Substance Use in the Obstetrical Patient

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Purpose

To provide guidelines for obstetrical patients experiencing substance use.

Policy Statement

Services for birthing and breastfeeding parents with substance use disorders (SUD) are supported by a comprehensive multidisciplinary team that assesses and addresses the complexity and multifaceted nature of SUD and their antecedents. This Medical Center provides compassionate and evidence-based care to birthing parents who seek treatment to improve health for themselves and their infants.

LIP Order Requirement

Elements of this (procedure or protocol) require a licensed independent practitioner's (LIP) order.

Responsible Persons

Registered nurse (RN), Case Manager /Social Worker (MSW), LIP, Addiction Recovery Services (ARS) Team.

Prerequisite Information

In this document the term "birthing parents" and not "pregnant women" is used to be inclusive of people of all genders who have the capacity to become pregnant.

Use of Trauma-Informed communication, shared-decision making, and non-judgmental approaches facilitate patient-centered care (see *Trauma Informed Care* in Attachments section). Request permission to discuss options with patient to enhance relationship building such as toxicology screening, pain management, couplet support, and breastfeeding.

This medical center follows evidence-based clinical practices to support patient-centered care, autonomy, patient's individual values and gender identity. Birthing parents with a SUD is fully informed about the risks and benefits of available treatment options, medical treatment and testing for themselves and their fetus or infant.

Toxicology lab testing of the birthing parent requires a patient's permission. Toxicology screening of the newborn may be performed without obtaining parental consent. Screening for perinatal use of marijuana is

determined by maternal verbal report. **Marijuana use is not a contraindication for breastfeeding.** See *Marijuana During Pregnancy and Breastfeeding* in Attachments section.

SIGNS AND SYMPTOMS OF SUBSTANCE USE

Behavior Patterns	Physical Signs	Medical History
• Sedation • Inebriation • Euphoria • Agitation, Irritability • Aggressiveness • Paranoia, Hallucinations • Increased physical activity • Anxiety and nervousness • Disorientation • Depression • Suicidal ideations or attempt	• Vaginal bleeding (suggestive of abruption) • Dilated or constricted pupils • Rapid eye movements or Nystagmus • Tremors • Track marks or abscesses or injection sites • Inflamed or eroded nasal mucosa, nose bleeds • Increased pulse, blood pressure, temperature • Gum or periodontal disease (methamphetamine use) • Skin conditions: abscesses, dry or itchy, acne type sores • Weight loss, low BMI	• Frequent hospitalizations • Gunshot or knife wound • Unusual infections (cellulitis, endocarditis, atypical pneumonias, HIV) • Cirrhosis • Hepatitis, Pancreatitis • Frequent falls, unexplained bruises • Chronic mental illness

Protocol

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<table>
<tr><td colspan="2">► Requires LIP order</td></tr>
<tr><th>Responsible Person</th><th>Steps</th></tr>
<tr><td>LIP, RN</td><td>
SCREENING BIRTH PARENT FOR SUBSTANCE USE DISORDER (SUD)
1. Upon hospital admission, complete and document verbal screening for any substance use including alcohol. NOTE: Use positive regard and strength-based language to establish a welcoming environment and to engage in a therapeutic shared-decision making conversations.
2. If patient has a positive verbal screen, history or active substance use including alcohol within the past 12 months:
◦ Request permission to obtain appropriate sample
◦ ►Place order for: " Drugs of Abuse, Screen, Urine (aka) Toxicology"
◦ ►Place order for "Blood for alcohol level"
Procedures
<table>
<tr><th>Name</th><th>Type</th><th>Pref List</th><th>Code</th><th>Cost to Org</th></tr>
<tr><td>DRUGS OF ABUSE, SCREEN, URINE (aka TOXICOLOGY)</td><td>Lab</td><td>SWED IP FACILITY LAB</td><td>LAB500</td><td>$$$</td></tr>
<tr><td>DRUGS OF ABUSE, MATERNAL/NEWBORN TOXICOLOGY, URINE, REFLEX C...</td><td>Lab</td><td>SWED IP FACILITY LAB</td><td>LAB13242</td><td>$$</td></tr>
<tr><td>HEAVY METALS SCREEN, URINE, RANDOM (aka TOXICOLOGY QUANTITAT...</td><td>Lab</td><td>SWED IP FACILITY LAB</td><td>LAB398</td><td>$$$$$</td></tr>
</table>
</td></tr>
<tr><td>LIP, MSW, RN</td><td>
BIRTHING PARENT POSITIVE TOXICOLOGY RESULT

NOTE: Any unexpected substances or medications that are not prescribed (anticipate prescribed medications) are considered a positive toxicology result.
1. ►Place order for a confirmatory test (GMCS-Gas Chromatography, i.e., confirmation opioids; confirmation amphetamine, confirmation benzodiazepine, etc.)
2. ►Place Social Worker consult to help with care coordination and potential Department of Children, Youth, and Families (DCYF) Notification. Marijuana self-report screening does not require a social work consult.
3. Continue daily birthing parent urine toxicology screening per LIP order until negative.
NOTE: Infants exposed to prescribed substances, including medications to treat substance use disorders, which were verified to be taken as prescribed, and those exposed to marijuana do not
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<tr><th colspan="2">► Requires LIP order</th></tr>
<tr><td></td><td>require a report.</td></tr>
<tr><td rowspan="2">LIP, MSW</td><td>NEWBORN POSITIVE TOXICOLOGY RESULT

Notify Social Worker to help with care coordination and potential DCYF Notification or Report screening.
Social Worker will work with patient to:

Provide information on Washington state policy regarding response to a positive (newborn or birth parent) toxicology screen.
Inform DCYF when a birth parent or newborn has a positive toxicology screen
See Abuse and Neglect Identification and Reporting: Child.

Notify newborn provider of positive toxicology result.
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<tr><td>DISCHARGE PLANNING

Coordinate with inpatient Social Worker or Substance Use Professional to provide discharge planning services as needed which may include:
<ol type="a">
Assisting in psychosocial treatment.
Coordination with Chemical-Using Pregnant Women (CUP) and /or Pregnant and Parenting Women (PPW) programs (WA State Program).
</td></tr>
<tr><td>RN, LIP, ARS</td><td>MANAGEMENT OF ESCALATING BEHAVIORS

Discuss and address within an interdisciplinary team incorporating Addiction Recovery Services team.
Recognize that behaviors that are interpreted as "escalating" or "difficult" could be related to trauma and attempts to process negative past experiences.
Recognize that birthing parents may undergo a more traumatic childbirth if they feel judged or shamed. Birthing parents of color may experience higher rates of disrespect and mistreatment around birth.
Offer comfort and positive regard, using a trauma-informed approach.
Reflect on what you bring to the interaction considering potential implicit biases.
Steps to address escalating behaviors:
<ol type="a">
Validate vulnerability and motivation for safe birthing experience.
Requesting permission prior to examinations and procedures may improve therapeutic approach.
Identify common goals and listen with compassion to build trust and effective supportive relationship.
De-escalate while using grounding and positive re-directing techniques.
Initiate Code Gray as needed and inform Security. See Code Grey: Violent or Self-Destructive Behavior.

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<tr><td>LIP, RN</td><td>ANTEPARTUM MANAGEMENT

Establish a welcoming and safe environment.
Consult ARS Team
►Assess for history of IV drug use (IVDU) and for potential challenges with placing IV. Consider anesthesia consult to help with IV placement as indicated
►Obtain LIP order for:
<ol type="a">
Initiation of MOUD (medication for opioid use disorder with methadone or buprenorphine) for appropriate patients or
Continuation of MOUD for those who have been stable on their medication prior to the current admission.

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► ***Requires LIP order***	
	▪ Patients treated with Methadone benefit from split dosing to maintain optimal therapeutic effect. ▪ Adjust and increase doses of MOUD to help with possible withdrawal symptoms. c. ►Screen for tobacco use disorder and start Nicotine Replacement Therapy d. Consider Dietary consult. e. Initiate fetal monitoring f. For any patient with a SUD who has left the unit and is exhibiting withdrawal and/or intoxication symptoms, or who has had visitors who are exhibiting the same, consider a random urine and/ or blood toxicology screen.
LIP, RN	**INTRAPARTUM** 1. Monitor for respiratory depression and sedation levels when providing pain medications. 2. Implement continuous fetal monitoring 3. Consider consult with anesthesia provider 4. ►LIP considerations: a. Discuss benefits of using high affinity opioids such as hydromorphone or fentanyl. b. Continue daily dose of MOUD (methadone or buprenorphine). c. Discuss long acting reversible contraceptives (LARC) options including post- placental IUD and Nexplanon.
LIP, RN	**POSTPARTUM MANAGEMENT** 1. Pain Management - optimize epidural and LIP-ordered scheduled multimodal medications. 2. Encourage hydration, ambulation and healthy nutrition. 3. Validate birth parent's efforts to promote bonding with infant. 4. Review Breastfeeding Guidelines with birthing parents as below: a. Review urine toxicology screen prior to breastfeeding. b. Discuss policy/guidelines outlined below: i. **NEGATIVE URINE TOXICOLOGY SCREEN** ▪ Encourage breastfeeding ▪ Offer Lactation consult ii. **POSITIVE URINE TOXICOLOGY SCREEN** (a screen is considered positive if it shows use of any substances not currently prescribed to the birthing parent): ▪ Positive for marijuana only - encourage breastfeeding but counsel to avoid marijuana use during the period of lactation and breastfeeding (See *Marijuana During Pregnancy and Breastfeeding* in Attachments section). ▪ Continue daily urine toxicology screening until a negative result is obtained if the parent wishes to breastfeed. ▪ Breastfeeding can begin once the birthing parent has one negative toxicology result. iii. Obtain Lactation consult. iv. Birthing parents who wish to breastfeed and have a positive toxicology screen (other than marijuana) are encouraged to work on establishing milk supply and to pump and discard until able to breastfeed. c. Refusal of urine toxicology screening will result in being ineligible for breastfeeding. **CAUTION: Breastfeeding is contraindicated if the birthing parent is HIV positive, actively using illicit substances.** See *Breastfeeding the Term Infant* and *HIV Management: Maternal and Infant*. **Hep C+ status is a contraindication for breastfeeding if nipples are cracked or bleeding.**

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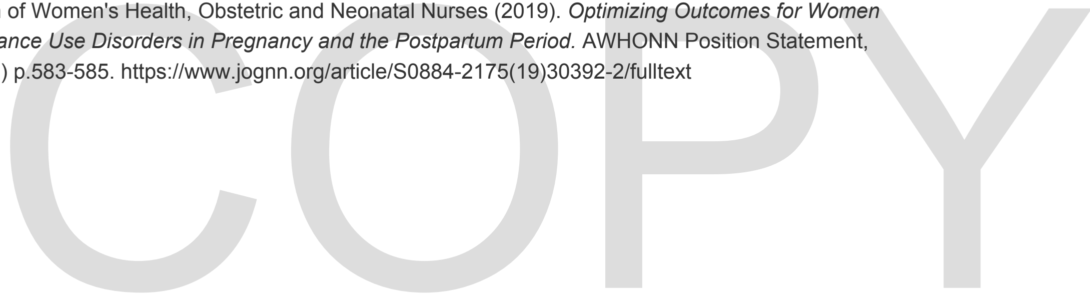
► ***Requires LIP order***	
	5. Discuss counseling on available LARC options including IUD and Nexplanon. 6. Refer to *Care of the Substance Use Exposed Newborn: Eat, Sleep, Console (ESC) Method*.
RN, Social Worker, LIP, ARS	**DOCUMENTATION** 1. Document care in EMR.

American College of Obstetricians and Gynecologist (2017). *Opioid Use and Opioid Use Disorder in Pregnancy*. (ACOG Committee Opinion 711). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

Association of Women's Health, Obstetric and Neonatal Nurses (2019). *Optimizing Outcomes for Women With Substance Use Disorders in Pregnancy and the Postpartum Period.* AWHONN Position Statement, JOGN,48(5) p.583-585. https://www.jognn.org/article/S0884-2175(19)30392-2/fulltext



Addenda

See Attachments section:

Trauma Informed Care in Obstetrics

See addenda below:

Substance Use in the Obstetrical Patient: Pain Management Recommendations

Substance Use in the Obstetrical Patient - Pain Management Recommendations

Choose appropriate pathway

Labor	Early epidural	Consider TAP							

		block							
Vaginal Delivery	Continue daily dose of MOUD (methadone or buprenorphine)	Acetaminophen 1000mg Q6H	Ibuprofen 600mg Q6H	Consider addition of scheduled Gabapentin 100mg Q8H	Prescribe oral opioids only if indicated (3rd, 4th degree repair, episiotomy, forceps/ vacuum-assisted vaginal delivery)				
Cesarean Delivery	Continue daily dose of MOUD (methadone or buprenorphine)	Acetaminophen 1000mg Q6H	Ketorolac 30mg Q6Hx4	Ibuprofen 600mg Q6H,	Consider oral hydromorphone dose 4mg Q4H and 2-4mg Q4H prn severe pain	Gabapentin 200mg Q8H	Lidocaine patch	Abdominal binder	Scheduled stool softeners

Providing opioid medication will not compromise patient's SUD and will boost a timely post-operative recovery.

Attachments

Trauma Informed Care in Obstetrics.pdf

NOTE: The electronic version of this document or form is the latest and only acceptable version. You are responsible to ensure any printing of this document is identical to the e-version.

TRAUMA INFORMED CARE (TIC) IN OBSTETRICS

Trauma- Informed Care is based on the understanding that the vulnerabilities or triggers of trauma survivors requires a framework for approaching care that is patient-centered and provides meaningful support and avoids re-traumatization. It includes:

- Appreciation of how past trauma can directly affect experiences in the present
- A stance of "what happened?" instead of "what is wrong with you?
- Understanding of how disease drives the behavior not the other way around
- Compassionate communication that fosters equity thereby mitigating interpersonal bias

Trauma is an event that is extremely upsetting and at least temporarily overwhelms internal resources.

- Single or multiple events over time (complex, prolonged).
- Experiences that are shocking or overwhelming such as abuse, neglect, violence, disaster, etc.
- Potential lasting negative effects on the individual's functioning including mental, physical, social, emotional and/or spiritual well-being.
- Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.
- Can lead to poor physical and mental health, obsessive behaviors, substance use, and social dysfunction.

Adverse Childhood Experiences (ACE)

Studies have found a strong graded relationship between the exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. A comprehensive assessment and careful history of their past exposure to adverse conditions and maltreatment. Interventions aimed at reducing these exposures may result improved overall health.

Long term effects of ACEs

- Alcoholism and alcohol abuse
- COPD
- Depression
- Fetal Death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease
- Liver disease
- Obesity
- Hallucinations
- Poor work performance
- Financial Stress
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Risk for sexual violence
- Poor academic achievement
- Autoimmune Diseases
- Cancer
- Frequent Headaches

Compassion and Positive Regard

Compassion and unconditional positive regard are essential both in the clinical setting and in everyday life to appreciate that people make choices based on their unique needs, experiences, and circumstances.

Patients are different in their unique way and when they are treated with dignity and respect and when they are trusted to make their own decisions, they are more likely to be sincere and adherent if you address the whole person. Use of trauma-informed communication, shared-decision making and a compassionate non-judgmental approach facilitate safe patient-centered care

<table>
<tr><th colspan="2">Communication</th></tr>
<tr><th>Terminology to use</th><th>Terminology to <u>avoid</u></th></tr>
<tr><td>• Substance use disorder
• A person with substance use disorder, drug use
• Person in recovery
• Positive drug screen
• A person with mental health disorder
• A person with mental illness</td><td>• Drug abuse
• Drug addict, druggie, junkie, crackhead
• Clean, sober
• Dirty urine
• A psycho
• A crazy patient/ “squirrely”</td></tr>
<tr><th>Trauma Informed Language</th><th><u>AVOID</u> non-trauma informed Language</th></tr>
<tr><td>• Respond sensitively
• Ask questions in a non-judgmental way
• Be mindful of tone
• Develop comfort asking and talking about trauma
• Know what to do if they say “yes”
• Avoid disapproving or implied messages</td><td>• Blaming
• Judging
• Assuming
• Dictating
• Categorizing
• Problem-based
• Dismissive
• Blunt</td></tr>
</table>

Tips for Trauma-Informed Communication

1. Ask permission to support and provide care.
2. Thank the birthing parents for their effort and hard work.
3. Establish a compassionate rapport-building relationship using the following principles:
   - **Awareness:** Appreciate the role of trauma
   - **Safety:** Place priority on physical and emotional safety
   - **Trustworthiness**: Optimize trustworthiness and maintaining boundaries
   - **Choice:** Respect autonomy
   - **Collaboration/Empowerment:** Empower thru collaboration and skill-building

Steps to Address Trauma Related Behaviors

- Request for permission, use non-judgmental signage and effectively engage in therapeutic conversation.
- Recognize that behaviors that are interpreted as “escalating”, “difficult” or “unintended” could be related to trauma and attempts to process negative past experiences.
- Recognize that birthing parents can undergo traumatic childbirth if they feel judged or shamed. Validate vulnerability and motivation for safe birthing experience.
- Black, indigenous and other birthing parents of color can experience higher rates of disrespect and mistreatment in birth that can contribute to negative encounters.
- Offer support thru comforting and positive regard; embrace a whole person trauma-informed approach. Focus on compassionate rapport-building and creating a collaborative interpersonal relationship.

- Evaluate your role as a provider and what you bring to the interaction including past experience, race, religion and internal bias towards substance use and vulnerability.
- Do not force conversation if the patient is not ready to talk. Meet the person "where they are".
- Identify common goals and listen with compassion.
- If needed, de-escalate while using grounding and positive re-directing techniques:
  - *Shared goals:* create a safe emotional experience
  - *Offer* an invitation to engage immediately, honestly, and compassionately
  - *Earn trust:* birthing parents and family members with whom clinicians have little or no previous relationship need significant attention to trust. Trusting clinician patient relationships are associated with greater treatment adherence and perceived quality of services
  - *Respond with Empathy:* Use empathic statements. A series of open-ended questions and empathic responses may help individuals feel heard and may also give time for clinicians to reflect critically on the equity of their recommendations

MOTIVATIONAL INTERVIEWING (MI)

MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

MI is a tool used to guide respectful, compassionate communication, facilitate trust building, and navigate challenging conversations and behavior change. MI is practiced with an underlying spirit or way of being with people.

Core Elements of MI

CAPE: COMPASSION, ACCEPTANCE, PARTNERSHIP, EVOCATION

Compassion: The MI practitioner actively promotes and prioritizes clients' welfare and wellbeing in a selfless manner.

Acceptance: The MI practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths, and respects a person's right to make informed choices about changing or not changing.

Partnership: MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.

Evocation. People have within themselves resources and skills needed for change. MI draws out the person's priorities, values, and wisdom to explore reasons for change and support success.

Consistent with MI = Embrace these A's	**Inconsistent with MI = Avoid these A's**
• Acceptance • Accurate Empathy • Absolute Worth • Autonomy Support • Affirmation	• Advice without permission • Arguing • Asserting Authority Instead

Four Key Principles of Motivational Interviewing

1. Resist the "righting reflex". The urge to "fix" the patient can have a paradoxical effect.
2. Understand: The patient's reasons for change are most important because these will most likely trigger behavior change.
3. Listen: MI involves as much listening as informing.
4. Empower: Convey hope around the possibility of change and support of patients' choice and autonomy related to their change goals.

Core Foundational Skills in Motivational Interviewing: OARS+I

OARS+I (**O**pen-ended questions, **A**ffirmations, **R**eflections, **S**ummaries, Asking permission to provide **I**nformation)

- ***OPEN-ENDED*** *questions encourage elaboration.*
- ***AFFIRMATIONS*** *promote optimism and acknowledge the client's expertise, efforts and experience of the client. Affirmations are not about the practitioner's approval of the client.*
- ***RELECTIONS -*** *the skill of accurate empathy:*
    - *Simple reflections: paraphrase, repeat the content*
    - *Complex reflections: reflect what the client has said as well as what he or she is experiencing but has not yet verbalized (the meaning beneath the client's words)*
- ***SUMMARIES*** *are targeted and succinct, and include elements that keep the client moving forward. The goal is to help the client organize their experience.*

References

Center for Disease Control and Prevention. Adverse Childhood Experiences (ACEs). https://www.cdc.gov/violenceprevention/aces/index.html

Felitti, V.J., et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. Am J Prev Med 1998;14(4)

Flaherty, F.G. et al. Adverse childhood experiences and child health in early adolescence. JAMA Pediatrics June 30 2013: 167(7); 622-629.

Miller, W.R. & T.B. Moyers (2017) Motivational Interviewing and the clinical science of Carl Rogers. *Journal of Consulting and Clinical Psychology, 85*(8), 757-766

Saia, K.A., et al. Caring for Pregnant Women with Opioid Use Disorder in the USA: Expanding and Improving Treatment. *Curr Obstet Gynecol Rep* **5,** 257–263 (2016). https://doi.org/10.1007/s13669-016-0168-9

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