Policy Directive

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Neonatal Abstinence Syndrome Guidelines

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Summary Procedures to improve the health outcomes for opioid-dependent pregnant women, mothers and their newborn infants, and their families.

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NEONATAL ABSTINENCE SYNDROME GUIDELINES

The Department has developed and published the Neonatal Abstinence Syndrome (NAS) Guidelines to address recommendations from the Child Death Review Team and the NSW Pregnancy and Newborn Services Network to improve the health outcomes for opioid-dependent pregnant women, mothers and their newborn infants, and their families. A copy of the Guidelines is attached and they can also be accessed via the Health website.

The Guidelines apply to all Health workers involved with the care of pregnant women and mothers and their newborn infants who are dependent on drugs. This includes maternity, neonatal and paediatric units, early childhood health services and specialist alcohol and other drug units providing services to this target group.

The focus of the Guidelines is on:

1. The care of the Opioid-dependent pregnant woman from a drug and alcohol perspective based on the "Harm Minimisation" principle, and;
2. The care of the newborn from a child protection perspective.

Minimum standards on the management and treatment of the psychosocial and medical issues relating to NAS are established by the Guidelines through a multidisciplinary, interagency approach.

It is recognised that women who are dependent on other illicit drugs and alcohol may have similar care needs and issues. The care elements of these Guidelines also apply to this group.

Significant issues of care have been identified in the development of local clinical guidelines and underpin the Guidelines for NAS.

The Guidelines should be read in conjunction with *NSW Health Frontline Procedures for the Protection of Children and Young People (2000),* and NSW Health Department Circular, *2001/123 - Protecting Children and Young People.*

Consultation with NSW Health Drug Programs Bureau and expert practitioners in the area of maternal and neonatal health care took place to develop the Guidelines and they have been endorsed by the Perinatal Services Network, the Maternal and Perinatal Advisory Committee and the Department of Community Services.

Robyn Kruk
Director-General

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GUIDELINES

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NEONATAL ABSTINENCE SYNDROME GUIDELINES

Foreword

Neonatal Abstinence Syndrome (NAS) occurs in newborns going through withdrawal as a result of the mother's dependence on drugs during pregnancy. It is characterised by signs and symptoms of central nervous system hyperirritability, gastrointestinal dysfunction and respiratory distress, and by vague autonomic symptoms that include yawning, sneezing, mottling and fever. This syndrome usually begins within 72 hours, but may appear up to two weeks after birth.

The NAS Guidelines address recommendations from the Child Death Review Team and the NSW Pregnancy and Newborn Services Network regarding improving the health outcomes for opioid-dependent pregnant women, mothers and their newborn infants, and their families.

The Guidelines apply to all Health workers involved with the care of pregnant women and mothers and their newborn infants who are affected by drugs. This includes maternity, neonatal and paediatric units, early childhood health services and specialist alcohol and other drug units providing services to this target group.

The issue of NAS and the management of newborns to mothers with a history of opioid use is addressed in these Guidelines. It concentrates on two main aspects of care:

1. The care of the opioid-dependent pregnant woman from a drug and alcohol perspective based on the "Harm Minimisation" principle, and;
2. The care of the newborn from a child protection perspective.

The focus of the Guidelines is opiate dependent women and NAS, however, it is recognised that women who are dependent on other illicit drugs and alcohol may have similar care needs and issues. Therefore, the care elements of the Guidelines (which excludes elements specifically relating to opiate pharmacology as found in parts of Section 4.1 and 5.3) also apply to this group of women and their infants.

Minimum standards in the management of NAS are outlined in the Guidelines. Area Health Services are responsible for ensuring that maternity services develop clear clinical guidelines and protocols relevant to each maternity health care facility, based on these Guidelines.

Significant issues of care have been identified in the development of local clinical guidelines and underpin the Guidelines for NAS. The issues include: the early detection and engagement of the opiate dependent pregnant woman and new mothers into multi-disciplinary team care, the care of the newborn child, the postnatal care of both the mother and child, and the care and protection responsibilities incumbent on all those clinically involved in the care of the newborn.

The Guidelines should be read in conjunction with:
NSW Health Frontline Procedures for the Protection of Children and Young People (2000)
NSW Health Department Circular, *2001/123 - Protecting Children and Young People.*

Introduction

In line with a growing worldwide trend of increasing recreational drug use there is an increase in the incidence of women of childbearing age becoming dependent on drugs of addiction, resulting in higher chemical use in pregnancy. The precise incidence of illicit drug use in Australia is unknown. The NSW Pregnancy and Newborn Services Network[1] suggests that there has been a widespread increase in the number of opioid-dependent pregnant women, often involving polydrug use, presenting to maternity hospitals in New South Wales.

Newborn infants of opioid-dependent women are at risk of adverse effects from these drugs or "withdrawal" from intra-uterine exposure. This condition is called Neonatal Abstinence Syndrome (NAS), which usually begins within 72 hours, but may appear two weeks after birth. It is characterised by signs and symptoms of central nervous system hyperirritability, gastrointestinal dysfunction and respiratory distress, and by vague autonomic symptoms that include yawning, sneezing, mottling and fever[2].

The NSW Health Department recognises that there are many drugs of addiction that may also need to be considered in the overall management of opioid-dependent pregnant women. Other drugs may include cocaine, amphetamines, benzodiazepines, alcohol and tobacco. Specific information on the management of other drug issues can be accessed through the Area Health Service Drug and Alcohol Units, specialist pregnancy drug and alcohol services, the Statewide Specialist Drug and Alcohol Advisory Service (SAS) (see Section 9), NSW Health *Alcohol and Other Drugs Policy for Nursing Practice in NSW: Framework for Progress 2000-2003* and *Alcohol and Other Drugs Policy for Nursing Practice in NSW: Clinical Guidelines* (2000).

NSW Health recognises that people with opioid dependence usually have simultaneous psychological, social and health problems that can be exacerbated in times of increased stress such as pregnancy. Many women are more motivated during pregnancy to make important health and lifestyle changes. This is an ideal time to engage, or more fully engage, a woman in care for her drug and other problems. A range of services is required to work collaboratively in order to ensure optimal outcomes for both the mother and newborn. The aim is to minimise the likelihood of complications and to provide comprehensive antenatal and postnatal care in a non-judgemental, non-threatening environment.

Additionally, every Health worker has a responsibility to protect the health, safety and welfare of newborns that may be at risk of harm. Major policy changes have occurred in the area of child protection through the enactment of the *Children and Young Persons (Care and Protection) Act* 1998 (NSW). The Act emphasises the importance of reporting children who may be "at risk of harm" to the NSW Department of Community Services (DoCS), in circumstances where current concerns exist for their safety, welfare or wellbeing.

Under Section 25 of the Act, a person who has reasonable grounds to suspect before the birth of an infant that it may be "at risk of harm" after birth, may make a prenatal report to DoCS. The purpose of this report is to secure supportive intervention for the

pregnant woman. A report must also be made by the Health worker if the other children of the pregnant mother are at risk (Section 27).

It may be important to inform families that they may also make a request to DoCS for assistance (Sections 20-22). Health workers should refer to the NSW Health *Frontline Procedures for the Protection of Children and Young People* (2000). This document outlines the relevant Guidelines including the documentation of situations where consideration may be required for a prenatal report to DoCS.

1. Continuum of Care

NSW Health recognises that pregnancy, labour, birth and parenting are significant and meaningful life events, and acknowledges the right of the consumer to access safe maternity care and quality maternity services. Continuity of care and consistent information that is culturally sensitive and appropriate are essential to the provision of maternity care[3].

The continuum of care (see Diagram 1), includes care of the mother and infant from antenatal care through discharge and follow up. To provide this type of care, Area Health Services must ensure that attention to child protection issues, drug and alcohol and relevant obstetric management is provided through:

- Active collaboration between maternity hospitals, drug and alcohol services;
- Promotion of links between specialist drugs in pregnancy services and primary care services, and;
- Health services working together to provide appropriate care for the pregnant woman through mechanisms such as case discussion, joint care planning, as well as regular communication in providing care prior to the birth through discharge and post natal care.

To ensure optimal outcomes for both the mother and infant, a collaborative effort is required for care provided by a multi-disciplinary team. Local policies and guidelines need to be formalised to ensure that the roles and responsibilities of the multi-disciplinary team are clear. A Health worker should be identified to be responsible for establishing and coordinating the multi-disciplinary team on presentation to the health facility of a pregnant woman with a history of drug use.

Area Health Services must ensure that these teams comprise, as a minimum, a representative from each of the following professional groups:

- Obstetrician/obstetric registrar/or General Practitioner (GP) obstetrician;
- Midwife;
- Paediatrician or medical officer skilled in paediatrics;
- Drug and alcohol worker;
- Social worker, and;
- Early childhood/primary health nurse.

Where appropriate, the team will also include:

- Mental health worker;
- Aboriginal/ethnic health worker;
- GP
- Methadone prescriber or clinic representative;
- DoCS case worker;
- Non government organisation family support services, and;
- Allied health worker.

Where underlying mental illness is suspected, a mental health worker should be involved in the multi-disciplinary team. If possible the GP should also be included in the multi-disciplinary team, because in most cases the GP is the initial provider of maternity care and may also be involved in the postnatal care of the woman and infant after their discharge from the hospital.

The multi-disciplinary team has a pivotal role in the case management of the pregnant woman to enable the maintenance of contact and a good rapport, irrespective of the necessary intervention/s to ensure mother-infant wellbeing. This type of early coordination and planning aims to safeguard the health, safety and wellbeing of the infant and is likely to reduce the need for statutory intervention.

The role of the multi-disciplinary team is to:

- Provide continuity of staff to avoid fragmentation of care;
- Appoint a case manager;
- Engage with clients as early as possible in the ante-natal period;
- Develop written, formalised care plans for the management of infants born to mothers with a history of drug use;
- Provide a foundation for a comprehensive program of ongoing case management;
- Act as "advocate" for the welfare of the mother-infant unit;
- Develop and implement a clear discharge plan, including referral to appropriate services;
- Conduct a preliminary assessment of possible risk to the child before and after birth, and;
- Ensure that care includes attention to psychosocial as well as medical needs.

Additional information on the management of this issue may be provided by the following organisations:

- For information on perinatal and neonatal clinical management contact the Chemical Use in Pregnancy Service (CUPS) at the Langton Centre on (02) 9332 8777;
- For information on maternal drug and alcohol management contact the Statewide Specialist Drug and Alcohol Advisory Service (SAS) on (02) 1800 023 687 (24 hrs a day);
- For information on organisational issues of obstetric and neonatal care, contact the NSW Pregnancy and Newborn Services Network (PSN) on (02) 9351 7318.
- Additional contacts are provided in Section 9.

Diagram 1. **Continuum of care for babies with NAS born to substance using mothers.**

Antenatal

Yes - Attended antenatal care

- Woman assessed prenatally and parental substance use identified.
- Multi-disciplinary care team established with nominated case manager.

Action:

- Comprehensive physical, and psychosocial assessments undertaken;
- Woman's needs identified eg referral to DoCS, Chemical Use in Pregnancy Service;
- Refer to Families First Health Home Visiting;
- Antenatal collaboration and communication between drug and alcohol treatment providers and antenatal care provider;
- If in pharmacotherapy treatment ensure regular review is built into treatment plan. This includes antenatal collaboration and communication between drug and alcohol treatment providers and antenatal care provider.

Note: Prenatal reports to DoCS may be made before the birth of the child if there are concerns of risk of harm to the child after birth.

No - Antenatal care not attended

- No prenatal assessment of pregnant woman as no or infrequent contact with birthing hospital.

Action:

- Contact other health facilities or GP known to mother;
- Active attempt by staff to engage in care processes. Woman's needs identified eg referral to DoCS, Chemical Use in Pregnancy Service;
- Refer to Families First Health Home Visiting;
- If in pharmacotherapy treatment ensure regular review is built in to treatment plan. This includes antenatal collaboration and communication between drug and alcohol treatment providers and antenatal care provider.

Note: Prenatal reports to DoCS may be made before the birth of the child if there are concerns of risk of harm to the child after birth.

Perinatal

Planned presentation

- Woman's medical, psychosocial notes and history available.

Action:

- Assess woman's level of intoxication or withdrawal;
- If in withdrawal seek urgent drug and alcohol medical assessment and contact the local drug and alcohol service and if not available the Statewide Specialist Drug and Alcohol Advisory Service.
- Immediate care and assessment of the newborn at birth

***WARNING: Naloxone (Narcan) should not be administered to babies whose mothers are known or suspected to be addicted to opioids. In such cases, an abrupt and complete reversal of opioid effects may precipitate an acute withdrawal syndrome.**

- Where parental substance use is identified on the ward, hospital staff, in consultation with a health worker with expertise in child protection should conduct a preliminary assessment of risk to the infant, and where child protection concerns are identified a report to DoCS must be made.

Note: May be a flag on file from previous report to DoCS.

Unplanned presentation

- No notes available.
- Possible limited verbal communication with woman.
- Substance use may be identified.

Action:

- Assess woman's level of intoxication or withdrawal;
- If in withdrawal seek urgent drug and alcohol medical assessment and contact the local drug and alcohol service and if not available the Statewide Specialist Drug and Alcohol Advisory Service.
- Immediate care and assessment of the newborn at birth

***WARNING: Naloxone (Narcan) should not be administered to babies whose mothers are known or suspected to be addicted to opioids. In such cases, an abrupt and complete reversal of opioid effects may precipitate an acute withdrawal syndrome.**

- Where parental substance use is identified on the ward, hospital staff, in consultation with a health worker with expertise in child protection should conduct a preliminary assessment of risk to the infant, and where child protection concerns are identified a report to DoCS should be made.

Note: May be a flag on file from previous report to DoCS.

*NSW Health Circular 2002/73: *Observation and management of newborn infants with respiratory maladaption to birth, including infants exposed to intrapartum opioids administered to the mother during labour;* and
NSW Health Circular 2002/30: *Framework for Area Health Services to develop policy and procedures relating to clinical care and resuscitation of the newly born infant*
Also refer to NSW Health Circular 2000/63: *Screening for sexually transmissable diseases (STDs) and blood borne viruses (BBVs) in pregnancy*

Postnatal

- Assessment of baby for withdrawal symptoms using standardised measures eg Finnegan scale[#].
- Assessment of maternal well being and parenting skills.

Action:

- A case conference should be convened by the multi-disciplinary team to formulate a discharge plan with clear responsibilities and timeframes;
- A discharge planning meeting should be attended by the parent/s, members of a multi-disciplinary team and representatives from relevant services eg Early Childhood Health Service, drug and alcohol services, Community Health Centres and family support services. **Infants should not be discharged from hospital without a formal discharge plan, which attends to the parents' and child's needs, including referral to drug and alcohol services.**
- A formal, written discharge plan completed and circulated to all parties;
- Continuing drug and alcohol treatment for mother confirmed and organised eg will she require methadone to be organised post discharge;
- Report any child protection concerns to DoCS.

[#] See Finnegan in Ward et al 1998

- Assessment of baby for withdrawal symptoms using standardised measures.

Action:

- Where necessary treat baby as per NAS management protocol;
- Monitor woman for withdrawal signs and obtain a drug history as soon as possible. In conjunction with the woman and the drug and alcohol medical specialist an appropriate treatment plan to be developed or if specialist unavailable, contact the Statewide Specialist Drug and Alcohol Advisory Service. Multi-disciplinary team, community care providers and parents to be involved.
- A case conference should be convened by multi-disciplinary team to formulate a discharge plan with clear responsibilities and timeframes;
- A discharge planning meeting should be attended by the parent/s, members of a multi-disciplinary team and representatives from relevant services eg Early Childhood Centre, drug and alcohol services, Community Health Centres and family support services. **Infants should not be discharged from hospital without a formal discharge plan which attends to the parents' and child's needs, including referral to drug and alcohol services.**
- A formal, written discharge plan completed and circulated to all parties;
- Continuing drug and alcohol treatment for mother confirmed and organised eg will require methadone to be organised post discharge;
- Report any child protection concerns to DoCS.

Discharge and Follow up

Do not discharge before 5-7 days

- Formal written discharge plan discussed with mother and partner, circulated to multi-disciplinary team care team and referrals made if required;
- Mother and baby discharged home after 5-7 days or later, following medical and psychosocial assessment that indicates a stable condition.

Infant follow up:

- Infants at risk of NAS should be referred to appropriate paediatric follow up and on-going follow up at an Early Childhood Health Service or with early intervention teams;
- If on medication for NAS, infants require regular reviews to reduce medication and monitor progress.

Mothers follow up:

- Mothers referred back to community case managers for follow up and ongoing management as per discharge plan eg Early Childhood Health Service and if available with domiciliary midwife via home visit or Families First Health Home Visiting for 8 - 10 weeks or for longer as required;
- Mothers in methadone treatment require continuation of dosing immediately post-discharge to be organised.

Self-discharged against medical advice.

Steps to Take:

- If mother indicates intention to leave hospital with baby before 5-7days or against medical advice at a later date, the multi-disciplinary team must be informed about the mother's intent and the following steps should be taken:
  1. Alert DoCS on telephone Helpline-133627 or fax-96337666. If urgent DoCS may consider assuming care of the infant;
  2. Follow DoCS reporting procedure - refer to NSW Health Frontline Guidelines for the Protection of Children and Young People (2000);
  3. Additionally, contact DoCS case worker if allocated;
  4. Record in medical notes of intention of mother to leave hospital against medical advice.

Note: Possible activity by DoCS may include assessment of situation that may result in DoCS assuming emergency care of infant.

Infant follow up:

- Infants at risk of NAS should be referred to appropriate paediatric follow up and on-going follow up at an Early Childhood Health Service or with early intervention teams;
- If on medication for NAS, infants require regular reviews to reduce medication and monitor progress.

Mothers follow up:

- Mothers referred back to community case managers for follow up and ongoing management at eg Early Childhood Health Service and if available follow up with domiciliary midwife via home visit or Families First Health Home Visiting for 8-10 weeks or for longer as required;
- Mothers in methadone treatment require continuation of dosing immediately post-discharge to be organised via methadone prescriber or methadone clinic.

2.Pregnancy Care

The assessment and management of women and their infants with intrauterine drug exposure poses significant challenges for the Health worker. Health services for these women should be accessible, appropriate and provided in a non-judgemental and non-threatening environment to encourage attendance at antenatal clinics. Research indicates that women who use illicit drugs and who are supported by financial, social and antenatal care services during pregnancy, have comparable outcomes to non-drug using mothers[4,5,6].

To improve the health outcomes of opioid dependent pregnant women the treatment of choice is methadone. The *NSW Health Department*, *Pregnancy Care Handbook*[7], indicates that replacing heroin as soon as possible in pregnancy reduces the risks to the baby, improves the health status of the mother, and:

- Improves maternal nutrition, increasing the weight of the newborn;
- Improves the woman's ability to participate in prenatal care;
- Reduces obstetric complications and lessens possibility of foetal death;
- Improves overall lifestyle, and;
- Reduces the risk of HIV infection.

Early engagement and early recognition of risk indicators are important as they provide an opportunity to:

- Develop a rapport between the mother and Health workers;
- Establish a baseline health assessment of both the mother and unborn baby;
- Provide for support and referral to relevant health and social services that may include DoCS and accommodation services.

2.1 Early Engagement

Early engagement is a key component of effective antenatal care for all women. The objective is to engage women in aspects of their own health during pregnancy as well as that of the unborn child and to develop effective relationships that build trust and confidence. Some key strategies in achieving this objective are:

- Encouraging regular antenatal visits by women affected by drug use in pregnancy to a midwives clinic. Where possible this will include a midwife drug specialist and referral to a drug and alcohol service specialising in drug use in pregnancy;
- Meeting with the multi-disciplinary team to ensure continuity of care including clinical assessment and the development of a formal written care plan;
- Providing information about general aspects of pregnancy, labour, birth and early parenting;
- Providing information on the effects of drugs during pregnancy on the unborn baby and complications that may result in poor pregnancy outcomes eg antepartum haemorrhage, low birth weight and Neonatal Abstinence Syndrome;
- Undertaking regular care plan and drug and alcohol treatment plan reviews for those in pharmocotherapy treatment. Attendance for antenatal visits should be incorporated into the drug and alcohol treatment plan;
- Informing the mother and her partner early about the plans for her care including the length of hospital stay;

- Referral for home based support to Families First Health Home Visiting where available, for ongoing support before and after giving birth;
- Referral of women who are concerned about birth defects resulting from chemical use to the Mothersafe Program (NSW Medications in Pregnancy and Lactation Advisory Service) to discuss these issues on 02 9382 6539.

2.2 *Early Recognition*

The objective of early recognition is to assess and diagnose in a timely manner, any condition or change in the progress of the pregnancy or the woman's overall health and wellbeing.

Early recognition includes the following:

2.2.1 Antenatal history/screening

- Ensure that an accurate history is taken of maternal drug use for all women attending antenatal care, including the type of drug used such as methadone, the frequency, amount, duration, and type of treatment at the time of admission, and;
- Preparation of a prenatal report to DoCS if appropriate.

2.2.2 Assessment and identification of risk

The women who are most vulnerable and “at risk” include adolescent mothers, intravenous drug users and victims of domestic violence. Careful consideration needs to be given to the need to make a prenatal report to DoCS for women who are assessed as drug dependent. Area Health Services must ensure that there are mechanisms for undertaking further risk assessment with women in these target groups. Issues covered will include drug use patterns and their likely impact on the child and, supports and risks posed by the mother’s partner including the presence of domestic violence. The Integrated Perinatal Care psychosocial screening assessment may form the basis of such an assessment.

Where an unborn child is identified "at risk", a pre-natal report should be made to DoCS. Further indicators of child abuse and neglect can be found in the NSW Health *Frontline Guidelines for the Protection of Children and Young People* (2000). Considerations need to be documented in the patient's medical records as to the reasons for the decision to proceed or not to proceed with a report as per NSW Health *Frontline Guidelines for the Protection of Children and Young People* (2000). Indicators of risk include:

- A lack of medical care due to inconsistent or non attendance at prenatal clinic;
- An apparent lack of adequate social supports;
- The mother and/or partner is engaging in high risk behaviours;
- Where the mother is experiencing domestic violence;
- Where intervention by DoCS has previously occurred in the family;
- Where a baby is likely to be at risk because of mental illness of one or both of the parents;
- Previous child death, and/or;
- The cumulation of any of the above.

Every Health worker should have a clear understanding of their responsibilities to protect the safety, welfare and wellbeing of children under the Children and Young Persons (Care and Protection) Act 1998 (NSW). Health workers should refer to the NSW Health *Frontline Guidelines for the Protection of Children and Young People* (2000), for further information when assessing if a child is at risk of harm from abuse or neglect.

3. Perinatal Care

3.1 Monitoring health of mother and baby

Consideration has been given to the effects of substance use on the mother and infant during labour. Adequate treatment of opioid withdrawal during labour is important to minimise the mother's discomfort and assist in optimising health outcomes for the mother and infant.

Other clinical issues specific to substance using mothers in labour should be considered:

- Frequent monitoring - mother and foetus eg foetal heart rate, rate of dilatation, bleeding and signs of withdrawal by mother;
- Pain relief, and;
- Infection status - HIV, hepatitis, sexually transmitted diseases.

4. Postnatal Care

Postnatal care of the mother and baby affected by drug use is very important[8,9]. Approaches to the overall care of the baby which are seen by the mother to be ineffective or punitive may lead to greater alienation of the mother and poor outcomes for herself and her infant.

The postnatal period offers an opportunity for the:

- Facilitation of mother-baby relationship;
- Assessment of maternal wellbeing and parenting skills;
- Discharge planning meeting held with the multi-disciplinary team, community care providers and parents. When the written discharge plan is completed it should be circulated to all parties, and;
- Report of any child protection concerns to DoCS.

For symptomatic babies, Area Health Services should ensure that maternity units provide ‘rooming-in’ facilities for mothers while the baby is on the ward, to support the attachment process. A Health worker, with expertise in child protection, will be accessible to medical and other Health workers on each obstetric ward to assist in the:

- Recognition of child protection issues arising from parental substance use;
- Appropriate care planning, and;
- Referral.

Child at Risk Committees and Physical Abuse and Neglect of Children (PANOC) services may be a useful resource.

The principle for asymptomatic babies is to remain with the mother.

Area Health Services will ensure that where NAS is diagnosed (see glossary for symptoms), mothers and infants are to remain in hospital for no less than 5-7 days[2,10]. This is based on the premise that the onset of NAS usually begins within 72 hours, but may appear up to two weeks after birth. Additionally, this period allows reasonable time for medical and psychosocial assessments, formal discharge planning and arrangement for adequate follow up. Signs and symptoms of drug withdrawal should be monitored by a standardised method such as the Finnegan scoring chart (See Ward et al, 1998).

If control of the infant's NAS symptoms is not achieved within 5-7 days, or the infant is considered "at risk", the timing of discharge should be a decision determined by the multi- disciplinary care team.

4.1 Medical management of mother and baby

The management of the mother should include an assessment of drug use and drug related problems, explanation of treatment options, and offer of treatment that could commence in hospital. If pharmacotherapy treatment is appropriate for the mother, methadone maintenance is currently the treatment of choice for breast feeding women. If the mother is already in methadone treatment, changes to the methadone dose may be required. Breastfeeding is encouraged where there are no contraindications and mothers should be counselled regarding the small amount of drug transferred from breast milk.

Urine and /or meconium drug screening may be indicated if drug history is less than satisfactory. Clinicians should be aware of the possibility of false negative or positive results.

Morphine is the medication of choice in the management of narcotic dependent infants. Phenobarbitone is useful in opioid withdrawal, in combination with morphine when doses of morphine are escalated to "ceiling levels" but control is less than complete. Phenobarbitone is also the drug of choice in withdrawal from non-opioid drugs of addiction (where morphine is NOT indicated) and is particularly indicated when abstinence symptoms include convulsions.

Other agents, used overseas, are regarded by NSW Health as unsuitable. Though often seen to be effective, these medications have less specific modes of action in the clinical situation of abstinence and may have undesirable disadvantages. Chlorpromazine (Largactil) is commonly used in the UK but merely has a tranquillising effect and may cause dystonic reactions. Paregoric, recommended for first-line treatment for opiate NAS in the USA, contains Camphor (a CNS stimulant) and alcohol and is an unstable opiate compound. The use of methadone may seem

desirable as it permits convenient, 12 hourly dosing, however, its 26 hour half life makes it difficult to control for dose reduction.

Some special considerations for the care of the mother and infant are as follows:

- Avoid use of Naloxone (Narcan) during any resuscitation if the mother is dependent on opioids, as per Circular 2002/73: *Observation and management of newborn infants with respiratory maladaptation at birth, including infants exposed to intrapartum opioids administered to the mother during labour* . See also Circular 2002/30: *Framework for Area Health Services to develop policy and procedures relating to clinical care and resuscitation of the newly born infant*
- Monitor the baby for early signs of NAS using withdrawal monitoring mechanism eg the Finnegan scoring chart (See Ward J et al 1998) and;
- Provide appropriate medication for control of abstinence symptoms.

5. Discharge Planning and Guidelines

The role of the multi-disciplinary team is to manage discharge planning. This process should optimally involve discharge planners and support services post discharge eg physician/GP, postnatal midwives clinic or midwives home visiting services, mental health worker, social worker, drug and alcohol services, DoCS, early childhood services, Families First Health Home Visiting services and if appropriate, a private methadone prescriber or methadone clinic representative.

Area Health Services must ensure where parental substance use has been identified on the obstetric ward, that Health workers with expertise in child protection conduct a preliminary assessment of risk to the infant before the infant leaves hospital. This assessment needs to consider the cumulation of risk factors. Where child protection issues are identified (including where a parent is seeking early discharge of an infant before the infant is fully recovered against medical advice):

- A report to DoCS must be made;
- A protection planning meeting should be held prior to discharge in accordance with the NSW Health *Interagency Guidelines for Child Protection Intervention* and *Frontline Procedures for the Protection of Children and Young People* (2000).

If parental substance use is identified but the assessment of the multi-disciplinary team in consultation with a Health worker with expertise in child protection is that a report to DoCS is not warranted, a case conference should be convened by the multi-disciplinary team.

5.1 Planned Discharge with medical consent

The multi-disciplinary team should convene a case conference to formulate a written discharge plan with clear responsibilities and time frames. Ideally, this would include referral to a multi-disciplinary service with access to a midwife, paediatric clinician, drug and alcohol worker, and social worker who can provide adequate support and monitoring. Continuity of care is an important key to developing effective relationships with the mother, infant and family.

A formal documented discharge-planning meeting must be held prior to discharge. At this meeting the written plan should be handed to all the parties expected to provide care including the mother and all services to which referrals are made eg representatives from relevant services which might include Early Childhood Health Services, drug and alcohol services, Community Health Centres, GP, and family support services.

There may be situations where the mother relocates postnatally and/or post discharge. Planning needs to canvass this possibility with the mother to maximise the likelihood of ongoing care. In these situations the case manager should:

- Contact the local Area to provide early advice;
- Forward a copy of the discharge plan, and;
- Request the local Area to identify its own team to maintain continuum of care.

Where the multi-disciplinary team has identified child protection concerns, a Protection Planning Meeting (PPM) should be held prior to discharge in accordance with the guidelines and timeframes identified in the *Interagency Guidelines for Child Protection Intervention (2000).* The purpose of the PPM is to provide practical strategies that may minimise the need for DoCS involvement. The *Interagency Guidelines* document is available on the Health Child Protection Intranet site:

http://internal.health.nsw.gov.au/policy/hsp/child-protection

Infants should not be discharged from hospital without a formal, written discharge plan that attends to the needs of the mother and the infant, including referral to drug and alcohol services. Mechanisms also need to be established to ensure the plan is implemented and case coordinated following discharge.

5.2 Unplanned Early Discharge without medical consent

Local policy and guidelines should be established to cover circumstances where a mother seeks early discharge. Requests for the early discharge of an infant prior to 5-7 days should be refused and an immediate report to DoCS should be made if the mother indicates she does not intend to comply with the required hospital stay. The multi-disciplinary team should be informed immediately of the mother's intention to leave against the advice of Health workers. The following Guidelines also apply.

Health workers must follow the NSW Health Department Circular 2001/123: *Protecting children and young people:recognising and reporting suspected risk of harm and responding to requests from the Department of Community Services* for reporting*:*

- In an emergency, such as where the mother leaves the hospital with the infant against medical advice, the Health worker should use the DoCS Emergency Paging Procedure;
- Alert DoCS using the telephone Helpline on 133627. If after reasonable attempts to telephone the DoCS Helpline, Health workers are unable to get through they should fax the DoCS Helpline on 9633 7666;
- If appropriate, DoCS may consider assuming emergency care of the infant under the *Children and Young Persons (Care and Protection) Act* 1998 (NSW);

- Health workers should also contact the mother's DoCS case worker if allocated, and;
- Health workers must record in the medical notes the mother's intention and any action taken by the mother to leave the hospital against medical advice and resulting actions of staff.

5.3 Medication on discharge

The practice of discharging infants on a reducing regime of morphine is beneficial in promoting the mother-infant unit and reduces the duration of hospitalisation. This process should only be undertaken collaboratively by the multi-disciplinary team, the dispensing pharmacy and the parents with the support of a coordinated follow up clinic. A clinical decision on suitability should be based on the stable control of the infant's withdrawal symptoms, the reliability of parents in administering the withdrawal medication, and the home environment.

5.3.1 Discharge Protocols

A coordinated follow up program with the relevant drug and alcohol clinic should be established for the mother by the multi-disciplinary team as part of the discharge planning process. In addition, clear protocols must be developed, issued and discussed with the mother, partner or support person to address dispensing guidelines. For safety, the medication (eg morphine and/or phenobarbitone), should be prescribed and dispensed with consistency in formulation and only for a limited time period (usually until the next methadone clinic visit). Safety precautions including distinctively labelled childproof bottles and clear instructions should be employed. A side-bottle with small aliquot may be used to cover accidental spillage after hours.

5.3.2 Length of treatment

Current research indicates that the duration of the withdrawal period is usually several weeks but may be as long as six months. The emphasis should be on avoidance of the return of subtle, but disturbing, symptoms of abstinence, rather than the rapid move towards cessation of a treatment.

6. Coordinated Follow Up and Support

Area Health Services are encouraged to facilitate stronger links between maternity services, social work departments, early childhood health services, other community health services, GPs and methadone prescribers. This is to ensure a continuum of care for substance dependent women and their infants.

Follow up for the infant

- Infants at risk of NAS should be referred to appropriate paediatric follow up and on-going follow up at the appropriate Early Childhood Health Service or with early intervention teams.
- Infants on medication for NAS require regular reviews by the allocated carer as per their discharge plan, to reduce medication and monitor progress.

Follow up for the mother

The mother should be referred back to community care such as the Early Childhood Health Service for follow up and ongoing management for 8 to 10 weeks as per her discharge plan. Additionally, if available, a domiciliary midwife should conduct a home visit in this period. Sustained home visiting through the Families First Strategy should be considered for this group of mothers. A postnatal check at six weeks should include the partner and Health workers involved in the ongoing care of the mother and baby including the:

- Medical officer;
- Midwife, and;
- Social worker.

If appropriate other representatives may include:

- General practitioner;
- DoCS worker (if required);
- Drug and alcohol service, and;
- Methadone clinic or pharmacy provider.

In many instances where the mother is on methadone maintenance and the GP is also the mother's methadone prescriber, the GP can assist in monitoring the health of the mother and infant. Therefore, it is important to include the GP in the discharge planning process or have a mechanism in place to inform the GP of the mother's current treatment regime. Additionally, if the mother is in treatment through a methadone clinic, the methadone clinic nurses see the mother and baby regularly, in most cases daily, and can also monitor the mother's and infant's conditions.

7. Training

To assist with the assessment and identification of risk, Area Health Services will ensure that medical and other Health workers involved with substance using pregnant women, their partners and their infants have undertaken, as a minimum, the course "Playing your Part". This course assists Health workers to recognise and respond to risk of harm for children and young people under the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*.

Health workers can also access specialist training regarding working with parents with substance use issues through the Education Centre Against Violence (02) 9840 3737.

Additionally Area Health Services are to ensure that Health workers are trained to:

- Recognise the indicators of substance use;
- Conduct thorough multi-disciplinary psychosocial assessments;
- Understand the impact of parental substance use on the ability to parent and on infant and child health and development, and;
- Understand the role of the Health worker and their responsibilities regarding child protection.

8. Collaborative Data

It is recommended that each health care facility should maintain a record register to audit all aspects of management and workload. The NSW Pregnancy and Newborn Services Network (PSN) is undertaking a consultancy process in establishing a common data collection.

9. Contact Information

For further information on the Guidelines contact the NSW Health Department:

- Violence Prevention Unit, Primary Health and Community Care Branch (02) 9391 9317.
- Drug Programs Bureau (02) 9391 9262.

For additional information contact:

- Chemical Use in Pregnancy Service (CUPS) - (02) 9332 8777.
- Mothersafe Program (NSW Medications in Pregnancy and Lactation Advisory Service) – (02) 9382 6539
- Statewide Specialist Drug and Alcohol Advisory Service (SAS) 24 hours a day - 1800 023 687.
- NSW Pregnancy and Newborn Services Network (PSN) - (02) 9351 7318.

Further information is available on the NSW Health Department Child Protection intranet site: http://internal.health.nsw.gov.au/policy/hsp/child-protection.

Glossary

Assessment
A process used to determine and state a person's capabilities, needs and problems in order to develop an appropriate care plan.

Care plan
A comprehensive longitudinal documented plan for the care of the individual patient.

Case conference
Meetings of health and care providers to plan care for the individual patients with multi-disciplinary care needs.

Case manager
Title of the NSW Health Department Health worker appointed as the case manager for the care of the patient.

Case worker
Title of Department of Community Services officer responsible for child protection issues.

Discharge plan
A comprehensive plan for the care of the individual patient after discharge from hospital.

Family Support services
Non-Government agencies providing a range of home-based, group work and community development services with a holistic family focus.

Health care facility
Any public hospital setting or licensed private hospital, nursing home and day procedure centre.

Health worker
Persons employed by the NSW Health Department and Area Health Services in a health care profession.

Neonatal Abstinence Syndrome (NAS) symptoms
Neonatal withdrawal as a result of the mother's dependence on drugs during pregnancy and is characterised by signs and symptoms of central nervous system hyperirritability, gastrointestinal dysfunction and respiratory distress, and by vague autonomic symptoms that include yawning, sneezing, mottling and fever. This syndrome usually begins within 72 hours, but may appear up to two weeks after birth (Finnegan cited in Ward et al 1998:409).

Neonate
A live birth up to and including 28 days old.

Perinatal
The perinatal period commences at 20 completed weeks (140 days) of gestation and ends at 28 completed days after birth.

Protection planning meeting (PPM)
The protection planning meeting is an interagency process that provides a forum for pooling skills, knowledge and expertise of agencies.

Psychosocial assessment
An assessment by a psychologist, child psychiatrist, or social worker of the patient's neurological, intellectual, social, emotional and developmental functioning.

Report
Information is provided to DoCS in accordance with the Child and Young Persons (Care and Protection) Act 1998 ie where 'a person forms the belief, on reasonable grounds, that there are current concerns for a infant, child, young person or a class of children due to risk of harm from abuse or neglect'.

Risk assessment
An assessment of the likelihood of further risk of harm to a child or young person from abuse or neglect, based on the seriousness and circumstances of past and current risk of harm, the capacity of adults to protect the infant, child or young person and the age and vulnerability of the child or young person.

Risk of harm
Agencies and practitioners are required to make judgements about risk of harm to a child or young person from child abuse or neglect. The assessment requires an evaluation of both degree of harm and its probability and must take into account the age and vulnerability of the infant, child or young person.

Rooming in
The concept of 'rooming in' refers to the practice in postnatal wards in in-patient maternity services whereby the mother and baby stay together and are cared for as a unit to facilitate the attachment between the mother and baby, to promote breast feeding and enable ready access of the mother and family to the baby.

Related documents

NSW Health Circular 2002/73: *Observation and management of newborn infants with respiratory maladaptation to birth, including infants exposed to intrapartum opioids administered to the mother during labour*

NSW Health Circular 2002/30: *Framework for Area Health Services to develop policy and procedures relating to clinical care and resuscitation of the newly born infant*

NSW Health Circular 2001/123: *Protecting Children and Young People: recognizing and reporting suspected risk of harm and responding to requests from the Department of Community Services.*

NSW Health Circular 2000/63: *Screening for sexually transmissible diseases (STDs) and blood borne viruses (BBVs) in pregnancy*

NSW Health Circular 96/21: *Principles of discharge planning*

NSW Health *Alcohol and Other Drugs Policy for Nursing Practice in NSW: Framework for Progress 2000-2003*

NSW Health *Frontline Procedures for the Protection of Children and Young People (2000)*

NSW Health *Alcohol and Other Drugs Policy for Nursing Practice in NSW: Clinical Guidelines* (2000).

Children and Young Persons (Care and Protection) Act 1998 (NSW).

NSW Health. *Pregnancy Care Handbook*

Interagency Guidelines for Child Protection Intervention (2000). http://internal.health.nsw.gov.au/policy/hsp/child-protection

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