THE MANAGEMENT OF SUBSTANCE DEPENDENT PREGNANT WOMEN — A CLINICAL AUDIT

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INTRODUCTION

Use of any type of drugs can lead to a range of medical, psychiatric and social problems and the situation becomes further complicated if the user is pregnant. Prescribed and non-prescribed substances can affect pregnancy and substances are seldom used in isolation.

About 1/3 of drug users in treatment in the U.K are female, and over 90% of these women are of childbearing age (15-39). The National Pregnancy and Health Survey conducted in the USA, found over 5% of those who gave birth during the study period had used illicit drugs while they were pregnant, with 2.9% using cannabis and 1.1% using cocaine at some point in their pregnancy(compared with 20% smoking tobacco and 18.5% drinking alcohol). The problem is therefore a significant one, particularly as it has implications for both mother and child[1].

The pregnant, substance –using woman requires a continuum of care that includes a broad range of supportive 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. Normally multidisciplinary case management is essential for the recovery and well being of the substance using woman and her family. It helps to ensure that patients receive and appropriately utilise a variety of services necessary for their improved functioning[2].

SUBJECTS AND METHODS

8 in-patients who were pregnant opiate dependent were included in the audit. This was the total number identified from existing case records on the Max Glatt Unit. The MGU is a tertiary referral centre for detoxification in West London. Guidelines for the management of Opiate dependent pregnant women are available for use by medical/nursing staff on the MGU to ensure optimum co-ordination between agencies and safety of both mother and baby.

Current procedures for staff at the time of admission as per the Guidelines include:

1. On arrival of the patient on the ward check the referral from the local community drug/alcohol team and go through the clinical details mentioned there.
2. Check from the referral form the dose of prescribed Methadone and confirm from the referrer by telephone.
3. Check the Urine Drug Screen results done in the community.
4. Confirm the plan agreed by the referring team i.e, maintenance, reduction or detoxification as mentioned in the referral form.
5. Obtain a detailed health history, including alcohol and other drug use.
6. Enquire about the duration of pregnancy and the involvement or otherwise of social services.
7. Confirm that the patient has had an ante-natal check up including abdominal ultrasound.
8. Enquire whether the patient has had blood tests done to screen for hepatitis or HIV.
9. Enquire about whether the patient has been practising safe sex and whether there is an indication for referral to the local hospital GUM clinic.
10. Request for routine blood tests, MSU and urine drug screen.
11. Conduct a comprehensive physical examination.
12. Liase with Key-worker in the community to ensure there is a care-planning meeting at the clinical review before discharge.
13. Medical and nursing staff should be aware of the

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risks of prescribing any medication particularly during the first trimester of pregnancy. If need arises then the service pharmacist and/or the consultant should be contacted.

Data was collected as per proforma on to a standardised sheet from case notes on demography, period of gestation on admission, previous and current substance use, hepatitis/HIV status, presence of comorbid mental illness, reason for admission (whether detoxification or maintenance)after-care plan and untoward adverse events.

RESULTS

All women were aged between 22 and 30. 62.5% were single. The rest were in a cohabiting relationship whose partners were all substance users. 50% had children (range 1-4) and none were living with their mothers. They were either in foster-care or living with grand parents under a guardianship order. There was only one current child care proceeding in court.

75% of the cases were admitted during the 2nd (5/8) and 3rd trimester (1/8). The rest in their 1st trimester (one admission at 6 weeks gestation).

All cases were opiate dependent. 50% used heroine as their primary drug of choice whereas 50% were poly-drug users using heroine, cocaine, cannabis, benzodiazepines and alcohol. 25% were actively injecting at time of admission. All cases used alcohol of which 25% were dependent. 87.5% smoked nicotine, on average 10-30 cigarettes per day. 25% were Hepatitis C positive and 12.5% Hepatitis B positive.

37.5% had a comorbid mental illness. 2 cases had moderate depressive disorder and 1 case had generalised anxiety disorder.

5/8 cases were admitted for methadone detoxification out of which 3/8 completed the detox. The rest were maintained on a lower dose of methadone (Table 1). This was mainly due to caution being exercised to prevent premature labour.

7/8 completed treatment, however only one discharged against medical advise during the last 2 drug free days due to conflict over her partner being not allowed on the as he also had drug dependence.

All patients had an aftercare plan prior to admission. 2 cases proceeded to a residential rehabilitation programme, others continued to engage in day programmes, AA meetings and maintained contact with their key workers.

3/8 cases had suspected signs and symptoms of premature labour during the period of admission. All were referred to the obstetrics team at the Ealing General hospital. 2 had normal ultrasound scan reports but unfortunately one miscarried. The latter had had 3 previous miscarriages, was admitted at 6 weeks gestation and had PV bleeding on the day of admission.

DISCUSSION

Guidelines for the management of opiate dependent pregnant women were adhered to by the nursing/

Table 1

Break down of various substances and status of the patient

Case No.	Methadone Detox/ stabilisation	Alcohol detox	Methadone Dose (mls) on admission	Rate of Reduction (mls)	Stabilisation Mgms/d	Detox completed Yes/No
1	Detox		35	1-2		Yes
2	Stabilisation			1-2	25mgs	
3	Detox			1-2	15mgs	No
4	Detox			1-2	6mgs	No
5	Stabilisation	Complete		1-2	15mgs	
6	Detox			1-2		Yes
7	Detox			1-2		Yes
8		Complete		1-2		Yes

medical staff at the Max Glatt unit as revealed by this audit. However there were areas where further improvement could be made. Although all cases had comprehensive histories, information was lacking about their partners, views about the pregnancy, whether those who were Hepatitis B or C positive were any form of follow-up by a specialist and whether their obstetric care was up to date.

Although the sample size was small, the audit does support opiate detoxification for pregnant women in their 2nd or 3rd trimester of pregnancy to minimise risk of adverse events.

Education and advice on the adverse effects of alcohol, benzodiazepines and cigarette smoking should be provided to all patients. Nicotine replacement therapy should be offered to those willing to quit. Clients should be offered if relevant, advice about safe sex and breast feeding.

Policy around restricting partners who were drug users to visit clients on the ward need further discussion as this can lead to frustration and dis-engagement, particularly when their partners are their main form of social support.

Better record keeping to enable easy identification of cases for future reference should be implemented as only 8 cases were identified using the present records. A re-audit of new cases admitted in the next 2 years is recommended to complete the audit cycle.

CONCLUSION

All medical/nursing staff should adhere closely to the guidelines for management of opiate dependent pregnant women. A multi-disciplinary case management and liaison with other agencies should be adopted in their care. Those motivated to stop using substances should be offered detoxification in the 2nd and 3rd trimester of pregnancy.

REFERENCE

1. National pregnancy and Health survey; National Institute of Drug Abuse 1996.
2. Day E, George S. Management of drug misuse in pregnancy. Adv Psychiat Treatment 2005; 11: 253-61.