Perinatal substance use: maternal

Clinical Guideline Presentation v2.0

45 minutes

Towards CPD Hours

References:

Queensland Clinical Guideline: Perinatal substance use: maternal is the primary reference for this package.

Recommended citation:

Queensland Clinical Guidelines. Perinatal substance use: maternal clinical guideline education presentation E21.37-1-V2-R26

Queensland Health. 2021.

Disclaimer:

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

Feedback and contact details:

M: GPO Box 48 Brisbane QLD 4001 | **E:** guidelines@health.qld.gov.au | **URL:** www.health.qld.gov.au/qcg

Funding:

Queensland Clinical Guidelines is supported by the Queensland Health, Healthcare Improvement Unit.

Copyright:

Objectives

- Understand commonly used substances in pregnancy
- Identify women using substances early in pregnancy, and implement appropriate antenatal care and assessments
- Understand treatment and management options for the antenatal, intrapartum and postnatal periods

Abbreviations

BF	Breastfeeding
CS	Caesarean section
EPDS	Edinburgh Postnatal Depression Scale
HIV	Human immunodeficiency virus
LSD	Lysergic acid diethylamide
MDMA	3,4-methylene dioxyamphetamine
NAS	Neonatal abstinence score
PCP	Phencyclidine
SIDS	Sudden infant death syndrome
SNRI	Serotonin-noradrenaline reuptake inhibitors
SSRI	Selective serotonin reuptake inhibitors
TCA	Tricyclic antidepressants
TENS	Transcutaneous nerve stimulation

Commonly used substances

Effect	Common types (non-exhaustive list)
CNS depressants	Alcohol, barbiturates, benzodiazepines, cannabis
CNS stimulants	Cocaine, nicotine, ketamine, ecstasy, amphetamines
Opioids	Codeine, heroin, morphine, methadone, oxycodone, naloxone, buprenorphine
Hallucinogens	Inhalants: solvents, aerosols, glue etc Psychedelics: LSD, PCP etc Stimulants: MDMA etc
Anti-depressants	SNRI: Efexor, duloxetine SSRI: Cipramil, lexapro, zoloft TCA: Amitriptyline

Assessment of substance use

Considerations	Aspect of care
Risk factors	Women from all ages and backgrounds may use substances in pregnancy. However is more common in women with: • co-existing mental health problems, • experiencing domestic violence, • who are marginalised and/or • are homeless
Communication	Effective and non-judgemental communication will assist in building relationships and encourage open dialogue
Timing	Routinely screen women for signs of substance use at the initial antenatal appointment and at each subsequent visit
Tools	Use validated tools (e.g. in the Pregnancy Health Record) to screen for substance use (past and present

Antenatal care assessments

- All routine antenatal care indicated
- Screening for blood borne viruses:
  - Hepatitis B—discuss neonatal vaccination and immunoglobulin within 12 hours of birth, if required
  - Hepatitis C—treatment not recommended during pregnancy
  - HIV—maintain antiretroviral therapy during pregnancy and consider caesarean section (CS) to reduce risk of transmission to the baby
  - Syphilis—routine screening

Antenatal care assessments

- Fetal growth restriction is increased with maternal substance use
  - Monitor fetal growth
  - Consider growth scans in the third trimester
- Consider an early anaesthetic review to discuss analgesia during labour, birth and postpartum
- Engage in early discussions including:
  - Neonatal abstinence syndrome and circumstances requiring the baby to be admitted to the neonatal unit
  - Feeding preference
  - Child safety
  - Discharge preparation and referral to community supports

Mental health care and referral

- Screen women for risk of postnatal depression, psychological distress, other possible mental health issues and exposure to domestic violence
- Use validated tools (e.g. Edinburgh Depression Scale (EDPS))
- Regularly offer opportunity to discuss emotional wellbeing
- Early identification and referral

Antenatal support

- Explore options for known carer and continuity of care models
- Use a non-judgemental approach
- Refer and link with appropriate services (e.g. treatment and prevention programs, mental health services, drug and alcohol services, smoking cessation)
- Use a multidisciplinary approach to all care

Intrapartum care

- Birth is a stressful time for many women, especially for women with a history of trauma which may diminish coping mechanisms and lead to feelings of helplessness or loss of control, which may trigger re-traumatisation
  - Continuity of care by known carer reduces interventions and improves women's birthing outcomes
  - Analgesic requirements may be increased in substance dependent women due to opioid tolerance
- Offer both pharmacological and non–pharmacological options

Pain relief in labour

Options	Considerations
Non-pharmacological	• TENS machine, water immersion (if available), heat packs, mobilisation, massage
Opioid dependent women	• Avoid inhaled nitrous oxide as it may be less effective • Consider use of neuraxial analgesia (epidural or combined spinal-epidural)
Women on methadone or buprenorphine programs	• Continue prescribed daily doses throughout labour to prevent acute withdrawal and continue to support the underlying substance use concerns • Opioids are safe and effective • Consider regional anaesthesia if non–pharmacological means are ineffective

Newborn care at birth

- Communicate early with neonatal teams on anticipated resuscitation requirements
- If no clinical concerns, promote rooming-in
- Provide routine postnatal care and monitoring
  - Encourage skin to skin and early initiation of breastfeeding (if appropriate)
  - Monitor for early signs of NAS

Signs of NAS in the newborn

- Suspect NAS in any baby who:
  - Is unsettled
  - Is irritable
  - Has a high pitched cry
  - Has tremors or jitteriness
  - Does not feed well and/or has diarrhoea

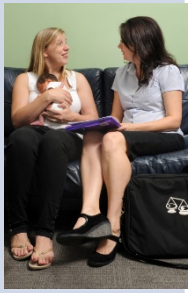
- Investigate to determine diagnosis

Postnatal

Consideration	Specific management
Pharmacological	• Support women to initiate, or continue, pharmacological withdrawal of substances used • Discuss pain management including use of a multimodal approach of nonsteroidal anti-inflammatory drugs and paracetamol
Mental health	• Continue to support women with pre-existing mental health concerns and monitor women for postnatal issues • Refer to appropriate teams for support

Parent education	• Discuss with care givers:
	  • Appropriate care of the baby
	  • Breastfeeding safety
	  • Safe sleeping and SIDS
	  • Ongoing substance use and care of the baby

Length of stay	• Support woman to remain in hospital with baby experiencing NAS, where possible, as patient or border • Consider child protection needs (as required)



Breastfeeding and substances

Substance	Breastfeeding consideration
Opioid	• Encourage BF unless other contraindications
Benzodiazepines	• Avoid BF immediately after short acting benzodiazepines • Avoid long-acting benzodiazepines
Amphetamines	• Discourage use when BF
Cocaine	• If regular use, BF not recommended
Alcohol	• Limit alcohol to two standard drinks in a day • Avoid consumption immediately before feeding
Codeine	• Contraindicated for BF women
Cannabis	• Insufficient evidence to recommend avoidance of BF • Discourage use when BF
SSRI/SNRI/TCA	• Encourage BF
Tobacco	• Encourage BF when not smoking • Support smoking cessation strategies (e.g. nicotine replacement therapy)

Breastfeeding

- Support the woman's choice of feeding and provide guidance based on substance use Breastfeeding choices based on substance/s used)
  - Discuss treatment (medication and psychological) options that would support a woman to breastfeed if she wishes
  - Support women who choose not to breastfeed

Discharge considerations

- Support woman to remain in hospital with baby, where possible
- Discuss
  - Adequate housing arrangements, and support available
  - Ability, and willingness, of the woman to care for her baby
  - Ongoing mental health issues
  - Continued substance dependence/abuse
  - Pain relief requirements on discharge and safe storage of the medications
  - Family/other support
  - Child health services
  - Mother’s groups

Discharge considerations

- Discuss community support services and refer appropriately
  - Ensure a formal handover from hospital to community services
- Discuss options for contraception
  - Particularly long-acting reversible methods
- Consider further assessment and use clinical judgement for long term follow up