Care of Mothers and Infants Affected by Substance Abuse Disorders

Purpose
To provide the following guidelines in the management of mothers and infants affected by substance use disorders: screening, linking families to treatment, rooming-in, breastfeeding, non-pharmacologic interventions, pharmacologic interventions, and safe discharge.

Guidelines
I. Screening, Brief Intervention, Referral to Treatment (SBIRT)
Background: All pregnant patients will be screened for substance use at all acute hospital encounters using the validated screening tool, “5 P’s” (see attachment). The screenings should be done every trimester in the outpatient setting.

Guidelines:
1. Patients with positive screens will receive brief intervention and maternal urine toxicology screening. Informed consent must be obtained prior to maternal urine toxicology screening.
2. The brief intervention is to help the patient understand that their substance use is putting them at risk and to encourage them to reduce, give up their substance use or begin medication assisted therapy (MAT). Brief intervention should be personalized and offered in a non-judgmental manner.
3. Patients should receive education (MNO Bundle). Refer patient to social services, behavioral health/recovery services, MAT services, and neonatology/pediatrics per individual site plan.
4. Patients should receive Narcan and contraceptive counseling.
5. The provider may request newborn toxicology screening (urine, meconium, or umbilical cord) to determine appropriate medical treatment and DCFS referral.
6. The provider may request lab testing including but not limited to HIV, Hepatitis B, and Hepatitis C.

II. Neonatal Care
1. The following infants should have urine and meconium/umbilical cord drug screens sent:
   a. History of maternal drug use
   b. Positive result on “5P’s “ integrated screening tool for maternal alcohol/substance use
   c. Maternal drug seeking behavior, agitated/altered mental status in the mother or symptoms of drug withdrawal in the mother
   d. No prenatal care
   e. Maternal incarceration or previous DCFS referral
   f. Placental abruption, IUGR, or preterm labor without other etiology
   g. Vascular accident of the mother or newborn
   h. Symptoms of drug withdrawal in the newborn (tachypnea, hypertonicity, excessive stooling/secretions)
   i. Changes in behavioral state of the newborn (jittery, fussy, lethargic)

2. Rooming-in for Eligible Infants and Families
Background: Rooming-in is a procedure wherein the parents of the infant stay in the same room with their infant. This allows for provision of non-pharmacotherapeutic intervention by the parents such as breastfeeding and skin-to-skin care, with the goal of decreasing the incidence and severity of NAS for infants with in-utero substance exposure. The benefits would include shortened length of stay, increased breastfeeding rates, a decreased need for pharmacotherapy, and enhanced bonding between parents and child.
**Guidelines:**
1. The provider should determine Rooming-in eligibility based on the infant’s clinical status/stability, maternal ability to provide infant care, and most recent maternal toxicology screening.
2. Mother or alternative caregiver is expected to stay with infant for the duration of the infant’s hospital stay. If unable to meet this requirement, the infant will be transferred to an alternate setting for care.

For Opioid Exposed Newborns (OENs)
1. The infant is assessed for withdrawal signs and symptoms within 4 hours of birth and continued every 3-4 hours. Assessments will occur after feeds/cares. Assessment tools include the Modified Finnegan Neonatal Abstinence Scoring System and Eat Sleep Console Care Tool (ESC) (see attachments).
2. Mother will be encouraged to provide non-pharmacological care to infant including breastfeeding (if eligible), skin-to-skin, feeding on demand, swaddling, decreased noise and stimulation, holding, and gentle rocking. Staff should provide appropriate printed educational information to mother and other caregivers regarding NAS and non-pharmacological interventions.
3. Upon mother’s discharge from the Mother/Baby Unit, she may continue rooming-in with the infant. It is acceptable for the mother to take brief 1-2-hour breaks for self-care. Mother should arrange for an alternative caregiver to be present during her breaks.

For Other Substance Use Exposed Newborns
Care and treatment plan to be determined on a case-by-case basis per neonatal care provider.

3. **Breastfeeding**
   
   **Background:** Breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.

   **Guidelines:**
   1. Shared decision making to initiate, continue, or discontinue breastfeeding should be individualized for each dyad with input from the health care team based on the mother’s history including self-report of substance use, mother’s intent to engage in and access to SUD treatment, substance(s) in question, specificity of drug testing and existing evidence available regarding safety of substance in breastfeeding.
   2. Breastfeeding recommendations from the Academy of Breastfeeding Medicine (revised 2015) for the following substances will be followed:
      a. Methadone - For pregnant and postpartum women with opioid dependence in treatment, methadone maintenance has been the treatment of choice. In contrast to other substances, concentrations of methadone in human milk and the effects on the infant have been studied. The concentrations of methadone found in human milk are low, and all authors have concluded that women on stable doses of methadone maintenance should be encouraged to breastfeed if desired, irrespective of maternal methadone dose. Use of this drug is not a contraindication to breastfeeding.
      b. Buprenorphine - Buprenorphine is a partial opioid agonist used for treatment of opioid dependency during pregnancy. Multiple small case series have examined maternal buprenorphine concentrations in human milk. All concur that the amounts of buprenorphine in human milk are small and are unlikely to have short-term negative effects on the developing infant. Use of this drug is not a contraindication to breastfeeding.
c. Other opioids - When use of narcotics during pregnancy is determined to be consistent with an opioid use disorder rather than a modality for short-term pain relief, consideration of initiation of maintenance methadone or buprenorphine as previously discussed is strongly encouraged, and these mothers should be supported in breastfeeding initiation. The health care team would be weighing the benefits against the risks and would have the last say in the appropriate course of care for the infant.

d. Marijuana – Mothers should abstain from marijuana use while breastfeeding due to risk for impaired ability to safely care for the infant, hazards of passive smoke exposure to infant, and risks of marijuana exposure through breastmilk. These risks include the psychoactive constituent THC, which is rapidly distributed to the infant’s brain and may cause the infant to be extra sleepy and experience long-term neurobehavioral/developmental impact.

3. Consider increasing caloric intake to promote adequate weight gain.
   a. Higher calorie feeding is designed to meet the exceptional caloric needs of infants with NAS and may prevent the documented weight loss seen in these infants and may allow lower use of narcotics in treatment.
   b. The higher calorie feeding is only needed at the onset of withdrawal. Discontinue when weight gain is firmly established.

4. Non-pharmacologic Care

   Background: Studies show that non-pharmacologic care is effective for managing withdrawal symptoms in infants. Its effects include a shorter length of stay, a decrease in withdrawal scores, a decrease need of pharmacologic treatment, and decrease severity of withdrawal symptoms. Parents are considered the primary caregivers and means of prevention and treatment for withdrawal symptoms. Staff should educate and encourage parents/caregivers to utilize non-pharmacological interventions.

   Guidelines:
   1. Non-pharmacologic interventions will be the first line of treatment for all infants exposed to substance use.
   2. Non-pharmacologic interventions will be utilized whether the infant is or is not treated pharmacologically for withdrawal symptoms.
   3. Non-pharmacologic interventions education will be provided by staff to parents and caregivers including when and how to increase their use.
   4. Parents/caregivers will be encouraged to utilize non-pharmacologic interventions to manage infant’s withdrawal symptoms.
   5. All caregivers will be educated on the principles of ESC and ESC interventions will be initiated on all infants. If sites wish to continue NAS scoring in addition to using ESC, all efforts are to be made to console the baby before NAS scoring including feeding.
   6. The following are recommended non-pharmacological care interventions:
      a. Rooming-in
      b. Skin-to-skin contact
      c. Holding/gentle rocking/swaying
      d. Use of cuddler program if available
      e. Safe swaddling/flexed positioning
      f. Optimal feeding at early hunger cues
      g. Quiet environment
      h. Non-nutritive sucking
      i. Additional help/support in room
j. Limiting visitors
k. Clustering infant’s care
l. Safe sleep/infant fall prevention
m. Ensuring adequate parent/caregiver rest and self-care.

7. As much as possible, a core care team should be identified and used.
8. Huddles should occur on a regular basis. The people involved in the huddle should include the family, the bedside nurse and, if available, the social worker. The physician should huddle with the group at least once a day and then whenever changes in medication are being discussed.

5. Pharmacologic Treatment

Background: Pharmacologic treatment is indicated for NAS infants whose symptoms are not controlled by non-pharmacological means. A standardized protocol for initiation and weaning of pharmacotherapy and NAS is associated to shorter duration of opioid treatment, shorter inpatient hospitalization, and less adjunctive drug therapy.

Babies who have received pharmacological treatment should be monitored per unit protocol. (Refer to current AC NAS pathway)

6. Coordinating a Safe Discharge:

Background: Federal law requires that all infants determined to be affected by maternal substance use must have a plan of safe care in place on discharge from the birth of hospital. Discharge planning should ideally begin during the antenatal period. Safe discharge will focus on child vulnerability, adult protective capabilities, and safety factors. If withdrawal signs or symptoms are minimal, then a comprehensive discharge plan that addresses maternal substance abuse treatment, a safe environment for both mother and baby, and parenting and community support.

Guidelines:
1. The following criteria will be met prior to discharge:
   a. 4-7 days for inpatient monitoring for infants that do not require medications
   b. 48 hours of inpatient monitoring after medication use for infants who require medication.
   c. Infants should feed well over 2 consecutive days (for infants who had received pharmacotherapy).
   d. Infants should gain weight over 2 consecutive days (for infants who had received pharmacotherapy).
   e. Social work on consult.
   f. Clearance from DCFS if applicable.
   g. Pediatrician f/u care 24-48 hours after discharge.
   h. APORS
   i. Discharge Summary report from Neonatologist.

2. The following referrals will be made if applicable:
   a. High Risk Clinic
   b. WIC
   c. DCFS for discussion of custody
   d. Early Intervention
   e. Home Health Nurse
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References


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