The Snuggle ME Project:
Embracing Drug Affected Babies and their Families in the First Year of Life
To Improve Medical Care and Outcomes Maine

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Table of Contents

1. Quick Reference: Overview of Screening for Substance Use 3

2. Quick Reference: Overview of Recommendations for Care of Pregnant Women.....4

3. Chapter 1: Screening for Substance Use during Pregnancy 8

4. Chapter 2: Antepartum Management of Opioid Dependent Women 12

*For prescribers: MaineCare information about pre-authorization 12

5. Chapter 3: Intrapartum Management 18

6. Chapter 4: Postpartum Management 20

7. Appendix A: Screening Tools 22

8. Appendix B: Hospital Policy Guideline for Intrapartum Screening for Substance Use among Pregnant Women.....28

9. Appendix C: Hospital Policy Guideline for Drug Screening and Reporting of Newborn Drug Exposure.....30

10. Appendix D: Finnegan Scoring Tool for Assessing Narcotic Abstinence Syndrome (NAS) 33

11. Appendix E: Draft of Hospital Drug Affected Infant Report and Referral Form for CDS, Public Health Nursing and Newborn primary care provider 34

12. Appendix F: Resources to contact for help with Substance Abuse 38

13. Appendix G: Treatment Definitions and Abbreviations 39

14. Appendix H: Sample Drug Contracts.....42

15. Appendix I: References 48

16. Appendix J: Patient Education handouts 50

    A. Screening and substance use in pregnancy
    B. Patient Education Tri-fold
    C. Patient Education Handbook

* The following recommendations are not intended to replace providers' clinical judgment or to establish a single protocol. Some clinical problems may not be adequately addressed in this document. As always, clinicians are urged to document management strategies and obtain consultations as indicated.

Quick Reference: Pregnancy Care Recommendations

Antepartum Care - 1st trimester

- ☐ Do SBIRT screening (Screening, Brief Intervention, Referral to Treatment)
- ☐ Ask if patient is enrolled in a treatment program and obtain appropriate consents for coordination of care.
- ☐ Check patient's record in the Prescription Monitoring Program. http://www.maine.gov/dhhs/samhs/osa/data/pmp/index.htm
- ☐ Patient receiving prescriptions for chronic pain should have a drug agreement in place (see Appendix H).
- ☐ Add HIV, Hepatitis C, and Sexually Transmitted Infections to routine lab panel.
- ☐ Perform Risk screening for tuberculosis (TB).
- ☐ Do Dating ultrasound upon entry to care.
- ☐ At first prenatal visit, assess need for anti-emetics and antacids for reflux/morning sickness.
- ☐ At first prenatal visit, consider bowel regimen of stool softeners, fluids, fiber products and hemorrhoid cream.
- ☐ Enroll in text4baby.org for anticipatory guidance during pregnancy and first year of life.
- ☐ Consider referral to Public Health Nursing, case management, or social worker.
- ☐ Make appropriate referrals such as Maine Families, legal services, child protective services, education and career building support, adoption, domestic violence counseling, WIC, public assistance, food stamps (SNAP), transportation, mental health services.
- ☐ Give patient information about maternal drug use/effect on infants.

Antepartum Care- 2nd and 3rd trimester

- ☐ Work with patient to develop pain management plan in the second trimester. Patients will most likely need an epidural for adequate pain control in labor.
- ☐ Order a 18-20 week ultrasound for anatomic abnormalities and cervical incompetence.
- ☐ Give family trifold about newborn care and NAS. See Appendix J Section B.
- ☐ Consider monthly ultrasounds starting at 28-32 weeks to monitor fetal growth, fluid, and placental function. Doppler studies are needed when intrauterine growth restriction and/or oligohydramnios is identified.
- ☐ Repeat labs (Hep C/HIV/STI panel) at 28 weeks if indicated by continued use of illicit drugs, multiple sexual partners, other high risk behaviors, or social situation.
- ☐ Consider anesthesia consultation in the third trimester if IV access is difficult or severe anxiety, or coexisting medical issues could prevent spinal analgesia.

- Discuss importance of having trained newborn providers care for infant after delivery. Encourage communication between patient and newborn care provider. Consider prenatal appointment with pediatrician/neonatologist who will care for infant after birth.
- If delivering hospital is not able to provide care for infant with NAS, discuss patient preference for transfer of care in last trimester of pregnancy vs. transfer of newborn after delivery if pharmacologic management is required.
- Confirm that hospital has buprenorphine available on formulary. If not available, the patient should bring her own medication.

Anticipatory guidance in 3rd Trimester

- Give families longer booklet about newborn care. See Appendix J Section C
- Inform families that a Drug Affected Infant (DAB) notification to DHHS will be done at the time of delivery.
- Advise families that recommended length of stay of newborns is 5-7 days with minimal symptoms and that NAS scoring will be done. Infants may need to stay longer if treatment or prolonged monitoring is required.
- Review hospital breastfeeding guidelines with mothers. Women who are stable in treatment on buprenorphine or methadone and do not use illicit drugs can be encouraged to breastfeed. Breastfeeding is not recommended if mothers continue to use marijuana. Mothers and providers should be aware that marijuana can be positive in the urine for up to 2 months. A recommended resource for medication safety during lactation is: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
- Refer for Childbirth education.
- Consider referral to Public Health Nursing if not done previously.
- Perform toxicology testing when clinically indicated. Routine toxicology tests may differ by institution. Testing for methadone, buprenorphine, and/or their metabolites may need to be specially ordered. Alcohol can be measured via serum alcohol level or urine ethanyl glucuronide. Positive toxicology tests should be sent for confirmation.

Intrapartum Recommendations

- When possible, contact addiction treatment provider to confirm dose of methadone or buprenorphine and notify of admission. While the patient is admitted to the hospital, an attending provider may legally prescribe buprenorphine and methadone to maintain a patient's outpatient dose during his/her

hospitalization. Documentation of this Federal regulation is available at: http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm

- Anticipate that an opioid dependent mother will require higher and more frequent dosing of narcotic pain medications during labor.
- Methadone or buprenorphine do not provide adequate pain relief during labor. These medications should be continued at their normal dose and time during labor and/or a cesarean section.
- ***Do not use Nubain or Stadol for pain control during labor in opioid dependent patients. All patients should be asked about substance use history prior to use of these medications. They should be informed that they can cause acute withdrawal.***
- ***If Nubain or Stadol is given inadvertently, withdrawal symptoms can be reversed with IV Fentanyl or Morphine.***
- ***Neuraxial analgesia (spinal or epidural) may be the most safe and effective way to control pain both for vaginal births and cesarean sections.*** Surgical patients delivered with general anesthesia will usually need a PCA with morphine or dilaudid to control post cesarean section pain.
- Patients who are suing illicit substances may require increased doses of pain medication. If a patient discloses illicit substance use at the time of delivery that was not recognized during pregnancy, consider phone consultation with an addiction specialist, treatment center, or Maternal Fetal Medicine physician.
- Consider acute withdrawal in the differential diagnosis of a patient with intractable nausea, vomiting or abdominal pain.
- PICC or central line may be needed when peripheral venous access is too difficult due to history of IV drug use.
- Review newborn testing recommendations with patients privately.

Postpartum Checklist

Vaginal

- Patients on chronic opioids are more sensitive to pain than those who are not and pain should be managed appropriately. They may require scheduled doses of NSAIDS and Acetaminophen for mild to moderate pain rather than prn. Short acting opioids can be added as needed.
- Patient's regular maintenance dose of Methadone or Buprenorphine prior to delivery. The dose should be re-evaluated with the addiction treatment provider after delivery.

Cesarean Sections

- Patients undergoing C-section should also continue their maintenance dose of Buprenorphine or Methadone. Patient controlled IV analgesia and/or duramorph added to the spinal are effective options for the first 24 hours. Oral opioids can be added for break-through pain in addition to the maintenance dose of Methadone or Buprenorphine. Anticipate scheduled dosing of 1.5 times their normal dose every 3 hours.

General Postpartum

- Hospital breastfeeding guidelines should be reviewed with mothers. Women who are stable in treatment on buprenorphine or methadone and do not use illicit drugs can be encouraged to breastfeed. Caution should be advised against the abrupt cessation of breastfeeding, particularly in patients maintained on methadone.
- Each hospital should have a clear policy regarding breastfeeding and marijuana use. Go to: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT for medication and breastfeeding recommendations.
- Breastfeeding is contraindicated in women who are HIV positive or who have herpetic lesions on the breast.
- If infant is on an opioid for treatment of NAS, consider maintaining mother on buprenorphine as opposed to Subuxone because of the potential risk of acute withdrawal in the newborn due to the Naloxone component.
- Skin to skin contact and rooming in should be encouraged.
- Complete drug affected baby (DAB) notification as required by law.
- Work with social workers or nursing staff to complete newborn referral sheet to public health nursing and Child Development Services, in collaboration with the newborn's primary care provider.
- Notify the addiction treatment provider upon discharge to confirm the patient has a follow up appointment. Give patient a list of medications administered during hospitalization as well as those prescribed at discharge. Be sure to indicate the timing of the last dose. Treatment providers will re-evaluate the patient's dose postpartum and provide all outpatient prescriptions.
- Some methadone clinics close by early afternoon. Check hours of methadone clinic prior to discharge so that the patient does not miss a dose.
- Be alert for symptoms of overmedication. When a patient appears somnolent, consider decreasing either pain medication or patient's regular dose of Buprenorphine or Methadone. It is best to consult with the addiction treatment provider prior to adjusting the dose of the medication assisted treatment.
- A postpartum visit should be scheduled, which should include making a reproductive plan, screening for postpartum depression, and connecting patient to a primary care provider for continued follow up.

Chapter 1: Screening for Substance Use during Pregnancy

Why screen for substance abuse during pregnancy:

Perinatal alcohol and drug use is an issue critical to the health of mothers and newborns. Substance abuse is associated with adverse pregnancy outcomes, including preterm birth, placental abruption, intrauterine death, low birth weight, and neonatal withdrawal. Exposure to alcohol and certain drugs is a leading preventable cause of birth defects and developmental disabilities in the United States.
Women are most likely to participate in health care while they are pregnant.

Screening for alcohol and drug use early in the course of pregnancy allows for timely referral to substance abuse treatment when needed. Research shows that integrating substance abuse treatment into prenatal care reduces prenatal exposure, improves pregnancy outcomes, and decreases the cost of care for mothers and newborns (Goler et al. 2008, 2012).

Who should be screened?

The American College of Obstetricians and Gynecologists and the American Society for Addiction Medicine recommend universal screening of pregnant women for drug and alcohol use, and the American Academy of Family Physicians recommends periodic screening for all adolescent and adult patients. Women of child bearing age should also be screened pre-conceptually and provided with education about the risks of substance use during pregnancy. Unfortunately, many women who use alcohol and drugs do not seek regular medical care until they are already in mid- pregnancy. (ACOG references 2011 and 2012, ASAM reference, AAFP)

When should screening occur?

The earlier screening and referral for treatment occurs, the greater the opportunity to reduce harm to both mother and fetus.

- Screen at first prenatal visit (ACOG and ASAM)
- Repeat in mid-second trimester (24-28 weeks) (Chasnoff, 4 Ps Plus)

How to screen:

Universal verbal screening for substance abuse allows the health care provider to discuss the risks of alcohol, drug, and tobacco use with every pregnant woman and eliminates provider bias in determining who is screened. Screening all patients using a validated instrument increases the chance that prenatal

substance abuse will be identified, addressed, and potentially reduced (Chasnoff et al., 2005, Chang et al., 2011)

Screening should be done with women in a private setting. Screening can be performed using interview-based or self-administered questionnaires. A number of instruments have been developed and tested for use with pregnant women. These include the 4Ps Plus, CRAFFT, TACE, and TWEAK (see Appendix B) (Chang et al., 2011; Burns et al., 2010; Chasnoff et al., 2005; Gavin et al., 1987; Humeniuk et al., 2008; Yonkers et al., 2010).

Some clinicians advocate universal urine drug testing for pregnant patients. Urine toxicology is a useful follow up test when a woman screens positive for drug or alcohol use, and to monitor progress during treatment. However, standard urine drug tests lack the ability to detect intermittent use, may not include drugs commonly used in a particular community, do not routinely test for alcohol use, and add significant cost to prenatal care. **Mandatory urine testing may be a deterrent to seeking prenatal care for some women.** The American College of Obstetricians and Gynecologists recommends against urine toxicology as a screening method for pregnant women (ACOG, 2008, 2012).

A significant correlation exists between depression, a history of trauma and/or current abuse, and substance use during pregnancy. Pregnant women who are at risk for substance abuse should also be screened concurrently for mental health problems and intimate partner violence (Hoorigan 2000, Moylani et al., 2001). Sample validated screening tools for mental health disorders and domestic violence are included in Appendix B.

Brief Intervention

Although screening may identify a patient *at risk* for alcohol or drug use, it does not diagnose drug or alcohol dependence. Following a positive screen, a brief intervention is necessary to explore a woman's use, her readiness to consider change, what type of treatment is indicated, and what treatment, if any, would be accepted. Because women are generally motivated to seek care because of the pregnancy, the initial intervention should be delivered by a woman's primary obstetrical provider. This should be done with a woman in a private setting.

Following a positive screen, **the provider should express concern that a woman is at risk for alcohol or drug use during her pregnancy. He/she should affirm the mutual goal of a safe and healthy pregnancy for the woman and her newborn; provide accurate information about the risks of prenatal alcohol and drug use; evaluate her readiness to change, and explore options for treatment** appropriate to the type of substance(s) used, the presence or absence of

physiologic dependence, her social environment, and her degree of acceptance. **Documentation of the above must be included in the medical record.**

Motivational Interviewing:

Techniques are useful in helping assess a woman's readiness to change. Three key questions are asked: On a scale of 1-10, how important is it to you to change your substance use? How confident are you that you can make this change? And how willing are you to make this change now? Her response will help guide treatment options. (SAMHSA TIP 43, 35)

Referral to Treatment:

If a woman is at risk for drug and/or alcohol use during pregnancy, the obstetrical provider should seek to refer her for further assessment and/or substance abuse treatment. If a woman is not ready to accept treatment, the provider may be able to point out the discrepancy between their mutual goal of a healthy pregnancy and substance use which is potentially harmful.

Women tend to under-report substance use in pregnancy; therefore evaluation by a professional trained in addiction treatment is essential if available. Referrals can be made to Licensed Alcohol and Drug Counselors (LADC), Certified Alcohol and Drug Counselors (CADC) or other professionals trained in addiction treatment. If a woman is physically dependent on drugs or alcohol, a provider trained in addiction medicine should evaluate whether she is appropriate for outpatient treatment or whether she may require admission for medically assisted stabilization (see algorithm, Appendix C).

When admission is not medically necessary, a provider should explore other strategies, including individual counseling, appropriate 12-step programs, the Maine Tobacco helpline, and other out-patient treatment programs. Referrals must fit a woman's needs, be covered by her health insurance, and accessible to her in terms of transportation and childcare. If possible, her initial treatment appointment should be scheduled by the obstetrical provider while the patient is in your office. When a referral is made, ask the patient to sign a medical release allowing communication between her obstetrical and substance abuse treatment providers.

Referral to the emergency department is recommended if a pregnant woman is in acute withdrawal and unable to access immediate treatment. Obstetrical providers should not attempt to treat a woman who is withdrawing from drugs in the outpatient setting or prevent withdrawal by prescribing opioids.

If a woman is unwilling to accept treatment, offer her relevant written information about the risks of perinatal substance use. Increasing the number of prenatal visits have been demonstrated to improve pregnancy outcomes, even when the mother does not enter substance abuse treatment. (El-Mohandes, 2003) Address co-existing psychiatric conditions and social risk factors which make accessing treatment more difficult.

Pregnant women should be given priority for treatment and should be seen by a treatment provider within 48 hours after requesting care. (SAMHSA TIP 43)

Appendix D contains a list of substance abuse treatment programs in the state and a link to the Maine State Substance Abuse Mental Health Services website.

Resources related to substance abuse screening and intervention:

Online continuing medical education is available to improve provider techniques for screening, brief intervention and referral for treatment:

1. SBIRT: http://www.sbirttraining.com/SBIRT-core. This program has been developed through collaboration between the American Society of Addiction Medicine (ASAM) and the National Institute for Drug Abuse (NIDA)
    - On-line, on–demand program
    - Cost: $75
    - AMA PRA Category 1 CME (4 hours)

2. The University of New England College of Osteopathic Medicine is hosting an ongoing, online CME course: Domestic Violence Response Initiative: Screening for Abuse. This course is taught by Daniel Oppenheim, MD and Karen Wentworth, Domestic Violence Community Educator. To register, go to: http://aicme.com/catalog_class.asp?clid=167
    - Cost is $29
    - CEU 1

3. Training in Motivational Interviewing is available through on-line programs: http://www.motivationalinterview.org/

4. Links to a few of the SAHMSA TIPS:

Buprenorphine guidelines: http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

Opioid maintenance therapy:
http://kap.samhsa.gov/products/trainingcurriculums/pdfs/tip43_curriculum.pdf

Motivational interviewing:
http://kap.samhsa.gov/products/trainingcurriculums/pdfs/tip35_curriculum.pdf

Buprenorphine guide for nurses: http://buprenorphine.samhsa.gov/TAP_30_Certified.pdf

Chapter 2: ANTEPARTUM MANAGEMENT OF OPIOID-DEPENDENT PATIENTS

GOALS OF TREATMENT PROGRAMS FOR OPIOID-DEPENDENT PREGNANT PATIENTS

Best results are achieved when women are enrolled in a comprehensive program of treatment which includes substance abuse counseling, psychiatric treatment, and social services. (Goler, 2008) Stabilization on opioid maintenance therapy using methadone is the standard of care; however, the use of buprenorphine is also widely accepted. (ACOG 2012, NEJM 2010) A multidisciplinary approach is recommended to improve pregnancy outcomes. By utilizing a team approach, prenatal care is improved, risk for relapses is reduced, and fewer patients will return to using illicit drugs. (Goler 2008, Clark 2011)

The use of buprenorphine monotherapy, previously known as Subutex, now available only in generic, (as opposed to buprenorphine/naloxone-Suboxone®) and is recommended during pregnancy due to the risks to the fetus of acute withdrawal if the buprenorphine/naloxone combination product is misused. The use of buprenorphine monotherapy during pregnancy is a service covered by Mainecare but it requires the prescriber to complete a prior authorization form. The approval generally covers the duration of the pregnancy. Similar to non-pregnancy, the use of buprenorphine doses greater than 16 mg daily during pregnancy requires the prescriber to complete a Mainecare prior authorization form. If the pregnant patient has been in buprenorphine treatment for more than 24 months while insured by Mainecare, the prescriber will also need to complete a prior authorization form. Pregnancy and/or a child under the age of 3 meet the medical necessity criteria for continuing treatment with buprenorphine. Pregnancy and/or child under the age of 12 meet criteria for continuing methadone. Please refer to Mainecare's preferred drug list (PDL) for the most up to date information, http://www.mainecarepdl.org/pafiles

This link will take you to the state website and webinar, PowerPoint and PA documents http://www.maine.gov/dhhs/oms/provider/addiction.html

Drug withdrawal should be prevented during pregnancy. Obstetrical providers should incorporate assessment for withdrawal symptoms at each prenatal visit and communicate with treatment provider if present. Dosage of methadone or buprenorphine should be sufficient to minimize both maternal drug craving and illicit drug use and consequently prevent fetal withdrawal and/or exposure to street drugs. To be most successful, the mother must be engaged and part of the treatment plan.

Providers should facilitate access to appropriate services:

- childbirth education
- child care
- parent skill building classes
- education and career building support and information
- legal services
- child protective services
- adoption counseling
- newborn follow-up with a primary care provider
- domestic violence counseling and services
- infant development follow-up services
- WIC nutrition
- public assistance
- transportation services
- mental health services

The American College of Obstetricians and Gynecologists has recognized methadone as the mode of treatment for maintenance therapy of opioid-dependent pregnant women based on the long standing evidence around safety for mother and fetus. However, more recent studies indicate that buprenorphine may have a shorter neonatal recovery time. It also has the convenience of being a "take home" medication that can be prescribed in the context of outpatient office visits by certified physician prescribers who may be local family physicians. ACOG recommends that if buprenorphine is to be utilized during pregnancy, the woman should be informed about the lack of evidence surrounding the long- term neurodevelopmental effects of exposure to buprenorphine in utero.

Treatment can be provided in a variety of clinical settings. Whether a residential treatment center, clinic, or private physician provides the services; medical screening, substance abuse counseling and full social assessment should be included. Provision of ancillary services improves retention in treatment as well.

BARRIERS TO TREATMENT

The major barriers to methadone treatment are the restricted hours of operation at clinics and the distance patients have to travel every day. These issues are particularly problematic for women in school, working, or with small children at home. Access to medication and the ability to realistically comply with a treatment program must be considered in the ultimate decision making regarding medication choice. Due to limitations in the number of providers of buprenorphine and the limited

availability of methadone clinics, patients often cannot choose the medication they prefer. Prior to accepting patients maintained on buprenorphine or methadone, obstetric providers must be sure that newborn providers in their hospitals can properly care for neonates with NAS. When local care is not available, there must be planned transition late in gestation to an institution with providers trained to care for both the opioid-dependent mother and the substance exposed neonate.

PRENATAL CARE OF WOMEN WITH HISTORY OF DRUG USE

At the initial visit, the obstetrical provider should obtain consent consistent with federal and state requirements to facilitate communication with all of the patient's providers, including the substance abuse treatment provider, counselor or psychiatrist, and other medical providers. In addition to usual prenatal care, smoking cessation/reduction counseling should be offered. HIV testing should be strongly encouraged. Screening for tuberculosis should be performed based on exposure risk.

ULTRASOUND TESTING

Pregnancy dating should be confirmed with early ultrasound as oligomenorrhea and irregular cycles are associated with opioid dependence. All patients should have complete ultrasound examinations for anatomical abnormalities by 18-20 weeks. Neither methadone nor buprenorphine are known to cause anomalies. However, lifestyle variations such as smoking, polysubstance use, diet, chaotic social environment, work or exercise have an impact on fetal growth. Clinicians should *consider* monthly ultrasounds starting at 28-32 weeks' gestation based on patient's individual risk. Doppler flow studies should be added to assess placental function when intrauterine growth restriction or oligohydramnios is suspected. Cocaine, amphetamines and tobacco particularly predispose the fetus to growth restriction and placental disruption. Alcohol exposure may also cause growth restriction. Patients still using illicit drugs, or whose lifestyles, toxicology tests, or physical signs and symptoms are concerning will require more frequent ultrasound surveillance to determine fetal wellbeing. If the patient is relatively stable in treatment and her only other risk factor is tobacco use, monthly ultrasounds are likely not necessary.

It is **NOT** necessary to schedule frequent fetal testing such as weekly NSTs or biophysical profiles for all patients on opioid maintenance therapy. Non-stress tests should be ordered only for usual obstetrical indications in a stable patient being treated with an opioid agonist. The fetus exposed to methadone or buprenorphine may have a less reactive NST or BPP with the greatest reduction in fetal activity noted at 2 to 3 hours after maternal dosage.

Women should receive adequate psychiatric treatment to address comorbid post traumatic stress disorder (PTSD), depression, anxiety, and eating disorders. Patients on opioid agonists often request

psychotropic medications like benzodiazepines to treat anxiety symptoms, however, the risk and benefits of additive therapy must be carefully considered. Many clinics discourage the use of benzodiazepines concurrently with opioid replacement therapy due to concerns about drug-drug interactions for the mother and increased rate and severity of abstinence symptoms in the newborn (SAMHSA TIP 43, Cleary 2012).

Patients with risk factors for sexually transmitted or blood born infections should have repeat testing for STIs, Hepatitis C and HIV in the third trimester.

DENTAL ISSUES

Dental disease should be treated during pregnancy. Patients insured by MaineCare may have no option other than extraction. Definitive treatment (extraction) is preferable to long term treatment for pain, multiple courses of antibiotics, and frequent ER visits. Dentists are often hesitant to treat pregnant patients, and may request guidance from the OB practitioner regarding the safety of antibiotics, analgesia, and anesthesia. A letter from the obstetrical provider may be necessary to assure treatment of these patients.

MUSCULOSKELETAL PAIN

Musculoskeletal pain may be the result of previous injury and is frequently exacerbated by pregnancy. MRI is safe in pregnancy if definitive diagnosis is needed. Patients should be referred to physical therapy, chiropractic, osteopathy, sports medicine, massage therapy, or acupuncture for treatment that does not involve narcotics. However, it should be noted that MaineCare does not cover all forms of complementary therapy.

GASTROINTESTINAL PROBLEMS

Maintenance therapy with opioids exacerbates the usual gastrointestinal problems of pregnancy. Common problems like "morning sickness" and reflux can become significantly worse for patients treated with methadone or buprenorphine, and may cause missed doses due to vomiting. Anti-emetics and antacids should be prescribed prophylactically. Patients on chronic narcotics generally have constipation. This common complication of pregnancy should be treated using a complete bowel regimen of stool softeners, fluids, fiber products, and hemorrhoid cream. The standard dose of docusate may be doubled for this population.

PAIN CONTROL

Pain control, both in labor and after surgery is a particular challenge for opioid dependent obstetrical patients and is often a source of particular anxiety. When possible, an anesthesia consultation is recommended in the third trimester. The various pharmacologic and nonpharmacologic options to manage pain in labor and their effectiveness should be discussed with the patient prior to labor onset.

TOXICOLOGY TESTING

Toxicology tests obtained without the patients' consent can be used as information for newborn providers caring for withdrawing neonates only. The decision to perform a urine drug test must be based on medical necessity. Patients can be offered toxicology testing to verify that they are using only their prescribed medications.

Toxicology tests may be medically indicated in patients who have:

- 3 visits or less prenatal care
- physical signs of substance abuse or withdrawal
- smell of alcohol and/or chemicals noted
- recent history of substance abuse or entry into treatment
- fetal distress
- placental abruption
- preterm labor
- intrauterine growth restriction (IUGR)
- unexplained, intermittent hypertensive episodes
- stroke or heart attack
- severe mood swings
- multiple medication sources

DRUG TESTING panels for drugs and alcohol vary with the lab used. Different institutions have "toxicology panels" that test for a spectrum of substances which may or may not reflect patterns of use in the local community. Providers should be knowledgeable about the composition of the panel available at their institutions because it may be necessary to order specific tests separately. Testing for methadone and metabolites and buprenorphine metabolites must be added in many institutions. Urine is most commonly tested for illicit drug use. Recent alcohol use can be detected using serum alcohol levels and urine testing for ethanyl glucoride detects alcohol use within 72 hours. Results need to be **confirmed** before they are considered accurate. Unless a clear "chain of evidence" has been established, drug tests performed in the medical context cannot be used in a court of law. Test results are used primarily to

assist in treating the exposed neonate and determining the need for services for the mother. Testing of neonatal meconium is often performed if there is suspicion of prenatal exposure.

Chapter 3: INTRAPARTUM MANAGEMENT

Women with a history of substance abuse often have significant anxiety regarding pain control in labor, or after cesarean section. These concerns must be respected and taken seriously by accepting and supportive providers. Women who lack social support or reliable people to serve in the traditional roles of significant other, friend, or family member may subsequently require more help coping with the stress of labor than a well supported patient. Opioid dependent women usually require significantly more narcotic analgesia than the average woman in labor. Cross-tolerance with other narcotics necessitates more frequent and higher doses of narcotics used for pain control. A common misconception about methadone or buprenorphine therapy is that the dose a patient takes for maintenance will provide pain relief and that a lower dose of labor analgesia will therefore be effective. On the contrary, her usual dose of maintenance therapy should be maintained and the amount needed to achieve effective analgesia will likely be higher. If a patient is in labor or scheduled for cesarean section, she should take her usual daily dose of methadone or buproenorphine at her usual time to avoid withdrawal symptoms and anxiety. While hospitalized the patient should have her usual dose ordered by the attending provider, whether during antepartum admission, an induction of labor that may take days, or a scheduled cesarean section. The patient should be reassured that providing her with adequate pain control is important to achieve a successful and comfortable labor and delivery or cesarean section. An anesthesia consultation prior to or during the third trimester can be very helpful in alleviating the patient's fears about pain control in labor, during a cesarean section, and postpartum/postoperatively. This provides an opportunity to explain the different modalities that are available and how they work.

Unusual complaints of pain requiring significantly higher doses of pain medication should not be viewed as "drug seeking behaviors" but should be anticipated due to the relative hyperalgesia (more sensitive to pain)associated with chronic narcotic use. ***Neuraxial analgesia (spinal or epidural) may be the most effective and safest way to control pain both for vaginal births and cesarean sections,*** and patients will be more receptive if they are prepared and educated. Surgical patients delivered with general anesthesia will usually need a PCA with morphine or dilaudid to control post cesarean section pain. Women maintained on methadone or buprenorphine should continue to take their established dose through labor and delivery and into the postpartum period.

Some patients and providers fear that using opioids for pain management will lead to a loss of control and fear re-addiction. Patients can be reassured that the methadone or buprenorphine will block the euphoric effects of opioid analgesia which will still provide pain relief. If nausea and vomiting is a

problem, patients should be pre-medicated with anti-emetics so that they can tolerate oral medications and food. Patients on methadone maintenance who have developed a prolonged Q-T interval should be treated with phenergan rather than zofran. Patients who cannot tolerate oral medication can be treated parenterally. Central lines or PICC lines may be needed in patients with a history of IV drug use with sclerotic veins.

Narcotics with mixed agonist/antagonist properties are **contraindicated** for pain relief in opioid dependent patients, as these drugs may precipitate withdrawal. Examples include: Talwin (pentazocine), Stadol (butorphanol), and nubain (nalbuphine). If inadvertent administration occurs, and the patient has withdrawal symptoms, an opioid agonist should be administered to alleviate withdrawal symptoms. Examples: morphine, fentanyl, Demerol.

Chapter 4: POSTPARTUM MANAGEMENT

Mandatory notification to DHHS and Institutional Policies:

Whenever possible, patients should be advised prior to admission for delivery that a notification will be made to DHHS in compliance with federal and state laws regarding drug affected neonates. Patients, who are late registrants, or those who have had no prenatal care, may need to be informed after delivery. Patients benefit from meeting with the social worker in the antepartum period to alleviate their fears and prepare them for DHHS notification. Patients should also be informed of their institution's policy on breast feeding and marijuana use earlier in pregnancy, but may need to have protocols explained again after delivery.

It may be helpful to mothers to be educated about NAS scoring – how it works, how it impacts length of stay for their neonate, whether or not they will be able to breastfeed or not, whether they will be able to stay at the hospital or an "off campus" facility. Mothers should be advised that the infant going through NAS may be very difficult to soothe.

Breastfeeding:

New mothers should be encouraged to hold and spend time with their infants as well as breastfeed when appropriate. "Skin to skin contact" and "rooming in" are encouraged. Patients with hepatitis B and C may be encouraged to breastfeed as long as they are not HIV positive. Breastfeeding is not limited by methadone or buprenorphine usage or dosage, as the small amounts that cross into the breast milk may reduce the severity of neonatal withdrawal symptoms. Caution against the abrupt cessation of breast feeding should be advised particularly in women maintained on methadone due to the possibility of rebound NAS that has been reported in the literature. The American Academy of Pediatrics does not support breastfeeding in women who use marijuana. This is due to the retention of the drug in "fatty" breast cells leading to bioaccumulation in breast milk. Patients using marijuana throughout their pregnancy as an anti-emetic should be made aware of this limitation early in gestation, particularly as THC is easily picked up in toxicology screens weeks after use. The following resource may be used to determine breastfeeding compatability: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Postpartum and pain control:

After a vaginal delivery, acetaminophen and non-steroidal anti-inflammatory agents should be used for mild to moderate pain. Short-acting opioid analgesics can be added on an as needed basis. Opioids for pain control should not be needed following discharge for a routine vaginal delivery, except in special

cases, (i.e. third and fourth degree tears). In cases of cesarean section deliveries, patient controlled IV analgesia or duramorph added to the spinal can assist with pain for the first 24 hours. Oral opioids can be added for break-through pain and can be utilized for the next week or longer in addition to the maintenance medication (methadone or buprenorphine). Upon discharge patients will often need a written letter from their provider that documents what medications they received in the hospital, including dose, date, and time.

Studies have shown that methadone-maintained patients have increased postpartum pain and require up to 70% more oxycodone equivalents after cesarean section deliveries than the average patient. (This is about 1.5 times to 2 times the usual dose of opioid analgesic.) Narcotics that are opioid agonists such as morphine, or fentanyl or dilaudid should be prescribed at more frequent intervals and higher doses, as dictated by patient response. Hydromorphone may need to be substituted for oxycodone for effective control of post-operative pain in this patient population. Patients who become somnolent or appear overmedicated can have dosages adjusted appropriately, but their providers need to be informed of the changes.

APPENDIX A

Screening Tools

Screening instruments specifically validated for use during pregnancy:

4P's - 4 questions, screens for alcohol and drug use
CRAFFT-valid for use in adolescents, piloted in pregnancy
PHQ9 – depression
Edinburgh-postpartum depression
WAST-domestic violence
PVS-domestic violence

4P's

The 4 P's has been tested and validated and effectively identifies pregnant women at highest risk for substance use during pregnancy.

Administration Time: 3 to 5 min.

Parents

Did any of your parents have a problem with alcohol or other drug use?

Partner

Does your partner have a problem with alcohol or other drug use?

Past

In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?

Present

In the past month have you drunk any alcohol or used other drugs?

Scoring: Any "yes" should trigger further questions

Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990

CRAFFT*

C – Have you ever ridden in a *car* driven by someone (including yourself) that was "high" or had been using alcohol or drugs?

R – Do you ever use alcohol or drugs to *relax*, feel better about yourself, or fit in?

A – Do you ever use alcohol or drugs while you are by yourself, *alone*?

F – Do you ever *forget things* you did while using alcohol or drugs?

F – Do your family or *friends* ever tell you that you should cut down on your drinking or drug use?

T – Have you ever gotten into *trouble* while you were using alcohol or drugs?

Scoring Instructions:

CRAFFT Scoring: Each "yes" response scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment

CRAFFT is available in multiple languages by going to:

http://www.ceasar-boston.org/CRAFFT/selfCRAFFT.php

Domestic Violence Screening Tools

WAST

1 In general, how would you describe your relationship—a lot of tension, some tension, no tension?

2 Do you and your partner work out arguments with great difficulty, some difficulty, or no difficulty?

3 Do arguments ever result in you feeling down or bad about yourself?
often, sometimes, never

4 Do arguments ever result in hitting, kicking, or pushing?
often, sometimes, never

5 Do you ever feel frightened by what your partner says or does?
often, sometimes, never

6 Has your partner ever abused you physically?
often, sometimes, never

7 Has your partner ever abused you emotionally?
often, sometimes, never

8 Has your partner ever abused you sexually?

A score of 4 indicates exposure to IPV

PVS

1 Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom?

2 Do you feel safe in your current relationship?

3 Is there a partner from a previous relationship who is making you feel unsafe now?

Scoring: Positive response to any question denotes abuse

Depression Screening

PHQ9 Depression

NAME *John Q. Sample* DATE _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	(2)	3
2	Feeling down, depressed, or hopeless	0	(1)	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	(2)	3
4	Feeling tired or having little energy	0	1	2	(3)
5	Poor appetite or overeating	0	(1)	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	(2)	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	(2)	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	(2)	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	(0)	1	2	3
			add columns:	+	+
			TOTAL:		

10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	 ✓

Free copy for download by going to: **http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire_sample/**

Edinburgh Postpartum Depression Screening

The Edinburgh Post Natal Depression Scale (EPDS)

(J.L. Cox, J.M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburgh)

The Edinburgh Postnatal Depression Scale (EDPS) was developed in 1987 to help doctors determine whether a mother may be suffering from postpartum depression. The scale has since been validated, and evidence from a number of research studies has confirmed the tool to be both reliable and sensitive in detecting depression. During the postpartum period, 10 to 15% of women develop significant symptoms of depression or anxiety. Unfortunately, many moms are never treated, and although they may be coping, their enjoyment of life and family dynamics may be seriously affected.

Instructions:

Please select the answer which comes closest to how you have felt **in the past 7 days** – not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things -

a. As much as I always could
b. Not quite so much now
c. Definitely not so much now
d. Not at all

2. I have looked forward with enjoyment to things -

a. As much as I ever did
b. Rather less than I used to
c. Definitely less than I used to
d. Hardly at all

3. I have blamed myself unnecessarily when things went wrong -

a. Yes, most of the time
b. Yes, some of the time
c. Not very often
d. No, never

4. I have been anxious or worried for no good reason -

a. No, not at all
b. Hardly ever
c. Yes, sometimes
d. Yes, very often

5. I have felt scared or panicky for no good reason -

a. Yes, quite a lot
b. Yes, sometimes
c. No, not much
d. No, not at all

6. Things have been getting on top of me -

a. Yes, most of the time I haven't been able to cope at all
b. Yes, sometimes I haven't been coping as well as usual
c. No, most of the time I have coped quite well
d. No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping -

a. Yes, most of the time
b. Yes, some of the time
c. Not very often
d. No, not at all

8. I have felt sad or miserable -

a. Yes, most of the time
b. Yes, some of the time
c. Not very often
d. No, not at all

9. I have been so unhappy that I have been crying -

a. Yes, most of the time
b. Yes, quite often
c. Only occasionally
d. No, never

10. The thought of harming myself has occurred to me -

a. Yes, quite often
b. Sometimes
c. Hardly ever
d. Never

Appendix B

Policy Title: Guidelines for Intrapartum Testing for Substance Use among Pregnant Women

Purpose:

1. To improve providers' ability to effectively identify and refer pregnant women for treatment of substance use during pregnancy.
2. To standardize guidelines for testing for prenatal drug exposure.
3. To improve the health and well-being of pregnant women and their fetus/newborn.

Performed by: All healthcare practitioners providing care for pregnant women admitted to labor and delivery.

Protocol: **A urine drug test will be performed with patient consent on pregnant women admitted to labor and delivery, who meet the following criteria**:

1. Known or suspected current substance abuse and/or substance abuse within the last year.
2. Non-adherence to recommended prenatal care (no prenatal care, history of inconsistent prenatal care with 3 visits or less, or entry to prenatal care later than 24 wks).
3. Medical history of Hepatitis B, Hepatitis C, or HIV.
4. Signs of abuse of prescribed substances and/or abuse of any illicit or non-prescribed substance (i.e., physical signs of substance abuse or withdrawal, intoxication (smell of alcohol or chemicals), admission of illicit drug use, inappropriate behavior, frequent and unscheduled evaluations at the office and hospital, multiple Emergency Room presentations with complaints of pain, suicidal ideation and self-harm, and self-mutilation, severe mood swings, multiple medication sources).

Consider **testing women, on a case-by-case basis, who**:

1. Present with preterm labor, fetal distress, IUGR (intrauterine growth restriction), preterm birth, or placental abruption, unexplained onset hypertension (significant change in baseline blood pressure), stroke, heart attack, multiple episodes of nausea and vomiting, anxiety, and/or abdominal pain.

2. Are currently participating in an opiate replacement program depending on the availability of previous drug screening and/or communication with the substance abuse treatment program.
3. Has a child in DHHS custody if a previous history of substance abuse is documented.

Guidelines:

1. The healthcare provider will inform the pregnant woman who meets these criteria of the medical indication for a urine drug test and this notification should be documented in the patient's medical record. The patient will have the ability to decline testing. A social work consult should be considered if this is the case and the newborn's provider should be notified.

2. A urine drug test should include assays for opiates, oxycodone, methadone, hydrocodone, benzodiazepines, marijuana, cocaine, amphetamines, and buprenorphine. Ethyl Glucuronide should be considered if alcohol intake within 72 hours is suspected. *If a provider is uncertain how to interpret the results of a urine drug screen, he/she should contact the hospital's laboratory and/or pathologist as needed. When lab results from a urine drug test will not be available until more than 24 hours, the newborn's provider should be notified to allow a meconium sample for drug testing.*
3. Providers should be aware that a negative urine drug test does not rule out the possibility of drug use during pregnancy. In addition, false positives can occur which must be ruled out by confirmatory testing.

4. If a pregnant woman has a urine drug test that is positive for illicit substances that she did not disclose, a confirmatory test should be sent. If the urine test was not done upon first arrival to the maternity unit, the women's medical record should be reviewed to see what medications were administered prior to the urine screen.

5. If a woman's urine drug test is positive, the newborn's provider should be notified and a social services consult should be ordered.

Appendix C

Policy Title: Drug Screening and Notification of Newborn Drug Exposure

Policy Statement: A meconium toxicology test will be performed on a newborn known or suspected of prenatal drug exposure. A newborn urine toxicology test will be sent if the mother refuses a urine toxicology screen, if the mother meets maternal criteria, or if the provider was unable to obtain a maternal toxicology screen within 8 hours of admission to Labor and Delivery.

Purpose:

1. To improve providers' ability to effectively identify newborns exposed to prescribed and non-prescribed substances that cause withdrawal symptoms.
2. To standardize guidelines for neonatal screening for prenatal drug and alcohol exposure.
3. To improve the health and well being of at-risk newborns.
4. To identify opportunities for early intervention and referral to available resources for families of at-risk newborns.

Performed by:

All healthcare practitioners providing care for neonates admitted to the hospital.

Protocol: A meconium drug screen will be performed on newborns meeting the following criteria:

1. The newborn manifests signs and symptoms consistent with withdrawal from exposure to drugs in utero.

2. Maternal urine toxicology screen is positive of substances not prescribed or the mother meets criteria for substance use and urine drug screen was not sent.

3. Unexplained intrauterine growth restriction (IUGR) and/or head circumference less than 10^{th} percentile (ACOG 2007).

4. If a mother has been tested for substance use during the admission for delivery of the newborn, a urine drug screen on the baby is not indicated, as the results are not expected to be different than those of the mother. If the mother has not been tested during the admission for delivery of the newborn and meets screening criteria, the newborn provider should consider ordering a urine toxicology screen for prompt identification of recent substance exposure in addition to a meconium testing.

Guidelines:

1. The health care provider or nurse reviews the prenatal record, admission assessment and lab results for an indication of maternal drug use during the prior year, with or without a prescription, or that the mother has 3 or less prenatal visits, entry to care later than 24 weeks, or no prenatal care.

2. The health care provider, nurse or social worker informs the mother of the need to obtain a drug screen on the baby "….according to our policy." The provider should explain the rationale for the testing, which should include, but not necessarily be limited to, proper medical management of the newborn, as well as identification of the need for and referral to early intervention services based on substance exposure. This notification should be documented in the newborn's medical record.

3. If a parent refuses the recommended testing on the baby after being notified of the policy for such testing, they should be informed that their refusal will be noted but the test will still be completed. Testing the baby after parental refusal is deemed acceptable given that the testing involves no risk of harm to the baby and the best interests of the baby are being served through proper identification and intervention for factors that will have an impact on the child's physical and developmental well-being both in the acute care setting and post-discharge.

4. The nurse initiates drug screen order set and obtains first available meconium (urine as needed).

5. Urine and meconium drug screens should test for oxycodone, buprenorphine, methadone, hydrocodone, opiates, benzodiazepines, marijuana, amphetamines and cocaine not necessarily in that order. *Every institution will need to explore what drugs are tested for in their drug screening panel and may need to specifically ask for the certain tests. If the healthcare provider is not familiar with interpreting these tests, he/she should contact the hospital's lab and/or pathologist as needed.*

6. The nurse will inform the newborn's health care provider that a meconium (and urine as needed) has been obtained because of maternal drug use, status of prenatal care, or newborn withdrawal symptoms. A system should be set up on the newborn unit to track results of meconium screening once ordered. If a urine toxicology screen is ordered because a maternal urine screen is not available and the result is positive, a confirmatory urine toxicology screen should be sent if the mother denies using the illicit substance.

7. If the newborn is at risk of narcotic withdrawal or demonstrates withdrawal symptoms, the nurse will initiate the clinical practice guidelines around Neonatal Abstinence Syndrome (NAS) including an objective scoring system such as Finnegan within 2 hours of birth. *Of note, the Finnegan Scoring system was developed for use in assessing babies with narcotic withdrawal in the first month of life. If the tool is used at greater than one month of age, consideration must be made for developmental norms, such as decreased amounts of sleep and improving muscle tone over time. It is not been validated for infants exposed to antidepressants or other substances that may cause a withdrawal syndrome in infants.*

8. Newborns should be hospitalized for at least 5 days after birth to observe for withdrawal symptoms and determine if further treatment is necessary. While observing the infant in the hospital, symptomatic care should be provided including rooming in as much as possible, swaddling, holding, skin to skin contact with parents, decreased stimulation (light, noise, tactile), and the use of pacifiers as desired. Also consider increasing the caloric density of breast milk or formula if the infant requires pharmacologic treatment for NAS. If the infant needs pharmacologic treatment, refer to hospital treatment guidelines.

9. The nurse will report NAS scores to the newborn's health care provider.

10. The newborn's health care provider will report the results to the mother and review the treatment plan if intervention is necessary.

11. When either maternal or neonatal factors are present to indicate a need to test for substance use/exposure, a social services or clinical counselor consult should be ordered. A social worker or clinical counselor will complete a psychosocial assessment of the family and provide recommendations to the medical team for safe discharge planning. This may include notification by the social worker (or health care provider in the absence of a social worker) to the Department of Health and Human Services (DHHS) regarding the baby having been affected by one or more drugs during the pregnancy according to Maine State Law Infants Born Affected by Substance Abuse or After Prenatal Exposure to Drugs (2003) Department of Health and Welfare, Title 22, Chapter 1071, Section 4004B and 4011B. Additional intervention by the social worker may be offered and will be based on an assessment of the parent's present stage of change. If there are any signs of child abuse and neglect, a report should be made to DHHS.

12. Referrals to Child Development Services (CDS), Public Health Nursing (PHN), and to the newborn's primary care provider should be initiated to inform them of infant's medical care in hospital and need for future services. A referral should also be considered to the Maine Families network.

Appendix D: Finnegan Scoring Tool

NEONATAL ABSTINENCE SCORING SYSTEM

SYSTEM	SIGNS AND SYMPTOMS	SCORE	AM						PM						COMMENTS
CENTRAL NERVOUS SYSTEM DISTURBANCES	Continuous High Pitched (or other) Cry	2													Daily Weight:
	Continuous High Pitched (or other) Cry	3													
	Sleeps <1 Hour After Feeding	3													
	Sleeps <2 Hours After Feeding	2													
	Sleeps <3 Hours After Feeding	1													
	Hyperactive Moro Reflex	2													
	Markedly Hyperactive Moro Reflex	3													
	Mild Tremors Disturbed	1													
	Moderate-Severe Tremors Disturbed	2													
	Mild Tremors Undisturbed	3													
	Moderate-Severe Tremors Undisturbed	4													
	Increased Muscle Tone	2													
	Excoriation (Specific Area)	1													
	Myoclonic Jerks	3													
	Generalized Convulsions	5													
METABOLIC/VASOMOTOR/RESPIRATORY DISTURBANCES	Sweating	1													
	Fever 100.4°-101°F (38°-38.3°C)	1													
	Fever > 101°F (38.3°C)	2													
	Frequent Yawning (>3-4 times/interval)	1													
	Mottling	1													
	Nasal Stuffiness	1													
	Sneezing (>3-4 times/interval)	1													
	Nasal Flaring	2													
	Respiratory Rate >60/min	1													
	Respiratory Rate > 60/min with Retractions	2													
GASTRO-INTESTIONAL DISTURBANCES	Excessive Sucking	1													
	Poor Feeding	2													
	Regurgitation	2													
	Projectile Vomiting	3													
	Loose Stools	2													
	Watery Stools	3													
	TOTAL SCORE														
	INITIALS OF SCORER														

Appendix E:

Drug Affected Infant Referral

Referent (person sending report):

Hospital:

Address:

Phone:

Requesting Confidentiality?

DRAFT

Child: DOB:

Mainecare#:

Birth Weight:

Gestational Age:

Mother: DOB:

Address:

Phone:

Siblings:

1) DOB/Age:

2) DOB/Age:

3) DOB/Age:

Father: DOB:

Address:

Phone:

Fax to: Infant's Primary Care Provider:

Fax Number:

PHN: fax number: (207) 561-4467

DAB: email to intakereports.dhhs@maine.gov, phone 1-800-452-1999

CDS: call 1-877-770-8883 *(this form not adapted fully yet for fax use for CDS due to confidentiality issues)*

Prenatal Care *(To be completed in Obstetric Care Providers Office)*

DRAFT

Provider Name:

Address:

Phone:

Mother's prenatal care (please indicate whether none, less than 3 visits, late care, routine care, etc):

Pregnancy complications (if yes, describe):

Medications/drugs taken by mother during the pregnancy (please list medications/drugs and indicate whether each was prescribed or illicit):

Did the mother self-disclose her drug use?

Did the mother have a urine drug screen?

If positive, was confirmatory testing completed?

Enrolled in narcotic treatment program?

Provider Name:

Address:

Phone:

Newborn Care (To be completed hospital by nursing or newborn physician or social worker prior to discharge)

Which substances affected the infant? (Please list all that apply and indicate whether prescribed or illicit):

Was the infant drug screened? (if yes, please indicate what method of screening was employed):

Is the infant experiencing withdrawal symptoms? (if yes, describe):

If the baby has Neonatal Abstinence Syndrome, are the Finnegan Scores:

Mild (less than 8) Moderate (8-12) Severe (12 or higher)

What care is the infant now receiving? *(Observation only, medication, other – describe):*

What specialized care will the parents need to provide to the infant after discharge? (medication, specialty formula, etc. Please describe):

DRAFT

Is the mother breastfeeding?

Lactation Support in Hospital?

Lactation support needed at home?

Family Assessment *(To be completed by Hospital Social Worker or Nursing Staff)*

What observations have been made of the parent's interactions with the infant?

What are the current living arrangements?

What preparations have the parents made for the infant's care? (does the family have diapers, crib, car seat, clothing, formula if needed, etc).

What Services have been offered and accepted by the parents and when will those services begin?

What additional supports are available to the infant and parents *(family, church, community based services)?*

Domestic Violence Issues *(if yes, describe; please indicate whether current or past and details):*

Mental Health Issues *(if yes, describe):*

In treatment?

Provider Name:

Address:

Phone:

Household member substance abuse *(if yes, describe):*

Treatment Location:

Provider Name:

Address:

Phone:

DRAFT

Service Providers:

Provider Name:

Address:

Phone:

Relative resources:

Relative Name:

Relationship:

Address:

Phone:

Native American heritage (ICWA):

If yes, please indicate tribal affiliation:

Primary Language:

Was an interpreter used in the hospital?

APPENDIX F

Maine Office of Substance Abuse
11 State House Station
41 Anthony Avenue, Augusta Maine 04333-0011
Phone: 1-800-499-0027 or (207) 287-8900
All TTY users call Maine Relay 711
Email: osa.ircosa@maine.gov
Online: http://www.maineosa.org

Maine Office of Substance Abuse Programs & Service Directory

*This online searchable directory is the most **up-to-date** listing of Maine agencies and programs*
http://www.maineosa.org/help/directory.htm

SAMHSA Buprenorphine Physician & Treatment Program Locator (by State)

The Locator is an on-line resource designed to assist States, medical and addiction treatment communities, potential patients, and/or their families in finding information on locating physicians and treatment programs authorized to treat opioid addiction with buprenorphine (Suboxone® and Subutex®)
http://buprenorphine.samhsa.gov/bwns_locator/

The Women's Project

Southern Maine: 1-800-611-1588
Northern Maine: 1-800-611-1779

2-1-1 Maine

A comprehensive statewide directory of over 8,000 health and human services available in Maine
Dial 211

24-Hour Statewide Crisis Hotline

If you are concerned about yourself or about somebody else, call the crisis hotline. This will connect you to your closest crisis center.
1-888-568-1112

APPENDIX G

Treatment Definitions:

Below is a listing of Substance Abuse treatment options and definitions. It is important to remember that this is a simply a guideline for reference and you are not responsible for determining what level of treatment your patient needs.

Co-Occurring (Integrated) Treatment:

Many individuals who have been diagnosed with a substance abuse disorder also have co-occurring mental health conditions and/or diagnoses. Agencies that provide co-occurring or integrated treatment provide treatment that addresses both issues at the same time and following the same track, not treating them as separate diagnoses.

DSAT (Differential Substance Abuse Treatment):

DSAT is a treatment program designed to reduce substance abuse and related criminal behaviour within the Maine offender population. This treatment is an evidenced based practice that addresses the different needs of men and women in substance abuse treatment, but also the individual level of substance use severity. This model can be used in institutional and/or community outpatient services.

Detoxification "Detox":

A "detox" may be a hospital based or outpatient program that helps stabilize people who are experiencing withdrawal from alcohol or other drugs. These programs provide evaluation, observation, medical monitoring, and addiction treatment in a short term inpatient setting.

Detoxification Management:

This service includes a call center and coordination of services provided by Aroostook Mental Health Center (AMHC) for individuals looking for a "detox" program in the northern Maine region. This service includes a central access point where individuals call and AMHC helps to access a "detox" bed in various hospitals in the Region III area (Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties.)

Emergency Shelter:

This service provides food, lodging, and clothing for individuals who abuse alcohol and other drugs, with the purpose of helping people enter alcohol and drug treatment. Shelter services are provided at least 12 hours per day, with some shelter services providing 24 hour care. Services include referrals for

detoxification, arrangements for needed health care services, transportation, and help with coordinating care.

Extended Care:

Extended Care provides a residential treatment program for more than 180 days to individuals with extensive substance abuse or co-occurring substance abuse and mental health conditions. This service includes a structured environment where substance abuse treatment is provided along with life skills training, relapse prevention, and the development of a social network that supports recovery.

Halfway House:

Halfway house is a residential program that provides less intense treatment services to support recovery from substance abuse. It is designed to improve the individual's ability to structure and organize daily living and recovery. Services include assessment, group/individual/family counseling, life skills, employment preparation, transportation between programs and coordination of services.

Intensive Outpatient Services:

These services are located at an agency office and provide intensive and structured substance abuse treatment, three to four days a week. The programs usually last three or four weeks and may be conducted during the daytime or in the evening.

Outpatient Services:

These services are located at an agency office and provide individual, group, and family sessions, usually for an hour or ninety minutes once a week.

Medication Assisted Treatment for Addiction:

Opioid Treatment Program (OTP) - Under medical supervision for maintenance or detoxification, OTP clinics administer opioid agonist medication (such as methadone), monitor dosages, and provide counseling to people with a dependence on heroin or prescription opioid medications.

Other: Some other forms of Medication Assisted Treatment used for detoxification and/or long term treatment include, but is not limited to, Suboxone, Buprenorphine, Subutex, Vivitrol, and Antabuse which are prescribed medications by a physician in an inpatient or outpatient setting.

Residential Rehabilitation:

Residential rehabilitation services are designed to treat persons who have significant social and psychological problems. The goals of treatment are to promote abstinence from substance use and enhance participant's lifestyles, attitudes, and values. For placement in this level of service an individual would have multiple challenges, which may include substance related disorders, criminal activity, mental health problems, and impaired functioning.

Residential Rehabilitation – Adolescent:

Residential rehabilitation services as described above that are designed to treat adolescents who have significant social and psychological problems.

Residential Rehabilitation 1:

Residential rehabilitation services as described above that are designed to treat persons (specifically women and their children) who have significant social and psychological problems.

APPENDIX H

Maine Medical PARTNERS

Controlled Substances Contract

Controlled Substances are regulated by law and my Doctor needs a special license to prescribe them. These medicines are controlled because they have a risk of addiction and drug abuse.

This contract lists the conditions for my use of controlled substances.

1. I will only use controlled substances that are prescribed by my doctor, named below. If another person prescribes a controlled substance for me, I will let my doctor know immediately.

2. I will use the medication only as prescribed. I will not sell, share or trade my medication.

3. I will not use any illegal substances or controlled substances that were not prescribed to me.

4. I will fill my prescriptions for controlled substances only at one pharmacy, named below. I will let my doctor know immediately if I change pharmacies.

5. I will keep my medications in a safe place. I know that lost or stolen prescriptions will not be replaced.

6. I will call for refills at least 24 hours before my medication runs out. Refill requests made on Friday will not be completed until the following Monday. Refills will not be issued after hours or on weekends or holidays. If I feel I need a change in my dose of controlled substance, I will discuss this with my provider before making a change in the dose. Otherwise no early refills will be granted. If I use up my controlled substance before I am due for a refill, I will have to do without this medication until I am due for a refill.

7. I agree to provide a urine sample for drug testing at any time.

8. I agree to bring my controlled substance pills in for a pill count at any time at the request of my doctor.

9. I understand that breaking this contract will result in stopping my controlled substance prescription.

10. Additionally, there may be other reasons my controlled substance prescription may be discontinued, such as 1) chronic pain, which may require referral to a pain clinic, 2) the treatment is not working, 3) missing appointments or other inappropriate behavior, 4) my doctor determines that the source of my pain is not obstetrical or gynecologic.

Patient Signature/Date_____

Patient Name/DOB_____

Doctor Signature/Date_____

Pharmacy_____

Maine Dartmouth Family Medicine Residency (MDFMR)
Contract for Treatment with Buprenorphine (Suboxone ®)

Patient Name: _____DOB:_____

1. I understand that I have been diagnosed with opioid dependence. I have elected to enter MDFMR's outpatient buprenorphine treatment program.

2. I understand that buprenorphine is a narcotic medication and that buprenorphine, like all narcotics, may make me drowsy. If I have this side effect, I should not drive, operate equipment, or perform any duty or task that requires complete mental or physical alertness.

3. I understand that not everyone is appropriate for treatment with buprenorphine. If, at any point within treatment, my provider thinks that methadone is a more appropriate treatment option for me, I will be referred to a methadone clinic. In these cases, I understand that MDFMR is not obligated to provide any further buprenorphine prescriptions and that MDFMR has no control over the availability of treatment at methadone clinics.

4. I agree to take my buprenorphine only as prescribed. I will not increase my dose or frequency of use under any circumstances. The only person who can adjust my buprenorphine dose is my provider. If I take more buprenorphine than I am prescribed, I understand that my prescription will not be refilled early and may not be refilled at all.

5. I understand that any lost, misplaced, or stolen buprenorphine prescriptions or medication will not be replaced or refilled early even if I have a police report.

6. I understand that I need to meet regularly with my provider to assess my progress. Depending upon my individual needs, these visits may be up to daily. I understand that, even if I am stable in recovery, I need to schedule an office visit at least once a month. It is my responsibility to schedule these appointments.

7. I understand that my buprenorphine may not be refilled if I am not able to attend my appointments as scheduled.

8. I understand that frequent cancellations and/or no shows for office visits will be considered a violation of this contract.

9. I will abstain from the use of medications and/or substances not prescribed to me (both legal and illegal) during my treatment for opioid dependence. I will also abstain from alcohol, and other sedatives, anxiolytics, or tranquilizers, which may have an addictive effect, as well as any and all paraphernalia.

10. I understand that the misuse of buprenorphine on its own or in combination with other substances particularly benzodiazepines and alcohol may result in drug overdose and/or death.

11. I understand that it is my responsibility to be sure that MDFMR can reach me. I understand that MDFMR must have at least two ways to contact me by phone including by voicemail. I must return voicemail messages within 24 hours. If my phone numbers change, I must notify MDFMR within 24 hours.

12. If I use more than one last name (i.e., a maiden and married name), I will provide a list of these names to MDFMR.

13. I understand that if prescriptions for narcotics and/or other controlled substances are needed, these medications should only be prescribed by MDFMR. If I am in treatment with another specialist, I will notify MDFMR of any new medications or changes to my current medication regimen within 48 hours.

14. If I need to seek emergency care and I think that I have been prescribed, and/or provided with, a narcotic medication or other controlled substance, I must notify MDFMR within 24 hours.

15. I understand that substance abuse counseling is a mandatory component of MDFMR's buprenorphine treatment program. My provider will help me identify the best counseling option. I understand that the frequency and/or type of counseling may depend upon my recovery progress. My provider may require me to attend more intensive treatment at any time. I understand that failure to comply with these recommendations is grounds for dismissal.

16. I understand that I must sign a release for MDFMR to speak with my substance abuse counselor.

17. I understand that I am expected to keep a record of my substance abuse counseling and that I need to present this to my provider at every office visit.

18. I understand that, if I do not complete my counseling requirements, I will likely no longer be able to receive care at MDFMR's buprenorphine treatment program.

19. I understand that I am expected to leave a urine drug screen at every visit. I will only supply my own urine and I agree not to tamper with my urine in any way. If I am unable to leave a urine sample, I understand that I may be asked to leave a catheterized specimen prior to receiving my medication.

20. I understand that the collection of my urine drug screen may be observed by a member of the MDFMR clinical staff at any time.

21. I agree to random urine and/or blood tests to assess my compliance with my prescribed medications, including buprenorphine

22. I also agree to random requests for medication verification through pill/film counts.

23. I understand that I will be asked to present for a random urine drug screen and/or pill/film count within 24 hours. I understand that failure to comply with this request will be considered a violation of this contract.

24. I understand that if my provider determines that the medication has lost its effectiveness in increasing my function, I will promptly taper off the medication.

25. I understand the eventual goal is to taper my buprenorphine while in outpatient treatment.

26. I understand that I must behave appropriately at all times. Abusive and/or threatening behavior, physical or verbal, will not be tolerated and are grounds for immediate dismissal. Illegal activities including, but not limited to, prescription alterations and/or selling prescribed medications are also grounds for immediate dismissal. I understand that MDFMR will also notify the appropriate authorities as indicated.

27. I understand and agree to the release of all information regarding my use or misuse of medication, whether legal or illegal, by MDFMR to any pharmacy, other physician, or medical treatment facility to which my provider deems medically necessary.

28. I understand that, like all health care providers, MDFMR's providers are mandated reporters of suspected abuse, neglect or exploitation of certain groups of people including children. Maine also has a specific law mandating the referral of all drug affected infants to DHHS.

29. I understand that it is not the responsibility of MDFMR or MaineGeneral Medical Center to supply any of my medications, and I am solely responsible for them.

30. I understand that buprenorphine is pregnancy category C. It is my responsibility to notify my provider if I think I might be pregnant, if I am trying to get pregnant or if I am not always using contraception when I am sexually active. Under these circumstances, buprenorphine may or may not be the right medication for me.

31. I am aware that failure to comply with any of the rules in this contract is grounds for my dismissal from the program without further medications or a rapid taper off of the medication (at a rate at or above 25% per day).

I have read, understand, and have been afforded answers to any and all questions that I have asked. By signing this contract, I agree to all the conditions of this contract.

_____ _____

Patient name (Print) Date

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

Appendix I

References

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Appendix J: Patient Education Resources

A. Screening and Substance Use during Pregnancy

B. Caregiver for NAS baby Tri-fold

Your Baby *and* Neonatal Narcotic Abstinence Syndrome

Your baby is at risk for Neonatal Narcotic Abstinence Syndrome (NAS). NAS is a group of signs and symptoms of withdrawal that a baby can have when a mother has taken certain medications during her pregnancy. These medications include methadone, Subutex, Oxycontin, Vicodin, and Codeine.

Many babies exposed to these drugs will have to spend more time in the hospital than other newborn babies. The exact length of time that your baby will stay is not known. It will depend on if your baby has withdrawal, how severe the withdrawal is, and how long it takes to wean the medications to doses safe for discharge. It is common for babies to be in the hospital for two weeks. *Please remember:* all babies are different. Withdrawal happens in different ways.

If your baby is healthy at birth, he or she will go to the newborn nursery. Withdrawal from medications can take five to seven days. The nurses will watch your baby closely beginning at birth. They will give him or her a "score" every three hours. The nurses use a special form to check withdrawal symptoms in newborns.

If your baby's score or clinical condition shows withdrawal, your baby will be moved to another unit. Nurses and doctors there will keep watching your baby. If needed, they will give medication to lessen your baby's withdrawal symptoms.

During withdrawal, your baby may:

- Be irritable or difficult to comfort
- Feed poorly, spit, vomit, have diarrhea
- Have more jaundice (yellow skin)
- Have a hard time sleeping
- Suck very strongly or with no coordination
- Be jittery
- Have higher risk of seizures
- Have frequent hiccoughs and/or sneezing

- Have mild fever
- Sweat
- Have diaper rash

You can help comfort your baby by:

- Holding
- Skin-to-skin contact (kangaroo care)
- Rocking gently
- Swaddling
- Offering a pacifier
- Not waking him or her between feedings
- Allowing less light and noise in the room

If these do not help your baby, medications may be considered. These may be Phenobarbital and Morphine. Your baby's doctor will review the symptoms and how strong they are, then choose what is best for your baby.

We encourage breastfeeding if:

- Your urine toxicology testing is negative when you are admitted to the hospital
- You are HIV negative

You and your baby's doctor should review all drugs and doses you are taking before beginning or continuing breastfeeding.

Resources:

www.aap.org

Neonatal Drug Withdrawal Policy, 2012; Transfer of drugs and other chemicals into human milk, 2001.

www.samhsa.gov

Substance Abuse and Mental Health Services Administration

www.ibreastfeeding.com

www.drugabuse.gov

National Institute on Drug Abuse

http://www.toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Public Health Nursing in Maine

Statewide Central Referral

(During pregnancy and for newborns)

1-877-763-0438

Care for
You and Your Baby:

NAS

The Barbara Bush Children's Hospital
At Maine Medical Center

22 Bramhall Street
Portland, Maine 04102

www.bbch.org

C. Patient Education Handbook

The Barbara Bush Children's Hospital
Maine Medical Center
Portland, Maine

The Barbara Bush Children's Hospital
At Maine Medical Center

NEONATAL
ABSTINENCE SYNDROME:
NAS

A Guide for Families

This guide is a gift for you and your baby to help you learn about the care given to your baby.

Table of Contents

Introduction 2

Part One: What to Expect Before You Deliver.....3

Signs and Symptoms of NAS.....4

Part Two: Care In the Hospital 5

Special Considerations

NAS Scoring

Medications

Visitation

Part Three: Transition to Home 10

Establishing a Routine

Feeding

Sleep

Awake Time

Crying

Other Resources

Appendix 16

Glossary 18

INTRODUCTION

Congratulations on the birth or upcoming birth of your baby!

The early moments with your baby can be both exciting and overwhelming. This book will review what to expect with a new baby who may be having symptoms of withdrawal. This guide can also help others who may care for your baby, including relatives and day care providers.

We all have the goal – to help you and your baby through the withdrawal process to plan for discharge home as soon as possible.

How do I use this book?

This guide has three parts:

Part One: What to expect Before You Deliver

Part Two: Care in the Hospital

Part Three: Transition to Home.

We suggest you read it from the beginning. The back of the book has a list of symptoms with some suggestions that may help. There is also a glossary of words which may be helpful during your hospitalization.

PART ONE

What to expect before you deliver:

The days and weeks before the birth of your baby are very exciting, but can be very stressful. Many people have a fear of the unknown. We hope this guide will help answer many of your questions and leave you feeling prepared. All questions are encouraged so write down and ask your care providers questions.

We understand you may feel emotional right now, but the goal is a healthy delivery and a safe start for you and your newborn

Neonatal Abstinence Syndrome (NAS) is a term to refer to the symptoms babies may have when withdrawing from contact with narcotics. Heroin, morphine, codeine, oxycodone Oxycontin or percocet, hydrocodone (Vicodin), meperidine, (Demerol) or fentanyl, are just a few of the drugs that may cause

NAS to occur in a baby. Withdrawal also may occur if the mother has been on methadone or buprenorphine (Subtex)treatment during pregnancy.

How can I help?

- All pregnant women are asked questions to help their healthcare professional help you have a healthy baby. Be honest with the people who take care of you and your baby. Tell them about your symptoms and cravings.
- Follow the plan of care as recommended.
- For the health and safety of your baby, continue to take the medications that have been prescribed for you by your care provider. They may have been given to you for conditions like depression, anxiety, or drug dependence. These medications can cause NAS in your newborn baby, but it is far worse for you and your baby if you are not treated. Your baby needs a healthy mom.

I seem to be very emotional. Is this normal?

- Being emotional is normal as you prepare for the birth of your baby.
- It will help to have a support network that includes friends and family as well as trained counselors in this time of change.
- If you think you need more help, please tell your care provider or call
- There are many resources available to help including your primary care physician. Other resources include:

Office of Substance Abuse Information and Resource Center:

1-800-499-0027 (in Maine only)

Or 207-287-8900

Public Health Nursing

1-877-763-0438

Division of Community Based Care Services Bureau of Behavioral Health (New Hampshire)

105 Pleasant Street

Concord, NH 03301

Phone: 603-271-5000

1-800-852-3345, x5000 (statewide)

Emergency Mental Health

(New Hampshire)

Hotline: 1-800-852-3388 (statewide)

Fax: 603-271-5058

- If you are using illegal drugs or alcohol, we encourage you to get help right away.
- Contact the hospital you plan to deliver at for tours, classes, and other info.

Signs and symptoms of NAS

Your baby may have signs of withdrawal, which we call Neonatal Abstinence Syndrome (NAS). Caring for any baby with NAS can take extra time and patience.

Will my baby be born with NAS and will NAS affect my baby?

- It is hard to tell before a baby is born how he or she will be affected by drugs. After birth, there are things that can help your nurses or doctors determine if your baby has signs of NAS.

How soon will we see signs of NAS?

- Most babies who have NAS will show signs 24 to 72 hours, or as late as five to seven days after birth.
- This depends on the
    - dose of subutex, methadone or other opiates
    - Exposure to prescribed medications, including some psychiatric medications
    - Exposure to other drugs – such as opiates (heroin), amphetamines, marijuana, and tobacco-particularly in the days just before the birth
- The type of childbirth (vaginal or c-section)
- Your baby's gestational age

What signs will we see?

The potential signs of NAS include:

- High-pitched cry
- Tremors/jitters
- Stuffy nose
- Hard time feeding and sucking
- Poor weight gain
- Increased breathing rate

- Irritability or fussiness and difficult with comforting
- Trouble sleeping
- Sneezing
- Tight muscles (arms & legs seem stiff)
- Vomiting, diarrhea
- Skin irritation
- Hyperactive reflexes (very big response to being startled)

What do the doctors look for to be certain my baby has NAS?

Your baby must have several of the signs previously listed to be diagnosed with NAS. Some of the signs may also be seen in babies who have other problems so your baby will be closely checked to confirm NAS.

How long can the signs and symptoms of NAS last?

Many babies need treatment even after they have gone home.

PART TWO:

Care in the hospital:

What will happen after my baby is born?

- Your baby will be watched closely after the delivery. If your baby was exposed to medication or other drugs before birth, he or she will be watched in the hospital for a minimum of 5 to 7 days.

When will my baby show signs of NAS?

- Most babies will show signs of NAS in the first 24-72 hours. It is possible to see symptoms start as late as 5-7 days.
- Your baby's doctor will decide how long your baby needs to be observed in the hospital.

Does my baby need any special care?

- After birth, your baby will usually go with you to the mother/baby unit.
- We will care for you and your baby in the same way as we care for any other new mom and baby.

- You will be encouraged to care for your baby in the hospital as much as possible.
- Please look at your hospital's guide for information on the basic care of yourself and your newborn.

Will my baby be tested for drugs?

- Most babies who have risk factors for NAS will have their urine and first bowel movements (called meconium) sent to the lab for testing.

Other things to expect:

- While you are in the hospital, someone from social work department, case management, or nursing will come and talk to you to help in the transition home.
- A Drug affected baby report is submitted in order for you and your baby to receive support services. The Drug Affected baby services are here to help you and your baby, they are not here to take your baby away. We also refer your baby to child development services. This report is a mandated by the federal government.

Feedings and weight gain:

Why do you need to watch my baby?

We will watch to see how your baby is feeding. We will keep close daily checks on his or her weight.

How will my baby's weight be different from a baby who has not been exposed to drugs?

Most babies will lose 6% to 8% of their birth weight after birth. We expect these babies to be back to their birth weight in two weeks. Babies with NAS may lose more than this and have a hard time putting the weight back on.

Why do babies with NAS have a hard time putting weight back on?

- Babies with NAS are very active and use a lot of energy.
- Some babies with NAS may have a hard time feeding.
- Many babies with NAS need to be on special formulas with higher calories.

Can I breastfeed my baby?

- While breastfeeding is an excellent way for a mother to feed and bond with a baby, the decision to support breastfeeding must be made on a case-by-case basis.

- Talk to your baby's health care provider to decide if it is safe for you to breastfeed.
    - Be open and honest with your baby's health care provider.

Is there anything about the stools I need to watch?

- Babies who are withdrawing can have very loose or water stools.
- Babies with NAS are more prone to diaper rash, and may need special cream.
- Watch the diaper area closely. Please let the baby's caregiver know if you see redness at a diaper change.

Is there anything else my baby will be watched for?

Your baby will be watched for signs of withdrawal. We do this with the NAS scoring system described in the next section.

NAS scoring:

How will my baby be checked for signs of withdrawal?

- The nurses taking care of your baby will use the Finnegan scoring system to check your baby for signs of withdrawal. All the nurses have been trained in the use of the Finnegan scoring system.

What is the Finnegan Score?

- This score rates your baby's symptoms of withdrawal over a specific time period.
- You will see differences in the scores for your baby over the time period. This is because every baby has differences during the adjustment period after birth.
- We use the scores as one way to decide on the plan of care.

What score would show my baby has NAS?

- Many babies have one or two of the symptoms on the Finnegan scoring sheet. Most babies would not have more than three or four symptoms. Scores that are near eight tell us that your baby is having withdrawal symptoms and may need medication.
- If the score for your baby is eight or above, two or more times, the doctor is called. Your baby may need medicine and may need to go to a special nursery or pediatric unit to be watched more closely or for special treatment.

Medications:

Our goal with medications and treatment is to keep your baby comfortable during the withdrawal process.

How much medication will my baby be given?

The dose given will depend on:

- Your baby's Finnegan scores
- Your baby's weight
- Your baby's response to treatment

How will the doctors know my baby is getting enough?

- The baby's dose will be adjusted according to his or her symptoms.
- A health care provider will check your baby each day and the Finnegan scores will be taken every two to four hours.
- The medicine can be adjusted as needed. Weaning will start when your baby shows minimal signs of withdrawal.
- Each baby responds differently to being weaned off the medicine. A plan will be made each day for your baby.

How long will my baby have to stay in the hospital?

- If your baby is on medicine, he or she may need to stay in the hospital for two to three weeks, sometimes longer.

Providing Supportive Care for your Baby

Can I spend time with my baby?

Yes, we encourage you to spend time with your baby and learn about your baby and how to care for him or her. Please understand that babies with NAS are very sensitive to the sounds, lights, and activity around them.

Suggestions:

- We encourage skin to skin care as much as possible. This can help
    - to settle your baby
    - lowers his or her breathing and heart rate.
    - you bond with your baby.

Safe Sleep:

Anytime your baby is put to sleep, it is always safest to place them on their back. Babies should sleep in a crib near their parents but should not sleep in the bed, couch, or chair with their parents. Remember if you are sleepy put your baby down.

PART THREE:

Transition to home:

Will my baby still have signs of withdrawal when he or she goes home?

Most infants have an amazing ability to recover from early problems. This includes babies with NAS.

- Once at home, your baby may have mild signs of withdrawal for several weeks or months. The symptoms slowly become less severe.

Is my baby fussy because of NAS?

- There are many things that all newborns have in common, such as a fussy time. Most babies have a fussy time in the evening.
- The loving care you provide is the most important influence on your baby's future.

Are there special things I need to do to care for my baby?

- Babies with NAS have all of the same needs as babies who were not exposed but they also have specific care needs. We highlight needs specific to babies with NAS, but please refer to the information given to you at your hospital for general care issues.

Establishing a routine:

Is getting my baby into a routine a good thing?

- NAS babies need a good routine.
- You may already know what your baby likes. Please ask your baby's nurse about any routines the baby may already have.
- Most parents of small children have busy lives, full of appointments and errands. Try to work these activities around your baby's schedule. Well-rested babies eat better and are usually happy, alert and ready to learn about their world.

What should I know about feeding my baby?

Feeding times may be difficult in the beginning

Looking for cues of hunger, which include sucking on hands, munching, increased movements, and crying may not indicate true hunger with your newborn.

- He/She may appear to act hungry but is not able to eat because of uncoordinated sucking and swallowing
- Cues such as pulling away from the bottle or breast while feeding your baby may appear to indicate your baby getting tired. Before stopping a feeding try to burp or gently encouraging him/her to finish the feeding.

How often should my baby eat?

- Bottle fed babies eat about every two and a half to four hours, while breastfed babies may eat every one and a half to three hours (good guide is: eight to 12 times in 24 hours)
- Babies will take more at some feedings than at others so ask the nurse what your baby has been taking.
- If your baby seems to spit up often, try smaller frequent feedings.
- As your baby grows, he or she will take larger feedings less often.

Is there anything special I should do when feeding my baby?

- Providing optimal nutrition is a challenge
    - feeding behavior may be impaired
    - decreased intake
    - even an adequate intake may not promote weight gain
- Providing high calorie formula may be needed
- Babies like to be in a comfortable position while eating
    - Always hold babies while they are eating
    - Some babies like to be swaddled or held closely.
    - Others like their arms free.
- Some like to be reclined
- Others more upright.
- Your baby will let you know what he or she likes best.

Sleep:

How long should my baby sleep?

- Most babies with NAS will go home from the hospital when they are one to six weeks old. At this age, infants usually sleep 16 to 20 hours a day.

- Falling asleep and staying asleep are important things for your baby to know how to do. Setting a routine for daytime naps and nighttime sleeping is an important developmental step for your baby.

- It may be 6-9 months for NAS babies to develop a good sleep routine.

How can I help my baby sleep better?

- Low lighting
- Care can be coordinated with feeding times.
- A pacifier might provide some soothing sucking while falling asleep.
- Place your baby on his back to sleep
- For your baby's safety, bed sharing with parents or siblings is not recommended.
- You can help your baby set a sleep routine by providing a place that is consistently safe and quiet.
- A bedtime routine
    - can be as simple as reading a story or singing a lullaby.
    - Then, place your baby down-always on the back-when he or she is still drowsy.
- Remember to keep nighttime feedings a time for "business only."
- Babies with NAS may be active or have jerky movements.
- Babies usually only need one more layer than you have on.
- Using music to soothe the baby
    - play soft music for about 20 minutes
        - try a tape or CD player instead of a wind-up
        - this gives the baby time to fall into a deep sleep before the music stops.

Awake time:

What should I do when my baby is awake?

Sometimes between naps, your baby will cry and other times your baby will be awake and alert. This is a time when you can interact with your baby, and offer some beginning play activities.

- Babies need to be in different positions during the day to learn about their world, and develop muscle control. Try things like holding the baby facing you or facing out, on your shoulder or on your hip, or secured in a swing or seat. Many babies like swings and vibrating seats but some babies with NAS may find them too stimulating.
- "Tummy time" is very important. Although your baby should always sleep on his or her back, when awake he or she should spend 10 to 20 minutes on the tummy on a firm surface (a blanket on the floor is best) while you are watching. This will strengthen the back and shoulder muscles, and your baby will learn to move around.
- Cuddle up with a book or a song. Rhythmic, soft music can be soothing for both of you, especially when your baby is restless or tired. Reading to your baby has the same effect.

Daily Schedule:

How should I touch my baby?

Babies with NAS can be very sensitive to touch. However, touch is one of the ways all babies learn and become more aware of their bodies.

Gentle, slow massage is a wonderful, soothing way to interact with your baby and to give loving care. If you make time for massage as part of your regular routine, such as at bath time, your baby will begin to look forward to and enjoy this activity.

Crying:

Why does my baby cry?

Crying is your baby's way of talking to you. Some babies cry more than others.

What should I check when my baby cries?

- Check the diaper to see if it needs to be changed.
- See if the baby needs another burp or is hungry.
- Try swaddling the baby in a blanket so he or she feels more secure.
- Look around for things that could be bothering your baby.
    - Is he or she too warm or cool?
    - Are there sights and sounds from the television or music that are too stimulating rather than soothing?
    - Is light shining in your baby's eyes?
    - Has your baby been in the same position for a long time?
    - Has it been a busy day, and your baby needs to go to sleep?

What if I can't stop my baby from crying?

If your baby seems to be crying more than you would expect, please call you baby's health care provider. This could be a sign that something is wrong. Your health care provider may be able to suggest some other helpful techniques or resources. Do not let yourself get too upset by the crying before you ask for help. Remember to never shake a baby.

The Period of PURPLE Crying:

Is a new way to help parents understand this time in their baby's life, which is a normal part of every infant's development. It is confusing and concerning to be told your baby "has colic" because it sounds like it is an illness or a condition that is abnormal. When the baby is given colic medicine it reinforces the idea that there is something wrong with the baby when in fact the baby is going through a very normal developmental phase. That is why we prefer to refer to this time as the Period of Purple Crying**.** No, it is not because the baby turns purple when he/she cries but provides a meaningful and memorable way to describe what parents and their babies are going through.

The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months. There are other common characteristics of this phases, or period, which are better described by the acronym PURPLE. All babies go through this Period it is just that during this time some can cry a lot, some far less, but they all do go through it. You will receive a period of Purple Crying DVD upon discharge.

Other resources:

If you find that you need more help please ask. You are not alone. Staff from the visiting nurses may visit you at home and check on your baby from time to time. This will be arranged before your baby leaves the hospital. If you are concerned or worried about your baby's health, contact your baby's health care provider.

Other resources that offer help include:

Maine Association of Alcoholism and Drug Abuse Counselors (MAADAC)

maadac2001@yahoo.com

(207) 548-2877 (fax)

Maine Association of Substance Abuse Programs (MASAP)

www.masap.org

Maine Alliance for Addiction Recovery (MAAR) - www.masap.org/site/recovery.asp

(207) 621-8118

The Woman's Project

Southern Maine - 1-800-611-1588

Northern Maine - 1-800-611-1779

1-800-452-6457

Helping women affected by substance abuse

www.propeople.org/women.htm

Maine Statewide Crisis Hotline

1-888-568-1112

Maine Families

Augusta, ME 04333-0011

(207) 624-7900

www.mainefamilies.org

BEHAVIOR	***CALMING SUGGESTIONS***
Difficult or poor feeding	• Your baby may need more time to feed than others • Feed your baby with the same nipple type as was used in the hospital • Feed small amounts more often. You may need to use a special formula to make sure the baby is taking in enough calories. • Feed in a quiet, calm place with little noise and interruptions. • Swaddle baby to keep arms and hands close to midline and reduce extra movement. • Be alert to your baby's cues. They may include searching or pulling away from nipple or needing to pause to swallow or burp.
Sneezing, stuffy, nose	• Call your pediatrician, especially if your baby is working to breathe. • Keep your baby's nose and mouth clean. • Do not overdress or wrap your baby too tight. • Keep your baby in a position where the head is above the heart, well supported and supervised. • Do not let your baby sleep on his or her tummy. • Ask your baby's doctor about saline drops.

Spitting up	• Feed your baby slowly. Let your baby rest between feeds. • Feed your baby less but more often. • Burp your baby often. • After feeding, keep your baby upright in your arms for 20 minutes to help with digestion.
Trembling	• Keep your baby in a warm quiet room. • Swaddle your baby snugly. • When positioning your baby, move slowly and carefully to not startle him or her. • Gently and slowly, massage your baby's arms and legs.

GLOSSARY

Department of Health and Human Services: a system of health and human services where access to services is easier, care is coordinated and costs are contained. Virtually every citizen in Maine encounters the Department of Health and Human Services in one way or another.

Finnegan score: a rating system developed by Dr. Loretta Finnegan for babies withdrawing from opiates.

Gestational Age: The age of the baby in weeks, starting from the beginning of the pregnancy to the date of birth.

Meconium: the first stool passed by the baby. It is often black and sticky like tar.

Neonatologist: a pediatrician trained specifically in caring for high-risk newborns.

Visiting Nurse Association (VNA): nurses who can make home visits to check weights and babies