

Neonatal Abstinence Syndrome Guidelines

Summary This is to provide guidance for the early detection and engagement of the opioid dependent pregnant woman and new mothers with multi-disciplinary team care; the care of the newborn child; postnatal care of both the mother and child; and the care and protection responsibilities of health workers clinically involved in the care of the newborn.

Document type Guideline

Document number GL2013_008

Publication date 04 September 2013

Author branch Centre for Alcohol and Other Drugs

Branch contact (02) 9424 5938

Review date 04 September 2018

Policy manual Patient Matters

File number 11/4313

Previous reference N/A

Status Active

Functional group Clinical/Patient Services - Baby and Child, Maternity

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Government Medical Officers, Private Hospitals and day Procedure Centres, Public Hospitals

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Audience Clinical;Allied Health;Nursing - Maternity;Neonatal & Paediatric;Early Childhood;Drug & Alcohol

Neonatal Abstinence Syndrome Guidelines

Document Number GL2013_008

Publication date 04-Sep-2013

Functional Sub group Clinical/ Patient Services - Baby and child
Clinical/ Patient Services - Maternity

Summary This is to provide guidance for the early detection and engagement of the opioid dependent pregnant woman and new mothers with multi-disciplinary team care; the care of the newborn child; postnatal care of both the mother and child; and the care and protection responsibilities of health workers clinically involved in the care of the newborn.

Replaces Doc. No. Neonatal Abstinence Syndrome Guidelines [PD2005_494]

Author Branch Mental Health and Drug and Alcohol Office

Branch contact Kate Williamson 9391 9038

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Government Medical Officers, Private Hospitals and Day Procedure Centres, Public Hospitals

Audience Clinical, Allied Health, Nursing - Maternity, Neonatal & Paediatric, Early Childhood, Drug & Alcohol

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Review date 04-Sep-2018

Policy Manual Patient Matters

File No. 11/4313

Status Active

NEONATAL ABSTINENCE SYNDROME GUIDELINES

PURPOSE

These Guidelines specifically address the management of newborns to mothers with a history of opioid use or opioid dependence, including women currently receiving opioid substitution treatment (methadone or buprenorphine) or using prescription pharmaceutical opioids (such as oxycodone, morphine, pethidine or tramadol).

While Neonatal Abstinence Syndrome (NAS) is more common in infants born to opioid dependent women than in infants born to women dependent on other drugs, the effect of polydrug use on NAS is not clearly established and is most likely dependent upon the specific combination and quantities of drugs used by the mother.

Provided that neonatal abstinence syndrome is appropriately managed, it is not currently known to be associated with long-term health problems.

KEY PRINCIPLES

The Guidelines concentrate on two main aspects of care:

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

These guidelines should be used to guide clinical management; however clinicians must always consider the pregnant woman they are managing as an individual, and apply the guidelines appropriately.

Opioid dependent pregnant women have an increased risk of experiencing complications during pregnancy and of their infants experiencing adverse outcomes. The association is complex and may be affected by a range of factors including: poly substance use; inadequate antenatal care; poor nutrition; blood borne virus exposure; mental health problems; housing; and domestic violence. Births in mothers with opioid, stimulant or cannabis use diagnoses are associated with a number of negative neonatal outcomes. Babies are more likely to be born before the gestational age of 37 weeks, to be of low birth weight, and to be admitted to neonatal intensive care units or to special care nurseries than babies born to mothers without such a diagnosis.

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 use and other problems. A range of services are 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.

USE OF THE GUIDELINE

While the focus of these Guidelines is opioid dependent women it is recognised that other illicit drugs such as stimulants, sedatives, alcohol and some psychotropic medications may also be associated with NAS and these women and newborns may have similar care needs. Therefore, the care elements of the Guidelines (which exclude elements specifically relating to opioid pharmacology as found in parts of Sections 8.1, 8.2 and 9.5) also apply to this group of women and their infants.

The Guidelines outline minimum standards for the management of NAS. Local Health Districts are responsible for ensuring that maternity services develop clear clinical protocols relevant to each maternity health care facility, based on these Guidelines.

Local policies and guidelines need to be formalised to ensure that the roles and responsibilities of the multidisciplinary team are clear. The guidelines provide advice on a continuum of care (Diagram 1), that includes care of the mother and infant from antenatal care through discharge and follow up.

A number of key priorities are identified in the NAS Guidelines and should be included in any local clinical guidelines or business rule: the early recognition and engagement of the opioid dependent pregnant woman and new mothers into multi-disciplinary team care (Section 6); the care of the newborn child (Section 7); the postnatal care of both the mother and child (Sections 8, 9, 10); and the care and protection responsibilities of health workers clinically involved in the care of the newborn (Section 3).

Severe neonatal withdrawal is an indication for pharmacological management of NAS. The Neonatal Abstinence Score (or Finnegan Score – Refer Appendix 3) was developed to monitor the progress of infants experiencing neonatal abstinence due to opioid exposure in utero. It can be used as a trigger for pharmacological treatment of neonatal abstinence (Refer Section 8.2). Provided that neonatal abstinence is appropriately managed, it is not currently known to be associated with long-term health problems.

Section 5 deals with care of the mother’s drug dependence during pregnancy and provides advice regarding withdrawal from heroin and assistance in determining a suitable Opioid Substitution Therapy, if required.

Section 6.6 provides advice regarding appropriate assessment and identification of risk for mother and foetus. This section outlines the process for prenatal reporting, including when reporting should be undertaken and the criteria used in assessing a need to report.

Section 8.2 outlines postnatal care of the infant. All infants born to drug dependent mothers should receive routine postnatal monitoring, along with specific assessment for the signs and symptoms of NAS using the Finnegan Neonatal Abstinence Severity Score (NASS) or modified Finnegan scale (See Appendix 3). Monitoring should commence within 2 hours after birth and be conducted 30 - 60 minutes after a feed. The score is an important guide for the appropriate pharmacologic treatment of NAS and health-care providers involved in the care of opioid-exposed infants must be educated in the appropriate application of these scores.

The issue of breastfeeding is complex because of the range of drugs used, their half-life and their interactions. Section 8.4 provides advice for breastfeeding based on the premise that breast milk is the most complete form of nutrition for infants, with a range of benefits for health, growth, immunity, and development. There are times however when the breast milk should be expressed and discarded, particularly following psychostimulant use.

REVISION HISTORY

Version	Approved by	Amendment notes
GL2013_008	DDG	Substantial update to Child Protection policy
PD2005_494	DG	Rescinded and replaced by GL2013_008
2002/101	DG	Rescinded and replaced by PD2005_494

ATTACHMENTS

1. Neonatal Abstinence Syndrome Guidelines

NEONATAL ABSTINENCE SYNDROME



Issue date: September-2013

GL2013_008

Contents

1. Foreword	2
2. Introduction.....	4
3. Child Protection	7
4. Continuum of Care	9
5. Opioid Substitution treatment.....	13
5.1 Choice of opioid substitution treatment: Methadone or Buprenorphine	14
5.2 Safety of other pharmacotherapies for use in pregnancy.....	15
5.3 Withdrawal from heroin and other opioids.....	15
5.4 Withdrawal from opioid substitution treatment	16
6. Pregnancy Care	17
6.1 Early Engagement.....	17
6.2 Early Recognition	18
6.3 Antenatal history/screening	18
6.4 Blood Borne Virus Screening.....	19
6.5 Tobacco and NRT	20
6.6 Assessment and identification of risk.....	20
6.7 Prenatal Reporting	21
6.8 Family Referral Services (FRS).....	24
6.9 Brighter Futures.....	25
7. Perinatal Care	26
7.1 Monitoring health of mother and baby	26
8. Postnatal Care	27
8.1 Medical management of mother	28
8.2 Medical management of the infant.....	28
8.3 Medical management of non-opioid withdrawal	30
8.4 Breastfeeding	30
8.5 Contraception.....	31
9. Discharge Planning and Guidelines.....	32
9.1 Minimum length of stay of baby	32
9.2 Planned Discharge with medical consent	32
9.3 Criteria for safe discharge of infants home	33
9.4 Unplanned Early Discharge without medical consent	34
9.5 Medication on discharge.....	34
9.6 Discharge Protocols	35
9.7 Length of treatment	35
10. Coordinated Follow Up and Support.....	36
10.1 Follow up for the infant	36
10.2 Follow up for babies at risk of vertical transmission of Blood Borne Viruses .	36
10.3 Follow up for the mother	37
11. Training	38
12. Collaborative Data.....	38
13. Contact Information	39
14. Appendices	40

Appendix 1. Summary of key documents	40
Appendix 2: Check List for Mandatory Reporters.....	42
Appendix 3: Royal Prince Alfred Hospital modified Finnegan’s Scale	43
Appendix 4. Modified Finnegan Neonatal Abstinence Severity Score Guideline	45
Appendix 5: Supportive care	46
Appendix 6: SAFE START Psychosocial assessment questions	47
15. Glossary	49
16. Related documents	51
17. References.....	53

1 FOREWARD

Neonatal Abstinence Syndrome (NAS) occurs in newborns experiencing withdrawal as a result of the mother's dependence on drugs during pregnancy. NAS in infants of opioid dependent mothers is characterised by signs and symptoms of central nervous system hyperirritability, gastrointestinal dysfunction and respiratory distress, and symptoms that include poor feeding, sleep-wake abnormalities, vomiting, dehydration, poor weight gain and occasionally seizures. This syndrome usually begins within 72 hours after birth, but may appear up to two weeks after birth.

The NAS Guidelines address recommendations from the Child Death Review Team, the NSW Pregnancy and Newborn Services Network, and are consistent with the *National clinical guidelines for the management of drug use during pregnancy, birth, and the early development years of the newborn* regarding improving the health outcomes for opioid-dependent pregnant women, mothers and their newborn infants, and their families. The Guidelines emphasise the importance of establishing a sound therapeutic relationship with the woman based on Harm Minimisation principles, respect and non-judgemental attitudes; of engaging the woman in antenatal care and; maintaining continuity of care throughout the pregnancy and postnatal period.

These 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 services providing services to this target group.

NAS is more common in infants born to opioid dependent women than in infants born to women dependent on other drugs. As a result, these Guidelines specifically address the management of newborns to mothers with a history of opioid use or pharmaceutical opioid dependence, including women currently receiving opioid substitution treatment (methadone or buprenorphine) or using prescription opioids (such as oxycodone, morphine, pethidine or tramadol).

The Guidelines concentrate on two main aspects of care:

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

While the focus of these Guidelines is opioid dependent women it is recognised that other illicit drugs such as stimulants, sedatives, alcohol and some psychotropic medications may also be associated with NAS and these women and newborns may have similar care needs. Therefore, the care elements of the Guidelines (which exclude elements specifically relating to opioid pharmacology as found in parts of Sections 8.1, 8.2 and 9.5) also apply to this group of women and their infants.

Minimum standards for the management of NAS are outlined in the Guidelines. Local Health Districts are responsible for ensuring that maternity services develop clear clinical protocols relevant to each maternity health care facility, based on these Guidelines. The key priorities identified in the NAS Guidelines to be included in any local clinical

guidelines include: the early detection and engagement of the opioid 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 of health workers clinically involved in the care of the newborn.

The Guidelines should be read in conjunction with:

- NSW Health *Prenatal Reporting Guidelines* GL2011_008
http://www.health.nsw.gov.au/policies/pd/2013/PD2013_007.html
- NSW Health Department Circular, *PD2005_299 – Protecting Children and Young People, Child Wellbeing and Child Protection – NSW Interagency Guidelines*
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm;
- *Keep Them Safe – Making a Child Protection Report*
http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_007.html
- *Information Sharing – NSW Health and DoCS- Opioid Treatment Responsibility – Children Under 16* PD2006_085
http://www.health.nsw.gov.au/policies/pd/2006/PD2006_085.html A revision of this document is expected to be published in 2012.
- *NSW Health/Families NSW Supporting Families Early Package – Improving mental health outcomes for parents and infants SAFE START guidelines*
<http://www.sfe.nswiop.nsw.edu.au/file.php/1/SafeStartGuidelines.pdf>;
- NSW Health Policy Directive PD2006_084 *Policy and Procedures for Identifying and Responding to Domestic Violence* (2006)
http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_084.html.

Key features of a number of these policies are briefly described in Appendix 1.

2 INTRODUCTION

In line with a growing worldwide trend of increasing illicit drug use there has been an increase in the incidence of women of childbearing age becoming dependent on drugs of addiction, resulting in higher drug use in pregnancy. The precise incidence of illicit drug use in Australia is unknown. The latest National Drug Strategy Household Survey reported that in 2010 approximately 7.3 million people (or about 2 in 5 people) in Australia reported having ever used an illicit drug, while almost 3 million reported use of an illicit drug in the previous 12 months (AIHW, 2011). The number of pregnant women who use illicit drugs is not well known despite increased awareness that drug misuse has an impact on maternal and child wellbeing. Surveys conducted in the ACT and NSW suggest that up to 6% of all infants are affected by illicit drug use (Abdel-Latif, Bajuk, Lui et al., 2007). This is 6 times more than in the general population (Burns, Mattick, & Cooke, 2006).

Opioid dependent pregnant women have an increased risk of experiencing complications during pregnancy and of their infants experiencing adverse outcomes. The association is complex and may be affected by a range of factors including: poly substance use; inadequate antenatal care; poor nutrition; blood borne virus exposure; mental health problems; housing; and domestic violence. Births in mothers with opioid, stimulant or cannabis use diagnoses are associated with a number of negative neonatal outcomes. Babies are more likely to be born before the gestational age of 37 weeks, to be of low birth weight, and to be admitted to neonatal intensive care units or to special care nurseries than mothers without such a diagnosis (Burns, Mattick, Lim & Wallace, 2006). The NSW Pregnancy and Newborn Services Network suggests that there has been an increase in the number of opioid-dependent pregnant women, often involving polydrug use, presenting to maternity hospitals in New South Wales (Neonatal Abstinence Working Group, 2001).

Opioid substitution treatment (methadone, buprenorphine) is associated with improvements in obstetric and neonatal health. Methadone and more recently buprenorphine have been associated with improvements in neonatal mortality and morbidity. Replacing heroin (an illicit substance of uncertain composition and dose) with methadone/buprenorphine (a pure substitute at a stable dose) 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 antenatal care; reduces obstetric complications; improves overall lifestyle and; reduces the risk of Hepatitis C and HIV infection (Burns, Mattick, Lim & Wallace, 2006).

Dependent opioid use including the use of heroin, methadone, buprenorphine and the use of prescription opioids (such as oxycodone, morphine, pethidine, tramadol) is associated with neonatal abstinence syndrome (NAS). This syndrome is characterised by the following symptoms in the neonate: gastrointestinal dysfunction (including feeding problems, vomiting, regurgitation, diarrhoea) respiratory distress (such as sneezing, yawning, tachypnoea); mottling; fever; tremors; high-pitched cry and increased muscle tone (Finnegan, Connaughton, Kron, Emich, 1975). The infant may also experience, sleep-wake abnormalities, dehydration, poor weight gain and occasionally seizures. The

syndrome usually commences within 72 hours of birth and can last for up to several weeks (Finnegan, Connaughton, Kron, Emich, 1975).

Severe neonatal withdrawal is an indication for pharmacological management of NAS (Finnegan, 1980). The Neonatal Abstinence Score (or Finnegan Score – Refer Appendix 3) was developed to monitor the progress of infants experiencing neonatal abstinence due to opioid exposure in utero (Finnegan, 1980). It can be used as a trigger for pharmacological treatment of neonatal abstinence (Refer Section 8.2). Provided that neonatal abstinence is appropriately managed, it is not currently known to be associated with long-term health problems.

NAS is more common in infants born to opioid-dependent women than in infants born to women dependent on other drugs. The effect of polydrug use on NAS is not clearly established and is most likely dependent upon the specific combination and quantities of drugs used by the mother (Oei & Lui, 2007). NSW Health 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 (Oei, Kingsbury, & Dhawan et al. 2012), benzodiazepines, cannabis, alcohol and tobacco. It is acknowledged that the use of these drugs in pregnancy may be associated with NAS. This is an emerging issue which may require different management strategies. Further revisions of this policy may include guidelines specifically to address amphetamines or other drugs, as new evidence becomes available.

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. Drug users may not use general health services until late into pregnancy and are therefore more vulnerable to medical and obstetric complications. 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 use and other problems. A range of services are 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.

Specialist services working with women who use substances in pregnancy have a range of names including: Drugs in Pregnancy Services (DIPS), Substance use in Pregnancy Services (SUPS) and Chemical Use in Pregnancy Services (CUPS). These services broadly have the same remit and the terms are used interchangeably throughout this document.

These guidelines are written for medical, nursing, midwifery, drug and alcohol clinicians and allied health staff involved in the management of opioid dependent women who are pregnant. These guidelines should be used as a guide to clinical management; however clinicians must always consider the pregnant woman they are managing as an individual, and apply the guidelines appropriately.

Specific information on the management of other drug issues can be accessed through:

- Local Health District Drug and Alcohol Units;
- Specialist pregnancy drug and alcohol services;
- Drug and Alcohol Specialist Advisory Service (DASAS) (see Section 12);
NSW Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment of opioid dependence
http://www.health.nsw.gov.au/policies/gl/2006/GL2006_019.html A revision of this document is expected to be published in 2012.
- Nursing and Midwifery Clinical Guidelines - Identifying and Responding to Drug and Alcohol Issues GL2008_001
http://www0.health.nsw.gov.au/policies/gl/2008/GL2008_001.html
- *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008)* (GL2008-011) http://www0.health.nsw.gov.au/policies/gl/2008/GL2008_011.html
- A review article of Amphetamine use in pregnancy and child outcomes: Oei, JL, Kingsbury, A., Dhawan, A., Burns, L., Feller, JM., S Clews, S., Falconer, J. and Abdel-Latif, ME. Amphetamines, the pregnant woman and her children: a review. *Journal of Perinatology* (2012), 1–11.
- *Management of Cannabis use disorder and related issues – A clinicians Guide*
<http://ncpic.org.au/ncpic/news/ncpic-news/pdf/management-of-cannabis-use-disorder-and-related-issues-a-clinicians-guide>
- *National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn*
http://www.health.nsw.gov.au/pubs/2006/ncg_druguse.html and;
- *NSW Revision of the National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn.*

3 CHILD PROTECTION

Child protection is a key issue for consideration in working with families who have complex needs. Significant legislative and policy changes were implemented following the Report of the *Special Commission of Inquiry into Child Protection Services in NSW*, released in November 2008. *Keep Them Safe, a Shared Approach to Child Wellbeing 2009-2014* (KTS) is a five year interagency action plan formulated in response to the Special Commission which has led to significant changes in the way children's safety, welfare and wellbeing are monitored and addressed in NSW.

The implementation of *Keep Them Safe* (KTS) and related initiatives has been supported by legislative changes. Legislative changes are relevant not only to those who provide services for children and young people, but also those providing services to adult clients (including drug and alcohol) who may be parents or carers. *Keep Them Safe* emphasises that child protection and wellbeing is a shared responsibility across the whole community.

The most significant change has been that the *Children and Young Persons (Care and Protection) Act 1998* and *related Acts* were amended in January 2010 with the statutory threshold for reporting children and young people at risk of harm to the Child Protection Helpline being raised to "risk of *significant harm*" (ROSH).

In October 2009, the *Children and Young Persons (Care and Protection) Act 1998 (Care Act)* was revised to include Chapter 16A, which enables exchange of information relating to the safety welfare or well-being of a child or young person or class of children or young persons' between prescribed bodies. Prescribed bodies are defined in section 248 (6) of the Care Act and Clause 7 of the *Children and Young Persons (Care and Protection) Regulation 2000* as being:

- a division of the Government Service
- a public authority
- a public health organisation within the meaning of the [Health Services Act 1997](#)
- a private health facility within the meaning of the [Private Health Facilities Act 2007](#)
- organisations the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children.

Chapter 16A provides that any law that prohibits or restricts the disclosure of information does not operate to prevent the provision of information under Chapter 16A. A prescribed body is not required to obtain consent before exchanging information with another prescribed body under Chapter 16A. Before exchanging information under Chapter 16A prescribed bodies should ensure that the criteria set out in Chapter 16A is met.

The object of Chapter 16A is to facilitate the provision of services to children and young persons' by agencies that have responsibilities relating to the safety, welfare or well-being of children and young persons' by requiring those agencies to take reasonable steps to co-ordinate the provision of those services with other such agencies. Chapter 16A provides that because the safety, welfare and well-being of children and young persons

are paramount the need to provide services relating to the care and protection of children and young persons, and the needs and interests of children and young persons, and of their families, in receiving those services, take precedence over the protection of confidentiality or of an individual's privacy. Chapter 16A includes protection of those exchanging information where it is given in good faith.

The process for making a prenatal report is described in detail in Section 6.6 *Assessment and Identification of Risk*. A summary of key child protection related documents is included in Appendix 1. Further information about Family and Community Services, Community Services (referred to as 'Community Services' from this point on) Case Management Policy is available at:

http://www.community.nsw.gov.au/docswr/assets/main/documents/case_mgmt_policy.pdf

4 CONTINUUM OF CARE

Continuity of care and carers throughout pregnancy and in the perinatal and postnatal period is considered best practice in Australia (Commonwealth of Australia, 2006). The term 'continuity of care' refers to the provision of care by the same caregiver or small group of caregivers throughout pregnancy, during labour and birth, and in the period following birth. Continuity of care and consistent information that is culturally sensitive and appropriate is essential to the provision of quality maternity care (NSW Health, 2000).

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, Local Health Districts must ensure that attention to child protection issues, drug and alcohol and relevant obstetric management is provided through:

- Active collaboration between maternity hospitals and 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 to discharge and post natal care.

To ensure optimal outcomes for 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 multidisciplinary team are clear. Local Health Districts are responsible for determining how long these services are to engage with families. This will largely be dependent on the availability of sufficient resourcing within the region. 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.

Local Health Districts must aim to have multi-disciplinary teams or networks comprised of as a minimum, a representative from each of the following professional groups:

- Obstetrician/obstetric registrar/or General Practitioner (GP);
- Midwife;
- Paediatrician or medical officer skilled in paediatrics;
- Drug and alcohol nurse / Opioid substitution prescriber and/or Addiction Specialist or clinic representative;
- Social worker, and;
- Early childhood/primary health nurse.

Where appropriate, the multi-disciplinary team will also include:

- Mental health worker;
- Aboriginal/ethnic health worker;
- Community Services 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.

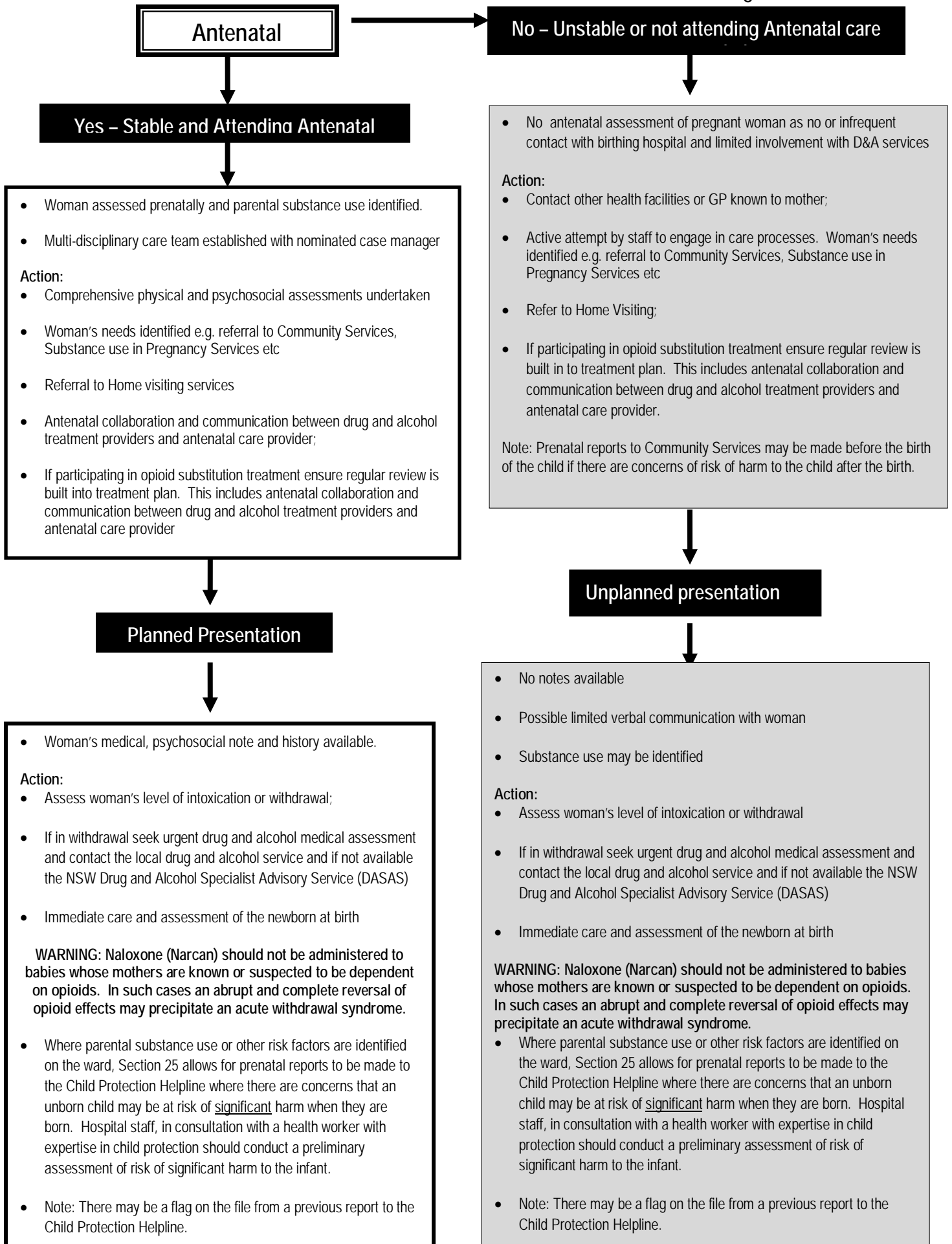
The role of the multi-disciplinary team or network is to:

- Provide continuity of staff to avoid fragmentation of care;
- Appoint a case manager;
- Engage with clients as early as possible in the antenatal 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;
- Provide timely and accurate information and documentation;
- 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:

- MotherSafe (02) 9382 6539 (Sydney Metropolitan Area) 1800 647 848 (Non-Metropolitan Area).
- For information on maternal drug and alcohol management contact the Drug and Alcohol Specialist Advisory Service (DASAS) 24 hours a day on (02) 9361 8006 (Sydney Metropolitan Area) or 1800 023 687 (Non-Metropolitan Area).
- Additional contacts are provided in Section 12 of this document.

DIAGRAM 1. Continuum of care for babies at risk of NAS born to substance using mothers.



Postnatal

- Assessment of baby for withdrawal symptoms using standardised measures e.g. Finnegan Scale.
- Assessment of maternal wellbeing and parenting skills

Action

- A case conference should be convened by the multidisciplinary team to formulate a discharge plan with clear responsibilities and timeframes;
- A discharge planning meeting should be attended by the parent/s, members of the multidisciplinary team and representatives from relevant services e.g. Early Childhood Health Service, Drug and Alcohol Services/private prescriber, 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 appropriate 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 e.g. will she require methadone to be organised post discharge;
- Report any child protection concerns to the Child Protection Helpline.

Discharge and Follow up

Do not discharge before 5-7 days

- Formal written discharge plan discussed with mother and partner, circulated to a multidisciplinary 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 or GP follow up and for 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 e.g. 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 receiving opioid substitution treatment require continuation of dosing immediately post-discharge to be organised via existing private prescriber or opioid substitution clinic.

- 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. Multidisciplinary team, community care providers and parents to be involved.
- A case conference should be convened by multidisciplinary 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 multidisciplinary team and representatives from relevant services e.g. Early Childhood Health Service, Drug and Alcohol Services/private prescriber, 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 appropriate 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 e.g. will she require methadone or buprenorphine to be organised post discharge;
- Report any child protection concerns to the Child Protection Helpline.

Self discharged against medical advice

Steps to take:

- If mother indicates intention to leave hospital with baby before 5-7 days or against medical advice at a later date, the multidisciplinary team must be informed about the mothers intent and the following steps should be taken:
 1. Alert the Child Protection Helpline on 13 36 27 or fax 96337666. If urgent Community Services may consider assuming care of the infant;
 2. Follow child protection reporting procedure – refer to NSW Health Frontline Guidelines for the Protection of Children and Young People (2000)
 3. Contact Community Services case worker if allocated or the Child Protection Helpline if the worker cannot be contacted;
 4. Record in medical notes of intention of mother to leave hospital against medical advice.

Refer to [Section 9.4](#) for more guidance.

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

Infant follow up:

- Infants at risk of NAS should be referred to appropriate paediatric or GP follow up and for 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 e.g. 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 receiving opioid substitution treatment require continuation of dosing immediately post-discharge to be organised via existing private prescriber or opioid substitution clinic.

5 OPIOID SUBSTITUTION TREATMENT

Replacing heroin (an illicit substance of uncertain composition and dose) with methadone (an opioid agonist) or buprenorphine (a partial agonist) 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 antenatal care;
- Reduces obstetric complications and lessens possibility of foetal death;
- Improves overall lifestyle, and;
- Reduces the risk of hepatitis C and HIV infection.

These effects may be reduced by continued use of heroin and/or other drug use including the nonmedical use of prescription opioids (such as oxycodone, morphine, pethidine, tramadol) tobacco, benzodiazepines, amphetamines, alcohol or when stabilisation on opioid substitution treatment occurs in late in pregnancy.

At the time of writing, the *New South Wales Opioid Treatment Program- Clinical Guidelines for methadone and buprenorphine treatment of opioid dependence* were under review. It is envisaged that pregnant and/or breastfeeding women will continue to have priority access to public clinics under the NSW Opioid Treatment Program.

To improve the health outcomes of opioid dependent pregnant women the treatment of choice is opioid substitution treatment (i.e. methadone or buprenorphine maintenance) in conjunction with a comprehensive drug and alcohol and antenatal programme. If it is confirmed that a pregnant woman is opioid dependent but not participating in an opioid substitution program, and she gives informed consent, she should be inducted into methadone or buprenorphine treatment. This may include admission to an inpatient obstetric unit for stabilisation and rapid dose titration. Inducting a woman into opioid substitution treatment should be done in consultation with an addiction medicine specialist.

The methadone/buprenorphine dose during pregnancy should be titrated to a level that blocks withdrawal symptoms and suppresses heroin use. During pregnancy the methadone/buprenorphine dose may need to increase due to changes in metabolism and increased blood volume. Regular dose reviews should be conducted throughout the pregnancy. A dose review should be conducted in the third trimester. There is no clear dose-response relationship between either methadone or buprenorphine and risk of NAS.

Vomiting of a methadone dose may lead to withdrawal in both mother and infant (Refer to 3.4.7 in *The National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*) for guidance on management of this situation. Split dosing may be considered where there is a clinical need. The second dose may be provided as a takeaway, provided that the usual safety criteria for takeaways are met.

5.1 Choice of opioid substitution treatment: methadone or buprenorphine

Methadone and buprenorphine can both be considered as suitable opioid substitution treatments during pregnancy. Methadone maintenance in pregnancy has a well established safety record and has been used for a longer period of time than buprenorphine.

Recent research suggests that buprenorphine is safe and effective during pregnancy. For example, a recent multi-site, blinded, randomised control study (the MOTHER study) compared the effectiveness of buprenorphine and methadone substitution in pregnancy (Jones, Kaltenbach, Heil, & Stine et al. 2010). The study confirmed that both methadone and buprenorphine are safe for use in pregnancy. Buprenorphine was found to result in shorter duration of withdrawal symptoms in newborns (Jones, Kaltenbach, Heil, & Stine et al. 2010). Exposure to either buprenorphine or methadone during pregnancy does not appear to be associated with adverse postnatal development in children of opioid dependent women.

There are a number of key issues which should be considered when determining which opioid substitution treatment should be used for a heroin dependent pregnant woman currently not receiving opioid substitution treatment. Decisions should involve the pregnant woman in the decision making process and be based on individual clinical assessment. These are listed in the table below with considerations specific to methadone and buprenorphine listed on the left and right respectively.

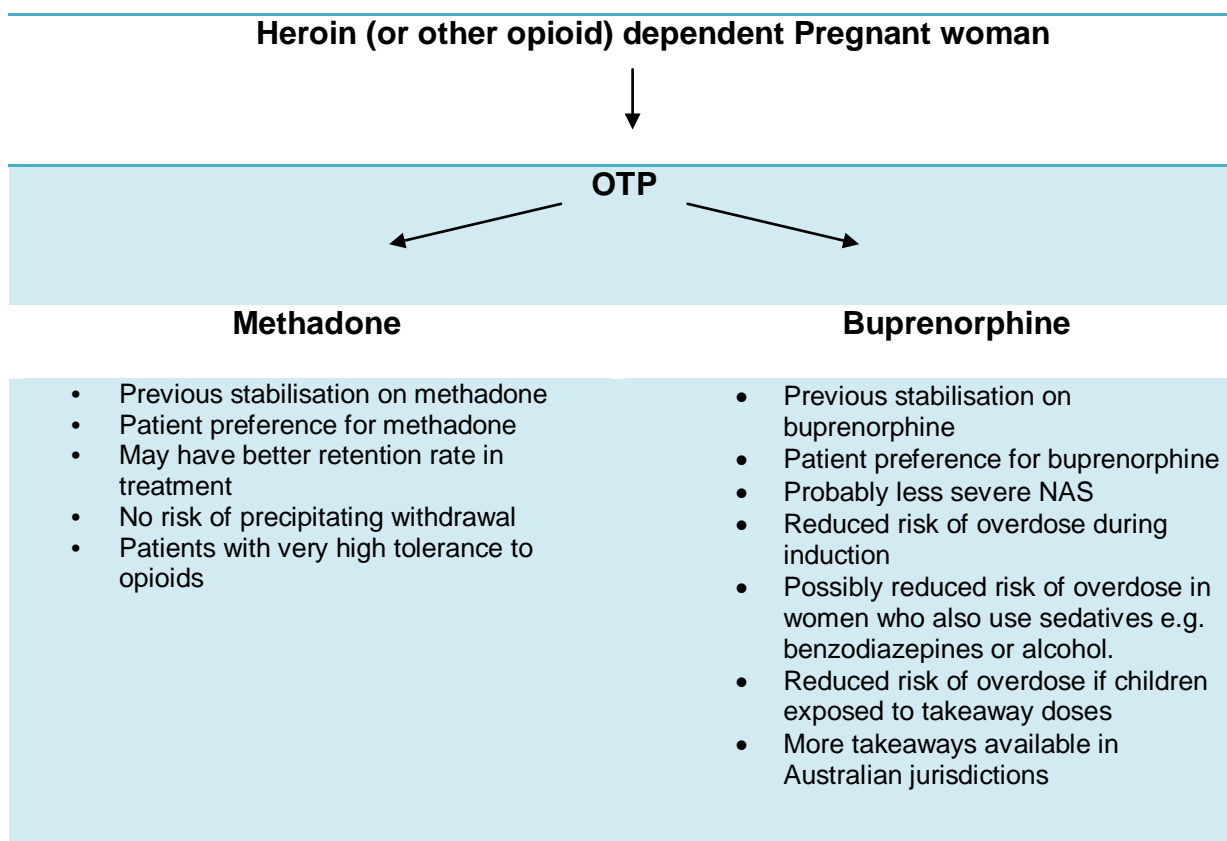


Diagram 2. Considerations in the clinical management of the opioid dependent pregnant woman.

5.2 Safety of other pharmacotherapies for use in pregnancy

Buprenorphine-naloxone (Suboxone)

The safety and efficacy of buprenorphine-naloxone in pregnancy is not established. Studies regarding the effects of buprenorphine-naloxone in pregnancy are very limited. According to the *National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, buprenorphine-naloxone should not be offered in pregnancy, and women of childbearing age who are not using contraception or are planning a family should consider buprenorphine over buprenorphine-naloxone (Commonwealth of Australia, 2006). Buprenorphine-naloxone should not be offered in pregnancy, except in the context of clinical trials. Women on buprenorphine-naloxone should be transferred to buprenorphine. Women on buprenorphine-naloxone should be transferred to buprenorphine (Commonwealth of Australia, 2006). Follow-up of babies exposed to buprenorphine-naloxone in utero is recommended, such as a comprehensive developmental assessment by a paediatrician at 2 years of age.

Naltrexone

The safety and efficacy of naltrexone in pregnancy is not established. Naltrexone should not be offered in pregnancy except in the context of clinical trials. According to the *National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, if a woman receiving naltrexone becomes pregnant and is progressing well in treatment, she should be advised that the safety of naltrexone is not established. If she wishes to continue naltrexone and can provide informed consent, it is acceptable to continue naltrexone during pregnancy. It is recommended that a record of the patient giving consent is obtained and kept in patient records (Commonwealth of Australia, 2006). The most significant risk associated with naltrexone is the risk of overdose if the patient does not take their medication and uses illicit opioids. This should be made explicit in discussions regarding the suitability of naltrexone with pregnant women. Follow-up of babies exposed to buprenorphine-naloxone in utero is recommended, such as a comprehensive developmental assessment by a paediatrician at 2 years of age.

5.3 Withdrawal from heroin and other opioids

Withdrawal from heroin (and other opioids) during pregnancy is not routinely encouraged as evidence of safety and effectiveness of this approach is very limited. There are no data to suggest that the risk of relapse is reduced per se by pregnancy. In addition, there is minimal success with withdrawal treatment during pregnancy.

Theoretical concerns on the effect of heroin withdrawal during pregnancy are that in the first trimester withdrawal may precipitate uterine contractions, and thus increase the risk of spontaneous abortion and withdrawal. In the third trimester withdrawal may be associated with an increased risk of intrauterine growth restriction, premature labour or fetal death.

Heroin withdrawal is associated with fetal stress, in utero meconium aspiration and an increase in the oxygen requirement of the infant. The principal cause of fetal death is thought to be hypoxia.

In summary, due to the risk of relapse into heroin use, it is important for pregnant heroin-dependent women to be stabilised and maintained on opioids such as methadone or buprenorphine as part of a structured treatment program. Relapse to illicit heroin use is more likely to pose a significant risk of morbidity and mortality to the mother and infant than neonatal opioid withdrawal, which, once identified, can be managed.

5.4 Withdrawal from opioid substitution treatment

Withdrawal from methadone or buprenorphine is associated with an increased risk of relapse to dependent illicit opioid use and should not be encouraged during pregnancy. However if after a detailed discussion of the risks and benefits of withdrawing from opioid substitution, a pregnant woman still wishes to withdraw from opioids a specialist obstetrics team along with drug and alcohol specialists should manage the pregnancy and withdrawal. There is evidence that opioid withdrawal can be supported by using a reduced methadone/buprenorphine dose regime over a prolonged time period should the woman decide to withdraw from opioids during pregnancy.

6 PREGNANCY CARE

Opioid dependent pregnant women often have poor antenatal attendance, chaotic lifestyles and poor nutrition. Health services for these women therefore need to be accessible, appropriate and provided in a non-judgemental and non-threatening environment to encourage attendance at drug and alcohol and 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 (Wagner, Katikaneni, Cox & Ryan, 1998; Jaudes, PK, Ekwo, E. & Van Voorhis, J, 1995; Delaney-Black, Covington, Templin, Ager et al. 1998).

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 support and referral to relevant health and social services that may include Community Services, or referral to Whole Family Teams, support or counselling services and accommodation services.

The use of prenatal screening tests has added to the complexity of prenatal care. These screening tests give a risk indication only and are not definitive tests. Use and interpretation are dependent on a number of factors including accurate gestational age, the stage of pregnancy, maternal age, and in the case of ultrasound, operator expertise. They are associated with varying levels of false positive and false negative results, depending on different combinations of tests offered. Women indicated to be at high risk on screening tests should be offered follow-up definitive testing by amniocentesis or chorionic villus sampling.

Each screening test has advantages, disadvantages and limitations. Offers of screening need to be accompanied by sufficient information and counselling, with professional interpreter services if necessary, to help women choose screening on an informed basis. This includes accurate information about the health and development issues for children with Down syndrome and the potential ramifications for women entering into the screening process.

There is no evidence that suggests that any additional screening or testing should be conducted for substance using pregnant women or that gross abnormalities are more likely in this cohort. Detailed information about prenatal testing is contained in the Prenatal Testing/Screening for Down Syndrome and Other Chromosomal Abnormalities PD2007_067 http://www0.health.nsw.gov.au/policies/pd/2007/PD2007_067.html

6.1 Early Engagement

Early engagement is a key component of effective antenatal care for all women and is especially important for women with complex needs such as opioid dependence. Timely assistance, scheduling flexibility, empathy and optimism for change is needed. Intake appointments should be completed within the same day or no later than 2 working days after first contact to significantly reduce the attrition rate between initial contact and the

intake appointment ([Festinger et al., 1995, 1996, 2002](#); [Stark, Campbell & Brinkerhoff, 1990](#); [Stasiewicz & Stalker, 1999](#)). Induction into an opioid treatment program early in the pregnancy is recommended as longer duration of opioid treatment for example, is associated with increased attendance at antenatal care and improved maternal and antenatal outcomes (Burns, Mattick, Lim & Wallace, 2006).

The objective is to engage women in aspects of their own health during pregnancy as well as that of their 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, a drug and alcohol staff specialist and where possible 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 child and complications that may result in poor pregnancy outcomes;
- Undertaking regular care plan and drug and alcohol treatment plan reviews for those participating in opioid substitution treatment. Attendance for antenatal visits should be incorporated into the drug and alcohol treatment plan;
- Informing the mother and her partner as early as possible about the plans for her care including the length of hospital stay to assist with preparation (including childcare for older children) and to manage expectations;
- Referral for home based support to the SAFE START Home Visiting where available, for ongoing support before and after giving birth;
- Referral of women who are concerned about birth defects resulting from the use of alcohol and other drugs (licit or illicit) to the MotherSafe Program (NSW Medications in Pregnancy and Lactation Advisory Service) to discuss these issues on (02) 9382 6539.

6.2 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:

6.3 Antenatal history/screening

Ensure that an accurate history is taken of maternal drug use for all women attending antenatal care at the initial assessment (time of confirmation of pregnancy, at first booking-in visit, or first presentation) and periodically throughout antenatal care, including

the type of drug/s used, the frequency, amount, duration, and type of treatment at the time of admission.

If required, the woman may be admitted to an inpatient obstetric unit for stabilisation and rapid dose titration, and respite from related social problems. This may allow for the opportunity to reduce or cease use of substances such as tobacco, cannabis, alcohol. If benzodiazepines are currently being used, the recommended management of a benzodiazepine dependent pregnant woman is transfer to a long acting benzodiazepine (diazepam) and gradual dose reduction. Further information for the management of each drug type is provided in the *National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*.

6.4 Blood Borne Virus Screening

Hepatitis B (HBV)

Antenatal blood borne virus screening should be conducted as per The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Australasian Society for Infectious Diseases (ASID) recommendations. Universal screening is recommended and all pregnant women should be offered a test for HBV in pregnancy, regardless of previous testing or vaccination. The recommended screening test for HBV is hepatitis B surface antigen (HBsAg). This should be offered at the first antenatal visit (Palasanthiran, Starr, & Jones, 2007).

Hepatitis C (HCV)

Antenatal screening for HCV should be encouraged for pregnant women with identified risk factors including: history of injecting drug use, history of incarceration, tattoos/skin piercings, people born in countries with high HCV prevalence; Aboriginal and Torres Strait Islander populations and the sexual partners of those with HCV (National Hepatitis Screening Policy, Commonwealth of Australia 2012). Antenatal testing must only be performed with informed consent of the pregnant woman and must be offered in the context of appropriate risk assessment and discussion.

The recommended screening test for HCV is an HCV RNA or HCV antigen (HCV Ag). The latter test is not routinely undertaken at present and is not funded. All women who test positive for the HCV antibody should have confirmation with a second HCV RNA test before they are reported as positive as there is a greater risk of a false positive anti-HCV result during pregnancy.

Pregnant women with a positive Human Immunodeficiency Virus (HIV) test should be referred to a specialist clinic for treatment and management to reduce the risk of mother to child transmission.

Further guidance regarding antenatal blood borne virus testing can be obtained from the Australasian Society for HIV Medicine (ASHM) http://www.ashm.org.au/images/pdfs/publications/1976963383_antenatal_web.pdf

6.5 Tobacco and NRT

Pregnant women who use drugs and/or alcohol may also smoke cigarettes. Smokers are more likely to experience a range of obstetric and neonatal complications including miscarriage, prematurity, low birth weight and sudden infant death syndrome (SIDS) and therefore should be encouraged to quit smoking. In addition, heavy cigarette smoking is associated with increased severity of NAS symptoms. Choo, Huestis, Schroeder et al. 2004 identified that babies born to women who used methadone during pregnancy and smoked tobacco heavily (>20 cigarettes per day) had higher NAS scores that also took longer to peak (113 hours vs. 37.8 hours) than infants of women who smoked <10 cigarettes per day.

In pregnancy, it is preferable for women to try to quit first without using nicotine replacement therapy (NRT). However, NRT is less harmful than smoking during pregnancy, as the pregnant woman and the baby receive less nicotine and no exposure to carbon monoxide and other toxic substances. NRT in the forms of gum, lozenges, sublingual tablets or inhalers (rather than patches) may be used in pregnancy. The benefits of quitting smoking are likely to outweigh the risks from using NRT or continuing to smoke. NRT is beneficial to highly dependent smokers who are likely to have greater difficulty in quitting and who also have a greater risk of developing problems during the pregnancy and birth. Additional support is available through local Public Health Units and Community Health Services.

6.6 Assessment and Identification of Risk

Early identification of families with complex needs who may have difficulties providing a safe and nurturing environment for their children is imperative. Early identification can support, strengthen and empower the family and ensure optimal health outcomes.

A comprehensive psychosocial assessment which includes a screen for depression should be included as part of routine antenatal and postnatal care. The SAFE START psychosocial assessment questions cover seven key variables that have been identified as highly significant in contributing to poor maternal and child mental health outcomes:

- Lack of social or emotional support
- Recent stressors in the last year
- Low self-esteem (including self-confidence, high anxiety and perfectionistic traits)
- History of anxiety, depression and other mental health problems
- Couple relationship problems
- Adverse childhood experience
- Domestic violence.

SAFE START is a program provided by NSW Health that assesses women who are expecting or caring for an infant, and assists in identifying and supporting women who may be experiencing or at risk of developing mental health problems, including postnatal depression. All pregnant women booked in for routine antenatal care with a health service can access SAFE START. Health professionals may contact the SAFE START Consultation Liaison Worker to investigate any opportunity for a coordinated case

management of the pregnant woman through a SAFE START Multidisciplinary Case Discussion meeting. Refer: Appendix 4: SAFE START psychosocial assessment questions http://www0.health.nsw.gov.au/policies/gl/2010/GL2010_004.html

As women may not readily disclose domestic violence, all women who present to antenatal and alcohol and other drugs services are to be screened for domestic violence according to the protocol outlined in the *Policy and Procedures for Identifying and Responding to Domestic Violence* (2006) http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_084.html

6.7 Prenatal reporting

Careful consideration needs to be given of the need to make a prenatal report under Section 25 of the Children and Young Persons (Care and Protection) Act 1998 if there are reasonable grounds to suspect, before the birth of a child, that the child may be at risk of significant harm after his or her birth. Assessments should include drug use patterns by the mother and other adults living in the home and the potential impact on the child, and any other supports and risks posed by the mother's partner including the presence of domestic violence. Other considerations include the pregnant woman's capacity to care for a newborn baby if she has an unmanaged mental health issue, a severe intellectual or physical disability, or is homeless/transient and has not been able to adequately prepare for the child's birth. Local Health Districts must ensure that there are mechanisms for undertaking further risk assessment with women in these target groups in accordance with NSW Health Prenatal Reporting Guidelines http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_007.html.

While operating within the NSW statutory framework, clinicians should bear in mind that the fear of possible intervention by child protection authorities can be a significant obstacle to the willing participation of women with a history of drug use in antenatal care, whether in a maternity or drug and alcohol setting. Whatever reassurances and involvement can be honestly given to the woman will be useful in maintaining trust and in alleviating anxiety. The mother should be advised by her clinician/health worker if the need to discuss concerns about her unborn child with other professionals or services arises, unless the provision of such advice is likely to increase the risk of harm to the unborn child or to the woman herself.

Mandatory reporters are encouraged to access Mandatory Reporter Guide (MRG) to help them decide what to do when they are concerned about a child or young person, including whether or not they should make a report to the Child Protection Helpline or whether other action is indicated. The Mandatory Reporter Guide is available at www.sdm.community.nsw.gov.au/mrg/ or via the Keep Them Safe webpage. Mandatory reporters working for NSW Health can contact the NSW Health Child Wellbeing Unit (CWU) to discuss whether or not they should make a report to the Child Protection Helpline, including after they have consulted the Mandatory Reporter Guide and remain unsure about what to do, and what service responses may be appropriate. The Health CWU can be contacted on 1300 480 420 from 8:30am – 5:30pm Monday to Friday.

A prenatal report is not mandatory, but may be advisable if any of the following are present:

- Serious and persistent substance abuse by pregnant woman
- Domestic violence
- Unstable living arrangements or homelessness
- Suicide risk (either threatened or attempted)
- Unmanaged mental illness
- Cognitive disability
- Apparent lack of adequate social supports
- Inadequate preparations for the birth
- Medical condition or physical disability
- The pregnant woman is a child or a young person with limited social support, such as those under the parental responsibility of the Minister for Community Services
- History of abuse or neglect of other children in the family i.e. the woman or her partner had a previous child removed or die in circumstances reviewable by the Ombudsman

Cumulative harm refers to a series of acts or omissions that, when viewed separately may not indicate significant risk, but when viewed together suggest a pattern of significant harm. Mandatory reporters should keep good records of concerns they have about a family as these concerns may continue and the pattern may constitute a report to the Child Protection Helpline. The Mandatory Reporter Guide includes questions which assist in determining cumulative harm.

Prenatal reports are not mandatory. However, Health workers with mandatory reporting responsibility should consider the potential benefits of making a report to enable Community Services, NSW Health and other agencies to mobilise services for the benefit of the child and the mother. By alerting Community Services to potential risks, NSW Health and Community Services are able to work collaboratively to ensure that all available preventative and early intervention strategies are in place to reduce the risk of harm to a child when born. Prenatal reports allow assistance and support to be provided early to an expectant mother to reduce the likelihood that her child, when born, will need to be placed in out-of-home care. These preventative reports also assist in providing early information that a child who is not yet born may be at risk of significant harm subsequent to his or her birth.

In any circumstance, including where a prenatal report is made, the health professionals should liaise closely with all agencies involved in the provision of services, including Community Services, throughout the pregnancy and the postnatal period. A review of the level of risk can occur in the context of a case meeting or clinical review at appropriate key milestones along the clinical care pathway (e.g. before discharge). Case meetings or reviews aim to establish an agreed plan of care for the infant, and should include the mother/parents and their advocates (such as an Aboriginal health worker), as

well as a Community Services case worker, drug and alcohol liaison worker, health care providers, and representatives of all other agencies involved in the care of the family. At each meeting, a time frame for review of the plan should be determined.

Prenatal reporting may be particularly important to the unborn child and to the child's future safety, welfare and wellbeing when the pregnant woman is in a domestic violence situation; is suffering from an unmanaged mental illness or where there is hazardous drug and/or alcohol misuse. This includes where the newborn child is likely to be exposed upon discharge from the maternity unit to significant domestic violence, neglect, sexual or physical assault or psychological harm. It is also appropriate to consider prenatal reporting where a parent has previously demonstrated an inability to safely parent. A report must also be made by the Health worker if the other children of the pregnant mother are also at risk of significant harm (Section 27). Mandatory reporters' identities are protected by law. Making a report cannot be seen as breaching professional ethics or as a departure from acceptable standards of professional conduct.

NSW Health Mandatory reporters can also seek advice from a NSW Health Child Wellbeing Unit (CWUs) to discuss whether identified concerns warrant a risk of significant harm report being made (including where they have consulted the Mandatory Reporter Guide and remain unsure as to whether a report should be made) and what service responses may be appropriate. Health workers can seek advice from a Health Child Wellbeing Unit (CWU) about the need to make a report and what service responses may be appropriate. CWUs may be contacted on **1300 480 420** from 8.30am – 5.30pm Monday to Friday. Further information on the Health CWUs is available at www.health.nsw.gov.au/Initiatives/kts/cwu.asp.

Child Wellbeing Units (CWUs) are operated by the NSW Health, the NSW Police Force, the NSW Department of Education and Communities and Community Services. CWUs have a role in monitoring vulnerable children and in minimising the risk of these children "falling through the gaps". By having some access to other agencies' information on concerns related to a child or young person, CWUs are well placed to advise workers on cumulative risks of harm to a child and the support needs of a family. CWUs may also be able to:

- identify whether another health worker or agency, including Community Services has reported concerns or is working with a particular child, young person or family and whether this information impacts on the level of risk
- identify whether Community Services has issued a High Risk Birth Alert
- provide advice and assistance in planning what referrals and services may be offered to assist the child, young person and family
- conduct a cumulative risk appraisal (where previous concerns have been recorded).

A prenatal report can be made to the Child Protection Helpline (ph 13 36 27) 24 hours per day, 7 days per week. When a prenatal report or child protection report is made to the Child Protection Helpline, it should be documented in the client Health record consistent with the relevant child protection policies and procedures cited in the introduction to these Guidelines.

Section 25 of the Act allows for a person to make a prenatal report when they have reasonable grounds to suspect, before the birth of a child, that the child may be at risk of significant harm after his or her birth. The intentions of section 25 are:

- to allow assistance and support to be provided to the expectant mother to reduce the likelihood that her child, when born, will need to be placed in out-of-home care, and
- to provide early information that a child who is not yet born may be at risk of significant harm subsequent to his or her birth, and to provide for mandatory reporting after the child is born (section 27) if there are reasonable grounds to believe that the child is at risk of significant harm.

Once a prenatal report is made, the Child Protection Helpline will review the information and known history to assess whether the matter should be referred to a local Community Service Centre for action. [Section 245C](#) of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* enable s Community Services to issue an Unborn Child High Risk Birth Alert (HRBA) which provides information about an unborn child who has been the subject of a prenatal report, to NSW Health and to other prescribed bodies. A HRBA may be issued to the Local Health District Central Contact Point (CCP) where the birth is likely to take place if, in addition to a risk of significant harm, at least one of three following factors is present: the pregnant woman is unable to engage with services; is not accepting supportive intervention; or is transient. The *Prenatal Reporting Guidelines* GL2011_008 provide health workers with advice on how to engage the pregnant woman in appropriate health services.

NOTE: [Chapter 16A](#) and [Section 248\(1\)](#) of the *Children and Young Persons (Care and Protection) Act 1998* enable a prescribed body to share information with another prescribed body about the parent(s) or family of an unborn child **who is the subject of a prenatal report**, in the same way that information may be shared about the safety, welfare and wellbeing of a child or young person or class of children or young people, without the need for parental consent. If the unborn child is not a subject of a prenatal report (which can be verified through the Health CWU or Child Protection Helpline), Health workers require the pregnant woman's consent to exchange information with prescribed bodies.

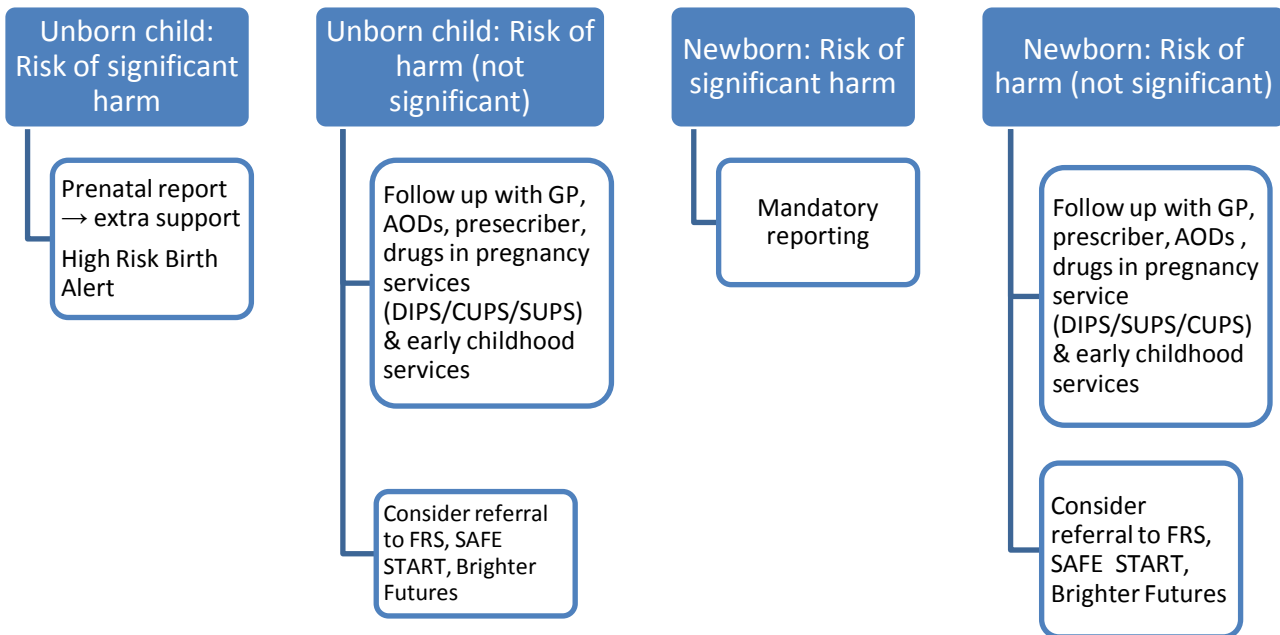
6.8 Family Referral Services (FRS)

Where the level of risk is deemed not to be significant enough to warrant statutory reporting, the new mother and her family should be encouraged to make a follow up appointment with their GP, her drug and alcohol service (if appropriate) and engage with early childhood services. The family may also benefit from being referred to Family Referral Services, a Keep Them Safe initiative operated by non government organisations to help vulnerable families to access support services, such as emergency housing, furnishings or transport, and longer term intervention such as counselling and parenting courses.

6.9 Brighter Futures

Health practitioners may also consider referring the family to the Brighter Futures Early Intervention Program operated by non government organisations and designed for vulnerable families. Families may be referred to a Brighter Futures program by a health worker directly, by a Child Wellbeing Unit or via the Aboriginal Maternal and Infant Health Strategy (AMIHS).

Diagram 3. Referral Pathways for Unborn and Newborn Children according to risk of harm



Note: It is recommended that health professionals use the online Mandatory Reporter Guide to determine if risk of significant harm to be reported to the Child Protection Helpline. Further information is available from CWUs.

7 PERINATAL CARE - Monitoring health of mother and baby

Adequate treatment of maternal opioid withdrawal during labour is important to minimise the mother's discomfort and assist in optimising health outcomes for the mother and infant. In order to avoid withdrawal, opioid substitution treatment may be continued without interruption (e.g., daily dosing) during labour and delivery and the immediate post-partum period (CSAT, 2005; Jones, Johnson, Milio, 2006).

The majority of opioid dependent patients require greater-than-typical doses of opioid analgesics for pain management ([Gunderson & Stimmel, 2004](#)) individualized pain control is therefore required. The maintenance medication provided to treat opioid dependence is usually inadequate for pain management. If nitrous oxide does not provide adequate analgesia then an epidural may be more appropriate than morphine to provide adequate pain relief in women who choose to have analgesia for childbirth or require analgesia for caesarean delivery (Meyer, [Wagner, Benvenuto, Plante, & Howard D, 2007](#)). Ideally, the patient and anaesthetist should discuss pain management options well before delivery. Clear explanations and reassurance that their pain will be adequately managed should be given to patients.

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

- Frequent monitoring for signs of opioid withdrawal in the mother as well as the standard labour ward monitoring using a partogram to record cervical dilatation, descent of the foetal head and other parameters of progress in labour. Continuous foetal heart rate monitoring is recommended. Reduced foetal heart rate variability may be associated with opioid use in the mother; however foetal heart rate decelerations are not.
- Infection status – hepatitis C and B, HIV, sexually transmitted diseases (such as HSV 1 and 2). If the mother has positive serology for hepatitis C, B, and HIV the following are not recommended – artificial rupture of the membranes (ARM), application of a foetal scalp electrode (FSE), and taking foetal scalp capillary blood samples.

8 POSTNATAL CARE

Postnatal care should also be viewed as an opportunity for intervention. Postnatal care of the mother and baby affected by drug use is very important (Ornoy, Michailevskaya, Lukashov, Bar-Hamburger & Harel, 1996; Koren, Nulman, Rovet, Greenbaum et al 1998). 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 the Child Protection Helpline (ph 13 36 27).

In principle and wherever possible, the infant should be kept with the mother. Individual circumstances, the healthcare facilities available, the condition of the baby and the ability of the mother to safely care for the baby will determine where the infant is cared for. For symptomatic babies, Local Health Districts 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.

Asymptomatic babies should also remain with the mother on the maternity ward.

Local Health Districts will ensure that where risk of NAS is identified, **mothers and infants are to remain in hospital for no less than 5-7 days** (Ward, Mattick & Hall, 1998; Oei, Feller & Lui, 2001). 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 **Appendix 3**).

Note: The Finnegan scoring system is validated only for opioid exposure in TERM or NEAR-TERM infants and that its use in preterm or stimulant exposed infants may result in erroneous assessment of the withdrawal or intoxication status of the infant.

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 multidisciplinary care team.

8.1 Medical Management of Mother

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 opioid substitution treatment is appropriate for the mother, methadone or buprenorphine maintenance is the treatment of choice for breast feeding women.

If the mother is already on an opioid substitution treatment program, changes to the pharmacotherapy maintenance dose may be required. The maintenance dose should be reviewed in first few days after birth and regularly as indicated thereafter to support stability and to identify any signs of withdrawal or intoxication and assess risk of returning to illicit drug use. Dose reduction after birth is a common practice; however there is currently little available evidence to guide the timing of dose reductions. Due to the large individual variability among patients, dose changes should be guided by signs and symptoms of over-or under-medication ([Kaltenbach](#), Berghella, Finnegan, [1998](#)).

Effective liaison between the midwife, obstetric and neonatal services and drug treatment services is crucial in the post natal period and can be facilitated by the case manager. Where available, involvement of the Drug and Alcohol Hospital Consultation Liaison Nurse or Worker at an early stage in the assessment and treatment planning process is recommended.

Urine and/or meconium drug screening may be indicated where it is considered of diagnostic importance to know the drug history of the mother or where there are concerns about the accurate and/or timely disclosure of drug use. The test should be explained as soon as practical to the parents or carers of the child. Clinicians should be aware of the possibility of false negative or positive results.

8.2 Medical Management of the Infant

All infants born to drug dependent mothers should receive routine postnatal monitoring, along with specific assessment for the signs and symptoms of NAS using the Finnegan Neonatal Abstinence Severity Score (NASS) or modified Finnegan scale (See Appendix 3). Monitoring should commence within 2 hours after birth and be conducted 30-60 minutes after a feed. The score is an important guide for the appropriate pharmacologic treatment of NAS and health-care providers involved in the care of opioid-exposed infants must be educated in the appropriate application of these scores.

Morphine is the medication of choice for infants with NAS symptoms due to opioid withdrawal (Commonwealth of Australia, 2006). Guided by clinical judgement, the starting dose of morphine at 0.5 mg/kg/day in four divided doses (6 hourly) is currently recommended (Commonwealth of Australia, 2006). Doses should be titrated to NAS scores to control infant signs and symptoms of NAS.

Phenobarbitone (2.5mg/kg/dose 12 hourly) may be used as an adjunct for neonatal opioid withdrawal. This may be especially helpful if used in combination with morphine

when symptoms are not controlled despite “ceiling levels” (e.g. 0.8 mg/kg/day) of morphine. A loading dose of phenobarbitone (e.g. 10 mg/kg stat) is usually not necessary. Phenobarbitone may also be considered early (i.e. before morphine dose reaches 0.8mg/kg/day) if there is definitive evidence (e.g. by maternal history or by neonatal/maternal toxicology) of concurrent non-opioid drug use e.g. benzodiazepines, cocaine.

Phenobarbitone is also the primary drug of choice for the treatment of non-opioid drugs, where morphine is contraindicated due to the risk of respiratory depression. Seizures caused by opioid-related withdrawal will respond better to morphine than phenobarbitone (Wiiburg 1991). The dose of phenobarbitone should be titrated according to the Finnegan Score. Due to the long half life (>24 h) of phenobarbitone in the newborn, doses should be weaned by ~10-20% every 2-3 days if the infant improves symptomatically. It is suggested the phenobarbitone be weaned before morphine in infants who are primarily exposed to opiates due to the adverse effects of phenobarbitone on infant sucking behaviour (Kron 1976). Both morphine and phenobarbitone, despite significant first pass metabolism, can be administered orally unless there are contraindications to enteral intake (e.g. excessive vomiting, severe respiratory distress). No titration schedules are provided as they are as yet without evidence. Changes in dosing should be based on infant symptoms and the dose should not be changed too quickly in case of rebound.

In addition to pharmacotherapy other supportive care interventions such as being in a quiet setting, breastfeeding, use of a dummy/pacifier, cuddling, swaddling, small and frequent feeds, close contact such as using a sling or baby carrier may also assist to settle and support newborn experiencing NAS. NAS heightens sensitivity to environmental stimuli therefore excessive noise, movement and lighting around babies cots should be avoided. Refer to Appendix 5 for additional sleep and settling suggestions.

Special considerations for the care of the mother and infant include:

- Avoid use of Naloxone (Narcan) during any delivery room resuscitation if the mother is dependent on opioids, as its use may precipitate severe rapid onset of withdrawal associated with seizures (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.* http://www0.health.nsw.gov.au/policies/PD/2005/PD2005_256.html)
- NSW Health, Policy Directive PD2008_027 Maternity – Clinical Care and Resuscitation of the Newborn infant http://www0.health.nsw.gov.au/policies/pd/2008/PD2008_027.html
- Monitor the baby for early signs of NAS using appropriate withdrawal monitoring mechanisms, e.g. the Finnegan scoring chart (See Ward, Mattick and Hall, 1998) and;
- Provide appropriate medication for control of abstinence symptoms.

8.3 Medical Management of non-opioid withdrawal

If an infant has signs of NAS and the drugs used by the mother are unknown, an experienced drug and alcohol worker ideally should make a full assessment of maternal drug use. Infant urine and meconium may be used for toxicological analysis where it is of diagnostic importance to work out what drugs the mother has been using, particularly where there is no established therapeutic relationship with the mother. The test should be explained to the mother and informed consent obtained, preferably in writing. It is rare for infants to require pharmacological treatment for NAS due to other drugs including tobacco, cannabis, amphetamines, cocaine or antidepressants.

If an infant has signs of NAS and reaches the treatment threshold (Refer 8.2) and the drugs used by the mother are unknown, or are sedatives such as benzodiazepines, or the infant was born to a mother intoxicated with alcohol, then phenobarbitone should be used as the initial treatment. If used as an initial treatment (as opposed to in addition to an opioid), then a loading dose is likely to achieve more rapid control of symptoms.

Phenobarbitone should be commenced at a dose of 5 mg/kg/day split into two divided doses. Doses should be titrated to NAS scores to control infant signs and symptoms of NAS.

Note: The Finnegan scoring system is validated only for opioid exposure in TERM or NEAR-TERM infants and that its use in preterm or stimulant exposed infants may result in erroneous assessment of the withdrawal or intoxication status of the infant.

8.4 Breastfeeding

Breast milk is the most complete form of nutrition for infants, with a range of benefits for health, growth, immunity, development. Mothers stabilised on methadone should be encouraged to breastfeed and supported if they choose to breastfeed (including referral to Lactation Consultants as required). The level of methadone in breastmilk is low, unrelated to the maternal methadone dose (Jansson, Dipietro, Elko, Velez, 2007) and does not affect the infant's blood level of methadone. Ingesting breast milk relative to formula has also been found to be associated with less severe NAS (Abdel-Latif, Pinner, Clews, Cooke et al., 2006). Abrupt cessation of breastfeeding may precipitate NAS (Malpas & Darlow, 1999).

Opioid-using women who are intoxicated or uncertain about recent drug use should not be encouraged to breast feed during the acute incident. Excessive somnolence or fatigue may lead to accidental injuries (e.g. smothering) of the infant and the mother should be advised to express and discard the milk feed that occurs around the event.

The safety of benzodiazepines in breast milk is not known therefore the potential risks should be weighed up against benefits of breastfeeding. As specified above, women on rapid acting benzodiazepines should be advised not to breastfeed immediately post dose because of the risk of falling asleep and potentially smothering the baby and the risk of the infant receiving a maximum dose and becoming excessively drowsy (NSW Health Department, 2007).

Women who rarely use or binge use should be informed of the risks and provided with information on minimising harm to the baby, for example:

- Express and discard milk after psychostimulant use.
- Do not breastfeed for 24 hours after amphetamine or cocaine use.
- Do not breastfeed for 24–48 hours after using ecstasy (NSW Health Department, 2007).

Note: Opioid-exposed infants, if withdrawal is controlled, may be hyperphagic (Martinez, Kastner and Taeusch, 1999) and may consume in excess of 250 ml/kg/day of milk feeds during the end of the first week of life. This does not result in excessive weight gain and usually resolves by the end of the 2nd -3rd weeks of life (Martinez, Kastner and Taeusch, 1999).

The safety of buprenorphine in breastfeeding has not been established. Women who choose to breastfeed while taking buprenorphine should be informed of the risks and supported in their decision. The amount of buprenorphine in breastmilk is small and considered to be clinically insignificant (Lindemalm, Nydert, Svensson, Stahle, Sarman, 2009).

Infant weight should be closely monitored and when caloric intake appears to be insufficient from breastfeeding alone, supplemental breast milk or formula may be considered until adequate caloric intake from breastfeeding alone is established.

Women who choose to formula feed their babies should be given education and information regarding preparation, transport and storage of formula; appropriate heating/reheating of prepared infant formula and; cleaning and sterilisation of feeding equipment.

8.5 Contraception

Options for contraception should be discussed before discharge and information should be provided. It should be emphasized that it is possible to get pregnant when breastfeeding. It is suggested that the means of contraception be reliable and easy to use. There are a range of contraceptive options available including long-acting reversible contraception (LARC) such as Intra Uterine Device (IUD) and the contraceptive injection (Depo-Provera) given every three months or Implanon (a rod inserted in the arm which prevents pregnancy for up to three years). These options may be useful options for women unable to use other forms of contraception. Contraceptive advice will facilitate planned rather than unplanned pregnancies, and reduce harm to the unborn child.

9 DISCHARGE PLANNING & GUIDELINES

The role of the multi-disciplinary team is to manage discharge planning. This process should optimally involve the members of the multidisciplinary team and support services post discharge e.g. GP, mental health worker, drug and alcohol services, Community Services representative, and the OTP prescriber and/or clinic representative.

Local Health Districts must ensure that where parental substance is initially identified at the time of birth, Health workers conduct a preliminary comprehensive assessment of risk to the infant before the infant leaves hospital. This assessment needs to consider the cumulative sum 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):

- The Health worker should use the MRG to help determine whether or not to make a report to the Child Protection Helpline;
- Contact the Health Child Wellbeing Unit to discuss and record any concerns if the matter falls below the threshold of risk of significant harm;
- If parental substance use is identified but the level of risk does not warrant a *report to the Child Protection Helpline*, a case conference should be convened by the multidisciplinary team within the health facility overseeing the care of the patient to prepare a discharge plan as outlined below in Section 9.2. Consultation with Local Health District Child Protection Coordinators or Child Wellbeing Coordinator should occur as part of developing this Plan. The Multidisciplinary Care Coordinator in consultation with the multidisciplinary team should evaluate and document assessment of stability of drug and alcohol use, parental mental health, parental preparation for baby and initial assessment of parenting capacity.

9.1 Minimum Length of Stay of Baby

Infants at risk of NAS should remain in hospital for at least 5 days. This allows for a minimum time to monitor for signs of NAS, assess the parents' parenting skills, establish feeding and check for excessive weight loss. Benzodiazepines and barbiturates have a longer half life and withdrawal in the newborn may not manifest itself until about the 2nd week of life (Oei & Lui, 2007). If a polydrug-exposed infant is discharged, services should be available to provide consistent monitoring of changes in NAS.

9.2 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 Child and Family Health Nurse, Paediatric midwife, Paediatric clinician, drug and alcohol worker, and other workers as listed in point 5 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 nominated case manager, the mother and all services to which referrals are made e.g. representatives from relevant services which will include Child and Family Health Services, drug and alcohol services, GP, and family support services.

There may be situations where the mother relocates post-natally and/or post discharge. Care planning needs to raise this possibility with the mother to maximise the likelihood of ongoing care. In these situations the case manager should:

- Contact the local Service Providers (as listed above) to provide early advice;
- Forward a copy of the discharge plan, and;
- Request the local Service Providers to identify their own team to maintain continuum of care.

Where the multidisciplinary team has identified child protection concerns, consultation should occur with Local Health District Child Protection Coordinators or Child Wellbeing Coordinator.

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. The nominated case manager will ensure the plan is implemented and the case is coordinated following discharge.

9.3 Criteria for Safe Discharge of Infants Home

All mothers should be assessed adequately before discharge with respect to current drug use and psychological stability, parenting skills and social situation. The infant's wellbeing must also be assessed.

According to the '*National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*' (Commonwealth of Australia, 2006) absolute contraindications to discharge home include:

- Excessive weight loss (10% or more of birth weight)
- Baby not yet 5 days old
- Suspected infant neglect or abuse
- Suspected domestic violence
- A court order preventing the infant from being discharged home
- Further assessment for withdrawal is required.

Relative contraindications to discharge home include:

- Poor parenting skills of the mother or primary carer;
- Inadequate home support or refusal of assistance offered;
- Inadequate housing or material goods;
- Continued dependent drug use (non-prescribed) and/or poly drug use;
- Inability to provide adequate monitoring of infant wellbeing.

9.4 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 following discussion with the family, a report to the Child Protection Helpline 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.

Health workers must comply with the NSW Health Prenatal Reporting Guidelines (GL2011_008) and other relevant child protection policies and procedures as cited in the Introduction above.

In an urgent situation where there is assessed to be an imminent risk of significant harm to the infant should the parent/carer/guardian leave the Health premises with an infant against medical advice, the Health worker should immediately make a report to the Child Protection Helpline on 13 36 27.

- If after reasonable attempts to telephone the Child Protection Helpline, Health workers are unable to speak to a Helpline Officer, and the parent is leaving the Health premises with the child NSW Police Force should be contacted;
- If appropriate, Community Services may consider assuming emergency care of the infant under the *Children and Young Persons (Care and Protection) Act 1998* (NSW);
- 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.
- It is also imperative where a mother is on an opioid treatment program, to inform the program of the unplanned discharge, with a progress report or discharge summary and the details of the last dose.
- Health workers should also inform the mother's general practitioner and any other service providers of the unplanned discharge.

9.5 Medication on Discharge

The practice of discharging infants on a reducing regime of medication 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 service for example, paediatrician/GP. 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 safety of the home environment and of the parents' parenting abilities.

9.6 Discharge Protocols

A coordinated follow up program with the relevant drug and alcohol service should be established for the mother by the multi-disciplinary team as part of the discharge planning process. In addition, for the neonate discharged from hospital on medication (morphine/phenobarbitone) clear dispensing information needs to be provided to the mother, partner or support person/foster carer.

For safety, the medication (e.g. morphine and/or phenobarbitone), should be prescribed and dispensed with consistency in formulation and only for a limited time period (usually until the next neonatal/paediatric clinic or GP visit). Safety precautions including distinctively labelled childproof bottles, parental provision of a locked box for medication storage and clear instructions regarding administration should be employed along with a 24 hour contact phone number for any carer concerns.

Women and their partners/support persons should also receive information about safe sleeping practices, especially when parents are using alcohol or sedating medications, including methadone or buprenorphine. Documentation that Safe Sleeping and SIDS risk have been discussed should also be documented within the mother and baby's files. Families should also be advised about the risks associated with environmental tobacco exposure.

9.7 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.

10 COORDINATED FOLLOW UP & SUPPORT

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

10.1 Follow up for the Infant

The case manager should ensure that:

- Infants with, or at risk of NAS, should be referred to appropriate paediatric or GP 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.

The case manager should ensure a postnatal check is conducted at six weeks post birth which includes the partner (or support person) and Health workers involved in the ongoing care of the mother and child including the:

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

Further follow-up should be considered at a later age: ophthalmological review for various conditions such as myopia and strabismus and growth and developmental follow-up to identify and provide intervention for growth, neurodevelopmental and behavioural problems.

10.2 Follow up for Babies at Risk of Vertical Transmission of Blood Borne Virus

If a baby is shown to be infected with a BBV, they should be referred to an appropriate paediatric specialist for ongoing monitoring, follow-up and treatment.

Hepatitis B

Infants born to hepatitis B surface antigen (HBsAg) positive mothers should be given HBV immunoglobulin (HBIG) preferably within 12 hours of birth, as the efficacy of this treatment decreases if administration is delayed more than 48 hours (Palasanthiran, Starr, & Jones, 2007). The first dose of HBV vaccine should be given at the same time as the HBIG, but in the opposite thigh. Three additional doses of HBV vaccine should be given at two, four and either six or twelve months of age (depending on the combination vaccine used) so that the infant receives a total of four doses of HBV vaccine. The newborn should be tested for HBsAg and hepatitis B surface antibodies at three to twelve months after the final dose of HBV vaccine.

Hepatitis C

Diagnosis of HCV infection in infants born to HCV-infected mothers is established by testing for HCV RNA. It is recommended that HCV RNA be tested at 8 weeks and again 4 to 6 weeks later to confirm ongoing infection and to exclude transient viraemia which can occur in infants. If the test is positive on both occasions, the child should be referred to a Paediatric Gastroenterology or Infectious Diseases Unit for 6 monthly monitoring of liver function (this may require travel to a major centre where this service is available).

All children born to anti-HCV positive mothers should have antibody testing at 18 months of age to detect the rare instance where transmission has occurred from mothers with low and/or fluctuating HCV RNA levels.

Babies of mothers who have had a positive HIV antibody test should be referred to a specialist paediatrician for ongoing management, which includes chemoprophylaxis, monitoring and a revised vaccination schedule.

10.3 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, a domiciliary midwife should conduct a home visit in this period. Sustained home visiting through the SAFE START program should be considered for this group of mothers. The mother should receive a postnatal check at six weeks from her GP.

If appropriate other representatives may include:

- General practitioner;
- Community Services caseworker (if required);
- Drug and alcohol service, and;
- Opioid substitution treatment prescriber (or representative from the Opioid Substitution Treatment Program or GP prescriber).

In many instances where the mother is receiving opioid substitution treatment and the GP is also the mother's pharmacotherapy 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 an opioid substitution treatment service, the clinic nurses see the mother and baby regularly, in most cases daily, and can also monitor the mother's and infant's health.

11 TRAINING

Health workers can access specialist training regarding working with parents with substance use issues through the Education Centre Against Violence (ECAV) on (02) 9840 3737. Information on ECAV training and course related to child protection can be accessed from the NSW Health Keep Them Safe webpage: www.ecav.health.nsw.gov.au/

Additionally Local Health Districts 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 safety and wellbeing;
- Understand the legislative changes related to child protection and threshold for statutory intervention.

12 COLLABORATIVE DATA

It is recommended that each health care facility should maintain a record register to audit all aspects of management and workload of these families.

13 CONTACT INFORMATION

For further information on the Guidelines contact the NSW Ministry of Health:

- Mental Health and Drug and Alcohol Office (02) 9391 9038.
- Children, Young People and Family Health and Wellbeing Unit, Primary Health and Community Partnerships Branch (02) 9424 5719.

For additional information contact:

- MotherSafe Program (NSW Medications in Pregnancy and Lactation Advisory Service) – (02) 9382 6539 or 1800 647 848 (Non-Metropolitan Area)
- Drug and Alcohol Specialist Advisory Service (DASAS) 24 hours a day - (02) 9361 8006 or 1800 023 687 (Non-Metropolitan Area)
- The Newborn and Paediatric Emergency Transport Service – (02) 9633 8700
- Alcohol and Drug Information Service (ADIS) – (02) 9361 8000 or 1800 422 599 (Non-Metropolitan Area)

NGO Services for Women and Children

- Jarrah House <http://www.jarrahouse.com.au/>
- Kamira <http://www.kamira.com.au/>
- Phoebe House <http://www.phoebehouse.org.au/>
- Kathleen York House
<http://www.adfnsw.org.au/kathleen-york-house/index.html>
- WHOS (We Help Ourselves) Residential Treatment of Opioid Dependence
<http://www.whos.com.au/> Tel:+61 2 8572 7488

Further information is also available on the NSW Health website:

<http://www.health.nsw.gov.au/mhdao/>

<http://www.health.nsw.gov.au/initiatives/kts/index.asp>

14 APPENDICES

1. Summary of Key Documents
2. Check List for Mandatory Reporters
3. Royal Prince Alfred Hospital modified Finnegan's Scale
4. Modified Finnegan Neonatal Abstinence Severity Score Guideline

[Adapted from: D'Appolitto K. A scoring system for assessing neonatal abstinence syndrome. Instruction Manual. 1994.]

5. SAFE START Psychological Assessment Questions

Appendix 1. Summary of Key Documents

A. The Children and Young Persons (Care and Protection) Act 1998

Summary of key changes resulting from the amendments to the Act:

- The mandatory reporting threshold being raised from "risk of harm" to "risk of significant harm".
- Alternative referral options for mandatory reporters in major government reporting agencies for those children assessed as not at risk of significant harm but where there are concerns for their wellbeing
- Chapter 16A allows government agencies and non government organisations (NGOs) who are "prescribed bodies" to exchange information that relates to a child or young person's safety, welfare or wellbeing, whether or not the child or young person is known to Community Services and whether or not the parent of the child or young person consents to the information being exchanged. A prior ROSH report is a requirement for prenatal information exchange under Chapter 16A. These changes are in addition to the existing rules governing the exchange of information between Community Services and prescribed bodies contained in Section 248.
- Removal of criminal penalties for not reporting.
- Allowing disclosure of the reporter's identity to a law enforcement agency investigating a serious offence against a child or young person if the strict requirements imposed by the Act are met.

More information on information sharing is available from:

- the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* published by Community Services available at www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm

Further information on **Keep Them Safe** and changes related to child protection is available at: www.health.nsw.gov.au/initiatives/kts/index.asp

B. The NSW Health Prenatal Reporting Guidelines

These Guidelines have been developed to provide the principles and steps to engage a vulnerable pregnant woman with the NSW Health System. The Guidelines are to be referenced by Local Health Districts when developing local response mechanisms. http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_007.html

C. The NSW Health Frontline Policy and Procedures for the Protection and Wellbeing of Children and Young People

Health professionals should also be guided by NSW Health policy *NSW Health Frontline Policy and Procedures for the Protection and Wellbeing of Children and Young People* (2011). This document, available online as from 2011, is an update of the *NSW Health Frontline Procedures for the Protection of Children and Young People* published in 2000. The revised policy captures all existing child protection

policies and documents a range of situations where consideration may be given to report a child to Community Services for statutory intervention.

This policy is available at:

http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_007.html

D. The 2006 NSW Health policy directive - Information Sharing - NSW Health and DoCS - Opioid Treatment - Responsibility - Children Under 16

This policy is intended to support appropriate child protection responses by facilitating information sharing between Community Services and health practitioners. It is intended to support a shared approach to monitoring risks related to children's potential exposure to the methadone or buprenorphine, which is dispensed to their parents or carers as registered opioid treatment clients.

This policy is available at:

http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_085.html

Appendix 2: Check List for Mandatory Reporters

- Adopt a family sensitive approach to practice: http://nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources/family-sensitive-policy-and-practice-toolkit/
- Always be alert to the possibility of harm to the unborn and the newborn child. All drug and alcohol assessments should include an assessment of any children or young people in the parent's care and the impact that drug and alcohol use may be having on the safety, welfare and well-being of all children concerned (including the child to be born), whilst also identifying protective and resilience factors.
- Discuss concerns with clients, so that they understand why you may need to talk with others and initiate referrals to other services.
- Exchange information with other professionals involved in the care of the pregnant woman with the client's consent N.B. Under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, client consent is not required to exchange information on prenatal concerns where a prior ROSH report has been made to the Child Protection Helpline. Assess the risks of harm to the unborn/newborn child using the Mandatory Reporter Guide.
- Contact a Child Wellbeing Unit or Child Wellbeing Area Coordinators for advice by calling 1300 480 420 or www.health.nsw.gov.au/initiatives/kts/contact.asp
- Report risk of significant harm to the Child Protection Helpline (133 627 - NSW Health workers or 132 111 – and other mandatory reporters) as required by the *NSW Children and Young Persons (Care and Protection) Act 1998*.
- Where the MRG advises refer the pregnant woman/new mother to a Family Referral Service or to community based support services that may assist with immediate support needs including parenting skills, counselling etc. For information on Family Referral Services access NSW Health Keep Them Safe webpage, www.health.nsw.gov.au/Initiatives/kts/frs.asp

Appendix 3: Royal Prince Alfred Hospital modified Finnegan’s Scale

Source: Department of Neonatal Medicine Protocol Book Royal Prince Alfred Hospital, Sydney, NSW

Infants of mothers known or suspected to be drug users who are showing signs of withdrawal should be scored every 4 hours. The scoring should be applied in a consistent manner by personnel who are experienced in dealing with such infants.

	Date							
System	Signs & symptoms	Score						
Central Nervous System	High-pitched cry	2						
	Continuous high-pitched cry	3						
	Sleeps <1 hour after feeding	3						
	Sleeps <2 hours after feeding	2						
	Sleeps <3 hours after feeding	1						
	Mild tremors when disturbed	1						
	Mod-severe tremors when disturbed	2						
	Mild tremors undisturbed	3						
	Mod-severe tremors undisturbed	4						
	Increased muscle tone	2						
	Excoriation (specify area)	1						
	Myoclonic jerks	3						
	Generalised convulsions	5						
Metabolic/Vasomotor/Respiratory Disturbances	Fever (37.3-38.3 deg C)	1						
	Fever (>38.3 deg C)	2						
	Frequent yawning (>3-4 times in ½ hour)	1						
	Nasal snuffiness	1						
	Sneezing (>3-4 times in ½ hour)	1						
	Nasal flaring	2						
	Respiratory rate > 60/min	1						
	Respiratory rate > 60/min + retractions	2						
Gastrointestinal disturbances	Excessive sucking	1						
	Poor feeding	2						
	Regurgitation	2						
	Projectile vomiting	3						
	Loose stools	2						
	Watery stools	3						
	Total score							

Infants scoring 3 consecutive abstinence scores averaging more than 8 (e.g, 9-7-9) or ≥ 12 for 2 scores require treatment. The scoring interval should be 4 hourly until the infant has been stabilised. Infants withdrawing from non-opioids frequently display similar behaviours to those withdrawing from opioids.

NOTE: Caution must be exercised before symptoms listed here are accepted as part of drug withdrawal. For example, symptoms such as fever, tachypnoea or seizures could be due to sepsis, which should be excluded first with appropriate tests.

Appendix 4: Modified Finnegan Neonatal Abstinence Severity Score Guideline

System	Sign	Description – should be scored if:
Central nervous system disturbances	High pitched or excessive cry	Cries intermittently or continuously for up to 5 minutes despite caregiver intervention. Baby is unable to decrease crying within a 15 sec period using self consoling measures.
	Continuous (high pitched) cry	Baby cries intermittently or continuously for greater than 5 minutes despite caregiver intervention. NB. Since a baby's cry may vary in pitch, this should not be scored if high pitched crying is not accompanied by other signs described above.
	Sleep	Scores based on the longest period of sleep within the entire scoring interval. Include light and deep sleep (Deep – regular breathing, eyes closed, no spontaneous activity. Light - irregular breathing, brief opening of eyes at intervals, some sucking movements).
	Mild tremors when disturbed	Baby exhibits observable tremors of the hands or feet whilst being handled.
	Moderate to severe tremors when disturbed	Baby exhibits observable tremors of the arm/s or leg/s with or without tremors of the hands or feet whilst being handled.
	Mild tremors when undisturbed	(Undisturbed tremors should be assessed by observing the baby for at least 2 one - minute undisturbed periods). Baby exhibits observable tremors of the hands or feet whilst undisturbed.
	Moderate to severe tremors when undisturbed	Baby exhibits observable tremors of the arm/s or leg/s with or without tremors of the hands or feet whilst undisturbed.
	Increased muscle tone	Should be assessed when the baby is awake but not crying. There is tight flexion of the baby's arms and legs (unable to slightly extend the arms or legs).
	Excoriation	If occurs on chin, knees, cheeks, elbow, toes or nose . Score only when excoriations first appear, increase or appear in a new area. Does not include excoriated nappy area caused by loose stools.
	Myoclonic jerks	The baby exhibits twitching movements of the muscles of the face or extremities or if jerking movements of the arms or legs are observed.
	Generalised convulsions	Generalised activity involving tonic (rigid) extensions of all limbs (but may be limited to just one limb), or manifested by tonic flexion of all limbs. Generalised jitteriness of extremities is observed. Hold or flex the limbs, if the jitteriness does not stop it is a seizure. If subtle seizures are present (eye staring, rapid eye movements, chewing, fist clenching, back arching, cycling motion of limbs with or without autonomic changes) then they should be scored in this category.
Gastrointestinal disturbances	Excessive sucking	The baby shows increased (greater than 3 times) rooting (turns head to one side searching for food) while displaying rapid swiping movements of hand across mouth prior to or after a feed.
	Poor feeding	The baby demonstrates excessive sucking prior to a feed, yet sucks infrequently during feeding, taking small amounts and/or demonstrates an uncoordinated sucking reflex. Also score if the baby continuously gulps the milk and stops frequently to breathe.
	Regurgitation	Regurgitation not associated with burping occurs 2 or more times during a feed.
	Projectile vomiting	1 or more projectile vomiting episode occurring during or immediately after a feed.
	Loose stools	Scored if stool which may or may not be explosive, is curdy or seedy in appearance. A liquid stool, without a water ring on the nappy should also be scored as loose.
	Watery stools	The baby has soft, mushy, or hard stools that are accompanied by a water ring on the nappy.
	Fever	Score as per score sheet.
	Frequent yawning	The baby yawns greater than 3 times within scoring interval
	Nasal stuffiness	The baby exhibits noisy respirations due to the presence of exudate with or without a runny nose.
	Sneezing	The baby sneezed more than 3 times in the scoring interval. May occur as individual episodes or may occur serially.
	Nasal flaring	Present at any time during the scoring interval. Score only if present without other evidence of lung or airway disease.
	Respiratory rate	NB. Cannot be assessed while the baby is crying.

Appendix 5: Supportive care

Aligned with Modified Finnegan Scoring System – only symptoms that respond to supportive therapy are included

System	Sign	Suggested supportive measure
Central nervous system disturbances	Excessive or high pitched crying	Soothe baby with swaddling, talk quietly/sing/hum, hold baby firmly to body, rock gently use an infant sling. Reduce environmental stimuli (slow movements, reduce lighting and noise level).
	Sleeplessness	Reduce environmental stimuli, swaddle baby, minimise handling, rock gently and encourage skin to skin cuddles with parent(s).
	Excoriation (chin, knees, elbow, toes, nose)	Apply protective skin barriers to affected areas to protect skin and prevent damage.
	Myoclonic jerks, tremors, jitteriness, irritability	Prepare everything prior to disturbing the infant to minimise handling. Slow movements, reduced lighting, reduced noise levels, soft music, massage, relaxing baths.
Gastrointestinal disturbances	Excessive sucking	Agitation may result in scratching of the skin. Use of mittens will minimise sucking of the fists, keep hands clean and consult with parents about the use of a pacifier.
	Poor feeding (infrequent/uncoordinated suck)	Feed on demand. Reduce environmental stimuli during feeding. Frequent small feeds with rest between sucking. Assess coordination of suck/swallow reflex – support cheeks and jaw if necessary. Refer to Lactation Consultant as required. Monitor weight loss closely during withdrawal as feeding disturbances are common. Assess hydration. If caloric intake appears insufficient with breastfeeding alone use supplemental expressed breast milk or formula until adequate caloric intake is achieved. If insufficient fluid intake refer to medical staff.
	Regurgitation/vomiting	Wind or burp baby regularly when he/she stops sucking and at end of feed. Do not over feed.
	Peri – anal excoriation due to loose stools/diarrhoea	Change baby’s nappy with every feed, use barrier creams. It may be necessary to expose baby’s buttocks to air to dry.
	Pain	Provide pain relief for procedures based on need as for any baby.
Respiratory/vasomotor disturbances	Sweating	Clean skin regularly, dry clean clothing and bedding to prevent skin infection.
	Fever – temperature greater than 37.2°C	Ensure adequate hydration and reduce environmental temperature. Dress in light clothing and use lightweight, soft cotton fabric to swaddle or nurse skin to skin with mother. Nurse in an open cot with adequate ventilation.
	Nasal stuffiness/excessive nasal secretions	Use gentle suction if nasal secretions cause obstruction to ensure adequate respiratory function.
	Nasal flaring/tachypnoea	Refer to medical staff if cyanosis or mottling observed. Avoid swaddling so that respiratory rate can be closely observed. Nurse supine unless receiving cardiorespiratory monitoring in the nursery.

Appendix 6: SAFE START Psychosocial assessment questions

Variables (Risk Factors)		Suggested format for psychosocial assessment questions	
I. Lack of support		1. Will you be able to get practical support with your baby? 2. Do you have someone you are able to talk to about your feelings or worries?	
II. Recent major stressors in the last 12 months.		3. Have you had any major stressors, changes or losses recently (i.e., in the last 12 months) such as, financial problems, someone close to you dying, or any other serious worries?	
III. Low self- esteem (including lack of self- confidence, high anxiety and perfectionistic traits)		4. Generally, do you consider yourself a confident person? 5. Does it worry you a lot if things get messy or out of place?	
IV. History of anxiety, depression or other mental health problems		6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks? 6b. <i>If so, did it seriously interfere with your work and your relationships with friends and family?</i> 7. Are you currently receiving, or have you in the past received, treatment for any emotional problems?	
V. Couple's Relationship Problems Or dysfunction (if applicable)		8. How would you describe your relationship with your partner? 9. a). <u>Antenatal</u> : What do you think your relationship will be like after the birth OR b). <u>Postnatal (in Community Health Setting)</u> : Has your relationship changed since having the baby?	
VI. Adverse childhood experiences		10. Now that you are having a child of your own, you may think more about your own childhood and what it was like. As a child were you hurt or abused in any way (physically, emotionally, sexually)?	
VII. Domestic violence Questions must be asked only when the woman can be interviewed away from partner or family member over the age of 3 years. Staff must undergo training in screening for domestic violence before administering questions		11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner? 12. Are you frightened of your partner or ex-partner? (If the response to questions 11 & 12 is "No" then offer the DV information card and omit questions 13-18) 13. Are you safe here at home? /to go home when you leave here? 14. Has your child/children been hurt or witnessed violence? 15. Who is/are your children with now? 16. Are they safe? 17. Are you worried about your child/children's safety? 18. Would you like assistance with this?	
Opportunity to disclose further		19. Are there any other issues or worries you would like to mention?	

15 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 of Health worker appointed as the case manager for the care of the patient.

Case worker

Title 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 Ministry of Health and Local Health Districts 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.

Opioids

Opioids act on opioid receptors in the central nervous system to produce analgesia and varying amounts of euphoria and sedation. This group includes morphine, an alkaloid of opium obtained from the poppy plant, and related synthetic chemicals (including diacetyl morphine [heroin], methadone, buprenorphine, dextropropoxyphene, fentanyl, pentazocine, oxycodone, pethidine, and codeine).

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 the Child Protection Helpline in accordance with The *Children and Young Persons (Care and Protection) Act 1998* and *related Acts* i.e. where 'a person forms the belief, on reasonable grounds, that there are current concerns that a infant, child, young person or a class of children is at risk of significant harm.

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 significant harm

Mandatory reporters who suspect that a child or young person is at risk of significant harm (the statutory threshold) should report their concerns to the Child Protection Helpline. This new statutory threshold has replaced risk of harm in the *Children and Young Persons (Care and Protection) Act 1998*). A child or young person is at risk of significant harm if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent. Significant means that which is sufficiently serious to warrant a response by a statutory authority irrespective of a family's consent. What is significant is not minor or trivial and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing. In the case of an unborn child, what is significant is not minor or trivial and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child after the child's birth. Significance can result from a single act or omission or an accumulation of these.

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.

16 RELATED DOCUMENTS

- NSW Online Mandatory Reporter Guide (November 2011)
<http://www.keepthemsafe.nsw.gov.au/home>
- *Children and Young Persons (Care and Protection) Act 1998* (NSW)
<http://www.legislation.nsw.gov.au/fullhtml/inforce/act+157+1998+FIRST+0+N>
- NSW Health Department Circular, PD2005_299 – *Protecting Children and Young People, Child Wellbeing and Child Protection – NSW Interagency Guidelines*
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm
- Information Sharing – NSW Health and DoCS- Opioid Treatment Responsibility – Children Under 16 PD2006_085
http://www.health.nsw.gov.au/policies/pd/2006/PD2006_085.html A revision of this document is expected to be published in 2012.
- *NSW Health/Families NSW Supporting Families Early Package – Improving mental health outcomes for parents and infants SAFE START guidelines*
<http://www.sfe.nswiop.nsw.edu.au/file.php/1/SafeStartGuidelines.pdf>
- NSW Health Policy Directive PD2006_084 *Policy and Procedures for Identifying and Responding to Domestic Violence* (2006)
http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_084.html
- NSW Health Policy Directive PD2005_256: *Observation and management of newborn infants with respiratory maladaptation to birth, including infants exposed to intrapartum opioids administered to the mother during labour*
http://www0.health.nsw.gov.au/policies/PD/2005/PD2005_256.html
- NSW Health Policy Directive: PD2007_091 *Nursing and Midwifery Management of Drug and Alcohol Issues in the Delivery of Health Care*
http://www0.health.nsw.gov.au/policies/pd/2007/PD2007_091.html
- NSW Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment of opioid dependence
http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_019.html
- Nursing and Midwifery Clinical Guidelines - Identifying and Responding to Drug and Alcohol Issues GL2008_001
http://www0.health.nsw.gov.au/policies/gl/2008/GL2008_001.html
- *NSW Health: Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008)* GL2008-011
http://www0.health.nsw.gov.au/policies/gl/2008/GL2008_011.html

- NSW Health Guideline GL2005_024: *Screening for sexually transmissible diseases (STDs) and blood borne viruses (BBVs) in pregnancy*
http://www.health.nsw.gov.au/policies/GL/2005/pdf/GL2005_024.pdf
- *NSW Child Wellbeing and Child Protection – NSW Interagency Guidelines*
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm
- *NSW Health Policy Directive: PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*
http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_015.html
- NSW Health, Policy Directive PD2008_027 Maternity – Clinical Care and Resuscitation of the Newborn infant
http://www0.health.nsw.gov.au/policies/pd/2008/PD2008_027.html

17 REFERENCES

1. Abdel-Latif ME, Pinner J, Clews S, Cooke F, Lui K, Oei J. Effects of breast milk on the severity and outcome of neonatal abstinence syndrome among infants of drug-dependent mothers. *Pediatrics*. 2006;117:e1163–e1169.
2. Abdel-Latif, M.E., Bajuk, B., Lui, K. and Dei, J. Short term outcomes of infants of substance-using mothers admitted to neonatal intensive care units in New South Wales and the Australian Capital Territory. *Journal of Paediatrics and Child Health*, 2007; 43(3):127-133.
3. AIHW, 2011 (2010) *National Drug Strategy Household Survey report*. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW. Viewed 28 February 2012 <<http://www.aihw.gov.au/publication-detail/?id=32212254712>>.
4. Burns, L., Mattick, R.P. Lim, K. & Wallace, C. Methadone in pregnancy: treatment retention and neonatal outcomes *Addiction*, 2006; 102, 264-270.
5. Burns, L, Mattick, RP and Cooke M. The use of record linkage to examine illicit drug use in pregnancy. *Addiction* 2006; 101 (6):873-82.
6. Choo RE, Huestis MA, Schroeder JR *et al*. Neonatal abstinence syndrome in methadone-exposed infants is altered by level of prenatal tobacco exposure. *Drug Alcohol Depend*. 2004; **75**: 253–60.
7. Commonwealth of Australia, 2006. *National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (Sydney, Australia).
8. Commonwealth of Australia, 2012. National Hepatitis C Testing Policy. National HCV Testing Policy Expert Reference Committee – a joint working party of the BBVSS and MACBBVS
http://www.ashm.org.au/images/HCV_Testing_portal/HepC_TESTING_POLICY_FORMA_TTED_V10.pdf
9. CSTAT Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. (Treatment Improvement Protocol Series 43)* Rockville, MD: US Department of Health and Human Services; 2005.
10. Delaney-Black V, Covington C, Templin T, Ager J, Martier S and Sokol R. Prenatal Cocaine Exposure and Child Behaviour. *Pediatrics*. October 1998; 102 (4 Pt 1):945-50.
11. Festinger DS, Lamb RJ, Kountz MR, Kirby KC, Marlowe D. Pretreatment dropout as a function of treatment delay and client variables. *Addictive Behaviors*. 1995;20:111–115.
12. Festinger DS, Lamb RJ, Kirby KC, Marlowe DB. The accelerated intake: A method for increasing initial attendance to outpatient cocaine treatment. *Journal of Applied Behavior Analysis*. 1996;29:387–389.
13. Festinger DS, Lamb RJ, Marlowe DB, Kirby KC. From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors*. 2002;27:131–137.
14. Finnegan, LP, Connaughton, JR, Kron, RE, Emich, JP. Neonatal Abstinence Syndrome: assessment and management. *Addictive Diseases* 1975; 2:141-158.
15. Finnegan, LP. (1980). *Drug Dependence in Pregnancy*. London, Castle House Publications.
16. Gunderson EW, Stimmel B. Treatment of pain in drug addicted persons. In: Galanter M, Kleber H, editors. *Textbook of Substance Abuse Treatment*. 3rd Ed. Washington DC: American Psychiatric Pub Inc.; 2004. pp. 563–574.

17. Jansson LM, Dipietro JA, Elko A, Velez M. Maternal vagal tone change in response to methadone is associated with neonatal abstinence syndrome severity in exposed neonates. *Journal of Maternal, Fetal and Neonatal Medicine*. 2007;20:677–685.
18. Jaudes PK, Ekwo E and Van Voorhis J. Association of Drug Abuse and Child Abuse. *Child Abuse & Neglect* September 1995; 19(9):1065-75.
19. Jones HE, Johnson RE, Milio L. Post-cesarean pain management of patients maintained on methadone or buprenorphine. *American Journal on Addictions*. 2006;15:258–259.
20. [Jones HE, Kaltenbach K, Heil SH, Stine SM, Coyle MG, Arria AM, O'Grady KE, Selby P, Martin PR, Fischer G. Neonatal abstinence syndrome after methadone or buprenorphine exposure. *New England Journal of Medicine* 2010;363\(24\):2320-31.](#)
21. Kaltenbach K, Berghella V, Finnegan L. Opioid dependence during pregnancy: Effects and management. *Obstetrics and Gynecology Clinics of North America*. 1998;25:139–151.
22. Koren G, Nulman I, Rovet J, Greenbaum R, Loebstein M and Einarson T. Longterm Neurodevelopmental Risks In Children Exposed In Utero To Cocaine. The Toronto Adoption Study. *Annals of the New York Academy of Sciences*. 1998; 846:306-13.
23. [Kron RE, Litt M, Eng D, Phoenix MD, Finnegan LP. Neonatal narcotic abstinence: Effects of pharmacotherapeutic agents and maternal drug usage on nutritive sucking behavior. *Journal Pediatrics*. 1976 April; 88 \(4 Pt 1\):637-41.](#)
24. Latt, N. Conigrave, K. Saunders, J.B., Marshall, E.J. & Nutt, D. *Addiction Medicine*, 2009 Addiction Medicine, Oxford University Press, United Kingdom 2009.
25. Lindemalm S, Nydert P, Svensson JO, Stahle L, Sarman I. Transfer of Buprenorphine into breast milk and calculation of infant drug dose. *Journal of Human Lactation*. 2009;25(2):199-205).
26. Malpas TJ, Darlow BA. Neonatal abstinence syndrome following abrupt cessation of breastfeeding. *N Z Med J*. 1999; 112(1080):12-3.
27. Martinez, A. Kastner, B. & Taeusch, HW. Hyperphagia in neonates withdrawing from methadone. *Archive of Disease in Childhood: Fetal and Neonatal Edition* 1999; 80:F178-F182.
28. [Meyer M, Wagner K, Benvenuto A, Plante D, Howard D. Intrapartum and postpartum analgesia for women maintained on methadone during pregnancy. *Obstetrics and Gynaecology* 2007 Aug;110\(2 Pt 1\):261-6.](#)
29. Neonatal Abstinence Working Group, Report of the Neonatal Abstinence Working Group. NSW Pregnancy and Newborn Services Network, May 2001 (unpublished).
30. NSW Health Department, 2000. *The NSW Framework for Maternity Services*. Sydney: 2000.
31. NSW Health Department, 2007. *Nursing & Midwifery Clinical Guidelines - Identifying & Responding to Drug & Alcohol Issues*.
32. Oei, J, & Lui, K. Management of the newborn infant affected by maternal opiates and other drugs of dependency. *Journal of Paediatrics and Child Health* 2007, 43:9-18.
33. Oei, JL. Kingsbury, A., Dhawan, A., Burns, L., Feller, JM., S Clews, S., Falconer, J. and Abdel-Latif, ME. Amphetamines, the pregnant woman and her children: a review. *Journal of Perinatology* (2012), 1–11.
34. Oei J, Feller JM and Lui K. Coordinated Outpatient Care of the Opioid Dependent Infant. *Journal of Paediatric and Child Health*. 2001; 37 (3):266-70.
35. Ornoy A, Michailovskaya V, Lukashov I, Bar-Hamburger R and Harel S The Developmental Outcome of Children Born to Heroin-Dependant Mothers, Raised at Home or Adopted. *Child Abuse & Neglect*. May 1996; 20(5):385-96.

36. Palasanthiran, P. Starr, M. Jones, C. Editors. Management of perinatal infections. Sydney: Australasian Society for Infectious Diseases (ASID); 2002 (Rev 2007).
37. Royal Australian and New Zealand College Statement C-Obs 3. Antenatal Screening tests. 2008.
38. Stark MJ, Campbell BK, Brinkerhoff CV. "Hello, may we help you?" A study of attrition prevention at the time of the first phone contact with substance-abusing clients. *American Journal of Drug and Alcohol Abuse*. 1990;16:67–76.
39. Stasiewicz PR, Stalker R. A comparison of three "interventions" on pretreatment dropout rates in an outpatient substance abuse clinic. *Addictive Behaviors*. 1999; 24:579–582.
40. Wagner CL, Katikaneni LD, Cox TH and Ryan RM. The Impact of Prenatal Drug Exposure on the Neonate. *Obstetrics & Gynecology Clinics of North America* 1998; 25(1):169-94.
41. Ward J, Mattick RP and Hall W. *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Harwood: Academic Publishers, 1998; 409.
42. Wijburg FA, de Kleine MJ, Fleury P, Soepatmi S. Morphine as an anti-epileptic drug in neonatal abstinence syndrome. *Acta Paediatr Scand*. 1991; Aug-Sep; 80(8-9):875-7.

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		