

NAS Maternal Guidelines

NAS MATERNAL GUIDELINES: PRECONCEPTION, PRENATAL, INTRAPARTUM, POSTPARTUM, DISCHARGE PLANNING

	RECOMMENDATION	RATIONALE	QUALITY OF EVIDENCE & CLASSIFICATION OF RECOMMENDATIONS	IMPLEMENTATION CONSIDERATIONS
Preconception	<p>1. Health care providers should routinely screen all women of childbearing age for use of medicinal and non-medicinal substances, including alcohol, opioids and other analgesics, selective serotonin reuptake inhibitors (SSRIs) and tobacco use.</p> <p>a) Routinely screen women for substance use.</p>	<p>Routine universal screening by primary health care providers is important to normalize conversation about this important and sensitive topic.</p> <p>A positive screen may indicate a risk for substance dependence; therefore, a more comprehensive evaluation by a specialist is recommended.</p> <p>Based on the literature, there is no optimal screening tool for substance use. Some options include Chasnoff's 4P's Plusⁱ, substance use risk profile and CAGE-AIDⁱⁱ.</p>	<p>IIIB</p>	<p>Screening opportunities may include: physicians, nurse practitioners, schools, Early Years centre, pain and methadone clinics, sexual health clinics, addiction services.</p> <p>Educational strategy to train providers about how to screen, raise public awareness about impact of substance abuse on pregnancy, fetus and neonate.</p> <p>Best Start Resource Centre (Health Nexus) materials are available to teach health care professionals how to ask questions about substance use. There is a video series about effective interviewing.</p> <p>Practitioners will require support to develop their comfort level to ask screening questions and to create a safe environment for women to report substance and alcohol use.</p>

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Preconception	b) Follow the Society for Obstetricians and Gynecologists of Canada (SOGC) Alcohol Use and Pregnancy Consensus Clinical Guidelines ⁱⁱⁱ to routinely screen for alcohol consumption.	<p>Pregnancy is a time when a woman is most willing to make lifestyle changes therefore assessment and counselling about substance use is important at this time.</p> <p>Often substance using women also consume alcohol.</p> <p>SOGC recommends Level 1 screening use questioning, motivational interviewing and supportive dialogue. If the woman does consume alcohol, then use Level II screening using standardized questionnaires such as the T-ACE or TWEAK tool.</p>		<p>Diagram A: Algorithm for Antenatal Assessment of Risk of NAS <i>Algorithm for Antenatal Assessment of Risk of Neonatal Abstinence Syndrome</i></p> <p>Health care providers need to be trained in administering Level I and II screening methods for alcohol consumption.</p>
	2. Contraception counselling is essential to prevent unplanned pregnancy whenever a woman changes from short to long-acting opioids, i.e. methadone or Buprenorphine.	<p>Unplanned pregnancy is preventable.</p> <p>Short acting opioids suppress ovulation therefore contraception is important when switching to long acting opioids.</p>	III B	Educate practitioners, including nurses and physicians at methadone clinics, family physicians, obstetricians, sexual health clinics.
Prenatal	3. Develop a written maternal and neonatal care plan to supplement the standard antenatal record.	A written care plan will support continuity of care and collaboration and eliminate gaps with other health care providers, for example addiction services.	IIIB	An example is the Prenatal Specialized Care Plan produced by St. Joseph’s Health Centre in Toronto.

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Prenatal	<p>a) Prepare and educate the substance using woman and her partner in advance for their baby’s hospital experience and management of NAS.</p> <p>Every substance using woman, her partner and family should receive written material explaining NAS, hospital stay expectations, role of the parent, and resource contacts including the healthcare team.</p>	<p>Overall goal is to link with hospital staff and initiate the therapeutic relationship, build trust and reduce anxiety for the parents about newborn care.</p>	<p>II-1 B</p>	<p>Urban hospitals may provide antenatal consultations with a pediatric care resource team. An example is the program at St. Joseph’s Healthcare, Hamilton</p> <p>Many smaller hospitals do not have a formal pediatric care resource team however they can often provide hospital tours and written information. An example is a booklet produced by the Special Care Nursery at St. Joseph’s Healthcare (Hamilton) titled <i>Neonatal Abstinence Syndrome: A guide for caregivers with a newborn withdrawing from drugs and medication</i></p> <p>Refer women to Healthy Babies, Healthy Children program (Public Health).</p>

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Prenatal	<p>b) Methadone is the treatment of choice for opioid dependent women in pregnancy and should be offered to all women who are eligible.</p> <p>c) Methadone is best initiated as inpatient or outpatient with close monitoring</p>	<p>Methadone dosing: keep the woman stable with no illicit use of opioids. Adjust dose as required.</p> <p>Third trimester dosing adjustments to account for increased metabolism: higher and or split dosing.</p> <p>If methadone is not available to treat opioid dependence or the patient is very motivated to stop opioid use in pregnancy, other options need to be explored. However, the decision to use other opioids or to taper must be made on an individual basis.</p> <p>If the risk of relapse is low, then opioid tapering may be considered in the second trimester by no more than 10% reduction in dose per day. Clonidine should be avoided in pregnancy. Switching to an immediate release preparation at the end of the taper allows for finer titration but close monitoring such as weekly dispensing or in some cases daily dispensing is necessary. Monitoring for relapse is important. At times the taper needs to be halted temporarily because of increased stress or emergence of withdrawal. Women who use other drugs are not good candidates for opioid tapering.</p>	<p>II-1 B</p> <p>II-2 B</p>	<p>The College of Physicians and Surgeons of Ontario has established program standards and clinical guidelines for Methadone treatment^{iv}.</p>

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Prenatal		<p>The only other opioid studied in pregnant women is buprenorphine (mono-product) available by special access through the manufacturer and Health Canada. No specific license is required to prescribe it but an online training program is recommended by Health Canada. It is associated with a milder withdrawal syndrome in neonates compared to methadone but women are also more likely to drop out of care. Using other opioids for maintenance may not be viewed as acceptable practice by regulators such as CPSO and Health Canada. Health Canada has the right to issue an exemption under Section 56 of the Controlled Drugs and Substances Act to use morphine to treat addiction.</p> <p>There are studies from Vienna where women maintained on single daily doses of morphine had acceptable outcomes. However, withdrawal in neonates was no different than compared to methadone^{v, vi}</p>		

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Prenatal	d) Methadone may be tapered during pregnancy providing the woman is stable. Taper during the second trimester only and monitor closely for relapse to opioids or related drugs including alcohol. Avoid withdrawal.		II-2 B	
Intrapartum	e) Methadone dosing during labour (intrapartum) should keep the woman stable. The volume of methadone drink may be reduced. Avoid withdrawal.		II-2 B	
	f) Pain management during labour should include epidural anesthesia where available.	Naloxone will cause immediate and severe withdrawal symptoms.	II-2B	
	g) Narcotic antagonists (Naloxone) are contraindicated for the opioid dependent woman or baby.		III B	
	h) Educate the mother, her partner and family care givers so they are prepared to effectively care for infant with NAS.	Integrate parents, caregivers or foster parents into the care of the infant while in hospital and involve them in discharge planning.	III B	This builds on the teaching involved in recommendation #3 a). The same printed materials can be used. Develop specific training for family care givers of NAS babies.

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Postpartum	<p>4. Create circumstances for success. Where possible, the goal is to position the family for success. When necessary, carefully assess social risk and anticipate needs.</p> <p>a) Involve the mother and her support person in all infant care unless contraindicated by child protection concerns.</p> <p>b) Implement a parental partnership contract to enhance communication with parents and support their involvement in the care of their infant, for example, rooming-in, feeding and handling.</p>	<p>Written and verbal communication is instrumental to gain commitment and enhance the relationship of the parents and the infant with NAS throughout the hospital stay. It is beneficial for the agreement to cover all aspects of infant care, including feeding, handling, skin- to-skin care, rooming-in and frequency of visits after mom is discharged.</p>	<p>III B</p>	<p>Expectations, terms & conditions will be described in a parental partnership contract.</p>

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Postpartum	<p>c) Anyone who has reasonable grounds to suspect that a child is or may be in need of protection must promptly report the suspicion and the information upon which it is based to a child protection agency (Child and Family Services Act Section 72. (1)) Positive screening results as well as information received from or about the mother and observations of her may raise a suspicion that requires reporting. This applies to concerns in addition to maternal substance use.</p>	<p>We all share a responsibility to protect children from harm. Section 72 of the CFSA states that members of the public, including professionals who work with children, must promptly report any suspicion that a child is or may be in need of protection and the information on which their suspicion is based to a child protection agency.</p> <p>Children are almost always better off being raised by their family. There are times when families experience problems that compromise the safety and well being of children. Under these circumstances, child protection agencies can provide support to strengthen the family so they are able to parent their children safely. Children’s aid societies can offer this support through a voluntary working relationship. However when this is not sufficient to address the concerns, intervention through a court order and/or substitute care may be required to achieve positive outcomes for children.</p>	III B	The professional's duty to report overrides the provisions of any other provincial statute, specifically, those provisions that would otherwise prevent disclosure by the professional or official. Solicitor client privilege is the only exception.
	<p>5. Discharge planning</p> <p>a) The primary care provider for the infant should be identified prior to discharge.</p>	<p>It is important to ensure there are no gaps in the care and monitoring of the infant with NAS and their family.</p>	III B	Educate practitioners about the importance of ongoing care and monitoring.

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Discharge Planning	b) Provide professional home visitor (high risk Public Health Nurse) to continue to address risk factors and support once the baby is discharged home.	Address child development, risks associated with co-sleeping, SIDS, smoking, relapse prevention and shaken baby syndrome.	III B	
	c) Every baby exposed to opiates/methadone should have ongoing assessments by a clinical expert in assessing developmental milestones.		II-3 B	
	d) Develop links between the Children’s Aid Society (CAS/CCAS) and the primary health care provider as a case management tool.	<p>Managing the care of an infant with NAS can pose many challenges for foster parents. As a result, they depend on expert medical advice to carefully manage these infants in their home to ensure the best possible care is provided.</p> <p>Management of these infants is specialized even for family doctors and pediatricians. Establishment of protocols of care with local neonatal specialists is optimal. Collaboration between foster parents and local medical providers with expertise and experience in neonatal abstinence is critical. Close follow up for associated medical and developmental complications must be arranged.</p>	III B	When infants with NAS are in foster care, medical care ought to be available to the infant in the same community where the foster parent resides.

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Discharge Planning	e) Ensure the substance abusing mother is linked to all the psychosocial, medical, addiction services and social services to make it safe for the baby to go home.		III B	
	f) Plan or prevent future pregnancies through education about risk of future pregnancy and NAS.	Thorough discharge planning provides an opportunity to decrease recurrence through education about birth control, tubal ligation, addictions services, referral to a methadone clinic, and public health.	III B	Education to reduce recurrence of NAS.
	g) Teach foster parents to recognize withdrawal symptoms in an asymptomatic infant at risk for NAS.	It is critical for a foster parent to recognize withdrawal symptoms in a symptomatic infant at risk for NAS to ensure that timely medical advice and intervention is sought.		Training of foster care personnel in scoring will be done by the hospital staff or another trained expert.

ⁱ Chasnoff IJ, Wells AM, McGourty RF, Bailey L. Validation of the 4P's Plus screen for substance use in pregnancy. *Journal of Perinatology*. 2007;27:774- 748

ⁱⁱ Brown RL, Rounds LA. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal*. 1995;94:135-140

ⁱⁱⁱ Society of Obstetricians and Gynecologists of Canada. Alcohol Use and Pregnancy Consensus Clinical Guidelines. August 2010; 32(8):S13-19

^{iv} College of Physicians and Surgeons of Ontario. Methadone Program: Methadone Maintenance Treatment Program Standards and Clinical Guidelines, 4th Edition. Feb. 2011.

^v Lee TS. Slow Release Morphine was not more effective than methadone in reducing neonatal abstinence syndrome. *The Western Journal of Medicine*. 2000 Jan;172(1):26

^{vi} Fischer G, Jagsch R, Eder H, Gombas W, Etzersdorfer P, Schmidl-Mohl K, Schatten C, Weninger M, Aschauer HN. Comparison of methadone and slow-release morphine maintenance in pregnant addicts. *Addiction*. 1999 Feb;94(2):231-9.