

NEONATAL ABSTINENCE WORK GROUP

SUMMARY OF RECOMMENDATIONS

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MATERNAL RECOMMENDATIONS

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. ***Algorithm for Antenatal Assessment of Risk of Neonatal Abstinence Syndrome***
 - a) Routinely screen women for substance use
 - b) Follow the Society for Obstetricians and Gynecologists of Canada (SOGC) Alcohol Use and Pregnancy Consensus Clinical Guidelines¹ to routinely screen for alcohol consumption.
2. Contraception counselling is essential to prevent unplanned pregnancy whenever a woman changes from short to long-acting opioids, i.e. methadone or Buprenorphine.
3. Development of a written care plan for maternal and neonatal care to supplement the standard antenatal record.
 - a) Prepare and educate the substance using woman and her partner in advance for their baby's hospital experience and management of NAS. 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.
 - b) Methadone is the treatment of choice for opioid dependent women in pregnancy and should be offered to all women who are eligible for methadone.
 - c) Methadone is best initiated as an inpatient or outpatient with close monitoring
 - d) Methadone tapering during pregnancy may be done 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.
 - e) Methadone dosing during labour (intrapartum) should keep the woman stable. The volume of methadone drink may be reduced. Avoid withdrawal.
 - f) Pain management during labour should include epidural anesthesia where available.
 - g) Narcotic antagonists (Naloxone) are contraindicated for the opioid dependent woman or baby.
 - h) Educate the mother, her partner and family care givers so they are prepared to effectively care for the infant with NAS.
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.
 - a) Involve the mother and her support person in all infant care unless contraindicated by child protection concerns.
 - b) Implement a parental partnership contract to enhance communication with parents and support their involvement in the care of their infant in, for example, rooming-in, feeding and handling.
 - 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.

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5. Discharge planning
 - a) The primary care provider for the infant should be identified prior to discharge.
 - b) Provide professional home visitor (high risk Public Health Nurse) to continue to address risk factors and support once the baby is discharged home.
 - c) Every baby exposed to opiates/methadone should have ongoing assessments by a clinician expert in assessing developmental milestones.
 - d) Develop links between the Children's Aid Society (CAS/CCAS) and the primary health care provider as a case management tool.
 - a) Ensure the substance abusing mom is linked to all the psychosocial, medical, addiction services and social services to make it safe for the baby to go home.
 - b) Plan or prevent future pregnancies through education about risk of future pregnancy and NAS.
 - e) Teach foster parents to recognize withdrawal symptoms in an asymptomatic infant at risk for NAS.

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6. Toxicology testing ***Algorithm for Assessment and Care of Infants at Risk of Neonatal Abstinence Syndrome (NAS)*** may be done on all known and suspected cases of NASⁱⁱ, defined as follows:
 - mothers identified by primary or obstetrical caregivers
 - mothers engaged in high-risk behaviour (i.e. taking street drugs)
 - mothers identified by child protection agencies or other community agencies
 - mothers who disclose illicit drug use in pregnancy
 - mothers who act in an intoxicated manner on admission or during office visits
 - mothers with a positive history of alcohol and/or drug use/abuse
 - mothers of newborns presenting with NAS symptoms
7. Toxicology screening may include the following but does not limit additional testing deemed necessary by the physician:
 - a) Urine and meconium testing using first sample passed.
 - b) Test urine for: cocaine (and its major metabolite benzoylecgonine), methamphetamine, amphetamine, canaboid, benzodiazepines, opioid narcotics and Oxycodone.
 - c) If the urine is positive do not repeat same tests on meconium. Test meconium only for FAEE.
 - d) If urine is negative, test meconium for all substances listed in 2 b) and also for FAEE.
 - e) Hair testing, at the discretion of the physician, after 2 days postnatal if the opportunity to collect first urine and meconium samples has been missed.
 - f) Positive test results for illicit substances require a duty to report to child protection services for further assessment.
8. Initiate in-patient psychosocial screening upon suspicion of use or abuse of substances. This may include social work, spiritual care, child protection services, etc.

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9. The **Modified Finnegan Scoring Tool**ⁱⁱⁱ should be used to assess suspected or known cases of NAS.
 - a) Score known or suspicious cases of NAS based on the criteria listed in recommendation 1.
 - b) Initiate scoring upon establishing suspicion and beginning testing.
 - c) Score for minimum of 72 hours if the score remains under the treatment threshold of 8. If the child does not reach treatment threshold within 72 hours they become eligible for discharge.
 - d) In cases of methadone exposure, the infant is to be observed for 120 hours since onset of withdrawal may be delayed.
 - e) Score with each care interaction, typically q 2-4 hrs. Initiate pharmacologic treatment if the average of 3 scores is ≥ 8 or the average of two scores or two consecutive scores are ≥ 12 . Continue scoring during treatment and weaning. After the end of treatment scoring should continue for 48-72 hours.
 - f) Mother- baby dyad care should be supported with rooming-in until the infant requires pharmacological treatment in the SCN.
 - g) If a methadone exposed infant does not withdraw in hospital they will require referral for ongoing monitoring for NAS as an outpatient.
 - h) The mother and caregivers should be educated about observing for signs of withdrawal after discharge.
10. Encourage participation of parents, family and care providers even when baby is in nursery.

During the weaning process or when monitoring is discontinued, and when family or facility circumstances permit, all efforts should be made to promote care-by-parent opportunities.
11. If parents wish to discharge their infant against medical advice, a child protection agency should be notified to complete a risk assessment.
12. Non-pharmacological interventions should be utilized first, prior to pharmacological interventions.
 - a) Swaddling is beneficial to lessen arousals and prolong sleep.
 - b) Breastfeeding is preferable and safe for methadone-maintained mothers. In the absence of contraindications, breastfeeding is recommended.
 - c) Breastfeeding is not recommended for illicit drug using women until sobriety is reached. These women should pump and discard their breast milk to establish and maintain their milk supply.
 - d) The baby's environment should be modified to reduce sensory stimulation, including minimizing visitors, minimizing overhead lighting, decreasing noise, using gentle handling, kangaroo care etc.
 - e) Soothing behaviours, positional support and frequent, hypercaloric, smaller volume feedings are beneficial and should be considered in the treatment of neonates with NAS both in hospital and the home environment.

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13. Medications should be considered for the treatment of NAS when supportive measures fail to adequately ameliorate the signs of withdrawal.
- When pharmacologic treatment is necessary the baby with NAS should be admitted to the SCN/NICU or paediatric unit where cardio-respiratory monitoring is available.
 - During the weaning phase of treatment parental interaction should be encouraged and observed to assess social risk and safety issues.
 - Discharge planning must include careful assessment of social risk and anticipate the need for CAS involvement prior to discharge.
14. Morphine should be considered the first line pharmacologic treatment for NAS when supportive measures fail to adequately ameliorate the signs of withdrawal. See ***NAS Pharmacologic Treatment Protocol: Dosing Guidelines***
- Morphine is indicated when the average of three scores is greater than or equal to 8 on the Finnegan Scoring tool or when the average of two scores or the scores for two consecutive intervals is greater than or equal to 12.
 - Cardio-respiratory monitoring is required for all infants started on morphine and continued for 4 days and/or until the dose is reduced. Further monitoring should then be at the discretion of the physician in charge.
 - Discharging the infant home on morphine is not recommended. However, in exceptional circumstances an infant may be discharged on morphine at the discretion of the physician in consultation with the health care team and only in the absence of social risk factors. Under these circumstances the following criteria should be met:
 - Stable and supportive home environment
 - Satisfactory psychosocial assessment
 - No identified risk for lack of neonatal follow-up
 - Primary care provider familiar with NAS and medication weaning for post discharge care
 - A clearly identified plan for weaning
 - An ability to monitor the appropriateness of timing of prescription renewals (no early renewals)
 - Parental education around symptoms of NAS and the need to contact a physician if symptoms increase
 - Post-discharge follow-up with Public Health, CAS, addiction services, etc.
 - Phenobarbital or clonidine may be considered as adjunct therapy to morphine in patients whose symptoms are not well controlled with morphine alone.

References

- Society of Obstetricians and Gynecologists of Canada. Alcohol Use and Pregnancy Consensus Clinical Guidelines. August 2010; 32(8):S13-19
- Murphy-Oikonen J, Montelpare W, Southon S, Bertoldo L, Persichino N. Identifying Infants at Risk for Neonatal Abstinence Syndrome. 2010. J Perinat Neonat Nurs; 24(4):366-372
- Jansson L, Velez M, Harrow C. The Opioid Exposed Newborn: Assessment and Pharmacologic Management. J Opioid Manag. 2009; 5(1): 47-55