MEDICALLY MONITORED ACUTE TREATMENT SERVICES

Introduction:

Pregnant women are a priority population for substance abuse treatment services. The Massachusetts Department of Public Health, Bureau of Substance Abuse Services (BSAS) is issuing this Brief Guide to support medically monitored (Level III.7) Acute Treatment Services (ATS) programs in serving pregnant women. These programs can successfully provide inpatient detoxification services for pregnant women, just as they provide these services for clients with other medical conditions (e.g., viral hepatitis or diabetes).

All ATS providers funded by the Bureau of Substance Abuse Services are required to serve pregnant women as priorities and may not deny admission to pregnant women for whom Level III.7 detoxification is appropriate. BSAS regulations (105 CMR 164.133(A)(1)(b)) establish requirements for determining level of care. Regulations (105 CMR 164.133(B)(3)) also require that programs conduct pregnancy tests for all women of child bearing age. While some pregnant women come to detox programs knowing they are pregnant, many women learn they are pregnant as a result of the pregnancy test.

This guide is intended to assist Level III.7 ATS providers in serving pregnant women by providing a brief summary concerning:

- Assessment and Admission, including pregnancy history and complications and initial planning for continuum of care
- Proximity to Obstetrical Care
- Detoxification Guidelines
- Alcohol
- Smoking
- Coordination with Behavioral Health and Medical Health Plans
- Care and Comfort During Treatment
- Resources
- Planning for the Next Level of Care
- DCF Involvement

1. Assessment and Admission:

American Society of Addiction Medicine (ASAM) Patient Placement Criteria in most cases will determine the appropriate level of care for additional treatment. It is important to know the stage of pregnancy (i.e., trimester) before initiating detoxification medications, but it is not necessary to confirm the due date prior to admission (although this must be established after admission).

1.1 Pregnancy history: A pregnancy history should be taken at admission as part of assessing the appropriate level of care. A history of any of the following indicates a need for Level IV placement in a hospital with an obstetrical service:

- Gestational diabetes
- Toxemia
- Seizures
- Hypertension
- Emergency vaginal delivery
- Emergency caesarian delivery
- Pre-term delivery

1.2 Pregnancy complications such as abdominal pain, bleeding, contractions, membrane rupture, or cessation of previously felt fetal movement indicate a need for obstetrical consultation and evaluation. In these cases, the obstetrician will determine whether the client needs hospital-based obstetrical services (including access to labor and delivery and neonatal services) or, in consultation with the ATS provider, whether the client can be safely treated in a Level III.7 setting, needs a medically managed hospital-based (Level IV) detoxification program, or needs hospital-based obstetrical care. When Level IV acute treatment is recommended, it may be best provided in a hospital with an obstetrical/labor and delivery service. This determination is made in consultation with an obstetrician.

Level IV detoxification services may also be necessary if a woman is unable to retain fluids or tolerate oral medications, due to nausea and vomiting, and thus requires intravenous fluids.

Obstetrical consultation should also be sought when the fetus is viable (c. 24 weeks or later), especially if the mother has had no prenatal care. In this case an obstetrical evaluation is important in establishing the status of the fetus. When a relationship with a pre-natal care provider exists, it is essential that the woman give consent for that provider to confirm the status of the pregnancy and health of the fetus. Similarly, consents from all prescribers of medications are necessary.

In late stages of the third trimester (34 weeks or later) the decision regarding level of care should be made in consultation with an obstetrician, due to the increased risk of preterm labor, even if no complications are present.

1.3 Other Considerations: Other assessments, such as for co-occurring disorders, should be followed as for any patient. Assessments regarding safety at home should be conducted as for any woman.

1.4 Initial Planning for Continuum of Care: It is critical to discuss discharge planning at admission. Stable transitions depend on early planning. This is particularly important for patients dependent on opioids, most of whom will require referral for medication-assisted treatment. Scheduling transfer to the Opioid Treatment Program (OTP) well before the Level III.7 detoxification discharge can avoid gaps in service and in dosing.

Women dependent on benzodiazepines (alone or in combination with other substances) will require a supportive environment, such as a Clinical Stabilization Service (CSS), to monitor withdrawal symptoms, or to monitor a slow taper from benzodiazepines when this is available. Pregnant women who may require residential rehabilitation services should be encouraged to contact the Institute for Health and Recovery, the central intake for residential services for pregnant women (617-661-3991 or toll-free 1-866-705-2807).

An obstetrical care plan should be in place before discharge from Level III.7 care. In addition, medical health insurance providers should be notified right away, since they may offer case management assistance (see item no. 6 on pg. 5).

2. Proximity to Obstetrical Care:

In most cases, pregnant women will not require care by an obstetrician during a stay in a Level III.7 program, where treatment is relatively short-term. Most pregnant women who seek detoxification services do so early in pregnancy — in fact, many discover they are pregnant as a result of the pregnancy test required at admission. Nevertheless, the possibility of complications means that proximity to obstetrical care is essential, and though the general absence of complications may mitigate that need, it is not possible to predict when and where complications will arise. For this reason, BSAS regulations (105 CMR 164.082(A)) require that programs serving pregnant women have an obstetrician on staff or available through a Qualified Service Organization Agreement.

3. Detoxification Guidelines:

As for all patients, care and treatment should be based on individual assessment and monitoring of withdrawal symptoms. For the most part, existing detoxification guidelines (e.g., use of clinical indicators of withdrawal) are applicable for pregnant women. There are some important considerations:

- Use of some anti-convulsants such as valproic acid is contraindicated during pregnancy due to risk to the fetus. Other anti-convulsants should be used only in consultation with an obstetrician.

- For opioid-dependent women, medication-assisted treatment remains the recommended course. Although methadone has long been the standard for medication-assisted treatment for opiate dependence, a growing body of literature comparing buprenorphine hydrochloride (i.e., without nalaxone, Subutex) and methadone in pregnant women reports less severe neonatal abstinence syndrome symptoms, on average, with Subutex.

  Although medication-assisted treatment is recommended, a woman may choose referral to an Opioid Treatment Program (OTP) for medically assisted withdrawal from opioids. In that case, she should be encouraged not to withdraw in the first (when the risk of miscarriage is greater) or third trimester (when the risk of preterm labor is greater). Of course, a woman may refuse transfer to an OTP for either medication-assisted treatment or medically supervised withdrawal.

- Benzodiazepine dependence presents a challenge, since withdrawal symptoms may not appear until after discharge from acute treatment. Pregnant women who detox from benzodiazepines should be encouraged to consider a 'step-down' placement where withdrawal symptoms might be monitored. While some research protocols recommend slow taper, there is no 'gold standard' as to the length of taper; lack of resources to manage a long taper can be a barrier; and practitioners express concern over potential effects of benzodiazepines on the fetus.

4. Alcohol:

According to BSAS data, opioids are the category of drug most often reported as the primary substance used by pregnant women. However, more than 40% of pregnant women admitted to all levels of care also report use of alcohol. When a pregnant woman reports any alcohol use, treatment should address alcohol regardless of whether dependence is established or

withdrawal symptoms appear. **Alcohol use during pregnancy can harm the fetus. There is no known safe level of drinking for pregnant women and any amount of drinking is risky for women who are pregnant.** Even moderate alcohol consumption during pregnancy may affect the fetus by altering psychomotor development, contributing to cognitive defects, and producing behavioral problems. Fetal Alcohol Spectrum Disorders (FASD), including Fetal Alcohol Syndrome, may result from alcohol use during pregnancy. These conditions are irreversible.

5. Smoking:

Smoking nearly doubles the risk of having a low birth weight baby, resulting from poor fetal growth or pre-term delivery. Smoking increases the risk of pre-term delivery and is associated with other pregnancy complications. The risk of relapse to other drugs is also increased by smoking. For all these reasons, if a pregnant woman smokes she should be informed of these risks and strongly encouraged to stop. Make available information about tobacco cessation services provided in your program and elsewhere. Information and telephone counseling is available through the Massachusetts Smokers' Helpline at 1-800-QUIT-NOW (Toll-free 1-800-784-8669).

6. Coordination with Behavioral Health and Medical Health Plans:

Many health plans consider pregnant women admitted for any acute care to be a priority for care, and provide some form of case management for pregnant women. The scope and components of these are not uniform across plans. Often, case management services are provided through the medical health plan (rather than the behavioral health plan). Some health plans require the woman's consent to the service before case management can be initiated.

Therefore, after obtaining a 42 CFR, Part 2 (and HIPAA as required) consent to release information, **it is important for the program or the woman to notify BOTH the behavioral health and medical health plan of the pregnant woman's admission**. Early notification of the health plan is essential to provide enough time for the health plan to contact the woman while she is still in detox.

- **If a woman does not have insurance, provide information about Healthy Start.** This is a health insurance plan for pregnant women who meet income eligibility guidelines. The program covers prenatal and post-partum care, counseling and referral. The number to call to apply is 1-800-841-2900.

7. Care and Comfort During Treatment:

The following are additional guidelines for care during a woman's stay.

Obstetrical Consultation: If a pregnant woman experiences any of the following symptoms, consult with an obstetrician (or, if one is not available, an emergency room):

- Abdominal pain
- Bleeding
- Contractions
- Rupture of membranes ('water breaks')
- If a woman has felt fetal movement and movement stops.

Fetal Heart Tone Monitoring: Some acute treatment settings have the capacity to monitor fetal heart tones. However, requiring fetal monitoring is considered a barrier to service, particularly since: it has not been established as essential for all pregnant women during what are usually brief stays in detox; is not meaningful in early stages of pregnancy; and it is not possible to state precisely when in early part of the second trimester a heart beat will be detectable. If an obstetrician determines that fetal heart tone monitoring is necessary, and the acute treatment program is not able to provide this service, the woman should be referred to a setting in a hospital with obstetrical service.

Vitamins: Some vitamins are especially important. For alcohol-dependent women, potential effects of thiamine deficiency should be addressed by providing thiamine. Folic acid, a B vitamin, helps prevent birth defects of the brain and spinal cord when taken during early pregnancy. A daily multivitamin with folic acid should be provided, as well as fortified breakfast cereals, leafy green vegetables, and orange juice, if available.

Comfort: Some pregnant women find it helpful to lie on the left side — this can make breathing easier, and improve blood flow to the fetus. It may also help to suggest that a pregnant woman put a pillow under her knees.

8. Resources:

Women entering an acute treatment setting are often uncertain and fearful of the consequences of both their substance use and their decision to enter treatment. Fortunately, a number of resources are available which can help answer questions and support women in deciding what their next steps will be.

(a) Information for Women and Their Families: BSAS has developed four resources providing specific information about pregnancy and detoxification. Three of these are designed for pregnant women:

- *Pregnant Women and Detox: The First 24 Hours:* A brief summary of what a woman can expect to happen when she first arrives at detox;
- *Detox Quick Start Guide: What Pregnant Women Need to Know:* A pocket-size summary of important steps and resources; and
- *Pregnancy and Detox: What You Need to Know:* A comprehensive guide to detox, self-care, resources for further treatment, pregnancy information, insurance, and other services.

BSAS has also developed a comprehensive guide for families, *Detox and Pregnancy: What Family and Friends Need to Know*. All of these are available at www.mass.gov/maclearinghouse.

(b) Psychoeducational Programming: Several videos and resources are available which are adaptable for use in short-term programs.

- March of Dimes (www.marchofdimes.com) website lists many downloadable resources for pregnant women.
- National Abandoned Infants Assistance Resource Center has a YouTube channel with many free resources for parents and providers regarding pregnancy, substance use, and care of substance-exposed infants (www.youtube.com/channel/UCAc3mbGcE9joIrWVJS5tLcw).

(c) Pregnancy Counseling and Choices: When entering a detoxification program, a woman may not be ready to make plans for her pregnancy. Discomfort related to withdrawal may make it difficult to think clearly. Women should be offered information about where they might discuss their choices. Prenatal providers are one resource. To find a local prenatal care provider, a woman can call a local hospital or her insurance provider. Additionally, Planned Parenthood (1-800-258-4448) can offer confidential counseling and referrals.

(d) Baby Safe Haven: Massachusetts has a "Baby Safe Haven" program which allows a parent to legally surrender a newborn less than seven days old to a hospital, police station or manned fire station without facing any charges.[1] The Department of Children & Families would be notified immediately, and the baby placed in a foster or pre-adoptive home.

(e) Parenting: Help is available for parents:

- The Children's Trust Fund of Massachusetts maintains lists of agencies offering parenting services, including parenting infants and young children. Call: 617-727-8957 www.childrenstrustma.org | e-mail: info@childrenstrustma.org.
- The Massachusetts Department of Public Health also offers a free home visiting service in 17 target communities. This website can help a woman find resources in her area: www.mass.gov/eohhs/gov/departments/dph/programs/family-health/home-visiting/about-home-visiting-programs.html

(f) Early Intervention: Early intervention programs provide developmental assessments and services both for children from birth to three years of age and for their parents. A list of early intervention services can be found at www.massfamilyties.org.

(g) WIC: The Women, Infants and Children program provides vouchers for food (such as milk, eggs, cereal, cheese, infant formula) for pregnant and post-partum women and for young children. Eligibility is based on income, residence in Massachusetts, and proof of identify. Call toll-free: 1-800-WIC-1007 or visit www.mass.gov/wic.

(h) Domestic Violence: Reports suggest that as many as one pregnant woman in ten experiences domestic violence, including verbal, emotional and physical abuse. Domestic violence during pregnancy leads to birth complications and increased risk of harm or death to the woman, the fetus and the young child. Domestic violence also increases the risk of substance abuse and depression. Pregnancy makes it harder for a woman to leave a violent home. Women should always be asked if they feel safe at home. Regardless of whether women report experiences of violence, or fear of violence, provide information about Safelink at toll-free: 1-877-785-2020 | TTY: 877-521-2601.

(i) Child care: For child care resources, visit www.masschildcare.org or call 800-345-0131.

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[1] NOTE: This may not apply if there has been a positive toxicology screen triggering a 51A at birth.

9. Planning for the Next Level of Care:

Be sure pregnant women are provided information about the range of treatment services available. The booklets *Detox Quick Start Guide: What Pregnant Women Need to Know, Pregnancy and Detox: What You Need to Know* and *Detox and Pregnancy: What Family and Friends Need to Know* summarize levels of care and list resources. Be sure women are aware of the following:

- The Bureau of Substance Abuse Services provides a helpline to locate treatment. This is available online at HelplineMA.org and by telephone at toll-free: 1-800-327-5050.
- The Institute for Health and Recovery is the central intake for residential treatment services for pregnant women. Call 617-661-3991 or toll-free: 1-866-705-2807.
- For Alcoholics Anonymous in Eastern Massachusetts call 617-426-9444. In western Massachusetts, call 413-532-2111. For a list of meetings throughout the country, visit www.aa.org.
- For Narcotics Anonymous contact info@newenglandna.org, visit www.nerna.org, or call 1-866-NA-HELP-U or toll-free: 1-866-624-3578.

10. DCF Involvement:

Women often worry about how substance use during pregnancy will affect the Department of Children & Families (DCF) involvement when the baby is born. In compliance with Massachusetts law, most hospitals will file a 51A report (a required report alleging possible abuse or neglect of a child) when a toxicology screen of the mother or newborn is positive for addictive drugs. Current DCF practice allows DCF to 'screen out' such a report if the drug is methadone or buprenorphine properly prescribed, **AND**, the mother is enrolled in an OTP and is participating in treatment, **AND** there are no other indicators of harm or threat of harm to the infant or other children in the home. It is important that treatment providers can communicate with DCF during this time to verify participation in treatment and to discuss the supports women have available to ensure their children's safety. Active engagement in treatment and other positive supports are important elements that DCF assesses. This gives women another good reason to complete their treatment in detox and seek further treatment to support their abstinence and recovery from illicit substance use. Written consent from the woman will be necessary for DCF to confirm engagement and progress in treatment.

DCF has booklets describing how they respond to these (and other reports). These are available online. Visit www.mass.gov/dcf. On the right hand side of this page, under "Publications and Reports," click "See All," then click on "Child Abuse and Neglect Publications." DCF has guides available for download in English, Spanish, Haitian Creole, Portuguese, Khmer, and Russian.

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