.

Symptoms of Cocaine Withdrawal

Withdrawal from cocaine dependence is characterized by depression, anxiety, and lethargy, which begin to resolve after approximately 1 week. Less common are signs of a paranoid psychosis during withdrawal from chronic use of high doses of cocaine. In cocaine withdrawal, medication is rarely needed for the serious sequelae that are associated with alcohol, barbiturate, and opioid withdrawal.

Maternal and Fetal/Infant Effects of Cocaine

1 Possible effects of maternal cocaine use during pregnancy:

- ◆ Intrauterine growth retardation (IUGR)
- ◆ Abruptio placentae
- ◆ Premature labor
- ◆ Spontaneous abortion
- ◆ No effect

2 Possible effects on the fetus and newborn infant that have been reported:

- ◆ Increased congenital anomalies
- ◆ Mild neurodysfunction
- ◆ Transient electroencephalogram abnormalities
- ◆ Cerebral infarction and seizures
- ◆ Vascular disruption syndrome
- ◆ Sudden infant death syndrome
- ◆ Smaller head circumference
- ◆ No effect

Guidelines for Withdrawal From Cocaine: Treatment Options

There are no data about the effectiveness of the following guidelines in pregnancy. In those guidelines that substitute other drugs, many of the drugs are problematic to the newborn and some have not been confirmed to be safe. Some centers do not generally use antidepressants for cocaine withdrawal depression. However, other programs prescribe antidepressants for the first 5 days to try to reduce the high dropout rate that occurs during this period. Sedatives and/or antidepressants may cause excessive drowsiness in a cocaine–dependent woman.

Cocaine–dependent women who require sedatives and/or antidepressants for any significant length of time often have

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an endogenous depressive disorder. Psychiatric consultation is usually indicated.

Procedures at the Time of Admission

- 1 Obtain a detailed health history, including alcohol and other drug use and arrangements for prenatal care.
- 2 Conduct a comprehensive physical examination, including weight, vital signs, and an obstetrical evaluation.
- 3 Obtain laboratory tests, including
 - a) Initial blood workup that includes, but is not limited to
 - ◆ Blood group, Rh factor determination, and antibody screen
 - ◆ Serological test for syphilis
 - ◆ Hepatitis B and C screens
 - ◆ Complete blood count with indices
 - b) Other initial laboratory tests that include, but are not limited to
 - ◆ Cervical cytology smear (Pap smear), unless the provider has results of a test performed within the past 3 months
 - ◆ Cervical culture for gonorrhea
 - ◆ Urine screen for urinary tract infection, kidney disease, protein, and glucose
 - ◆ Chlamydia screen
- 4 Obtain purified protein derivative of tuberculin (PPD) test with antigen panel.
- 5 Obtain urine and/or blood toxicologies (see [Guideline 15](#) -- *Urine Toxicology Considerations*).
- 6 Provide for HIV antibody counseling and testing.
- 7 Obtain baseline sonogram if appropriate.

Dosing Strategy

Determine the amount of drug being used and follow the dosing strategy listed below.

- 1 Evaluate the pattern of drug use, route of administration, and frequency and amount of drug use.
- 2 Obtain a detailed history of drug use within the past 24 hours.

To withdraw a pregnant woman dependent on cocaine, the following are options.

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1 No medications. Pregnant patients who are withdrawing from cocaine should not be medicated except in cases of extreme agitation and by individual order of the health care provider.

2 Anxiolytics. If medication is needed, low doses of diazepam (Valium) or chlordiazepoxide (Librium) (25 mg by mouth, 4 times a day, x 6 doses) may be used.

3 Antidepressants. A typical withdrawal guideline for cocaine–dependent women uses doxepin (Sinequan) or desipramine (Norpramin). For example,

- ◆ Days 1–2: Doxepin 25 mg (one tablet) by mouth 2 times a day, 50 mg maximum.
- ◆ Days 3–5: Doxepin 25 mg (one tablet) by mouth 2 times a day, then discontinue.
- ◆ Further therapy should be determined by the treating physician after an initial period of observation.
- ◆ No drug therapy is usually indicated after the first 5 days.

4 Barbiturates. For cocaine withdrawal symptoms:

- ◆ Days 1–2: Phenobarbital 30 to 60 mg every 4 hours as needed.
- ◆ Days 3–4: Phenobarbital 30 to 60 mg every 6 hours as needed.

5 Bromocriptine. Bromocriptine, a drug used to treat menstrual abnormalities and infertility in women, has provided striking and consistent relief from cocaine craving among inpatients.

Research indicates that cocaine, when used by the first–time user, seems to stimulate dopamine and also blocks the reuptake of dopamine, which produces the cocaine high. The brains of regular users of cocaine cannot make dopamine as quickly as the cocaine demands; the result is an eventual depletion that creates the crashing and craving effects.

The use of bromocriptine in pregnancy is not recommended because of the lack of proven efficacy and unknown effects, both short and long term, on the fetus.

6 Acupuncture. Acupuncture has been used in the treatment of cocaine addiction. Traditional use of acupuncture for other disorders has usually been contraindicated in pregnancy. At the time of publication, the National Institute on Drug Abuse has not concluded its evaluation of the efficacy of this treatment.

Guideline 6 -- Sedative–Hypnotic Medical Withdrawal

Inpatient medical withdrawal from barbiturates, benzodiazepines, and other sedative–hypnotic drugs is recommended because continual monitoring of the mother and the fetus is required. Drug doses must be tapered so that mother and fetus arrive at a drug–free state without experiencing an uncontrolled withdrawal.

Barbiturates and benzodiazepines are the most commonly abused sedative–hypnotics. There are marked similarities between the withdrawal syndromes seen with both of these drugs. Patients abruptly withdrawn from large doses of benzodiazepines may sustain withdrawal symptoms that closely resemble those associated with barbiturate physical dependence. Because of these similarities, only the barbiturate abstinence syndrome is presented in this guideline.

Symptoms of Barbiturate Abstinence Syndrome
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The barbiturate abstinence syndrome begins 6 to 24 hours after the last dose, and symptoms are generally more severe with the short–acting barbiturates. Signs and symptoms of barbiturate abstinence include

- Tremulousness
- Diaphoresis
- Anxiety
- Postural hypotension
- Insomnia
- Grand mal convulsions (between days 3 and 7)
- Agitation
- Anorexia
- Delirium
- Nausea and vomiting
- Tendon hyperreflexia

If untreated, withdrawal symptoms can progress to hyperpyrexia, electrolyte abnormalities, cardiovascular collapse, and death.

Guidelines for Withdrawal From Sedative–Hypnotic Drugs

The following recommendations are meant to be generic, to allow individual guidelines to be designed for specific treatment settings.

Management of Withdrawal

Management of withdrawal in patients who may or may not be pregnant can include

- ◆ Substitution of a long–acting agent (phenobarbital, diazepam, clonazepam), and subsequent withdrawal of this agent
- ◆ Slow withdrawal of the addicting agent

Risk categories for severe withdrawal

- ◆ Low risk: Sporadic use of a drug or use for relief of cocaine–induced anxiety or insomnia.
- ◆ Moderate risk: Daily use of a drug for at least 2 to 4 months at a therapeutic level; concomitant alcohol abuse at low doses; history of mild withdrawal symptoms.
- ◆ High risk: Prolonged daily use of a drug at higher than therapeutic doses; higher use of alcohol; history of serious withdrawal symptoms.
- ◆ Highest risk: Previous withdrawal seizures or a history of a seizure disorder that is exacerbated by sedative–hypnotic withdrawal.

Some considerations for withdrawal from sedative–hypnotic drugs during pregnancy

- ◆ Severe withdrawal from barbiturates can produce status epilepticus and maternal and fetal respiratory arrest. Immediate obstetrical intervention and hospitalization are warranted.
- ◆ Use of dilantin and other anticonvulsants have been considered for a patient with a history of withdrawal seizures. However, these drugs have been associated with congenital anomalies. Therefore, their use in pregnancy must be based on an assessment of the risks versus the benefits. Although there are concerns of teratogenicity regarding benzodiazepines and barbiturates, these appear to have a lower risk versus benefit ratio.

Procedures at the Time of Admission

- 1 Obtain a detailed health history, including alcohol and other drug use and arrangements for prenatal care.
- 2 Conduct a comprehensive physical examination, including weight, vital signs, and an obstetrical evaluation.
- 3 Obtain laboratory tests, including
 - a) Initial blood workup that includes, but is not limited to
 - ◆ Blood group, Rh factor determination, and antibody screen
 - ◆ Serological test for syphilis
 - ◆ Hepatitis B and C screens
 - ◆ Complete blood count with indices
 - b) Other initial laboratory tests that include, but are not limited to
 - ◆ Cervical cytology smear (Pap smear), unless the provider has results of a test performed within the past 3 months
 - ◆ Cervical culture for gonorrhea
 - ◆ Urine screen for urinary tract infection, kidney disease, protein, and glucose
 - ◆ Chlamydia screen
- 4 Obtain purified protein derivative of tuberculin (PPD) test with antigen panel.
- 5 Obtain urine and/or blood toxicologies (see [Guideline 15](#) – *Urine Toxicology Considerations*).
- 6 Provide for HIV antibody counseling and testing.
- 7 Obtain baseline sonogram if appropriate.

Dosing Strategy

Determine the amount of drug being used and follow the dosing strategy listed below.

- 1 Evaluate the pattern, frequency, and amount of drug use.
- 2 Obtain a detailed history of drug use within the past 24 hours.
- 3 Document signs and symptoms of withdrawal. The regular use of a standardized withdrawal assessment scale can be helpful.

- 4 Administer drugs for medical withdrawal. The drugs used for medical withdrawal may vary. For medical withdrawal of patients dependent on barbiturates, minor tranquilizers, or other sedatives, some programs suggest administering the drug of use. The use of a long–acting drug, such as phenobarbital, diazepam, or clonazepam, may be helpful.
- 5 Stabilize the patient to suppress withdrawal symptoms. Supportive measures should include a safe environment with proper nutrition and rest. Frequent reassurance and encouragement are vital.
- 6 Withdraw the pregnant patient in regular decrements of from 5 to 10 percent of dose daily.

Guideline 7 -- Mental Health Considerations

Mental disorders in pregnant, substance–using women often go undetected by health care providers and alcohol and other drug treatment staff. It is essential that a dual diagnosis be made, when appropriate, and addressed in subsequent treatment planning. The complex combination of pregnancy, addiction, and mental illness requires a carefully coordinated approach. The following general guidelines can be useful in assessing the mental health of pregnant, substance–using women.

Mental Health Assessment [19](#)

- ◆ **Distinguish between drug–induced psychiatric symptoms and a major mental disorder.** Symptoms such as anxiety, agitation, and paranoia can be manifestations of a state of drug intoxication or of the withdrawal syndrome itself and at times require no medications. Ongoing psychosocial support may help minimize many of these symptoms.

@BULLET TEXT = On the other hand, confirmed mental illness may necessitate the continuation of medications, such as antidepressants or antipsychotics, which have been previously effective in treating the underlying disorder. It is mandatory that a diagnosis of mental illness be ruled out before such medication is stopped. It must be remembered that evidence is inconclusive regarding the safe use of any psychotropic medication in pregnant women. A thorough assessment of the risks versus the benefits must be made prior to administering these medications.

- ◆ **Establish any previous history of psychiatric illness before developing the medical withdrawal treatment plan.** Efforts should be made to contact previous therapists, treating agencies, and mental health facilities for this crucial information.
- ◆ **Establish communication early in treatment with mental health personnel involved in the patient's care.** These individuals often can provide important history, help build an alliance with the patient, support discharge planning, and provide assistance in the event of an acute management crisis.
- ◆ **Individualize medical withdrawal plans for each patient.** Carefully review standard guidelines and amend them if there are significant psychiatric problems to be treated.
- ◆ **Set up arrangements to involve mental health personnel, where appropriate,** in establishing diagnoses and in developing the treatment plan.
- ◆ **Continue prescribed medications and provide appropriate followup** for patients who enter alcohol and other drug treatment programs with well–documented, diagnosed psychiatric illnesses that require psychopharmacologic medication.
- ◆ **Continue any prescribed medications,** such as methadone and chlorthalidone, except as advised by the patient's health and mental health care providers. Patients should be supported in this decision by treatment programs. Some support groups may inappropriately encourage women to abandon all medications.

TIP 2: Pregnant, Substance–Using Women

- ◆ **Do not avoid seeking therapy for the patient** because of the complex combination of pregnancy, addiction, and psychiatric problems. Careful planning and staff coordination are usually effective in treatment.
- ◆ **Use well–validated psychiatric assessment scales** in the diagnosis and followup of individual patients (see [Appendix B](#)).
- ◆ **Consider issues of codependency, adult children of alcoholics/other addictions, and deep trauma from childhood** in the evaluation of patients.

Guidelines for Medical Withdrawal

Orders for medication should be individualized to minimize the types and doses prescribed. Psychotropic drugs may need to be prescribed throughout medical withdrawal. The use of psychotropic drugs must be considered on a case–by–case basis, taking into consideration their effects on the mother and fetus, particularly with respect to interactions with methadone and possible congenital abnormalities. Behavioral management techniques should be developed to minimize the need for these medications. Providing adequate staff, structure, limits, and support are important treatment methods.

Other Issues

Agitation and oppositional or impulsive behavior can be manifestations of cognitive impairments, such as attention deficit disorder, limited intelligence, mild retardation, or psychotic illness. Patients with these behaviors can appear to have difficulty comprehending or complying with treatment expectations. Awareness of these deficits can help staff manage these problems and adapt treatment methods to minimize or avoid unnecessary confrontations.

Chapter 2 -- Medical Guidelines for Pregnant, Substance–Using Women

Overview

Alcohol and other drug use during pregnancy can have detrimental effects -- both specific and nonspecific -- on the perinatal outcome. Specific effects of drug use can include facial dysmorphology and organ system anomalies, such as alcohol–related birth defects. Pregnant women who use alcohol and other drugs are at an increased risk for preterm labor, thereby placing an already compromised fetus at increased risk. Nonspecific effects can include fetal growth retardation, resulting in small infants and decreased head circumference.²⁰

Substance–using women and their infants are endangered by the spread of the human immuno–deficiency virus (HIV). The number of women who are infected with the virus from shared needles and multiple sexual contacts, and the number of their infants who are infected through mother–to–infant transmission of the virus, is increasing at an alarming rate.²¹ Every medical institution should follow Occupational Safety and Health Administration (OSHA) standards and universal precautions with respect to the blood and body fluids of *all* patients. To use such precautions only with known HIV–infected persons or known alcohol and other drug abusers places health care workers at great risk and fosters stereotyping.

In this time of excessive use and abuse of alcohol, cigarettes, cocaine, and other drugs, it is clear that wider recognition of such abuse -- as well as active intervention efforts -- are needed. It is also clear that, in addition to the policies and procedures usually followed prenatally and during labor, delivery, and postpartum, specific attention must be paid to pregnant, substance–using women and their infants.

It is not enough to provide obstetrical care to substance–using women; a holistic approach is essential. This approach

TIP 2: Pregnant, Substance–Using Women

should incorporate alcohol and other drug treatment, as well as help for all of the problems of daily living and survival that confront and confound these women.

Scope of the Guidelines

The following guidelines are designed to ensure that women receive the prenatal care, alcohol and other drug treatment, and comprehensive help they need to provide for their own health and that of their fetuses. In addition to obstetrical care, the guidelines address HIV–infected women, urine and/or blood toxicology, neonatal care, and nutrition.

Guideline 8 -- Prenatal Intake

Procedures To Be Done During the First Prenatal Visit

- 1 Detailed health history, including alcohol and other drug use and psychosocial assessments
- 2 Comprehensive physical examination, focusing on the multiple medical problems of this population
- 3 Family psychosocial, medical, and alcohol and other drug use history
- 4 Health, psychosocial, and alcohol and other drug use history of the baby's father
- 5 Routine prenatal panel, *plus* other laboratory tests, including urine and/or blood toxicology screening, tuberculin test with an antigen panel, and baseline sonogram
- 6 Optional tests as needed, including screening for human T–cell lymphotropic virus (HTLV)–I and hepatitis C
- 7 Attention to areas of special concern in substance–using women
- 8 Attention to medical complications encountered in pregnancy
- 9 Referrals to an alcohol and other drug treatment program, nutritional counseling, social services, and other counseling
- 10 Additional referrals as needed

Guidelines for the First Prenatal Visit

A number of significant environmental, psychosocial, and treatment considerations should be taken into account at the time of the woman's first prenatal visit. These considerations can affect the accurate assessment and successful engagement of the woman in ongoing prenatal care. They are as follows:

- ◆ Services should be provided in a supportive, culturally sensitive, and nonjudgmental environment by all health care personnel, from the receptionist to the physician.
- ◆ An assessment should be made of the woman's literacy and reading level. This assessment should include the woman who is functionally illiterate or has low literacy in her native tongue as well as in English. Literacy– and reading–level information will affect patient education efforts and the ability to obtain informed consent.
- ◆ The woman may enter prenatal care in different stages of pregnancy and from a variety of settings, including hospital emergency rooms, community health centers, family planning clinics, abortion clinics, or social service offices. It is essential to be able to offer assessment, triage, case coordination, and referral services from any or all of these settings.

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- ◆ Case management services that coordinate the care of the pregnant, substance–using woman and her family are critical. Ideally, case conferences and referral to appropriate services should be managed by one health care professional who oversees the multidisciplinary team. An outreach worker who visits the woman in her home should be part of this team. The most difficult issue to resolve, given the financial and staffing constraints experienced by most health care and service providers, is the identification and designation of a case manager.
- ◆ Counseling about and obtaining of written informed consent for medical procedures and treatment are important. It is equally important to explain confidentiality, privacy, and other patient rights, as well as legal risks that may be posed by policies of the individual program.

The first prenatal visit should establish the components of the continuum of care that will extend through the woman's pregnancy and beyond. The visit should include the following components.

1 Obtain a detailed health history. This history should cover legal and illegal drug use and last date of use; drugs used at the time of the first visit; medical history; current medications; psychosocial history, including emotional problems, mental illness, and housing and current living arrangements, with a special focus on the presence or lack of support systems; complete reproductive history, including current and past pregnancies, previous preterm deliveries, history of Caesarean sections, birth weight, number of therapeutic abortions, menstrual history, and methods of family planning; and sexual history, including previous sexually transmitted diseases.

2 Conduct a comprehensive physical examination. This examination should be performed during the initial prenatal evaluation. It should include an evaluation of nutritional status, height, weight, and blood pressure, as well as an examination of the head, neck, breasts, heart, lungs, abdomen, pelvis, rectum, and extremities. Special attention should be given to those organ systems impacted by alcohol and other drug use, such as the liver in alcoholics and the skin in injection drug users. During the pelvic examination, attention should be given to the size of the uterus in relation to the presumed duration of the pregnancy.

3 Obtain a family psychosocial, medical, and substance–using history. This history should cover alcohol and other drug use by all family members, diabetes, tuberculosis, cancer, heart disease (hypertension), congenital malformations, multiple births, and bleeding disorders. If any part of the history will have a significant impact on the course or outcome of the pregnancy, appropriate followup should be initiated. A visit to the woman's living environment should be an option.

4 Obtain a health, psychosocial, and substance–using history for the infant's father. This history should cover legal and illegal drug use, alcohol and other drugs currently being used, medical history, and mental illness.

5 Complete a prenatal panel that includes

- ◆ Initial blood workup for all women that includes, but is not limited to
 - ◆ Blood group, Rh factor determination, and antibody screen
 - ◆ Rubella immune status and antibody titer measurement, unless previously documented
 - ◆ Serological tests for syphilis
 - ◆ Hepatitis B surface antigen screen
 - ◆ Complete blood count, including indices and platelets
 - ◆ Baseline liver function test
 - ◆ Baseline renal function test
- ◆ Other initial laboratory tests for all women that include, but are not limited to:

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- ◆ Cervical cytology (pap smear), unless the provider has results of a test performed within the last 3 months
- ◆ Cervical culture for gonorrhea (optional culture for rectal and pharyngeal)
- ◆ Chlamydia screen
- ◆ Hemoglobin electrophoresis as indicated
- ◆ Urine drug and/or blood screening (the selection of drugs for screening will vary by community and should be based on current local prevalence data).
- ◆ Human immunodeficiency virus (HIV) education and counseling. Offer antibody testing, with pre– and posttest counseling. Always obtain written informed consent that is consistent with the laws and regulations of the locale.
- ◆ Purified protein derivative of tuberculin (PPD) with antigen panel. If previously PPD–positive, a chest X–ray is recommended.
- ◆ Baseline sonogram. Level I scanning should be performed at a minimum to assess gestational age. Level II is recommended, especially when the gestational age is more than 18 weeks.

6 Obtain optional tests. The benefit–to–cost ratio of these tests at the initial prenatal visit may vary depending on the population:

- ◆ Screening for human T–cell lymphotropic virus (HTLV)–I and hepatitis C; such screening is recommended, particularly in areas of high seroprevalence
- ◆ Diabetic screening as indicated
- ◆ Complete urine analysis with screening for infection
- ◆ Group B streptococcal (GBS) carriage cultures (rectal and introital)
- ◆ Maternal serum–alpha fetal protein (MS–AFP) as indicated (16 to 20 weeks gestation)
- ◆ Toxoplasmosis, cytomegalovirus, and herpes screening tests as indicated
- ◆ Electrocardiogram (EKG) as indicated

7 Address areas of special concern. In the physical examination of pregnant, substance–using women, the following areas need special attention:

- ◆ Dermatologic: Presence of infections, abscesses, thrombosed veins, herpes infections, pyodermas, icterus, tattoos, bruising (as evidence of battering)
- ◆ Dental: Status of dental hygiene, existence of pyorrhea or abscessed cavities
- ◆ Otolaryngeal: Presence of rhinitis, excoriation of nasal septum
- ◆ Respiratory: Presence of wheezes, rales; signs of interstitial pulmonary disease
- ◆ Cardiovascular: Rate and rhythm abnormalities, presence of murmurs
- ◆ Gastrointestinal: Presence of hepatomegaly, scars from injuries, incisional or umbilical hernias
- ◆ Genitourinary: Presence of infections such as condyloma acuminatum, herpes vulvovaginitis, trichomonas vaginitis, bacterial vaginitis, and gonorrheal/chlamydial urethritis/cervicitis; condition of the uterus, including size configuration, fetal position, fetal heart rate, and fetal activity
- ◆ Breast: Nipples, evidence of trauma, "lumps or bumps," breast vein used for injection
- ◆ Musculoskeletal: Evidence of pitting edema, distortion of muscular landmarks due to subcutaneous abscesses, or brawny edema
- ◆ Lymphatic: Presence of lymphadenopathy and abscesses

8 Address medical complications. Complications encountered in pregnancy that require special attention include

- ◆ Anemia
- ◆ Bacteremia/septicemia

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- ◆ Cardiac disease, especially endocarditis
- ◆ Cellulitis
- ◆ Poor dental hygiene
- ◆ Edema
- ◆ Hepatitis, acute and chronic
- ◆ HIV infection
- ◆ Phlebitis
- ◆ Pneumonia
- ◆ Tetanus
- ◆ Tuberculosis
- ◆ Urinary tract infection, including cystitis, urethritis, and pyelonephritis
- ◆ Sexually transmitted diseases, including condyloma acuminatum, gonorrhea, herpes, syphilis, chlamydia, and other vulvovaginitides

9 Provide referrals for all women that include

- ◆ Nutritional counseling
- ◆ Alcohol and other drug counseling
- ◆ Social services, including case management and possible home visitation
- ◆ Early intervention, including parenting education
- ◆ Educational and employment counseling

10 Provide additional referrals, as indicated by the individual needs of the woman, that may include

- ◆ Genetic counseling
- ◆ Reproductive counseling and education about sterilization, contraceptive methods, abortion, adoption, and foster care planning. Explore the patient's knowledge of and feelings about the use of contraceptives, including cultural and religious issues and refusal and/or reluctance by the partner to use contraceptives.
- ◆ Childbirth and/or parenting classes as indicated
- ◆ Smoking cessation programs
- ◆ Mental health evaluation to rule out dual diagnosis (see [Guideline 7–Mental Health Considerations](#))
- ◆ Testing for mental capacity to rule out mental impairment due to alcohol and other drug use by the patient's mother
- ◆ Evaluation at infectious disease clinics for women who are HIV–infected. If they meet non–pregnant criteria for treatment with antivirals or prophylaxis, consideration should be given to initiating such treatment after careful discussion with the woman of known and unknown risks and benefits.

Guideline 9 -- Prenatal Followup

Prenatal Followup Care for Pregnant, Substance–Using Women	
1	Visits to identify and address medical and psychosocial problems, as well as health education considerations
2	Random urine and/or blood toxicologies
3	Encouragement to continue treatment and establish ongoing relationships with other service providers
4	Written release from the patient to enable service providers to exchange information

TIP 2: Pregnant, Substance–Using Women

- 5 Discussion of reproductive options
- 6 Management of common complications
- 7 Encouragement to involve the father of the baby and other persons the woman considers significant, where appropriate

Prenatal Followup Guidelines

1 Schedule visits to identify medical and psychosocial problems, as well as health education considerations. Prenatal followup visits should be determined by the woman's individual needs and risk assessment. Recognizing that the majority of substance–using women have high–risk pregnancies, it is desirable to see them every 2 to 3 weeks, up until 28 weeks, then weekly thereafter. It may not be necessary for all contacts to be with a physician; some contacts may be handled by a nurse or by the case manager. In some instances, a woman should be seen weekly throughout her pregnancy, particularly if she is not enrolled in a therapeutic alcohol and other drug treatment program. A woman with active medical or obstetric problems should be seen more frequently, at intervals to be determined by the nature and severity of her problems.

Up to 28 weeks

Up to 28 weeks, the following should be done at each visit:

- ◆ Measure weight and blood pressure; obtain urine dipstick for sugar, protein and ketones; test for nitrites and leukocyte esterase; obtain urine and/or blood toxicologies in accordance with the guidelines of the program.
- ◆ Assess for evidence of edema, abdominal pain, abnormal vaginal discharge, bleeding, headache, visual disturbances, nausea, vomiting, signs and symptoms of urinary tract infection, uterine contractions, pregnancy–induced hypertension, and common discomforts.
- ◆ Perform abdominal examination.
- ◆ Review the chart to compare weeks by date and weeks by examination.
- ◆ Auscultate fetal heart tones.
- ◆ Obtain sonograms as needed.
- ◆ Repeat blood work as needed.
- ◆ Provide for health education about the signs and symptoms of pregnancy, sexual intercourse, breast feeding, preterm labor precautions, common complaints of pregnancy, childbirth, and parenting.

From 28 to 34 weeks

From 28 to 34 weeks, in addition to the above, the following should be done when appropriate:

- ◆ Obtain diabetes screen.
- ◆ Administer RhoGAM, if indicated.
- ◆ Repeat blood work as needed (syphilis, complete blood count [CBC], antibody screen, repeat screens for gonorrhea and chlamydia, and HBsAg if initially negative).
- ◆ Repeat sonogram for growth or detection of other abnormalities.
- ◆ Initiate preterm labor precautions.
- ◆ Provide for antepartum testing, if indicated.
- ◆ Provide for health education and parenting considerations, including preterm labor precautions and early infant care.

From 35 weeks on

From 35 weeks on, the following should be done at each visit

- ◆ Repeat blood work as needed.
- ◆ Provide for antepartum fetal monitoring, if indicated.

2 Obtain random urine and/or blood toxicologies. The purposes of these screens are to

- ◆ Establish the extent of recent alcohol and other drug use.
- ◆ Identify alcohol and other drug use and the need for early preventive interventions.
- ◆ Identify crises or coping difficulties in the woman.

For additional information and guidance, see [Guideline 15](#) –– *Urine Toxicology Considerations*.

3 Encourage treatment and ongoing relationships with other service providers, including the patient's therapeutic alcohol and other drug program or support groups. Some patients need education and support to ready them for participation in a treatment program or support group, and to prepare them for change. Provide direct support or referral for pre–treatment intervention. If a patient is already involved in an alcohol and other drug treatment program or support group, establish a relationship with that provider after written informed consent is obtained from the patient.

- ◆ **Methadone maintenance:** Methadone maintenance has proved effective in the treatment of pregnant, opioid–dependent women. Participation in an alcohol and other drug treatment program is also important for those women using and abusing other drugs, such as alcohol, cocaine, amphetamines, benzodiazepines, cannabinoids, barbiturates, and hallucinogens.
- ◆ **Service provider communication:** It is important that the alcohol and other drug treatment provider and the prenatal health care provider have access to information about the progress of treatment in both disciplines.

4 Obtain written release of information to enable service providers to exchange information. Release forms, giving permission for the exchange of information, must be signed by the patient in accordance with Federal confidentiality laws and regulations (see [Chapter 3](#) –– *Legal and Ethical Guidelines for the Care of Pregnant, Substance–Using Women*). Multidisciplinary case conferences and communication between disciplines are essential. Meetings of the prenatal care provider, alcohol and other drug counselor, child protective service worker, probation officer, case manager, outreach worker, and social worker can help facilitate optimal prenatal care for the patient.

5 Conduct an initial discussion of reproductive options. Beginning in the prenatal period, ethnically and culturally sensitive education on birth control and family planning should be provided and emphasized. Several routine methods of birth control are not optimal choices for the woman who uses alcohol and other drugs. An individual evaluation is required to determine the best methods for each patient. Condoms can be used in combination with other methods for birth control and for prevention of sexually transmitted diseases. Termination of pregnancy, adoption, and foster care are other options.

- ◆ **Oral estrogen–progestin (contraceptive pill):** Oral estrogen–progestin, preferably given in low doses, should be prescribed with care, as many substance–using women have vascular disease secondary to prolonged abuse of alcohol and other drugs. They also may not be conscientious in taking prescribed medication as indicated.

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- ◆ **Intrauterine devices (IUDs):** These devices may be considered only if the patient's past history does not include pelvic infections. An additional complication with IUDs is the possibility of exposure to sexually transmitted diseases.
- ◆ **Barriers:** Barrier–type contraceptive methods, while the safest medically, are not the most effective and require consistent use. These methods include condoms — which also reduce the risk for HIV and other sexually transmitted diseases — and diaphragms.
- ◆ **Subcutaneous implants:** Norplant is an example of a long–acting, reversible contraceptive method.
- ◆ **Sterilization:** Permanent sterilization may be introduced as an option. The procedure can be completed before discharge postpartum.

The need for appropriate family planning must be stressed, because an unwanted pregnancy may add unnecessary anxiety to an already precarious situation. Counseling should be readily available and, at the discretion of the mother, should include significant others.

6 Manage common complications. Some prenatal complications are sufficiently common among substance–using women to warrant specific comment. These complications include preterm labor, intrauterine growth retardation, hepatitis B, and HIV.

Preterm labor (PTL)

- ◆ Substance–using women are at risk to deliver prematurely. Pertinent risk factors for preterm delivery, aside from the use of alcohol and other drugs, include preterm and premature rupture of membranes, placental abruption, and stress.
- ◆ Due to the anesthetic/analgesic properties of most drugs of abuse, the patient may not perceive the early signs and symptoms of preterm labor and present too late to benefit from tocolytic therapy.
- ◆ Due to late initiation of prenatal care, it is sometimes difficult to distinguish true PTL from labor at term with a growth–retarded fetus.

Recommendations:

1. Substance–using patients should be educated about their increased risk for preterm labor. Preterm labor precautions should be reviewed at each prenatal visit, especially between the 26th and 36th week. These patients often confuse symptoms of PTL with those of drug withdrawal.
2. Screen for and treat infections that predispose to PTL, such as gonococcal or chlamydial infections.
3. Some patients may benefit from serial cervical exams and/or antepartum fetal heart rate/uterine activity testing to rule out PTL, especially if they have a multiple gestation or a previous history of PTL or preterm delivery (PTD).
4. A complete history of alcohol and other drug use and a urine and/or blood toxicology screen should be obtained on any patient presenting in PTL and/or with preterm and premature rupture of membranes.
5. Betamimetic tocolytics, such as ritodrine or terbutaline, should be used with great caution in stimulant–abusing patients. Alternative tocolytic agents, such as magnesium sulfate, may be preferable.²²
6. Assessment of fetal lung maturity may be helpful in distinguishing between PTL and labor at term with a growth–retarded fetus.

Intrauterine growth retardation (IUGR)

- ◆ The pregnancies of some substance–using women are complicated by IUGR. Pertinent risk factors for IUGR, aside from the synergistic effects of polydrug abuse, include congenital infections, congenital anomalies, multiple gestation, and poor nutrition.

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- ◆ Since many of these patients present for prenatal care late in pregnancy, it is often difficult to distinguish between IUGR and poor estimation of dates. For this reason, serial scans for growth and weekly ante–partum fetal surveillance are often necessary.

Recommendations:

1. A complete history of alcohol and other drug use, and perhaps a random urine and/or blood toxicology screen, should be obtained on all patients with suspected or proven IUGR.
2. A complete nutritional assessment should be obtained on all these patients (see [Guideline 16](#) –– *Nutritional Considerations*).
3. Screen for common congenital infections, including syphilis, human immunodeficiency virus (HIV), cytomegalovirus (CMV), and toxoplasmosis, as indicated.
4. A baseline sonogram and at least one followup scan 3 to 6 weeks later are recommended for all substance–using women. These procedures will rule out multiple gestation and major congenital anomalies, and document fetal growth. A level II–III scan for anomalies is helpful for all patients with documented IUGR.
5. Additional scans for growth and biweekly antepartum fetal surveillance (Non–Stress Test [NST] with Amniotic Fluid Index [AFI] or biophysical profile) are recommended for those patients with suspected or proven IUGR.

Hepatitis B

Studies indicate that some substance–using women are chronic carriers of hepatitis B (HBsAg–positive).

Recommendations:

1. Universal screening for HBsAg is recommended for all pregnant women at the time of their first prenatal visit.
2. In order to prevent the perinatal transmission of hepatitis B virus (HBV) to the newborn, HBV immunization of the baby must be initiated within 2 hours of delivery (hepatitis B immune globulin [HBIG] plus hepatitis B vaccine), with additional doses of vaccine at 1 and 6 months of age.
3. Due to the high prevalence of hepatitis B carriage among substance–using women, a history of current alcohol and other drug use by a patient presenting for delivery without results of HBsAg (i.e., if she had no prenatal care) necessitates initiation of the HBV immunization guidelines while awaiting results of HBsAg drawn at the time of admission.
4. Children and significant others of HBsAg–positive, substance–using women should also be assessed for hepatitis B carriage and vaccinated if they are HBsAg/HBsAb–negative.
5. Substance–using women who are HBsAg/HBsAb–negative are candidates for HBV immunization.

Human immunodeficiency virus (HIV) infection

See [Guideline 13](#) –– *Obstetrical Care for HIV–Infected Women*.

7 Encourage involvement of the father of the baby and other persons the woman considers significant.

Involving persons whom the woman considers significant in her life can foster added trust in the program and facilitate discussion about reproductive choices. Their involvement can also provide insight into supports for and barriers to her sobriety.

Guideline 10 -- Labor and Delivery for Women Who Have Received Prenatal Care

Procedures To Be Done During Labor and Delivery

Ideally, substance–using women have received prenatal care at some stage of their pregnancies. Procedures that are appropriate for their care during labor and delivery include

- 1 Detailed history, including recent alcohol and other drug use, and comprehensive physical examination
- 2 Repeat hepatitis B surface antigen and HIV screens, unless previously known to be positive, and repeat serological test for syphilis (titer if previously positive)
- 3 Complete urine and/or blood toxicology screen
- 4 Notification of pediatric and nursing staff providing primary care
- 5 Notification of social services
- 6 Fetal monitoring as indicated
- 7 Pain management as appropriate
- 8 Selection of the delivery method
- 9 Insertion of a central line for injection drug users, if necessary
- 10 Observance of universal precautions for blood and body fluids and OSHA standards

Labor and Delivery Guidelines

1 Obtain a detailed history, including recent alcohol and other drug use, and conduct a comprehensive physical examination. The end of pregnancy is a period when women may relapse into previous substance– using behavior. Therefore, on admission to the labor room, a complete history and physical examination are needed. Information about alcohol and other drug use is important, as follows:

- ◆ Substance–using women often confuse the early signs of labor with signs of withdrawal, and they may medicate themselves during the early hours of labor.
- ◆ Substance–using women should be urged to admit all alcohol and other drugs taken recently. Once known, the effects of these drugs on the woman and her in– fant, and possible interactions with any medications used in labor, can be ascertained and the appropriate staff alerted.
- ◆ The use of alcohol or other drugs prior to arrival at the hospital can determine the type and amount of analgesic, if any, to be used during labor and delivery.

2 Repeat hepatitis B surface antigen and HIV screens, unless previously known to be positive, and repeat serological test for syphilis (titer if previously positive). Repeat these tests, with appropriate consents, to determine if there is any change from the previous tests, and to establish the present status of the woman and the fetus or neonate.

3 Obtain complete urine and/or blood toxicology screen. Substance–using women often arrive at the hospital with a high level of drugs in the blood due to recent use (see [Guideline 15](#) -- *Urine Toxicology Considerations*).

TIP 2: Pregnant, Substance–Using Women

4 Notify pediatric and nursing staff providing primary care. Advise staff of the patient's history of alcohol and other drug use, positive drug screening, and other pertinent medical conditions (e.g., results of hepatitis screen, serological test, and HIV test).

5 Notify social services. Advise staff of the patient's history of alcohol and other drug use and of any pertinent psychosocial concerns, such as unsafe living conditions.

6 Monitor the fetus as indicated. The greater likelihood of relapse at the time of labor increases the possibility of fetal stress and distress.

7 Provide pain management as appropriate. Analgesia and anesthesia administered during labor may include the same range of options available to all patients. Pain medication and attempts at adequate pain relief should never be withheld simply because the patient has a history of alcohol and other drug use. Regional anesthesia may be the procedure of choice. Analgesia and anesthesia administered during delivery may include

- ◆ Regional: Epidural or spinal
- ◆ Pudendal or local

The following statements also pertain:

- ◆ Due to tolerance, patients may require higher than usual doses of short–acting intramuscular/injection narcotics.
- ◆ Avoid use of combination narcotic agonist/ antagonists and pure narcotic antagonists because they may precipitate acute drug withdrawal.
- ◆ Methadone provides minimal analgesia for those women using opioids.

8 Select the delivery method dependent only on obstetrical indications.

9 Insert a central line if necessary. Because of the presence of sclerotic veins, many injection drug users require the insertion of a central line.

10 Follow universal precautions for blood and body fluids and OSHA standards that include

- ◆ Gowns, masks, eye protection, and double gloves for deliveries
- ◆ Gloves for invasive procedures, changing soiled linens or dressings, handling the placenta and cord, and handling the neonate prior to the first bath
- ◆ Mechanical or bulb aspiration of the newborn: Avoid mouth–operated aspiration traps.

Guideline 11 -- Labor and Delivery for Women With No Prenatal Care

Procedures To Be Done During Labor and Delivery

Many substance–using women receive no prenatal care and are first seen by a health care provider during labor and delivery. Moreover, some women are in advanced labor or deliver prior to entering the hospital. Procedures for the care of these women include the following:

TIP 2: Pregnant, Substance–Using Women

- 1 Detailed history, including alcohol and other drug use, and comprehensive physical examination
- 2 Complete baseline laboratory tests
- 3 Complete urine and/or blood toxicology screen
- 4 Sonogram for dating and to rule out multiple gestation
- 5 Notification of pediatric and nursing staff providing primary care
- 6 Notification of social services
- 7 Fetal monitoring as indicated
- 8 Pain management as appropriate
- 9 Selection of the delivery method
- 10 Insertion of a central line for injection drug users, if necessary
- 11 Observance of universal precautions for blood and body fluids and OSHA standards

Labor and Delivery Guidelines

1 Obtain a detailed history and conduct a comprehensive physical examination, although circumstances may impede these activities prior to delivery, that includes

- ◆ A complete medical, surgical, reproductive, and alcohol and other drug use history
- ◆ An appropriate family history, with special emphasis on alcohol and other drug use and mental illness
- ◆ Information about the baby's father, including alcohol and other drug use and medical history

2 Obtain complete baseline laboratory data that include

- ◆ Blood group, Rh factor determination, and antibody screen
- ◆ Rubella immune status
- ◆ Serologic test for syphilis
- ◆ Hepatitis B surface antigen screen
- ◆ Liver function tests
- ◆ Renal function tests
- ◆ Complete blood count with indices and platelet count
- ◆ Complete urinalysis and urine screen for bacteriuria

HIV counseling should be provided in the postpartum period and testing should be encouraged.

If the patient is seen early in labor, it may be technically feasible to obtain a Pap smear, GC culture, and chlamydia screen. Do a PPD, preferably with an antigen panel unless previously positive, in which case a chest radiograph is needed.

3 Obtain a urine toxicology screen, with or without blood alcohol level, as indicated (see [Guideline 15](#) –– *Urine Toxicology Considerations*).

TIP 2: Pregnant, Substance–Using Women

4 Obtain a sonogram. In order to decide about optimal delivery management, it is helpful to obtain a sonogram on intake prior to delivery. This procedure will provide information about approximate gestational age, estimated fetal weight (EFW), and presentation, and can rule out multiple gestation and major congenital anomalies.

5 Notify pediatric and nursery staff of the patient's history of alcohol and other drug use and other pertinent medical conditions.

6 Notify social services so that a psychosocial assessment is completed after delivery. Because of confusion and fear, some substance–using women abandon their infants at the hospital rather than discuss various options for the infant's care and legal custody. Assignment of a case manager is essential for the patient and her newborn to ensure followup medical care, initiate alcohol and other drug treatment, and provide access to social services.

7 Monitor the fetus as indicated. The greater likelihood of relapse at the time of labor increases the possibility of fetal stress and distress.

8 Provide pain management. Follow the pain management procedures presented in [Guideline 10](#) -- *Labor and Delivery for Women Who Have Received Prenatal Care*.

9 Select the method of delivery dependent only on obstetrical indications.

10 Insert a central line if necessary. Because of the presence of sclerotic veins, many injection drug users require the insertion of a central line.

11 Follow universal precautions for blood and body fluids and OSHA standards that include

- ◆ Gowns, masks, eye protection, and double gloves for deliveries
- ◆ Gloves for invasive procedures, changing soiled linens or dressings, handling the placenta and cord, and handling the neonate prior to the first bath
- ◆ Mechanical or bulb aspiration of the newborn: Avoid mouth–operated aspiration traps.

Guideline 12 -- Postpartum Care

Procedures for the Postpartum Care of Substance–Using Women
1 Continuation of or enrollment in an alcohol and other drug treatment program
2 Use of an appropriate family planning method
3 Breastfeeding in methadone–maintained patients
4 Prevention and health maintenance efforts for the mother and infant
5 Child care and parenting education
6 Postpartum followup

Guidelines for Postpartum Care

1 Encourage continuation of or enrollment in an alcohol and other drug treatment program. The supportive involvement of the patient's significant others in her treatment should be encouraged. This involvement can be extremely important in the treatment of addiction and in positively influencing the environment in which the newborn will be raised.

2 Encourage use of an appropriate family planning method. For further information, refer to the discussion of *Preconception Counseling* in the introduction to [Chapter 1](#), *Alcohol and Other Drug Treatment Guidelines for Pregnant, Substance–Using Women*.

3 Permit breastfeeding in methadone–maintained patients. A number of substance–using women express a desire to breastfeed their infants. Breastfeeding is not contraindicated in a methadone–maintained patient if she is known to be free of other drug use and is known to be HIV–seronegative. If the mother is abusing multiple drugs that would expose the infant to diverse agents in varying levels, then breastfeeding may still be contraindicated. Breastfeeding is not recommended if the mother is HIV–infected.

4 Initiate prevention and health maintenance efforts. The woman should be encouraged to start a preventive health maintenance program. This program should provide for immunizations and yearly checkups, including Pap smears and mammograms. For the infant, appropriate pediatric followup and referral to early intervention programs should be arranged.

5 Provide child care and parenting education. Information should be provided on infant feeding, bathing, umbilical cord care, breastfeeding, appropriate approaches for "fussy" infants, and age–appropriate discipline for other siblings.

6 Provide postpartum followup. The health care provider should meet with the woman 2 to 6 weeks after delivery to accomplish the following:

- ◆ Review the laboratory data.
- ◆ Review the care plan, including parenting education.
- ◆ Discuss the delivery and the well–being of the infant.
- ◆ Conduct a physical examination.
- ◆ Look for current alcohol and other drug use and perform screening.
- ◆ Encourage use of an appropriate family planning method.

Guideline 13 -- Obstetrical Care for HIV–Infected Women

Procedures To Be Done With HIV–Infected Women
1 Initial workup
2 Medical treatment for HIV–related conditions
3 Obstetric management

Obstetrical Care Guidelines for HIV–Infected Women ²³

1 Complete an initial workup. The initial workup should include a complete medical history, complete review of symptoms, comprehensive physical examination, and additional laboratory screening.

a) Complete medical history, with special attention to

- ◆ Sexual practices (sexual partners and their HIV status, practice of anal and oral sex, exchange of sex for money and drugs)
- ◆ Alcohol and other drug abuse (injection drug use, use of shared needles, drugs of choice, and sexual or drug partners' history of alcohol and other drug abuse)
- ◆ Blood transfusions, including dates and locations
- ◆ Tuberculosis (TB) exposure, past PPDs, and TB prophylaxis
- ◆ Sexually transmitted diseases (STDs), including herpes simplex genitalis/labialis, syphilis, genital warts, and chancroid
- ◆ Vaginal candidiasis
- ◆ Cervical dysplasia

b) Complete review of symptoms that includes

- ◆ Rashes, bruising, bleeding
- ◆ Fever, chills, night sweats
- ◆ Fatigue, exercise intolerance, dyspnea, cough
- ◆ Anorexia, nausea, vomiting, odynophagia, diarrhea
- ◆ Vaginal discharge, dysuria, abdominal pain
- ◆ Headache, visual changes, memory loss, depression, paresthesia, weakness
- ◆ Weight loss and/or poor weight gain prior to and during pregnancy

c) Comprehensive physical examination that includes:

- ◆ Vital signs: Temperature, weight, blood pressure, respiration
- ◆ Skin: Seborrheic dermatitis, folliculitis, track marks, purple lesions (Kaposi's sarcoma [KS] — rare in women)
- ◆ HEENT: Fundi: cotton wool spots, retinitis (CMV), hemorrhages; and Mouth: ulcers (herpes, syphilis), hairy leukoplakia, thrush (candida), purple lesions (KS)
- ◆ Nodes: Lymphadenopathy
- ◆ Chest: Dullness, rales, rubs (PCP, TB, CMV), murmurs, gallops
- ◆ Abdomen: Hepatomegaly, splenomegaly
- ◆ Genital (include full pelvic and rectal exam): Ulcers (herpes, chancroid, syphilis), chancroid, condylomata (HPV, syphilis), discharge (candida, STDs), Pap smear (dysplasia)
- ◆ Neurological: Cognitive deficits, cranial nerve defects, sensory or motor changes, weakness (HIV, toxoplasma, cryptococcus)

d) Additional laboratory screening that includes

- ◆ HIV culture and antigen assay where available
- ◆ CBC, differential, platelets
- ◆ Immunological status assessment, e.g., CD– or T–cell counts
- ◆ Serological tests for syphilis, GC, chlamydia—repeat screening as indicated
- ◆ PPD with antigen panel

TIP 2: Pregnant, Substance–Using Women

- ◆ Possible freezing of serum sample for later testing of titers for toxoplasma, CMV, and cryptococcus

2 Provide medical treatment for HIV–related conditions. Medical treatment should be provided in consultation with HIV specialists and consistent with current recommendations. Women with CD4 counts of less than 200mm³ should be placed on an antiviral agent and given appropriate prophylaxis.²⁴

- ◆ Aggressively evaluate and promptly treat any conditions diagnosed.
- ◆ If laboratory studies indicate significant immuno–suppression, consider prophylactic treatment against opportunistic infections.
- ◆ Consider the use of an anti–viral agent (zidovudine [AZT]).
- ◆ Consider other experimental treatment guidelines and refer the patient as indicated.

3 Provide obstetric management. Obstetric management should include all of the usual obstetric practices, with special attention to the following:

a) Antepartum care

- ◆ Provide close prenatal followup.
- ◆ Obtain interim history and conduct a physical examination to include HIV–related elements.
- ◆ Repeat serological tests for syphilis, GC, chlamydia, and other laboratory tests as clinically indicated.
- ◆ Assess immunological status every trimester, or more often if the patient develops an illness or if a declining trend is noted.
- ◆ Perform a fetal assessment if clinically indicated. To prevent possible HIV transmission and nosocomial infection, avoid invasive procedures if possible, but not at the expense of accepted standards of care (e.g., genetic amniocentesis).
- ◆ Discuss with the patient the need to share pertinent medical information with her other direct care providers and those of her infant.
- ◆ Ensure primary care and specialized pediatric followup.
- ◆ Ensure involvement in an alcohol and other drug treatment program.
- ◆ Reinforce the need to practice safer sex.
- ◆ Recommend involvement in an HIV/AIDS support group.

b) Intrapartum care

- ◆ Follow universal precautions for blood and body fluids and OSHA standards that include
 - ◆ Gowns, masks, eye protection, and double gloves for deliveries
 - ◆ Gloves for invasive procedures, changing soiled linens or dressings, handling the placenta and cord, and handling the neonate prior to the first bath
 - ◆ Mechanical or bulb aspiration of the newborn: Avoid mouth–operated aspiration traps
- ◆ Utilize fetal monitoring as indicated.
- ◆ There is no specific indication for Caesarean delivery.

c) Postpartum care

- ◆ Breastfeeding is not recommended; otherwise, encourage mother–infant bonding.
- ◆ Ensure comprehensive medical followup for the woman, infant, and family members as indicated.
- ◆ Educate the woman to care for the infant's special needs.

- ◆ Ensure followup in an alcohol and other drug treatment program.
- ◆ Encourage use of an appropriate family planning method.

Guideline 14 -- Drug–Exposed Neonates [25](#)

Effects on the Neonate From Maternal Use of Heroin, Methadone, and Cocaine

The following guidelines pertain to three substances that have a great impact on the health of infants -- heroin, methadone, and cocaine. Rapid recognition, careful assessment, and appropriate treatment of abstinence symptoms in infants exposed in utero to one or more of these substances will contribute to a satisfactory initial and long–term outcome for these neonates.

Programs dealing directly with drug–exposed neonates will find more detailed information on assessment and treatment in a protocol being developed by the Center for Substance Abuse Treatment. This detailed guideline is titled *Drug–Exposed Infants Treatment Improvement Protocol (TIP)*

Neonatal Effects of Heroin

The effects of heroin on the neonate may include the following:

1 Low birth weight. The low birth weight is due primarily to symmetric intrauterine growth retardation. In addition, low birth weight may be secondary to prematurity.

2 Meconium aspiration. Meconium aspiration may be caused by hypoxia in association with antepartum or intrapartum passage of meconium secondary to fetal stress.

3 Sexually transmitted diseases. Maternal lifestyle issues predispose the infant to congenital syphilis, gonorrhea, hepatitis B, and HIV infection.

4 Neonatal abstinence syndrome. Neonatal ab–stinence syndrome occurs in about 60 to 80 percent of heroin–exposed infants. Its onset is usually within 72 hours of birth, with a high mortality if the syndrome is severe and untreated. Premature infants have been reported to show a less severe abstinence syndrome following opiate exposure.

The syndrome involves the central and autonomic nervous systems, gastrointestinal system, and pulmonary system. Central nervous system (CNS) signs include irritability, hypertonia, hyperreflexia, abnormal suck, and poor feeding. Seizures are seen in 1 to 3 per–cent of infants. Gastrointestinal signs include diarrhea and vomiting. Respiratory signs include tachypnea, hyperpnea, and respiratory alkalosis. Autonomic signs include sneezing, yawning, lacrimation, sweating, and hyperpyrexia. If the infant is hypermetabolic, the postnatal weight loss may be excessive and subsequent weight gain suboptimal.

5 Delayed effects. Delayed effects include subacute withdrawal with symptoms such as restlessness, agitation, irritability, and poor socialization that may persist for 4 to 6 months. There is an increased incidence of Sudden Infant Death Syndrome (SIDS). Behavioral and developmental consequences, such as hyperactivity and poor school performance, have been inconsistently reported. Studies on these behavioral and developmental consequences are difficult to interpret because of poor long–term followup and inability to control for postnatal environmental

influences.

6 No effect. It is important to understand that many infants will show no adverse effects from maternal use of heroin. Many women will know this, based on their own experience or that of other women. Providers should acknowledge this reality so that women will not use this knowledge to discount their advice.

Treatment for Neonatal Effects of Heroin

Neonatal abstinence syndrome is best treated with a substitute opioid such as paregoric or with a CNS depressant such as phenobarbital.

Neonatal Effects of Methadone

The effects of methadone on the neonate may include:

1 Abstinence syndrome. The neonate suffers an abstinence syndrome similar to that seen with heroin. The abstinence syndrome for methadone usually starts later and lasts longer (due to longer half life) than for heroin. Central nervous system signs are prominent. Electroencephalograms (EEGs) are abnormal in about 50 percent of the infants. Seizures occur in about 7 percent of the infants, tend to occur between days 7 and 14, and are primarily myoclonic. Abstinence is more variable in onset and course than with heroin. Exposure to both heroin and methadone may produce a biphasic or atypical pattern of withdrawal.

2 Fetal growth and reduced perinatal mortality. Multiple risk factors may contribute to poor fetal growth in methadone–exposed children. Although birth weight and head size may be reduced, fetal growth is generally more normal than with heroin, and may be related to the first trimester dosage of methadone. Reduced perinatal mortality compared with heroin use may be due to positive changes in lifestyle, including increased prenatal care.

3 Postnatal effects. The postnatal weight change pattern may be suboptimal if the infant is hypermetabolic. A thrombocytosis may develop during the second week of life and peak at about the eighth week before returning to normal. There is biochemical evidence of hyperthyroidism in some infants.

4 Breastfeeding. Breastfeeding is encouraged if the woman is HIV–seronegative and not abusing other drugs.

5 Delayed effects. Delayed effects may include an increased incidence of SIDS. Long–term followup studies are incomplete and difficult to interpret. Generally, infants have performed within the normal range and no major neurologic or developmental disabilities have been reported.

6 No effect.

Treatment for Neonatal Effects of Methadone

Treatment with either paregoric or phenobarbital is effective.

Neonatal Effects of Cocaine

The effects of cocaine on the neonate may include the following:

1 Effects at birth. Generally, lower birth weights, head circumferences, and increased rates of prematurity have been reported compared to controls.

2 No abstinence syndrome. There is no clinically documented neonatal abstinence syndrome for cocaine as is seen with the opioids.

3 Neonatal dysfunction. Neonatal CNS dysfunction includes transient irritability, abnormal sleeping patterns, tremors, hypertonia, and lability of state. One study has reported that about 50 percent of the infants have abnormal EEGs in the neonatal period with reversion to normal within the first few months of life. Infrequent cerebral infarctions and seizures have been reported. Electroencephalographic abnormalities have been reported inconsistently. In addition, information on congenital malformation has been inconclusive.

4 Breastfeeding. Most drugs pass through breast milk. The amount of cocaine that passes to the infant in the breast milk reinforces the neurotoxic syndrome.

5 Delayed effects. Only preliminary long–term followup studies have been reported. A number of studies have suggested that incidence of SIDS is increased.

6 No effect. It is important to understand that many infants will show no adverse effects from maternal use of cocaine. Many women will know this based on their own experience or that of other women. Providers should acknowledge this reality so that women will not use this knowledge to discount their advice.

Treatment for Neonatal Effects of Cocaine

If treatment is indicated, a short course of phenobarbital is recommended. Use of the Brazelton Neonatal Behavioral Assessment Scale²⁶ is encouraged.

Guideline 15 -- Urine Toxicology Considerations [27](#)

Considerations for Urine Toxicology
1 Specific urine toxicology techniques
2 Factors contributing to false–negative and false–positive test results
3 Approximate duration that drugs can be detected in urine
4 Alternate methods of screening for drug abuse

Use of Urine Toxicology

Urine toxicologies are recommended for pregnant women in order to provide optimal, comprehensive medical care and alcohol and other drug treatment. They are, however, only an adjunct to good history–taking. The use of urine toxicology can reduce morbidity that may result from misdiagnosis and the subsequent use of inappropriate medications, such as betamimetic tocolytics for premature labor. The particular drugs for which a patient should be screened will depend on the specific geographic location and the substances most prevalent in that area.

Specific State laws may dictate approaches to the use of urine toxicologies. Test results in some States and localities are used for other than medical purposes and may have legal implications (see [Chapter 3](#) — *Legal and Ethical Guidelines for the Care of Pregnant, Substance–Using Women*).

A toxicology test that is positive for drugs and/or alcohol — whether it is a "true" positive or a "false" positive — may have extremely negative effects on women, such as criminal detention or possible loss of child custody. Because of this, the following guidelines recommend that urine drug testing be done only in cases where it is absolutely necessary. Since current urine toxicology techniques vary in their specificity (the extent to which they produce false–positive results), the Consensus Panel recommends that the alcohol and other drug abuse field adopt the standards used for urine drug testing in the workplace. These standards are contained in *Mandatory Guidelines for Federal Workplace Drug Testing Programs*, published in the *Federal Register* on April 11, 1988. Training in these new tests and procedures should be conducted for all pertinent personnel.

Issues of Informed Consent

Important issues related to urine toxicology include the need to uphold the civil rights of the patient and to ensure that there is informed consent for the procedure. Testing a woman for illegal drugs in the absence of medical indications may be discriminatory, violate the woman's civil rights, and constitute an unlawful search and seizure. The woman has the right, whenever possible, to be informed of the risks, potential ramifications, and benefits of urine toxicology testing.

There may be times when informed consent cannot be obtained because of medical considerations. If urine is being tested for forensic rather than medical reasons, a separate consent should be obtained. Before testing neonates, informed consent should be obtained from the mother.

Successful treatment for alcohol and other drug abuse depends on a positive therapeutic relationship between the patient and her caregivers. Informed consent helps foster and is an integral part of a trusting and cooperative therapeutic relationship. Urine testing is just one of a variety of ways of identifying a woman who is in need of treatment services. Urine toxicology should never be the only reason for providing these services to a woman.

Indications for Screening of Pregnant Women

Caregivers should ask questions regarding the use of alcohol, other drugs, and medications as a routine part of any medical history. Every effort should be made to identify which drugs are used; the frequency, pattern, and duration of use; last dosage; and the routes of administration. It should be made clear to the patient that this information is necessary for proper medical management of the following:

- ◆ Potential withdrawal, medical withdrawal, education, and alcohol and other drug treatment
- ◆ Physical manifestations attributable to alcohol and other drug use
- ◆ Potential interactions with other drugs or medications that may be given
- ◆ Fetal and neonatal effects

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A urine and/or blood toxicology screen is necessary only in those circumstances where a history of drug use cannot be reliably obtained, as when a patient is comatose or confused, or when a discrepancy exists between the clinical findings and the drug thought to have been ingested. Caregivers should obtain informed consent and follow a closely monitored specimen collection procedure and chain of custody.

Reports indicate that a pregnant woman's race, ethnicity, and socioeconomic status have an overwhelming impact on whether or not she is screened. The following are indications used by some programs to screen a pregnant woman for drug use:

- ◆ History of alcohol and other drug use
- ◆ Loss of custody of other children
- ◆ No prenatal care
- ◆ Altered mental state (e.g., incoherent, unconscious, lethargic, combative)
- ◆ Preterm delivery; preterm labor; preterm, premature rupture of membranes
- ◆ Third trimester vaginal bleeding (e.g., placental abruption)
- ◆ Physical evidence of alcohol and other drug use (e.g., track marks)
- ◆ Signs and symptoms of intoxication or withdrawal

A pregnant woman who is known to be using drugs, whether through self–report or positive toxicology, should be treated for the acute medical condition and referred for alcohol and other drug treatment. In addition, a positive history of drug use or urine toxicology may suggest the need for a newborn toxicology screen, which may be ordered and obtained after delivery. In a newborn, a positive toxicology for nonprescribed drugs suggests that a social work evaluation be done.

Testing Urine for Drugs

1 Specific urine toxicology techniques. Drug tests are most commonly performed on urine, since most drugs and their breakdown products are excreted in the urine in higher concentrations than in the blood. While alcohol can be detected in the urine, testing of blood or breath is more widely used.

- ◆ **Screening tests:** These are rapid, sensitive tests that may be lacking somewhat in specificity (i.e., there may be false–positive results) and may require confirmatory testing.
 - ◆ Thin Layer Chromatography (TLC). TLC is a practical, economical, and sensitive method for detecting drugs in urine specimens. Examples of drugs detectable with TLC and acid hydrolysis include heroin (detected as morphine), morphine, amphetamines, barbiturates, codeine, cocaine, glutethimide (Doriden), methadone, methaqualone (Quaalude), phenothiazine, and quinine.
 - ◆ Immunoassay techniques. A variety of immunoassays and equipment are available to screen for drugs of abuse. Laboratories may use enzyme immunoassays (e.g., Enzyme Multiplied Immunoassay Technique [EMIT]), radioimmunoassays, and fluorescence polarization immunoassays. Examples of drugs detectable by immunoassays include opioids, amphetamines, cocaine metabolites, and phencyclidine (PCP).
- ◆ **Confirmatory tests:** These are highly specific tests (i.e., false–positive results are rare when the tests are performed correctly).
 - ◆ Gas Chromatography/Mass Spectrometry: GC/MS is an example of a confirmatory test that allows for quantitative analysis. Drugs detectable with GC/MS include opioids, amphetamines, cocaine metabolites, and phencyclidine, among others.

2 Factors contributing to false–positive and false–negative test results. How samples are collected and handled is critical for avoiding false–positive and false–negative test results.

TIP 2: Pregnant, Substance-Using Women

- ◆ **Collecting samples:** Improperly preparing the surfaces through which test materials are to be collected (e.g., using anesthetic lubricants for urinary catheters, cleansing skin with isopropyl alcohol) may cause false-positive results.
- ◆ **Handling samples:** Mislabeling, switching, and dilution of samples may occur prior to testing.

Intermittent injections and diluted urine can result in false-negative results. False-positive TLCs, although rare, may occur when spots of identical coloring and motility caused by different drugs are seen on the chromatograph. Legally prescribed cough medications may yield a positive TLC for morphine, since a portion of the codeine is transformed into morphine in the body. In addition, both false-negative and false-positive results can occur from certain foods a woman might ingest (e.g., poppy seeds).

If the patient has a bacterial urinary tract infection, a false-positive reaction with EMIT may occur with each test, indicating polydrug use. When there is an actual or potential urinary tract infection, the presence of lysoenzyme should be determined to rule out the possibility of a false-positive reaction. Finally, the expertise of the testing laboratory may determine the reliability of the results. Even the best laboratories have a relatively high incidence of nonreproducible results.

3 Approximate duration that drugs can be detected in urine. The following table shows the approximate duration for detecting a number of drugs in the urine of non-pregnant adults.²⁸

Amphetamines	48 hours
Alcohol	12 hours
Barbiturates	10 to 30 days
Valium (Diazepam)	4 to 5 days
Cocaine	24 to 72 hours
Heroin (detected as Morphine)	24 hours
Marijuana	3 to 30 days
Methaqualone (Quaaludes)	4 to 24 days
Phencyclidine (PCP)	3 to 10 days
Methadone	3 days (depending on the dose)

Elimination times differ in neonates and adults. The elimination of certain fat-bound substances is unpredictable and may be enhanced by making the urine acidic. The length of time for detecting drugs in the urine depends to a great extent on dose and duration of use.

4 Alternate methods of screening for drug use. Other methods of screening for prenatal use of drugs are not readily available and may not be acceptable in a court of law. They include

- ◆ Newborn meconium
- ◆ Radioimmunoassay of maternal hair

Guideline 16 -- Nutritional Considerations

Considerations in Providing Nutritioin Services
<ol style="list-style-type: none"> 1 Nutrition assessment services 2 Nutrition care plan 3 Nutrition counseling 4 Special areas of concern

Possible Effects of Selected Substances on the Fetus

Alcohol and other drug use is often associated with poor nutrition. This association can result in serious health consequences for pregnant, substance–using women and their infants. Scarce financial resources and a lack of knowledge about the elements of good nutrition may further compound these effects. The following information describes the possible effects of maternal use of cigarettes, alcohol, marijuana, heroin, and cocaine. It is possible that infants will show no adverse effects from maternal use of these or other drugs. The use of other drugs in addition to those listed below, as well as polydrug use, may also impact the health of women and their infants. There are clinical recommendations for improved nutrition and guidelines for nutritional assessment and education.

Cigarette Smoking

Possible effects of maternal smoking during pregnancy. Decreased birth weight is the most consistently observed effect of maternal smoking on infants. This decrease in infant birth weight is on average 200 g. A recent review of the literature on the determinants of low birth weight has, like previous reviews, concluded that cigarette smoking is by far the single most important modifiable factor responsible for fetal growth retardation in developed countries.

Possible nutrition–related effects of smoking. Cigarette smoking may affect maternal nutrition and, consequently, fetal nutrition, in two important ways: (1) the increased metabolic rate in smokers can lead to lower availability of calories; and, (2) the exposure to tobacco may increase iron requirements and decrease the availability of certain nutrients such as vitamin B12, amino acids, vitamin C, folate, and zinc. In smokers, uteroplacental blood flow restricts nutrient and oxygen flow to the fetus.

Alcohol

Possible effects of excessive maternal alcohol consumption during pregnancy. Alcohol is now recognized as a potent teratogen. Infants of mothers who consume excessive amounts of alcohol during pregnancy may suffer from Fetal Alcohol Syndrome or Fetal Alcohol Effects (see [Guideline 3](#) -- *Medical Withdrawal From Alcohol* for more information).

Possible nutrition–related effects of alcohol consumption. Alcohol consumption may be related to decreased dietary intake, impaired metabolism and absorption of nutrients, and altered nutrient activation and utilization. Interactions between alcohol and deficiencies of such nutrients as protein and zinc may also play a role in the etiology of alcohol–related effects on the fetus.

Although there is no convincing evidence that nutritional supplementation will counteract the adverse effects of alcohol, standard prenatal vitamins plus folate, B12, and iron supplementation should be prescribed. However, since alcohol abuse has clearly been shown to be detrimental to the fetus, nutritional supplementation should not replace

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efforts to encourage women to limit or eliminate alcohol intake during pregnancy.

Marijuana

The marijuana of the 1990s is very different from the drug that was available in the 1960s. Today there is more THC (tetrahydrocannabinol) in marijuana because of plant hybridization.

Possible effects of maternal marijuana use during pregnancy. Decreased birth weight and body length are the most commonly noted effects among infants of mothers who use marijuana during pregnancy.

Possible nutrition–related effects of marijuana use. There are conflicting study results on the possible nutrition–related effects of marijuana use. Some studies indicate weight gain by infants, other studies show less weight gain, while still others show no difference between infants whose mothers used marijuana and infants whose mothers did not use the drug.

Heroin

Possible effects of maternal use of heroin during pregnancy. Decreased birth weight, prematurity, and intrauterine growth retardation are among the effects on the fetus of maternal heroin use during pregnancy. Medical complications from the use of dirty needles may also ensue, such as abscesses, bacterial endocarditis, and hepatitis (see [Guideline 4](#) –– *Opioid Stabilization* for more information).

Possible nutrition–related effects of heroin use. These effects include poor nourishment, with vitamin deficiencies, iron deficiency anemia, and folic acid deficiency anemia. Many of the effects on pregnancy and the fetus can be mitigated in a comprehensive methadone maintenance treatment program.

Cocaine

Possible effects of maternal use of cocaine during pregnancy. Spontaneous abortion, intrauterine growth retardation, premature labor, and abruptio placentae are among the effects of maternal use of cocaine. Information on the congenital effects of maternal cocaine use are inconclusive (see [Guideline 5](#) –– *Cocaine Withdrawal* for more information).

Possible nutrition–related effects of cocaine use. As is true for marijuana, little is known about the nutrition–related effects of cocaine use. Cocaine's vasoconstrictive ability may lead to fetal hypoxia and reduced nutritional supply to the fetus. Since cocaine, like amphetamines, acts as an appetite suppressant, an inadequate maternal diet may play a role in retarding growth in fetuses of cocaine abusers.

Clinical Recommendations

Prevention and intervention. The highest priority should be given to efforts to prevent or stop alcohol and other drug use by pregnant women. There is clear evidence that cigarette smoking and alcohol and other drug use adversely affect the health of the mother and fetus.

Nutrition counseling and intervention. Since nutritional deficiencies can be expected, especially among heavy abusers of alcohol and other drugs, diet counseling, referral to a social worker, and other intervention strategies to improve food intake are recommended.

Multivitamin–mineral supplementation. Because heavy abusers of alcohol and other drugs may have difficulty in taking the steps needed to improve their dietary intake, the use of multivitamin–mineral supplements is recommended.

Nutritional Assessment and Education Guidelines

More than 40 different nutrients are needed for good health. Essential nutrients are the amino acids from protein, vitamins, minerals, fatty acids, and calories obtained from carbohydrates, protein, and fat. Since no single food supplies all these nutrients in the amounts needed, it is recommended that women eat a variety of nourishing food daily. To plan meals and snacks, foods are divided into five groups: (1) vegetables; (2) fruits; (3) breads, cereals, rice, and pasta; (4) milk, yogurt, cheese, and other dairy products; and (5) poultry, fish, lean meat, dry beans and peas, eggs, and nuts.

The 1990 edition of the *Dietary Guidelines for Americans* recommends the following:

- ◆ Eat a variety of foods
- ◆ Maintain healthy weight
- ◆ Choose a diet low in fat, saturated fat, and cholesterol
- ◆ Choose a diet with plenty of vegetables, fruits, and grain products
- ◆ Use sugar only in moderation
- ◆ Use salt and sodium in moderation

1 Provide nutrition assessment services for all patients to identify and assess for

- ◆ Nutritional high–risk status
- ◆ Probable food deficiencies
- ◆ Probable food excesses
- ◆ Interest in breastfeeding
- ◆ Eligibility and certification for food supplement programs such as Women, Infants, and Children (WIC) and Food Stamps. If the woman has children, include school breakfast and lunch programs, summer feeding programs, and child care food programs.
- ◆ Smoking status
- ◆ Lactose intolerance
- ◆ Underlying eating disorder. It is not uncommon for substance–abusing women to have an underlying eating disorder — a possibility that needs to be considered as a woman stops using drugs and/or alcohol. Appropriate referrals for additional counseling may be needed.

2 Develop a nutrition care plan that describes the nature of the diet and counseling needs of the patient.

3 Provide nutrition counseling to

- ◆ Teach about the appropriate diet, taking into account the patient's cultural food patterns, access to food, and lifestyle.
- ◆ Teach management of the food budget and meal planning as needed.
- ◆ Explain the WIC Program and other federally funded food assistance and nutrition programs.
- ◆ Provide nutrition education.
- ◆ Make referrals for smoking cessation counseling, as indicated.

4 Address special areas of concern. All patients should receive instruction and assistance regarding the following:

Poor diet pattern

- ◆ Encourage the patient to eat nutritious foods as snacks, since these provide an important source of nutrients for a woman who does not eat three meals a day.
- ◆ Educate the patient on nutritious snacks, which may include, but are not limited to milk, cheese, yogurt, crackers, popcorn, fruit, carrot sticks, and leftover meat.

Poor quality diet and eating problems

- ◆ Instruct the patient on recommended servings of each food group and reinforce healthy choices, including foods that are culturally acceptable and are a part of the woman's diet.
- ◆ Recommend a decrease in "empty–calorie" (high in calories and lacking or low in essential nutrients) and high–fat foods.
- ◆ Recommend a decrease in or avoidance of stimulants such as caffeine (e.g., coffee, tea, and chocolate).

Underweight

- ◆ Assess the patient's attitude toward weight gain and obtain a past and current history of eating disorders. Assess for tobacco intake and encourage the patient to decrease use. Encourage the patient to discontinue stimulants such as cocaine that inhibit weight gain.
- ◆ Assess the patient's appetite, looking for
 - ◆ Poor appetite as a result of stress. A patient may need to have major stress factors handled before her underweight status can be successfully resolved.
 - ◆ Poor appetite as a symptom of protein, calorie, vitamin B, or vitamin C deficiency. A multivitamin supplement should be provided.
- ◆ Make dietary recommendations that include
 - ◆ A basic diet. The basic diet should include at least all recommended servings from each of the five food groups.
 - ◆ Additions to the basic diet. Additional food from any of the five food groups should be added to the diet.
 - ◆ High–density foods. Nutritious, high–density foods should be added as part of the diet (e.g., pizza, cheese, peanut butter, ice cream, and whole milk).
 - ◆ An eating schedule. The underweight patient should be encouraged to eat frequently throughout the day, with a goal of five to six feedings.

Overweight

- ◆ Assess the patient's attitude about being overweight and discuss with the patient ways to
 - ◆ Follow the five food group plan of eating, dividing the plan into at least three meals and two snacks.
 - ◆ Increase intake of fresh fruits and vegetables, whole–grain cereals, and dried beans.
 - ◆ Eliminate or decrease intake of "empty–calorie" food.
 - ◆ Decrease fat intake.
 - ◆ Avoid fad diets.
 - ◆ Review the patient's family history of diabetes and her diabetes screen during pregnancy.
 - ◆ Encourage the patient to increase moderate exercise, such as walking and other non–weight–bearing forms of exercise. Increased exercise is at least as important as dietary changes in weight maintenance.
 - ◆ Discuss goals. For an overweight patient, the goal is weight maintenance and minimal weight gain. *Weight loss is discouraged.* Periodic evaluation of urine ketones is a helpful monitoring method.
 - ◆ Follow up as necessary.

Potential vitamin deficiency

- ◆ Assess the patient's methods of preparing foods to uncover potential vitamin deficiencies caused by the preparation process.
- ◆ Determine the possible need for specific multivitamin supplements.
- ◆ Follow up as necessary.

Chapter 3 -- Legal and Ethical Guidelines for the Care of Pregnant, Substance–Using Women

Overview

Caring for pregnant, substance–using women and their infants can present complex legal and ethical issues concerning confidentiality, reporting, and the custody and protection of children. Service providers must understand and be prepared to address all aspects of these issues. To do so, they must be trained in the areas covered by these guidelines. This training should be developed at the Federal level and include examples that illustrate the applicability of the guidelines in a variety of environments.

The first level of training should be provided by the Federal Government to staff of State alcohol and other drug programs, maternal and child health agencies, child welfare offices, and child protective services agencies. Once trained, these staff will be better prepared to evaluate and recommend improvements to programs serving pregnant, substance–using women.

States, in turn, should offer training to local program staff. This training should inform service providers of new or clarified guidelines concerning the care of pregnant, substance–using women, and provide them with tools to use to document compliance with the guidelines.

An additional level of training should include those who interface with and are involved in the court process. Judges must be a priority target group for training, and attorneys, probation officers, and other court personnel should be encouraged to participate as well.

Training at all levels must be ongoing and updated at regular intervals to ensure that current information is available. Cross–training of health care professionals, child welfare specialists, and judges and attorneys involved in family law is highly desirable. New training funds are needed from the Federal level to ensure compliance with these guidelines.

Scope of the Guidelines

The following guidelines address Federal and State confidentiality and reporting regulations, training in ethical and legal issues, and protective services for children.

The Consensus Panel believes that criminal penalties should not be imposed on women based solely on their use of alcohol and other drugs during pregnancy. In the event a substance–using woman is incarcerated or detained for a criminal offense, she should be given access to treatment services. Furthermore, pregnancy should never be the pretext for changing sentences given to women who commit crimes.

Guideline 17 -- Confidentiality and Reporting

Jurisdictions may require that authorities be notified when an infant is born drug dependent or when an infant is exposed to alcohol and other drugs at the time of birth. When patient information is involved, treatment programs must follow Federal laws and regulations concerning the confidentiality of drug and alcohol treatment records.²⁹ State laws vary considerably, so overall national guidelines concerning confidentiality and the reporting of patient information are not possible. In circumstances where State laws are in conflict with Federal confidentiality regulations, the Federal regulations prevail.

All staff of alcohol and other drug treatment programs must be knowledgeable about Federal and State laws concerning confidentiality and patient records and how these laws affect their practices and the patients they serve. Treatment staff must be trained to understand and handle any conflicts between these laws and to recognize how such conflicts affect the delivery of services in their particular communities. Similarly, patients in alcohol and other drug treatment programs must be told about the extent of the confidentiality protection provided by law, and when this protection does not exist.

Impact of Confidentiality and Reporting Laws on Women

State and local laws that require maternal alcohol and other drug use and fetal drug exposure to be reported to authorities have a significant impact on women and their children. These reports can be the impetus to remove children from their mothers' care and have them placed in protective custody or foster care. Knowing that such a report is in the offing, some women may forego their prenatal care or the follow–up services they need. The closer communities move toward measures that detain pregnant, substance–using women, the more punitive, detrimental, and potentially dangerous it becomes for these women and their children.

Federal Regulations on Confidentiality of Alcohol and Other Drug Treatment Records

The following guidelines explain Federal regulations concerning the confidentiality of alcohol and other drug referral and treatment information.

Prohibition of Disclosure

The Federal confidentiality regulations prohibit disclosure of patient information as follows:

- ◆ Except under certain limited conditions, Federal confidentiality regulations prohibit the disclosure of records or other information concerning any patient in a federally assisted alcohol or drug abuse program.³⁰
- ◆ The prohibition on unauthorized disclosure applies whether or not the person seeking information already has the information, has other means of obtaining it, enjoys official status, has obtained a subpoena or warrant, or is authorized by State law.³¹
- ◆ Any State provision that would permit or require a disclosure prohibited by the Federal rules is invalid. However, State laws may require greater confidentiality than the Federal regulations.³²
- ◆ Re–disclosure of patient–identifying information is prohibited unless such disclosure is made in compliance with Federal confidentiality regulations.

Exceptions to the Prohibition of Disclosure

Although the general rule is that patient–identifying information may not be disclosed, the regulations set out a number of conditions permitting limited disclosures with patient consent and a very few circumstances in which

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disclosures may be made without patient consent. Each of these conditions or circumstances has its own requirements and limitations. In general, permitted disclosures are those made as follows:

- ◆ With the written informed consent of the patient
- ◆ Pursuant to internal program communications
- ◆ Pursuant to a medical emergency
- ◆ In response to a court order following a court hearing in which disclosure is authorized
- ◆ Pursuant to a crime at the treatment program or against program personnel
- ◆ For research or audit purposes
- ◆ In the course of reporting child abuse
- ◆ Pursuant to a qualified service organization agreement
- ◆ In response to a request for nonpatient identifying information

State Laws on Confidentiality of Alcohol and Other Drug Treatment Records

A variety of State confidentiality laws may affect how services are provided to pregnant, substance–using women. These laws may control the release of medical records; limit the ability of persons to testify in court based on information obtained when providing professional services (testimonial privilege); or prohibit disclosure of information regarding specific diseases, such as HIV and drug use. Service providers and alcohol and other drug treatment staff should consult with local counsel to determine which State confidentiality laws affect their practices, and develop protocols and training programs to help ensure that these laws are followed.

Training on Confidentiality and Reporting

All individuals who provide services to pregnant, substance–abusing women must understand Federal regulations on confidentiality and receive training on State and local laws, regulations, and reporting requirements.

- ◆ Providers of health care and social services include, but are not limited to, physicians, social workers, nurses, psychologists, psychiatrists, child protective service workers, teachers, child care workers, and alcohol and other drug counselors.
- ◆ Providers of health care and social services must be trained to understand the differences among Federal, State, and local laws regarding confidentiality of information pertaining to alcohol and other drug treatment, medical care, mental health care, child abuse, and HIV/AIDS.
- ◆ Providers of health care and social services must know the relevant reporting laws pertaining to child abuse and neglect. This knowledge should include who is mandated to report child abuse and neglect, under what circumstances they are to report child abuse and neglect, and the penalty for not reporting such abuse and neglect.
- ◆ Programs serving pregnant, substance–using women are often part of community–based organizations or health care clinics. Staff of these programs must be aware of confidentiality laws and the right to informed consent as it relates to alcohol and other drug treatment.
- ◆ Cross–training concerning confidentiality and reporting must be given to individuals who may not understand relevant laws. This includes individuals involved in medical, legal, educational, alcohol, and other drug treatment, and social service fields.

Patient Records and the Courts

Service providers and pregnant, substance–using women should be concerned with how courts handle patient records and the circumstances under which courts can order medical and psychiatric evaluations.

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- ◆ Once records go to adult court they become public record. Individuals concerned about court records and subpoenas need to understand the laws of their State. It should be noted that, in most but not all States, juvenile records are confidential.
- ◆ Courts can order an evaluation to determine if a woman needs treatment for alcohol and other drug abuse, to make a diagnosis, and to make a referral for treatment or services. This type of court–ordered evaluation, with the written informed consent of the woman, may be shared with those court officials involved in the disposition of her case.

Communicating With Patients About Confidentiality and Reporting

Providers of health care and social services should explain and discuss confidentiality and reporting laws with patients when they first seek care.

- ◆ The Federal confidentiality regulations require treatment programs to inform pregnant, substance–using women about their right to confidentiality, as well as their right to information about laws concerning reporting and court involvement.
- ◆ Pregnant, substance–using women should be informed by service providers about Federal, State, and local confidentiality and reporting laws, and how such laws will affect the delivery of services to them. Relevant areas of law may include the reporting of child abuse to appropriate authorities, custody consequences, and how courts may treat information contained in their records.
- ◆ No information that would identify a woman as an alcohol and other drug abuser or information from her treatment record may be disclosed to anyone outside the treatment facility without her written informed consent.
- ◆ When written informed consent is obtained, it must be time–limited, content–specific, and signed by the woman, in keeping with the requirements of the Federal confidentiality laws. A copy of the written informed consent document must be offered to the woman.

Confidentiality of Information on Infants and Children

A woman has the right to control the release of confidential records and information pertaining to her infant.

- ◆ In order to release confidential information, the written informed consent of the parent or legal guardian must be obtained.
- ◆ The written informed consent must meet all previously stated legal requirements controlling the release of confidential information.
- ◆ When a parent refuses to give consent, is incompetent to give consent, or cannot be found, the court may be requested to appoint a legal guardian for the child. This guardian is authorized to make medical decisions for the child, including the release of confidential information.
- ◆ Parental consent is not necessary when excused by law, which may vary by State. In many States, exceptions to blanket rules that require parental consent are made for medical emergencies and to report child abuse and neglect.

Unauthorized Release of Information

Nonconsensual and unauthorized release of confidential information may harm the child or mother and may subject the health care and social service provider to civil or criminal liability. To avoid this, agencies should develop protocols and procedures governing the release of information and train employees in their use. Agencies should also provide staff with access to counsel who are knowledgeable in the area of confidentiality. The following information, at a minimum, should be covered in protocols and training:

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- ◆ Elements of and procedures for obtaining written informed consent
- ◆ Situations where consent for the release of information is not necessary
- ◆ Whether to notify the mother when information is permitted to be and is released without her consent
- ◆ How to respond to a request for information; for example, how to avoid responding in a manner that inadvertently and inappropriately confirms the existence of a medical or drug abuse condition
- ◆ How to limit disclosures to the information necessary and relevant for the provision of services to the mother or child, or to satisfy legal grounds for nonconsensual disclosure.

Guideline 18 -- Child Protective Services

Child protective services agencies are mandated to help keep families together. Some women who enter alcohol and other drug treatment programs will be in contact with their local child protective services agency. These women may not view this involvement positively. In turn, many alcohol and other drug treatment programs find it difficult to deal with child custody and placement issues. As a result, some treatment programs exclude women who are or could potentially be involved with a child protective services agency. Until this circumstance changes, the doors to alcohol and other drug treatment will continue to close on pregnant, substance–using women — the very women who need to be admitted.

Women should not be barred from treatment or discriminated against because they are pregnant. It must be recognized that the family circumstances for women may be fluid, rather than static. Children may be periodically absent and subsequently return to the home. Furthermore, alcohol and other drug use is a chronic relapsing disease. Relapse prevention must be an important part of any treatment approach.

Cross–service training of alcohol and other drug treatment staff and child protective services personnel should be supported. The aim of this joint training is to promote a better understanding of the issues common to both groups and to promote a strong working relationship between these service providers.

The following guidelines address intervention and assessment, placement of children in temporary foster homes, and development of permanent placement plans.

Intervention and Assessment

Federal Laws

All health care and social service providers should be aware of the relevance of Public Law 96–272, the Child Welfare Act of 1980, for persons eligible for Aid to Families with Dependent Children (AFDC), as well as Public Law 95–608, the Indian Child Welfare Act of 1978, for Native American families. Responsible efforts should be made to keep children with the biological parents in their own home. When children are removed to temporary foster placement, reasonable efforts should be made to reunite the families.

State Laws

State laws should be understood as those laws that pertain to, build on, and are applicable to Public Law 96–272 and Public Law 95–608.

Agreements on Child Custody

When some women enter an alcohol and other drug treatment program, they will already have worked out an agreement about what must be done to keep their children. A treatment program should not discriminate against

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women on the basis of such agreements. However, women should also be informed of the legal risk they face with respect to program reporting policies. Information exchanged between the treatment program and child protective service agency must adhere to the guidelines on confidentiality.

Intervention With Children

If the child protective services worker, in attempting to work with the family, finds that the children may be at risk of imminent harm, then court intervention may become necessary (see Placement in a Temporary Foster Home below).

Anti–Discrimination Laws

Treatment programs must comply with other laws, such as the Americans With Disabilities Act and the Federal Rehabilitation Act of 1973, as amended. These laws prohibit discrimination in the use of public accommodations, including treatment programs.

Placement in a Temporary Foster Home

Involvement of the Court

When a child remains at imminent risk of harm despite ongoing work with the family, the court may become involved.

The child protective services worker is usually mandated to involve the court if the child is at imminent risk of harm and intervention services have failed. Alcohol and other drug use alone, however, should not be the sole criteria for court intervention.

Court Placement Outside of the Home

After adjudication, if the court finds the child at imminent risk of harm, the child may be placed with a suitable relative or in a foster home. This placement outside of the home should not be made until all reasonable efforts have been undertaken to keep the family together.

Development of a Permanent Placement Plan

Plans To Reunite the Family

When the child is removed from the home of the parent, the plan must be to return that child at the earliest possible date when it can be safely undertaken. To this end, reasonable ongoing efforts must be made to reunite the family as soon as possible.

Permanent Plans for Placement Away From Natural Parents

Under certain circumstances, the court may decide that the permanent plan will be placement away from the natural parent; this may occur after all reasonable efforts have been made to unite the family, when it is apparent that this unification cannot occur in the foreseeable future, and when such action is considered to be in the best interest of the child.

Endnotes

- ¹ The alcohol and drug treatment field uses different terms to refer to the population at risk and the problems that result from their use of alcohol and other drugs, including *chemically dependent*, *substance–abusing*, and *substance–using*. In this report, this at–risk population is referred to as *substance–using women*.
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- ¹⁰ This report uses the term *medical withdrawal* and not *detoxification* to more accurately reflect the actual process that occurs under medical observation.
- ¹¹ Although there are separate sections addressing individual drugs, it is important to recognize that many women will use more than one drug. Polydrug abuse is the norm, not the exception.
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- ¹³ Jessup, M., and Green, J.R. Treatment of the pregnant alcohol–dependent woman. *Journal of Psychoactive Drugs* 19(2):193–203, 1987.
- ¹⁴ Stabilization refers to maintenance or medical withdrawal.
- ¹⁵ Finnegan, L.P. Treatment issues for opioid–dependent women during the perinatal period. *Journal of Psychoactive Drugs* 23(2):191–201, 1991.
- ¹⁶ Providence Hospital, Inc., Elm Street Health and Human Services Center. *Pregnant Addicts Protocol: Methadone*

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[Back Matter]

Appendix A -- Training Guidelines for Programs

The training received by program staff helps to determine the quality of services that can be offered by programs serving pregnant, substance–using women and their families. The array of problems confronting these women suggests that training must be continuous.

The process should begin with an assessment of the training needs of staff and result in a goal–oriented training plan. Training resources are often close at hand. Program staff should be canvassed for the skills and knowledge they possess. Personnel of other community programs represent a wealth of expertise often waiting to be tapped. Community–based, collaborative training activities offer the added benefit of strengthening the networks that serve pregnant, substance–using women and their children.

Training Teams

The expertise of members of a training team should vary depending on the subject of the particular training being developed or delivered. Training teams may include a health educator (to develop curricula), nutritionist, social worker, public health nurse, certified alcoholism and drug counselor, program administrator, physician, and mental health counselor.

Training Areas

Training for medical staff, alcohol and other drug treatment providers, and others serving pregnant, substance–using women and their children should address these topics:

Diagnosis and treatment

- ◆ **Medical guidelines** — basics of prenatal, labor and delivery, perinatal, and postpartum care
- ◆ **Treatment readiness in substance–using women** — understanding aspects of the woman's readiness and/or motivation for treatment
- ◆ **Assessment instruments** — uses and benefits of various instruments to measure substance use, as well as psychosocial, psychiatric, and parental functioning
- ◆ **Dual diagnosis** — techniques for assessment and diagnosis, and treatment planning for mentally impaired, substance–using pregnant women
- ◆ **Women with positive toxicology screens in alcohol and other drug treatment programs** — procedures for referral, counseling, and followup. Ideally, pregnant women *should not* be discharged from treatment programs or from prenatal care services because of continual substance use.
- ◆ **Followup care** — approaches for relapse prevention, monitoring, and intervention

Federal/State guidelines and requirements

- ◆ **Federal and State guidelines for alcohol and other drug treatment** — techniques for assessment and diagnosis, treatment planning, monitoring, and followup care
- ◆ **Confidentiality and reporting** — requirements to report alcohol and other drug use and child abuse and neglect; Federal and State confidentiality provisions
- ◆ **Urine toxicology screening** — procedures for and implications of screening, and the importance of informed consent

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- ◆ **Legal issues** — approaches for coping with outstanding warrants, domestic violence, child custody, adoption, foster care, and divorce

Population–specific issues

- ◆ **Child abuse and neglect** — supportive counseling techniques for improved client functioning and healing, both for the adult or teenage client and for her children
- ◆ **Noncompliant patients** — procedures for the protection of the health and well–being of the mother and child
- ◆ **Gender–specific treatment** — discussion of the special needs of women for transportation, child care, financial support, safe housing, prenatal and postpartum care, issues of sexuality and skills training regarding how to negotiate for safer sex, and sexual abuse and victimization counseling
- ◆ **Sociocultural sensitivity** — discussion of the strengths and challenges presented by race, culture, and socioeconomic circumstances
- ◆ **Incest, adult and child sexual abuse** — discussion of the impact of abuse and issues of anger, fear, and self–esteem
- ◆ **Domestic violence** — discussion of safety concerns, self–worth, independence, legal action, and alternative living environments
- ◆ **Habilitation and rehabilitation** — education of patients in tasks of daily living, skill development, and behavior change
- ◆ **Child development** — discussion of developmental stages, problems, and the special needs of children of substance–using mothers

Case management

- ◆ **Case management** — definition of role and function, as well as measures of performance
- ◆ **Coordinating medical and social services** — conditions for referral, reporting, monitoring, and coordination of patient care
- ◆ **Documentation** — preparation and management of medical charts and case records
- ◆ **Ethics** — discussion of values and principles underlying the continuum of care and provider responsibilities to the client and the community

Community networking

- ◆ **Developing cooperative agreements between medical, alcohol and other drug treatment, and social service programs** — formal and informal approaches and mechanisms to develop cooperative agreements
- ◆ **Community services** — discussion of the types of services available, eligibility requirements, and barriers to service
- ◆ **Outreach** — identification and recruitment of clients into care

Staff development

- ◆ **Multidisciplinary team approach** — discussion of roles, communication, conflict resolution, and team–building techniques
- ◆ **Staff development and burnout** — identification of the causes of and techniques to reduce stress; creation of professional growth opportunities

Infectious diseases

- ◆ **HIV antibody counseling and testing** — procedures for the protection of patients and program staff and approaches for supportive care

- ◆ **Infectious diseases of drug users** — discussion of the signs and symptoms of disease, particularly sexually transmitted diseases, blood–borne infections (e.g., hepatitis B and C), and tuberculosis, and approaches for their prevention and treatment

Appendix B -- Assessment Instruments

Introduction

A comprehensive assessment of each patient entering treatment is needed and should include the following:

- ◆ History of alcohol and other drug abuse
- ◆ Psychosocial history
- ◆ Medical history
- ◆ Mental health history

A number of assessment instruments are widely used to collect information that is helpful in diagnosis and treatment planning. Examples of some of these instruments are listed below. Other instruments are available that illustrate the ways in which individual treatment programs have developed or tailored assessment tools to meet the particular needs of their patient populations. Examples of some of these latter instruments are also listed.

The listing of a particular assessment instrument in no way implies an endorsement of that instrument, nor is the following list intended to be inclusive or representative of all assessment instruments that may be used by treatment programs. The instruments included here are used or recommended by some treatment providers.

Ordering Information

A collection of sample assessment instruments is available as a package from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852, 1–800–729–6686. The specific instruments included in the package are identified below as "available from NCADI." Other assessment instruments are available commercially and may be ordered individually from the sources listed.

Alcohol and Other Drug Use and Psychosocial Assessment Instruments

Addiction Severity Index (ASI)

- ◆ The ASI is a highly structured clinical interview designed for a trained technician to use to rate the severity of problems in six areas: medical, psychiatric, legal, family and social, employment and support, and use of alcohol and other drugs.
 - ◆ Source: McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; and Woody, G.E. An improved evaluation instrument for substance abuse patients: The Addiction Severity Index. Commented out *ElementJournal of Nervous and Mental Disease* 168:26–33, 1980. Available from NCADI.

Addiction Severity Index Pregnancy Status

- ◆ This 22–question instrument was developed as an adjunct to the ASI.
 - ◆ Source: Maternity, Infant Care–Family Project, Medical and Health Research Association of New York City, Inc., 225 Broadway, New York, NY 10007. Available from NCADI.

Assessment/Psychosocial Client Form

- ◆ This 20–page self–administered questionnaire covers substance use patterns and treatment, psychological and behavioral issues, legal history, employment, education, activities and peer support, family history, health status, and current or imminent crises.
 - ◆ Source: Operation PAR, Inc., 10901–C Roosevelt Boulevard, Suite 1000, St. Petersburg, FL 33716. Available from NCADI.

Bio–Psychosocial Assessment

- ◆ This 21–page questionnaire covers substance abuse history, biological factors, behavioral factors, early background, culture/spirituality/religion, socio–leisure, sexual history, education, work history, self–identification, and self–image.
 - ◆ Source: Brandywine Counseling, Inc., 2400 West Fourth Street, Wilmington, DE 19805. Available from NCADI.

CAGE

- ◆ The CAGE Questionnaire is a simple, four–item instrument used to detect the addictive nature of drinking.
 - ◆ Source: Mayfield, D.G.; McLeod, G; and Hall, P. The CAGE questionnaire: Validation of a new alcoholism screening instrument. *Commented out ElementAmerican Journal of Psychiatry* 131:1121–1123, 1974.

Client Profile

- ◆ The Client Profile is a 47–item instrument that covers family history, alcohol and other drug use, health status, education, employment, and legal history.
 - ◆ Source: John W. Sherwood, M.A., Dimock Community Health Center, Project Catch the Hope, 55 Dimock Street, Roxbury, MA 02119. Available from NCADI.

Drug Interview Questionnaire

- ◆ The Drug Interview Questionnaire captures information about all drugs used by a patient, as well as a reproductive history.
 - ◆ Source: Georgia Addiction, Pregnancy and Parenting Project, Laboratory of Human and Behavior Genetics, Georgia Mental Health Institute, 1256 Briarcliff Road, N.E., Atlanta, GA 30306. Available from NCADI.

Inventory of Drinking Situations (IDS)

- ◆ Available in print and software formats, this 100–item questionnaire assesses 8 drinking situations and is intended to be used as a treatment planning tool to help clients avoid high–risk relapse situations.
 - ◆ Source: Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1, 1–800–661–1111.

Maternal Substance Use Survey

- ◆ This 22–item survey covers a woman's health status, alcohol and other drug use, and family circumstances. A separate form captures the pattern of drug use prior to and during pregnancy.
 - ◆ Source: Operation PAR, Inc., 10901–C Roosevelt Boulevard, Suite 1000, St. Petersburg, FL 33716. Available from NCADI.

Michigan Alcoholism Screening Test (MAST)

- ◆ The MAST was one of the earliest instruments designed to detect alcoholism. It originally consisted of 25 questions that could be administered in 10 to 15 minutes. It was subsequently revised to a 24–question instrument that can be rapidly administered by professional as well as nonprofessional staff. A Short Michigan Alcoholism Screening Test (SMAST), consisting of 13 items, was designed to be self–administered and easily scored.
 - ◆ Source: Selzer, M. L.; Vinokur, A.; and van Rooijen, L. A self–administered short Michigan Alcoholism Screening Test (SMAST). Commented out *ElementJournal of Studies on Alcohol* 36(1):117–126, 1975.

New York State Alcohol and Health Self–Test

- ◆ This test gathers information on alcohol use and may signal the presence of emotional problems. It can be completed by the patient or by a staff member.
 - ◆ Source: New York State Division of Alcoholism and Alcohol Abuse, 194 Washington Avenue, Albany, NY 12210. Available from NCADI.

Perinatal Substance Abuse Assessment Tool

- ◆ This six–page, broad–based questionnaire covers such areas as alcohol and other drug use, psychosocial history, and current relationships.
 - ◆ Source: Santa Clara County Health Department, Bureau of Alcohol and Drug Programs, 2220 Moorpark Avenue, Building H–10, San Jose, CA 95128. Available from NCADI.

T–ACE

- ◆ The T–ACE questionnaire is a four–item instrument appropriate for detecting heavy alcohol use in pregnant women.
 - ◆ Source: Sokol, R.J.; Martier, S.S.; and Ager, J.W. The T–ACE questions: Practical prenatal detection of risk–drinking. Commented out *ElementAmerican Journal of Obstetrics and Gynecology* 160:863–870, 1989.

Ten–Question Drinking History

- ◆ These questions explore how much and how often a woman drinks and changes in drinking habits during the past year.
 - ◆ Source: Rosett, H.L.; Weiner, L.; and Edelin, K.C. Fetal Alcohol Education Program, Boston University School of Medicine, 7 Kent Street, Brookline, MA 02146. Available from NCADI.

Parenting Skills Instruments

The Adult–Adolescent Parenting Inventory (AAPI)

- ◆ The AAPI is used to assess the parenting attitudes and child rearing practices of adolescents and adults. Responses on the AAPI provide a profile of parenting strengths and areas needing improvement.
 - ◆ Source: Family Development Resources, Inc., 3160 Pinebrook Road, Park City, UT 84060. 1–800–688–5822.

Parenting Interest Questionnaire

- ◆ This two–page questionnaire identifies a client's interest level on various parenting topics.
 - ◆ Source: Emory University School of Medicine, Clinical and Applied Research, 1256 Briarcliff Road, N.E., Atlanta, GA 30306. Available from NCADI.

Psychiatric Assessment Instruments

Beck Depression Inventory

- ◆ This 21–item inventory is used to assess the intensity of depression in psychiatrically diagnosed patients and to detect possible depression in populations.
 - ◆ Source: The Psychological Corporation, Order Service Center, P.O. Box 839954, San Antonio, TX 78283–3954. 1–800–228–0752.

Center for Epidemiologic Studies Depression (CES–D) Scale

- ◆ This 20–item, self–report scale is designed to measure depression symptoms. The items on the CES–D scale were chosen from previously validated scales.
 - ◆ Source: National Institute of Mental Health, National Institutes of Health, Bethesda, MD 20892. Available from NCADI.

SCL–90–R

- ◆ This instrument is a multidimensional, self–report, symptom inventory designed as a screening/ outcome measure for psychopathology.
 - ◆ Source: Clinical Psychometric Research, Inc., P.O. Box 619, Riderwood, MD 21139. 1–800–245–0277.

Appendix C -- Continuum of Care Model Program

This section presents a model program and sample budget for State agency and local treatment staff to use in providing services for pregnant, substance–using women. The section identifies specific services, presents staffing patterns, and includes costing assumptions recommended by experts from the fields of alcohol and other drug treatment and mental health.

A model program has been designed with the understanding that not all States or localities are able to begin new programs. This model program is intended to be used as a guide or standard for developing a program, adding new services, or incorporating some of the guidelines into an already–existing program.

The sample budget is based on the model program and lays out the requirements and formulas for estimating program costs. The cost assumptions can be tailored to conditions that prevail in different geographic areas. For example, to estimate labor costs in a specific location, the prevailing salary/wage rates should be substituted for the rates used here.

A list of Medicaid reimbursement rates for various medical procedures is presented as a guide. These rates represent the average reimbursement rate paid to States. A program's actual reimbursement rate for individual procedures may vary. Additional help on how to tailor the cost model is provided later in this section.

Continuum of Care Model Program

The model program is specifically designed to meet the special needs of pregnant, substance–using women. The goal of the program is to provide comprehensive services that are appropriate and sensitive to the needs of the target population — services that will enable women to secure prenatal care and other support throughout pregnancy, to achieve a successful delivery, and to receive 3 months of postpartum care.

Services will be provided by a multidisciplinary team of health professionals, including medical or psychiatric social workers, obstetrical/gynecological (Ob/Gyn) specialists, clinical nurse practitioners, and outreach workers. All health care services will be provided in one setting, with the exception of laboratory work. If the patient needs to undergo medical withdrawal or be hospitalized, referrals will be made to the appropriate programs.

The model program will provide outreach services, laboratory workups, obstetrical and gynecological physicals, social work intervention, and appropriate followup services. In addition, the program will provide diagnosis, evaluation, and short–term clinical interventions, along with medical management, to avoid exacerbation of symptoms and unnecessary hospitalizations.

A case management model is used and will be directed by the medical or psychiatric social worker to ensure that concrete services, advocacy, referral, and linkages to other service providers in the community are available. The woman's transition into providing child care and parenting will be facilitated by a complete and thorough assessment of her needs and the development of a comprehensive treatment plan.

Continuum of Care Process and Staffing Pattern

The staffing pattern for the model program is designed around a rotating team concept. There will be four treatment teams consisting of an outreach worker, medical or psychiatric social worker, Ob/Gyn physician, and clinical nurse practitioner. Each treatment team will have a caseload of no more than 20 women, and the overall program capacity will be 80 slots. Initial staffing, outreach, intake, and patient scheduling will vary, and it may take several months for the program to be fully operational.

During the first few months of program startup, the four outreach workers will be on–call each week. Based on their experience and knowledge of the treatment field, the workers will provide outreach to women who are suspected alcohol and other drug abusers. They will engage the women and facilitate their entry into the program for prenatal care, delivery, and followup.

The four clinical nurse practitioners will function as the intake team. Their duties will include facilitating all necessary workups prior to the first prenatal visit and physical examination by the physician. All laboratory tests will be completed and results given to the physician for review within 1 month.

Unless there is a medical emergency, an appointment with the physician will be scheduled for the patient within the first 2 months of the first trimester. The physician will see the patient on a monthly basis during the second trimester and weekly visits will be scheduled during the third trimester. It is anticipated that two part–time Ob/Gyn specialists should be able to handle the expected caseload.

The four medical or psychiatric social workers will serve as case managers. They will initiate case management services toward the end of the first trimester — after the patient has undergone preliminary assessment. Each case manager will be responsible for ensuring the patient has access to services within the program and in the community, and will serve as a liaison between the patient and her treatment team. The case manager will work with the patient to ensure that she understands her treatment, including all pertinent medical procedures, laboratory tests, preparation for childbirth, and followup plans.

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Additionally, the case manager will provide supportive counseling as needed, facilitate communication between all members of the treatment team, and conduct case conferences among all those involved in the woman's care, including community– based programs or services.

Clinical nurse practitioners will help train the mother in such key areas as child care, parenting, and nutrition. After delivery, the medical or psychiatric social worker will work with the clinical nurse practitioner to facilitate the appropriate integration of the woman and her child into the community.

Sample Model Program Budget and Costing Overview

The following section looks at the costs associated with the operation of the model program to provide comprehensive medical care and case management services for pregnant, substance–using women that is described above.

The sample budget is based on a static patient population of 80 slots per year. The total number of patients served by the model program will be greater than the number of slots allocated, since patients will enter and leave at different points in the treatment continuum.

The model program budget is based on these assumptions:

- ◆ The average length of stay in the model program is 1 year.
- ◆ The model program is fully operational.
- ◆ A range of salaries is presented, although the total budget reflects the high end of the range. Actual salaries will vary by geographic area.
- ◆ Two half–time physicians are hired for a total of one full–time equivalent (FTE) position.
- ◆ Laboratory charges are based on a limited national survey and on single–unit prices. Actual costs will vary by geographic area, particularly if volume– discounts are available. Costs for sonograms are not included.
- ◆ An administrative overhead charge of 20 percent of total wages and fringe benefits is included in the model budget to provide for the costs of administrative supervision and support.
- ◆ The fringe benefit rate is calculated at 30 percent.
- ◆ A transportation allowance of \$20 per patient slot is included in the budget to cover the cost of bus tokens, cab vouchers, and so forth.
- ◆ The budget does not include indirect costs necessary for the operation of a facility. Examples of indirect costs that should be considered part of an operating budget include
 - ◆ space rental
 - ◆ utilities
 - ◆ telephone
 - ◆ cleaning
 - ◆ insurance
 - ◆ equipment purchase/rental and maintenance/repairs
 - ◆ office supplies
 - ◆ depreciation
 - ◆ security services

Other Cost Implications

The sample budget does not include costs for delivery of the baby or for alcohol and other drug treatment, including medical withdrawal. These costs would be incurred regardless of the new services a program might offer, and vary from State to State.

The program budget also does not look at reimbursement issues. Before deciding to implement this program, Federal,

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State, local, and third party reimbursement programs need to be studied. These reimbursement sources may pay for part or all of any new services suggested by this model.

Summary

The need for comprehensive services for pregnant, substance–using women is clear. The model program offers a case management approach to address the total needs of this population. Given the complexities of treating pregnant, substance–using women and the relative lack of resources, a significant number of women do not receive adequate care. The information provided in the guidelines, along with the suggestions in this section for program design, staffing, and costing, are intended to guide States and local treatment programs in their efforts to provide services to this population.

Sample Program Budget

Pregnant, Substance–Using Women Sample Program Budget Program Capacity for 80 Treatment Slots			
Personnel Costs			
Position	Full Time equivalents needed	Salary Range Per Year	Estimated Cost*
Program Director	1	\$45,000–65,000	\$65,000
Nurse Practitioner	4	\$30,000–40,000	\$160,000
Physician (Ob/Gyn)	1	\$100,000–120,000	\$120,000
Psychiatric/Medical Social Worker	4	\$30,00–45,000	\$180,000
Outreach Worker	4	\$20,00–30,000	<u>\$120,000</u>
Total Wages			\$645,000
Fringe Benefits @ 30% of wages			\$193,500
Total Personnel Costs			\$838,500
Other Costs			Cost
Laboratory (80 patients @ \$783.42)			\$62,674
Clinical Supplies (80 patients @ \$40)			\$3,200
Publications			\$1,000
Training and Conferences (\$250/staff member)			\$3,500
Transportation (\$20/patient)			1,600
Administrative Overhead @ 20% of wages and fringes			\$167,700
Total Other Cost			\$239,674
Total Personnel and Other Costs			\$1,078,174
*Estimated personnel costs were calculated using the high end of the salary range. These costs will vary widely by State and locale.			

Medicaid Reimbursement Rates for Medical Procedures*

Medicaid Reimbursement Rates for Medical Procedures		
<i>Physicians'</i>	Name of Procedure	Average

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<i>Current Procedural Terminology code</i>		Medicaid payment
I. Routine Prenatal Workup -- Initial		
80009	Liver profile	\$11.08
80019	Chem screen 30(A generic for more than 19 tests and coded the same as Chem 20)	15.04
82055	Blood alcohol	15.56
82150	Amalyse	8.57
82660	Urine drug screen panel	14.49
82952	Glucose challenge	7.01
83053	Sickle cell	6.93
83690	Lipase	8.22
83705	Lipids, fractionated; cholesterol, triglycerides, and phospholipids	15.28
84450	AST	5.91
85024	CBC -- Complete Blood Count	10.98
86016	Antibody screen	8.89
86082	ABO type and Rh factor	6.72
86255	Fluorescent antibody; screen each antibody (e.g., chlamydia, toxoplasmosis, and herpes screening)	12.81 (price per antibody screen)
86287	Hepatitis B surface antigen screen	13.89
86299	Hepatitis A (IgM Anti–HAV)(HAA)	14.92
86312	HIV–EIA	13.06
86403	Particle agglutination rapid test (e.g., rubella antibody; cryptococcal antigen)	13.77
86580	Tuberculosis, intradermal (Mantoux)	6.49
86592	RPR–syphilis (qualitative)	4.70
87070	Neisseria gonorrhea culture	11.93
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types Cervical smear -- gonorrhea, gram stain of exudative material, vaginal culture	5.43
88150	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou smear) up to three smears	7.18
Subtotal		\$238.86
II. Confirmatory and Followup Tests		
83020	Hgb Electrophoresis -- for positive sickle cells Hemoglobin electrophorism	12.54
86299	HAA confirmatory test	14.92
86319	GC/MS confirmation -- for positive urine drug screens	23.41
Subtotal		\$50.87
III. Prepartum Periodic Monitoring		

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80019	Chem screen 20(repeat every 2 months; coded same as Chem 30)	\$45.12 (3 tests @ \$15.04)
82660	Urine drug screen panel (repeat every month)	101.43 (7 tests @ \$14.49)
84450	AST (repeat every month)	41.37 (7 tests @ \$5.91)
86016	Antibody screen (repeat every 2 months)	26.67 (3 tests @ \$8.89)
Subtotal		\$214.59
IV. Midterm Pregnancy		
86244	AFP	18.09
Grand Total	All Tests	\$522.41

Source: Special analysis for CSAT done by the Division of Medicaid Statistics, Office of Program Systems, Bureau of Data Management and Strategy, Health Care Financing Administration. Data are from the period July–September 1991. The data were obtained from the individual claims data supplied by State Medicaid agencies to the Medicaid Statistical Information System at the Health Care Financing Administration. The participating States were Alaska, Alabama, California, Delaware, Georgia, Indiana, Iowa, Kansas, Kentucky, Maine, Missouri, Montana, New Jersey, North Dakota, New Hampshire, Utah, Vermont, Washington, Wisconsin, and Wyoming.

Appendix D -- Quality Assurance Monitoring

Alcohol and other drug treatment programs have increasingly used quality assurance (QA) techniques to maintain or improve the level of care provided to patients and to contain costs. In addition, a quality assurance component is often mandated for the licensure and reimbursement of treatment programs. Every treatment program should have an ongoing and active quality assurance program.

Experience has demonstrated that pregnant, substance–abusing women entering treatment need a wide range of support services. To provide this comprehensive level of care, treatment staff must marshal the resources of a host of other agencies through referral and collaboration. The careful monitoring of these referral and interagency collaborative activities on behalf of patients is a key quality assurance function for treatment programs. Monitoring should cover these aspects:

- ◆ Documentation of referrals and the sharing of patient information
- ◆ Compliance with Federal and State confidentiality regulations
- ◆ Preparation of interagency agreements
- ◆ Assurance of linkage and documentation of collaborative activities

Referrals and Information Sharing

It is well known that merely making referrals for patients neither ensures that services are received nor guarantees the quality of the services that are delivered. One of the key functions of a QA program is to monitor the process of referral. A well–designed QA program will routinely select a sample of all patient records and related referrals and monitor these sources to ensure that linkage has occurred.

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Documentation must be made of the results of the monitoring and related actions taken to correct any problems and improve services. Examples of quality assurance monitoring activities are as follows:

- ◆ Monitor patient records to ensure that proper referrals were made.
- ◆ Monitor patient records to ensure that appropriate and necessary information was shared with the referral agency (e.g., reason for the referral and problems to be addressed).
- ◆ Monitor referral logs, payment vouchers, or other referral documentation for completeness and appropriateness (e.g., Is payment appropriate to the services provided?).
- ◆ Monitor patient records to ensure that linkage was documented (e.g., Was the patient evaluated and accepted for services?).
- ◆ Monitor patient records for notes of treatment progress and/or continued service (e.g., regular documentation of treatment progress), or documentation that services were no longer needed (e.g., documentation of the followup services that were being provided and why services were no longer needed).

Confidentiality Compliance

Every agency that provides services to pregnant, substance–using women must ensure that internal policies and procedures comply with both Federal and State confidentiality and reporting regulations (see [Guideline 17](#) – *Confidentiality and Reporting*). Once compliance is ensured through the development of policies and staff training, a process of quality assurance monitoring should be developed to routinely review a sample of all program records. Documentation must be made of the results of such monitoring and related actions taken to correct any problems and improve services. Examples of quality assurance monitoring activities are as follows:

- ◆ Monitor for documentation that service providers informed patients of their rights to confidentiality and offered information about possible court involvement.
- ◆ Monitor for documentation that service providers informed patients of all laws that were relevant to their specific circumstances.
- ◆ Monitor to ensure that there is a written informed consent on file whenever there were discussions concerning patients with individuals or organizations outside the treatment facility.
- ◆ Monitor to ensure that the written informed consent is time–limited, content–specific, person–to–person, signed, and witnessed.

Interagency Agreements

In order for interagency collaboration and linkage to be successful, there must be a written document that clearly delineates the responsibilities of the cooperating agencies. Interagency agreements, at a minimum, should have these characteristics:

- ◆ Describe the services to be provided by each agency.
- ◆ Describe the referral process to be used and the documentation requirements of each agency.
- ◆ Establish a timeframe for the review and possible revision of the agreement.

Examples of quality assurance monitoring activities are as follows:

- ◆ Monitor to ensure that the referring agency provided all appropriate and necessary patient information to the referral agency.
- ◆ Monitor to ensure that there is documentation that the referral agency provided all agreed–upon services in a timely manner.
- ◆ Monitor to ensure that the referral agency provided documentation to the referring agency of patient progress, continued need for services, or readiness for termination of services.

Other Important Areas for Quality Assurance Monitoring

Additional aspects of linkage and collaborative activity that are appropriate for quality assurance monitoring include:

- ◆ Monitor to ensure that linkage occurred, as demonstrated by the acceptance of patients into followup care.
- ◆ Monitor to ensure that there is documentation for patients who were not accepted for treatment (e.g., reasons why patients were not appropriate for the facility, and what steps were taken to link patients to appropriate services).
- ◆ Monitor to ensure that there is documentation for the discharge of pregnant patients. Although the discharge of pregnant patients from treatment is not recommended, occasions may arise that necessitate this course of action. There must be full documentation of the rationale for discharge and the attempts that were made to maintain patients in treatment. For example, when patients are discharged for noncompliance, there must be documentation of the steps taken to encourage treatment compliance. Similarly, there should be documentation of the referral of patients to alternative treatment.
- ◆ Monitor to ensure that there is documentation of the referral of patients when the agency was unable to provide necessary services (e.g., Are patients referred to a methadone program when needed?).

Monitor to ensure that patients have a treatment plan listing all required services and that there is documentation of patient progress for all referred services.

Appendix E -- Glossary of Terms

abruptio placentae:

premature detachment of a normally situated placenta.

adjudicate:

to pronounce or decree by judicial sentence.

AIDS:

acquired immunodeficiency syndrome. A disease characterized by opportunistic infections (e.g., *Pneumocystis carinii* pneumonia, candidiasis, Kaposi's sarcoma) in immunocompromised persons; caused by the human immunodeficiency virus (HIV) and transmitted by exchange of body fluids.

amniocentesis:

a procedure whereby fluid is aspirated from the amniotic sac through the abdomen.

anergy:

absence of demonstrable sensitivity reaction in a subject to substances that would be antigenic (immunogenic, allergenic) in most other subjects. Anergia; lack of energy.

anomaly:

deviation from the average or norm; anything structurally unusual or irregular or contrary to a general rule.

anorexia:

diminished appetite, aversion to food.

asymptomatic:

without signs or symptoms.

bacteremia:

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the presence of viable bacteria in the circulating blood.

booting:

any drug solution, such as cocaine or heroin, mixed with blood aspirated into a syringe and then injected into a vein, repeated one or more times to clear the syringe barrel and tip of any of the drug residue. Heavy blood contamination of the syringe may contribute to colonization with bacterial pathogens and to the more likely transmission of the human immunodeficiency virus (HIV).

case manager:

one who defines, initiates, and monitors the medical, drug treatment, psychosocial, and social services provided for the woman and her family.

cervical dysplasia:

abnormal tissue development of the uterine cervix.

chancroid:

an acute bacterial infection characterized by single or multiple ulcers or sores in the genital area; an infectious venereal ulcer with a soft base.

chlamydia:

a sexually transmitted disease manifested by mucopurulent endocervical discharge and inflammation of the endocervical columnar epithelium. Symptoms may be moderate or scanty discharge, urethral itching, and burning on urination, but patients are often asymptomatic.

condylomata:

a wart–like excrescence at the anus, vulva, or on the glans penis caused by the human papilloma virus (HPV).

congenital:

existing at birth. Refers to certain mental or physical traits, anomalies, malformations, or diseases which may be either hereditary or due to an influence occurring during gestation up to the moment of birth.

cross training:

]to be trained in several disciplines to facilitate broader coverage in a treatment unit.

dysuria:

difficulty or pain in urination.

diaphoresis:

increased perspiration.

dyspnea:

shortness of breath.

embryo:

the developing organism from conception until approximately the end of the second month.

endocarditis:

inflammation of the lining of the heart.

epidemiology:

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the study of the relationship between various factors that determine the frequency and distribution of diseases in human and other animal populations.

fetus:

the unborn young from the end of the eighth week to the moment of birth.

folliculitis:

an inflammation of the hair follicles. The lesions may be papules (small skin elevations) or pustules.

fungal infections:

a general term used to describe those diseases caused by diverse morphological forms of yeasts and molds.

genitourinary:

pertaining to the organs of reproduction and urination.

gestation:

the process, state, or period of pregnancy.

gonorrhea:

a sexually transmitted disease manifested by an inflammation of the genital mucus membrane.

hairy leukoplakia:

a white lesion appearing on the tongue of patients with AIDS. The lesion appears raised, with a corrugated or "hairy" surface, due to keratin projections (a substance found in the dead outer corneal skin layer and in hair and nails).

hemangiomas:

a congenital anomaly in which a proliferation of vascular endothelium leads to a mass that resembles neoplastic tissue. It can occur anywhere in the body, but is most frequently noticed in the skin and subcutaneous tissue.

hepatitis:

inflammation of the liver, usually from a viral infection, but sometimes from toxic agents.

hepatomegaly:

enlargement of the liver.

herpes simplex:

a virus that in humans causes fever blisters, usually on the lips and external nares (nose), and also on the genitalia. This virus may also cause acute stomatitis and meningoencephalitis.

histoplasmosis:

Darling's disease. An infectious disease manifested by a primary benign pneumonitis similar to primary tuberculosis.

HIV:

human immunodeficiency virus. The virus occurring in humans that causes a condition that results in a defective immunological mechanism, opportunistic infections, and eventually in the disease process know as AIDS (acquired immunodeficiency syndrome).

hyperpnea:

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breathing that is deeper and more rapid than is normal at rest.

hyperpyrexia:

an abnormally high fever.

hypotonia:

having a lesser degree of tension in any part of the body.

icterus:

relating to or marked by jaundice.

infant:

a child under the age of 1 year.

Kaposi's sarcoma (K.S.):

malignant neoplasm occurring in the skin and sometimes in lymph nodes, manifested by cutaneous lesions consisting of reddish–purple to dark blue macules, plaques, or nodules. It is seen mostly in men and as an opportunistic disease in AIDS patients.

ketoacidosis:

enhanced production of ketone bodies due to alcohol or diabetes.

lymphadenopathy:

any disease process affecting a lymph node or nodes; clinically refers to enlargement of nodes.

meconium:

the first intestinal discharge of the newborn infant.

microcephaly:

pertaining to abnormal smallness of the head.

morbidity:

pertaining to severe illness.

mortality:

pertaining to death.

mucopurulent:

containing or composed of mucus and pus.

myoclonic:

spasm or twitching of a muscle.

neonate:

a newborn. Refers to the period immediately following birth and continuing through the first 28 days of life.

neurotropic:

a virus or drug that has an affinity for nerve cells or tissue.

nosocomial:

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denotes a new disorder not related to patient's original condition that is associated with being treated in a hospital, e.g., a hospital–acquired infection.

ocular:

pertaining to the eyes.

odynophagia:

pain on swallowing.

paresthesia:

an abnormal sensation, such as burning, pricking, tickling, and tingling.

perinatal:

occurring during, or pertaining to, the periods before, during, or after the time of birth, i.e., from the 28th week of gestation through the first seven days after delivery.

postnatal:

occurring after birth.

prenatal:

occurring before birth.

prophylaxis:

to guard against or take precautions that will prevent either disease or a process that can lead to disease.

pruritus:

itching.

psychotropic:

pertaining to drugs used in the treatment of mental illness; affecting the mind.

pyoderma:

skin infection characterized by the formation of pus.

retinitis:

inflammation of the retina, which may be caused by the cytomegalovirus (CMV).

seborrheic dermatitis:

overactivity of the sebaceous glands resulting in a scaly macular eruption that occurs primarily on the face, scalp (dandruff), and pubic and anal areas.

septicemia:

systemic disease caused by the spread of microorganisms and their toxins via the bloodstream.

sonogram:

an image obtained by ultrasound, used to produce an image of the fetus.

splenomegaly:

enlargement of the spleen.

spontaneous abortion:

TIP 2: Pregnant, Substance–Using Women

the loss of an embryo or fetus prior to the stage of viability at about 20 weeks of gestation as a result of natural causes (not artificially induced).

stabilization:

the accomplishment of a steady, nonvarying physical state.

sudden infant death syndrome (SIDS):

the unexpected death of an apparently healthy baby, usually occurring during sleep, without apparent cause.

syndrome:

the combination of signs and symptoms associated with any morbid process, which together constitute the picture of the disease.

syphilis:

an acute and chronic infectious, sexually transmitted disease. Syphilis is manifested first by a chancre, followed by a slight fever, and progresses through several stages that include skin eruptions and functional abnormalities resulting from cardiovascular and nervous system lesions.

tachypnea:

rapid breathing.

tenesmus:

the urgent feeling of a need to urinate or defecate without the ability to do so.

teratogen:

a drug or other agent that causes abnormal fetal development.

thrombocytosis:

an increase in the number of platelets in the circulating blood.

toxemia:

a metabolic disorder of pregnancy characterized by hypertension, edema, and albumin in the urine. Also known as pregnancy–induced hypertension (PIH) or pre–eclampsia.

toxoplasmosis:

disease caused by protozoan parasite. This prenatally acquired human infection from cat litter boxes can result in an infant with micro–cephalus or hydrocephalus at birth as well as other abnormalities.

thrush:

infection of the oral (mouth) tissues with *Candida albicans*.

urine toxicology:

the science dealing with the detection of drugs in the urine.

vaginal candidiasis:

infection in the vagina manifested by yeast–like fungi.

Appendix F -- References

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Appendix H -- Contributors

These treatment improvement guidelines for pregnant, substance–using women were prepared using protocols and other materials that were developed by a broad range of programs from across the Nation. Many of these programs currently receive grant funds through the Center for Substance Abuse Prevention (formerly the Office for Substance Abuse Prevention [OSAP]). The Consensus Panel gratefully acknowledges the assistance of CSAP in providing access to these grantee materials. The Panel is also grateful to the many professionals in the alcohol and drug treatment field who so generously provided access to their program materials. These contributing programs are listed below.

The suggestions and comments of expert field reviewers were particularly helpful in enhancing the quality of the final guidelines. These individuals were selected to review and comment on the draft document based on their knowledge of and concern for the special needs of pregnant, substance–using women. The Consensus Panel appreciates and acknowledges the time and substantive quality of their comments. These individuals are also listed below.

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Appendix I -- Comprehensive Care Flow Charts

Pregnant, Substance–Using Women

Point of Entry: Alcohol and Other Drug Treatment

Patients	Assessment	Medical Withdrawal and Treatment				
All Pregnant, Substance–Using Women	Drug Use/Abuse	Alcohol	Cocaine	Opiates	Methadone	Sedative–Hypnotics
	<ul style="list-style-type: none"> • History ◆ Duration of use ◆ Frequency, type, amount ◆ Routes of administration 	<ul style="list-style-type: none"> • Setting ◆ Inpatient ◆ Under medical supervision • Follow admission procedures • Monitor for S/S of 	<ul style="list-style-type: none"> • Setting ◆ Inpatient ◆ Under medical supervision • Follow admission procedures • Medication contraindicated, except in cases 	<ul style="list-style-type: none"> • Setting ◆ Inpatient ◆ most effective • Follow admission procedures • Methadone maintenance recommended with 	<ul style="list-style-type: none"> • Setting ◆ Outpatient ◆ withdrawal from methadone not recommended • Encourage and monitor continued prenatal 	<ul style="list-style-type: none"> • Setting ◆ Inpatient ◆ Under medical supervision • Follow admission procedures • Monitor for severe symptoms:

TIP 2: Pregnant, Substance-Using Women

	<ul style="list-style-type: none"> ◆ Social context of use ◆ Past treatment ◆ Support group involvement • Consequences • Relapse factors • Motivation for treatment/continued use • Refer for prenatal care <p>Psychosocial</p> <ul style="list-style-type: none"> • Family history • Support system • Attitudes about pregnancy • Education • Employment • Abuse: physical, emotional, sexual • Legal • Current crises • Relationship to other children <p>Mental Health</p> <ul style="list-style-type: none"> • Mental status • Psychiatric symptoms • History of mental 	<p>AWS</p> <ul style="list-style-type: none"> • Antabuse: contraindicated • Inpatient AOD treatment whenever possible • Outpatient AOD treatment with special focus on pregnancy issues and drug use • Encourage and monitor continued prenatal care 	<p>of extreme agitation</p> <ul style="list-style-type: none"> • Inpatient AOD treatment whenever possible • Outpatient AOD treatment if necessary, with special focus on pregnancy issues and drug use • Encourage and monitor continued prenatal care 	<p>psychosocial care</p> <ul style="list-style-type: none"> • Medical withdrawal not recommended • Encourage and monitor continued prenatal care 	<ul style="list-style-type: none"> • Determine risk/benefit ratio when considering use of medication • Encourage and monitor continued prenatal care
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TIP 2: Pregnant, Substance–Using Women

	illness • Suicide risk • Family history of mental illness • DSM–III–R diagnosis • Treatment recommendations				
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LEGEND

Medical Caution

AOD: Alcohol and Other Drugs
Substance–Using: Women at risk for problems resulting from their use/abuse of alcohol and other drugs

Pregnant, Substance–Using Women

Point of Entry: Prenatal Care

Patients	Prenatal Intake	Prenatal Followup	Labor/Delivery with Prenatal Care	Labor/Delivery with No Prenatal Care	Postpartum	Neonatal
All Pregnant, Substance–Using Women	<ul style="list-style-type: none"> • Complete detailed health history • Perform physical exam • Complete family history • Complete health history of baby's father, if possible • Complete routine prenatal panel • Complete 	<ul style="list-style-type: none"> • Identify medical and psychosocial problems • Provide health education opportunities • Obtain random urine and/or blood toxicologies • Reinforce importance of AOD treatment • Discuss 	<ul style="list-style-type: none"> • Complete detailed health history • Perform physical exam • Query for recent AOD use • Repeat hepatitis B and HIV screens and syphilis test, if previously 	<ul style="list-style-type: none"> • Follow all guidelines in previous column, if possible, plus perform: ♦ Sonogram ♦ Complete baseline laboratory tests 	<ul style="list-style-type: none"> • Encourage continued participation in AOD treatment • Encourage and educate about family planning • Permit breastfeeding in methadone–maintained mothers • Complete preventive health maintenance program • Provide for child care and parenting education • Conduct 	<ul style="list-style-type: none"> • Obtain urine and/or blood toxicology • Monitor for effectiveness of drugs on the infant • Treat appropriate dependence on drug • Review case with mother

TIP 2: Pregnant, Substance–Using Women

	<p>other tests, including tuberculin test with antigen panel, urine toxicology/blood screening, and baseline sonogram</p> <ul style="list-style-type: none"> • Optional tests as needed • Check for tracks, abscesses, poor general hygiene, poor dental hygiene, infections • Refer for AOD treatment, social services, nutrition counseling, parenting education, employment counseling, others as needed • Review sexual practices and provide education on safer sexual practices • Obtain 	<p>reproductive options</p> <ul style="list-style-type: none"> • Manage common complications • Encourage involvement of father of baby or significant other 	<p>negative urine and/or blood toxicologies</p> <ul style="list-style-type: none"> • Complete • Follow universal precautions and OSHA standards • Notify pediatric, nursing, and social services • Monitor fetus • Provide pain management • Select delivery method • Insert central line if needed 	<p>postpartum followup</p>	<p>and education regarding specific care of infant</p> <ul style="list-style-type: none"> • Encourage involvement of father of baby or significant other and family members
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TIP 2: Pregnant, Substance–Using Women

	written release					
<p>Additions for HIV–Positive Women</p>	<ul style="list-style-type: none"> • Refer for specific HIV medical treatment • Conduct extensive review of symptoms • Obtain T4 or CD4 count 	<ul style="list-style-type: none"> • Reinforce importance of HIV medical treatment • Repeat CD4 count every trimester • Ensure special pediatric followup 	<ul style="list-style-type: none"> • Provide special handling of cord, placenta and neonate 	<ul style="list-style-type: none"> • Follow guidelines in previous column 	<ul style="list-style-type: none"> • Conduct postpartum followup • Breastfeeding contraindicated • Encourage continued participation with HIV specialist for medical followup for mother and infant • Educate mother regarding special needs of infant • Encourage and educate about family planning 	<ul style="list-style-type: none"> • Ensure special pediatric followup

----- End of Download Section -----