

# **SUMMARY DOCUMENT**

CLINICAL GUIDELINES  
FOR THE MANAGEMENT OF  
SUBSTANCE USE DURING  
PREGNANCY, BIRTH AND THE  
POSTNATAL PERIOD



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## General Principles Summary

### Substance use information for women

- Women of child bearing age, including those at school and who are already pregnant, are a high priority for interventions to reduce substance use.
- It is important to consider the social supports and emotional well-being of pregnant women who use alcohol, tobacco and other drugs.

### Care of pregnant substance-dependent women

- Pregnant substance-dependent women will benefit from specialist assessments and help (e.g., D&A specialist), a consistent case manager and care team during pregnancy, and specific drug and alcohol treatments (e.g., counselling, pharmacotherapies).

### Contraception

- All women with problematic alcohol, tobacco or other drug use should be provided with advice on contraception to reduce unplanned pregnancies and harm to the unborn child.

**Exposure to alcohol, tobacco and other drugs may have a serious effect on the fetus in the very early stages of pregnancy, particularly before the first missed period.**

### Vertical transmission of blood-borne viruses

- All substance-dependent women should receive information about vertical transmission of blood-borne viruses before falling pregnant, including transmission prevention, managing infections and pregnancy implications.

### Mental health issues

- Health care workers must recognise signs of mental illness in pregnant women and refer to specialist treatment.

### Confidentiality

- In all communications it is important to work within the privacy legislation and local guidelines to ensure privacy and confidentiality are maintained, particularly for substance-dependent women. The sharing of information across the

health system in relation to medical records for reasonably expected purposes is covered by the NSW Health Privacy Manual for Health Information. This includes information when being discharged from one health service to another, or concurrent treatment.

**Confidentiality is a fundamental right of all people using health care services.**

- It is important to note also that government agencies and NGOs who are 'prescribed bodies' are allowed to exchange information that relates to a child's safety, welfare or well-being.

### Pregnancy care facilities

- Pregnancy care facilities should have information about which services have the capacity to support their staff by secondary consultation, mentoring and training.
- The contact details of specialist support services should be readily available for pregnancy care providers, including after hours contact details.

### Child protection

- Substance use alone may not be an indicator for a child protection report or notification.

**Legislation requires that the safety and well-being of the child is a paramount consideration.**

### More information

- Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599.
- NSW Health offers information about the protection and well-being of children. Visit <[www.health.nsw.gov.au/initiatives/kts/index.asp](http://www.health.nsw.gov.au/initiatives/kts/index.asp)>.

## Continuity of Care and of Carers Summary

### Background information

- Continuity of care and of carers is now accepted as best practice for all pregnant women.

**Pregnancy care providers and maternity services should always provide continuity of care for pregnant women.**

- Multidisciplinary teams who work together can achieve optimal pregnancy, birth and parenting outcomes for each woman and her family.
- A multidisciplinary team can include a midwife, obstetrician, neonatologist, community health care worker, Aboriginal health worker, drug and alcohol counsellor and others as required in each case.
- The case manager, midwife or team should ensure that continuity of care is maintained into the postnatal period.

### Clinical implications

**Continuity of care and of caregivers is particularly important for vulnerable groups, such as women with substance use issues.**

- Continuity of care is established by:
  - effective engagement skills, including cultural awareness skills
  - an effective system that clearly identifies the main case worker/case manager
  - individualised care planning made in consultation with the woman
  - timely and accurate documentation and communication
  - a seamless referral system.

### Aboriginal women

**Effective partnerships between mainstream services and Aboriginal Community Controlled Health Services must be developed to improve communication, integrate service delivery and provide continuity of care.**

- Clinical interventions with pregnant Aboriginal women who use substances should be guided by six common principles. These are:
  1. The use of alcohol, tobacco and other drugs must be addressed as part of a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social well-being, community development and capacity building.
  2. Local planning is required to develop responses to needs and priorities set by Aboriginal communities.
  3. Culturally valid strategies that are effective for Aboriginal peoples must be developed, implemented and evaluated.
  4. Aboriginal peoples must be centrally involved in planning and implementing strategies to address use of alcohol, tobacco and other drugs in their communities.
  5. Aboriginal communities should have control over their health, drug and alcohol and related services.
- Resources to address use of alcohol, tobacco and other drugs must be available at the level needed to reduce disproportionate levels of drug-related harm among Aboriginal peoples.

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## Antenatal Care Summary

### Engage with the women

- Engagement aims to establish a professional, trusting and empathetic relationship.
- Engagement skills include having a non-judgement attitude, understanding the woman's attitudes and beliefs, acknowledging the woman's feelings, and adhering to privacy and confidentiality.

### Aboriginal women

- Cultural sensitivity and awareness are key skills of engagement, particularly when engaging Aboriginal peoples in care. Training is required to develop these skills in health care professionals.

### Literacy

- To engage all women, including those with low literacy, all pregnancy and substance issues should be discussed verbally with the woman (and her partner) to ensure understanding, as well as written down.

### Conduct regular screenings at antenatal visits

- If a pregnant woman is identified as using substances during pregnancy, the appropriate protocols should be followed which, depending on the substance, may include interventions and involving specialist services.

**Effective engagement skills and sensitive questioning by the health care worker may help to facilitate accurate disclosure of substance use by pregnant women.**

### Involve the partner/support person

- If the woman provides informed consent, the support persons should be involved in all stages of care, including discussions of substance use and offering them interventions for their substance use if appropriate.

### Conduct a psychosocial assessment

- At the first antenatal visit, a psychosocial assessment for discharge planning should be conducted.

**The supports that each woman needs will most likely change during the antenatal and postnatal stages.**

### Manage coexisting mental health and substance use issues

- Ongoing care of a woman with mental health problems requires consultation with her mental health case worker or other clinician as available, and a plan for the birth and after the birth.

### Involve a multidisciplinary team

- A skilled multidisciplinary team is ideal to provide care for the substance-dependent pregnant woman.
- A case manager should be appointed to oversee the woman's care and liaise with her care team.

### Develop a written care plan

- The woman must be involved in formulating and reviewing the plan for it to be meaningful to her, and for her to commit to it.

### Prepare for discharge

- Planning for discharge must begin at the first antenatal visit with the woman and her support people.

### Prepare for the birth and postnatal period

- This will include the usual antenatal preparations and childbirth education, as well as options for pain relief, breastfeeding advice and parenting education.

### Women who present late

- Women who present for the first time in the third trimester, or in labour, have a high risk of pregnancy complications as a result of inadequate antenatal care.

**Late presentation in pregnancy may indicate an infant at risk of neonatal abstinence syndrome (NAS).**

## Labour and Birth Summary

### Early admission in labour

- Women should be advised to attend early once they go into spontaneous labour.

**Early admission limits the woman's need to self-medicate at home during labour and makes it easier to monitor her substance use. It is suggested as a proactive management strategy.**

### Monitoring fetal growth

- It is important to monitor fetal growth to determine which obstetric protocols to follow, as there is an increased risk of reduced fetal growth in women who use alcohol, tobacco and other drugs.

### Out of hours emergency presentations

- Each health care service requires clear protocols to manage out of hour emergency presentations so that women are not lost to follow-up.

**Protocols should include which practitioner is to be notified, and clear guidelines on stabilisation and psychosocial management.**

### Induction of labour

- There is no need for an induction of labour if the baby is showing normal growth.
- If induction of labour is planned, preferably arrange for this to occur early in the week when experienced staff and neonatal specialists are available to observe the infant for signs of neonatal abstinence syndrome.

### Anaesthetic assessment

- Analgesic needs and potential crisis situations should be assessed and anticipated in the third trimester.

### Appropriate forms of pain relief

- All forms of pain relief, including non-pharmacological means, should be offered in labour after assessing the woman's needs.

**There is a tendency to underestimate the amount of pain relief needed by substance-dependent women during labour. Total analgesic requirements may be increased in women with a history of substance use.**

### Intractable pain

- Pain caused by an unknown pathology may be masked by substance use.
- Both common (e.g., pyelonephritis) and uncommon (e.g., sacroiliac joint abscess) conditions should be considered when the woman's pain cannot be controlled.

### Specific anaesthetic agents to avoid

- Among women using, or suspected of using, psychostimulants, ketamine should be avoided where possible.

### Difficulty with venous access

- Some substance-dependent women have damaged veins, making venous access difficult. This may be an indication for the use of a central venous line.

### Postpartum pain

- Pain after surgery such as caesarean section or tubal ligation (after vaginal birth) may be difficult to control and should be assessed in consultation with the drug and alcohol team.

## Postnatal Care Summary

### Timing of discharge

- Early discharge is not usually appropriate for substance-dependent women.

**Prepare opioid and sedative-dependent women for a postnatal stay of five or more days to allow assessment of neonatal abstinence syndrome (NAS).**

### Contraception

- Options for contraception should be discussed before discharge and information should be provided.

### Sudden Unexpected Deaths in Infancy (SUDI)

- SUDI is defined as the death of an infant less than 12 months of age and was sudden and unexpected.

### Sudden Infant Death Syndrome (SIDS) and tobacco

- All parents should be advised of the association between infant exposure to environmental tobacco smoke and SIDS, and offered smoking cessation support.

**An infant's most harmful exposure to tobacco is through environmental tobacco smoke.**

### Shared sleeping practices

- All women should be informed of the risks of co-sleeping and about safe sleeping practices before discharge.

### Aboriginal women

- Health care workers should be aware that it is common practice for family members to sleep with infants in some Aboriginal communities. Culturally appropriate education on the risks should be provided.

### Sedating substances and sleeping accidents

- Any person responsible for caring for the baby should be informed about the risks of using sedating substances (e.g., alcohol, prescription

medication) and safe sleeping practices both verbally and in writing.

### Safe sleeping practices

- All women should be provided with a SIDS brochure and information on D&A use and sleeping practices.

### Preparing for discharge

- The discharge plan, which should be written during the antenatal stage, must be reviewed with the woman and care providers before discharge, and each person must receive a copy of the plan.

### Assertive follow-up

#### Inpatient services

- At discharge, there must be a formal transfer of responsibilities from the hospital to the community services that will be continuing care, and referrals and supports must be in place.

#### Community services

- Community services must be active in engaging families and ensuring arrangements are followed up, including assessing the well-being and safety of the infant and/or other children at all points of contact.

#### Home visiting

- Families should be assessed individually as to the appropriateness and likely benefits of in-home visits.

#### Early intervention programs

- It may be important to intervene early for children affected by parental substance use, particularly children diagnosed with fetal alcohol syndrome (FAS).
- All children at high risk for development concerns require intensive developmental surveillance.

## General Principles of Breastfeeding Summary

### Background information

For mother	For child
<ul style="list-style-type: none"> <li>■ Early suckling minimises bleeding after birth.</li> </ul>	<ul style="list-style-type: none"> <li>■ Breast milk meets all your baby's nutritional needs for the first six months.</li> </ul>
<ul style="list-style-type: none"> <li>■ Breastfeeding may reduce the risk of pre-menopausal breast, ovarian and endometrial cancers.</li> </ul>	<ul style="list-style-type: none"> <li>■ Regular skin-to-skin contact and close interaction during breastfeeding encourages responsiveness and attachment.</li> </ul>
<ul style="list-style-type: none"> <li>■ Breastfeeding may lead to stronger bones and less osteoporosis.</li> </ul>	<ul style="list-style-type: none"> <li>■ Breast milk contains many anti-infective factors that help protect your baby from sickness.</li> </ul>

NHMRC Infant Feeding Guidelines (2012) state that 'maternal use of nicotine, alcohol, ecstasy, cocaine, amphetamines and related stimulants has been demonstrated to have harmful effects on breastfed infants'. These are noted to be 'maternal conditions that may justify permanent avoidance of breastfeeding'. Smokers are less likely to breastfeed but they should be encouraged to do so.

- If a woman who breastfeeds chooses to use substances, a harm minimisation approach is recommended, provided that:
  - the woman is informed about the likely effects on the infant of the substances she is, or may, use.
  - the woman is assisted to plan minimum exposure of the infant to the effects of these substances.

Appropriate support for substance-dependent women who wish to breastfeed requires integrated services from drug and alcohol services, paediatrician, lactation consultant or other health professional with breastfeeding expertise.



## Breastfeeding and blood-borne viruses

### Human immunodeficiency virus (HIV)

- To reduce the risk of HIV transmission to the infant, HIV-positive mothers should completely avoid breastfeeding and use formula milk instead.
- It is important that women who are not breastfeeding be informed of the benefits to the infant of skin-to-skin contact.

### Hepatitis C virus

- There is no evidence that breastfeeding increases the risk of transmission of hepatitis C from mother to infant.
- Women should be informed of the theoretical risks and discard breast milk if it may be contaminated with blood, such as by cracked, abraded or bleeding nipples.

### Hepatitis B virus

- There is no evidence that breastfeeding increases the risk of transmission of hepatitis B from mother to infant.
- To protect against transmission it is extremely important that all infants of HBsAg (hepatitis B surface antigen) positive mothers receive active and passive immunisation within 12 hours after birth.

### Role of lactation advice

- Seek advice from a child and family health nurse, a lactation consultant, or midwife with drug and alcohol experience if there is uncertainty on how to advise the substance-dependent mother about breastfeeding.

### More information

- NSW Health's 'Breastfeeding your baby' should be given to all women who are breastfeeding or considering breastfeeding. Visit <[www.health.nsw.gov.au/pubs/2011/pdf/breastfeeding\\_your\\_baby\\_w.pdf](http://www.health.nsw.gov.au/pubs/2011/pdf/breastfeeding_your_baby_w.pdf)>.
- Breastfeeding recommendations for specific substances are detailed in the guidelines and the summary sheets for each substance.

- NHMRC Infant Feeding Guidelines: Information for Health Workers [http://www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/n56\\_infant\\_feeding\\_guidelines.pdf](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n56_infant_feeding_guidelines.pdf)

### Vertical Transmission of Blood-Borne Viruses Summary

#### General considerations

- The OH&S of staff should be considered when managing people with blood-borne viruses.
- Normal body fluid precautions should be taken.
- All women of childbearing age should receive information about blood-borne viral infections and pregnancy.

### Human immunodeficiency virus (HIV)

#### *Antiretroviral therapy*

- Antiretroviral therapy reduces the risk of mother-to-child transmission.
- It should commence after the first 12 weeks gestation and be maintained during pregnancy.
- Combination therapy is more effective than single agent therapy at preventing perinatal transmission.

#### *Birth considerations*

- Short courses of certain antiretroviral medicines are effective in pregnancy and are not associated with any safety concerns in the short term. Elective caesarean section can reduce the risk of perinatal transmission to the infant before labour and before ruptured membranes and is effective among women with HIV not taking antiretrovirals or taking only zidovudine.

#### *Antiretroviral therapy and the newborn*

- Antiretroviral therapy for the infant is recommended immediately after birth and for the first 6 weeks of life.

#### *Immunisation*

- Advice on immunisations should be sought from a paediatric HIV specialist or infectious diseases specialist.

### *Monitoring*

**HIV status monitoring by PCR testing to exclude vertical transmission should occur for the first 18 months.**

- Advice from a paediatric HIV specialist should be sought in line of evolving new evidence.

### **Hepatitis C virus**

#### *Caesarean section*

- Caesarean section has not been shown to reduce HCV transmission.

#### *Monitoring*

- Any testing of babies should be accompanied by thorough counselling of parents before and after the test.
- The woman's primary health carer is responsible for following this up (typically her GP).

**Currently infants are tested for hepatitis C at 18 months, but PCR testing may be offered from 4-6 months.**

#### *Managing vertical transmission*

- Infants with HCV infection should be referred to a paediatric hepatologist or infectious disease specialist.

### **Hepatitis B virus**

#### *Caesarean section*

- Elective caesarean section to reduce risk of vertical transmission is not justified.

#### *Vaccination*

- Women who are HBsAb negative should be offered HBV vaccination after birth.
- It is public health policy in Australia that all newborns receive HBV immunisation, and babies of HBsAg positive mothers are given immunoglobulin.

## Protecting the Safety, Welfare and Well-Being of the Unborn or Newborn Child Summary

### Responding to risk of harm prenatally

- A person who has reasonable grounds to suspect before the birth that a child may be 'at risk of significant harm' (ROSH) after his/her birth may make a prenatal report to the Child Protection Helpline.
- Making a prenatal report is not mandatory in NSW
- Health professionals should liaise closely with all agencies involved in the provision of services during the antenatal and postnatal periods for each pregnant woman, including attending case meetings/reviews.
- Where appropriate, concerns may be discussed with clients, so that they understand why there may need to talk with others and initiate referrals to other services.

**Under Chapter 16A, services can exchange information without parental consent where a child is suspected to be at ROSH. However, 16A does not apply to unborn children unless a prenatal report has been lodged.**

- Health professionals must have the pregnant woman's consent to exchange information about an unborn child unless a prenatal report has been lodged for ROSH concerns to the Child Protection Helpline.

### SAFE START

- SAFE START assesses women expecting or caring for an infant, and assists in identifying and supporting those who may be experiencing or at risk of mental health problems (e.g., postnatal depression).
- All pregnant women booked in for routine antenatal care can access SAFE START.

### Responding to safety, welfare and well-being concerns about newborns

- Where risk factors have been identified, drug and alcohol and maternity services should work closely to ensure that services and supports are in place to secure the best possible outcome for a newborn child.
- Workers should consult the Mandatory Reporter Guide along with using their professional judgement to determine what initial action should be taken to protect newborns in response to identified risks.
- Where suspected ROSH is identified after the birth of a child, as mandatory reporters, health workers are required by law to report their concerns to the Child Protection Helpline.

**Mandatory reporters' identities are protected by law. Making a report cannot be seen as breaching professional ethics or as a departure from acceptable standards of professional conduct.**

### Child Well-being Units

- NSW Health Mandatory reporters can also call the NSW Health Child Well-being Units (CWUs) to discuss whether concerns warrant a risk of significant harm report being made.

### Referral services

- Where the child is not exposed to risks of significant harm, consider referring the woman to a Family Referral Service or community based support services that may assist with support needs (e.g., parenting skills).

### More information

- The NSW Health Prenatal Reporting Guidelines is available at [www.health.nsw.gov.au/policies/gl/2011/pdf/GL2011\\_008.pdf](http://www.health.nsw.gov.au/policies/gl/2011/pdf/GL2011_008.pdf).
- The NSW Mandatory Reporter Guide is available at [sdm.community.nsw.gov.au/mrg/](http://sdm.community.nsw.gov.au/mrg/).
- Child Protection Helpline is open 24/7. Phone 133 627 (mandatory reporters) or 132 111 (general public).

## Caring for Pregnant Women with Problematic Substance Use in Custodial Settings Summary

### General considerations

- All women of childbearing age are to be pregnancy tested on entry into custody and again after one month.
- If substance use problems are present, the drug and alcohol doctor on call should be consulted promptly.

### Pregnancy choices

- If a woman requests termination of pregnancy, this should be facilitated in a supportive and non-judgmental manner whilst maintaining strict confidentiality and professional attitudes.

### Withdrawal management

- Women experiencing withdrawal should be closely monitored at frequent intervals, particularly those with mental or intellectual disabilities, and medications titrated appropriately.

### Treatment options

- Pregnant, substance-using women should be offered drug and alcohol counselling and psychosocial support.
- Methadone treatment is offered to opioid dependent women. However, pregnant women entering custody on buprenorphine should generally be maintained on this if medically appropriate.

### Labour and birth care

- Women in custody are transferred to Westmead Public Hospital or Nepean Public Hospital at labour onset.
- Correctional centre staff may be present at the hospital for the duration of the woman's stay.

### Post delivery care

- The Justice and Forensic Mental Health Network (JFMHN) midwife completes a Community Services (CS) report on all pregnant women in custody.
- The hospital social worker assists women to plan for the care of their baby and liaises with CSNSW.

### Breastfeeding

- JFMHN promotes and supports breastfeeding and/or expressing breast milk.

### Bonding and attachment

- Hospital staff can assist with bonding and attachment by helping women to feel connected to their babies (e.g., giving the woman a photograph of their newborn, having regular visits with the baby).

### Release planning and reintegration

**Continuity of care should be a key goal for the management of pregnant, substance-using women who come into a custodial setting.**

- If a woman is released prior to giving birth, they should be booked into a hospital in the area in which they are going to be living.
- For women on methadone maintenance, a community prescriber should be found prior to their release.
- If the mother and baby are leaving prison together, there is a particular need to ensure that maintenance prescribing is sufficient to protect against a return to illicit opioid use.

### Contraceptive advice and pregnancy planning

- When substance-dependent women enter custody, their health and therefore their fertility is likely to improve. This may increase the risk of unplanned pregnancy. This possibility should be discussed with women entering custody, who need advice about reliable and easy to use methods of contraception.
- Long term contraception is offered to all women by JFMHN, which may include the use of Implanon (a sub-dermal implant).

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## Caring for Pregnant Women with Problematic Substance Use in Rural and Remote Settings Summary

Barriers to effective service delivery	Recommendations to overcome
Lack of availability of services	<ul style="list-style-type: none"><li>■ Consult with women in rural communities to find local solutions to increase service availability and access.</li><li>■ Adopt a holistic, multidisciplinary team approach using a combination of public and private sector resources.</li><li>■ Assign a case manager to each woman for consistency of care.</li><li>■ Provide transport assistance to/from services.</li></ul>
Lack of knowledge, training and support	<ul style="list-style-type: none"><li>■ Encourage professional networking and mentoring.</li><li>■ Engage in distance learning for ongoing education.</li><li>■ Update online learning modules with relevant clinical information.</li><li>■ Conduct trainings on how to screen and assess substance use amongst pregnant women.</li></ul>
Difficulty recruiting staff	<ul style="list-style-type: none"><li>■ Train and retain multi-skilled workers.</li><li>■ Adopt a case managed, multidisciplinary team approach, with the appropriate use of interactive mediums.</li><li>■ When a rural worker resigns, organise an immediate replacement, ideally before the worker leaves so they can do a hand-over to the new rural worker.</li><li>■ Consider offering better employment packages; avoid short term contracts; consider alternative methods of recruitment, such as advertising interstate or internationally and developing Aboriginal identified clinical and trainee positions; Study why some towns prosper and others always have difficulties.</li></ul>
Stigma	<ul style="list-style-type: none"><li>■ Gain rapport with women and support from the community.</li><li>■ At the first antenatal presentations, engage the woman and her partner, family and/or community member or support person through a non-judgemental, professional, trusting and empathic relationship.</li></ul>
Concerns of privacy and confidentiality	<ul style="list-style-type: none"><li>■ Advise women about their right to access services confidentially, as well as the limits to confidentiality.</li><li>■ Health and welfare services may consider sending workers into communities so women can access services with anonymity.</li><li>■ Alternatively, drug and alcohol workers could arrange to meet women at a neutral location (e.g., local GP office).</li></ul>

## Caring for Pregnant Aboriginal Women with Problematic Substance Abuse Summary

Gaps In service delivery	Recommendations to address
Engaging Aboriginal women into antenatal care	<ul style="list-style-type: none"> <li>■ Offer flexible services, such as home visits.</li> <li>■ Ensure that clinical settings are culturally appropriate.</li> <li>■ Focus on continuity of care, whereby women see the same health care professional at each visit.</li> <li>■ Employ Aboriginal clinicians and trainees</li> <li>■ Employ Aboriginal workers to work in equal partnership with clinical specialists.</li> <li>■ Treat women with respect and work with their strengths.</li> </ul>
Increasing knowledge about substance use in pregnancy	<ul style="list-style-type: none"> <li>■ Provide culturally appropriate information to the wider community.</li> <li>■ Educate pregnant women in an encouraging, non-judgemental way.</li> <li>■ Acknowledge women's desires to have a healthy baby.</li> <li>■ Affirm women for positive steps they have already taken to reduce their use.</li> <li>■ Link women with specialist services.</li> </ul>
Strengthen skills through collaboration	<ul style="list-style-type: none"> <li>■ Ensure that all health professionals have access to:               <ul style="list-style-type: none"> <li>- culturally safe referral services</li> <li>- educational resources for clients, and</li> <li>- ongoing professional development.</li> </ul> </li> <li>■ Health professionals should develop their cultural understanding by completing the 'Respecting the Difference' on-line training, developing links with Aboriginal communities including having a cultural mentor</li> <li>■ Make substance control a community responsibility through community activities.</li> </ul>
Service delivery challenges	Recommendations to address
Challenging environments	<ul style="list-style-type: none"> <li>■ Work with women to:               <ul style="list-style-type: none"> <li>- identify their environmental stresses</li> <li>- equip them with ways to cope and handle stress without substances</li> <li>- address the social determinants of health e.g. housing, education, employment and other lifestyle issues, such as housing</li> <li>- develop supportive social structures</li> <li>- establish trust and continuity of care.</li> </ul> </li> <li>■ Health professionals should also work in partnership and collaborate with health providers in Aboriginal and mainstream government and non-government health services and local Aboriginal community members</li> </ul>

## Caring for Pregnant Women who are Experiencing, or at Risk of, Acute Withdrawal Summary

### Substance-dependent women who present

- Pregnant women who present intoxicated or with symptoms consistent with drug dependence (i.e., there is a risk of withdrawal) may require inpatient admission to an appropriate facility.

**When dependent drug use is abruptly ceased (e.g., during a period of incarceration or a hospital admission) pregnant women should be closely monitored for withdrawal and treated early and assertively, to decrease the risk of adverse pregnancy outcomes.**

### General considerations and assessment

- Once it is established that the pregnant woman is substance dependent and at risk of substance withdrawal, a number of factors need to be assessed and/or investigated (e.g., current substance use pattern).

### Setting of withdrawal

- It is important to determine the most suitable location for the pregnant woman's withdrawal management.
- Have a discussion with the woman about this, while keeping in mind a number of factors, such as what trimester the woman is in, the type of drug withdrawal and child protection issues.

### Withdrawal management plan and care

- A comprehensive management plan should address issues of substance use, general health, mental health and social needs.

### After withdrawal management

- Health professionals need to consider a number of options for after withdrawal management of pregnant women, including referral to a specialist team for drug relapse prevention, engaging in a short term rehabilitation program, ongoing assessments of child safety, and preparing the mother, partner and home environment for the baby's birth.

### Risks from maternal drug withdrawal

- Pregnant women, who experience acute drug withdrawal, in particular those experiencing alcohol or opioid withdrawal, are at risk of miscarriage, premature labour, and fetal hypoxia and distress.

**Many dependent drug using women experience complex health and social problems (e.g., poor nutrition, homelessness, domestic violence, mental health issues), which can add to the risk of poor obstetric outcome.**

There is the added risk of these women relapsing into substance use in order to avoid the withdrawal process.

### Polydrug use

- Polydrug use is common, therefore a woman may be withdrawing from several substances concurrently.

**Validated withdrawal tools cannot be fully relied on and assessment by a skilled clinician is essential.**

- It is not uncommon for pregnant women to under report their substance use for fear of losing their child, however once rapport with the woman has been established, it may be advisable to retake substance use history.

### More information

- Withdrawal information for specific substances is detailed in the guidelines and the summary sheets for each substance.

# Alcohol Summary

## Background information

Possible harmful effects of using alcohol:

During Pregnancy	For the Child
Miscarriage	Fetal Alcohol Syndrome (FAS) (FASD)
Still birth	Physical abnormalities
	Intellectual disabilities

## Clinical implications

- All pregnant women should be asked about their level of alcohol consumption.

**If a woman is consuming alcohol during pregnancy, then a full assessment of alcohol intake should be undertaken and appropriate referrals should be made.**

- Incorporating a validated alcohol screening tool into antenatal assessment is likely to increase the detection rate of women using excessive amounts of alcohol.

**NHMRC Guidelines (Australian Guidelines to Reduce Health Risks from Drinking Alcohol)  
Guideline 4: Maternal alcohol consumption can harm the developing fetus or breastfeeding baby.  
A. For women who are pregnant or planning a pregnancy, not drinking is the safest option.  
B. For women who are breastfeeding, not drinking is the safest option.**

- The 'standard drink' measure of 10 grams of alcohol should be used in assess alcohol consumption.
- Pregnant women consuming risky levels of alcohol should have priority access to alcohol treatment services, including assessments, withdrawal, and therapeutic options.
- Women withdrawing from alcohol should be supported with medication, nutritional and vitamin supplementation, and have access to appropriate maternal and fetal monitoring.
- Neonates whose mothers have engaged in risky levels of drinking or have given birth previously to a baby with FAS, should be assessed at birth and at six months for FASD.

**Few affected babies have clear physical signs of FAS at birth and diagnosis is difficult. In suspected cases, the infant should be reassessed and undergo intensive developmental surveillance.**

- Infants/young children who demonstrate signs of FASD should be followed up regularly in the community by an appropriately trained health professional up to at least 7 years of age.

## Aboriginal women

- Health professionals should be aware that patterns of alcohol consumption vary markedly in Aboriginal communities from non-Aboriginal Australian communities.

## Breastfeeding

- For women who are breastfeeding, not drinking is the safest option for the baby.
- For women who wish to breastfeed, the following practical advice should be given:
  - Women should avoid alcohol in the first month after delivery until breastfeeding is well established.
  - Alcohol intake should be no more than two standard drinks a day.
  - Women should avoid drinking immediately before breastfeeding.
  - Women who wish to drink alcohol should consider expressing milk in advance.
  - There is no need to express and discard milk after drinking, however a breastfeeding mother should wait until her blood alcohol returns to zero before feeding her baby.

## More information

Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599



## Tobacco Summary

### Background information

Possible harmful effects of smoking:

During Pregnancy	For the child
Miscarriage	Death from SIDS
Premature birth	Breathing illnesses and infections
Stillbirth	Poor attention and learning problems

### Clinical implications

- Not smoking early on in pregnancy will give the greatest benefit to mother and fetus.

**All pregnant women should be asked at their first antenatal assessment about smoking status to identify those who need further support to stop smoking.**

- Deciding to quit smoking at any point during pregnancy is beneficial.
- Smoking information and quit options should be encouraged by all services dealing with sexual, reproductive and child health, including at all antenatal and clinic visits.

### Start the conversation

1. Establish a rapport with the woman.

**A non-judgemental attitude and sensitive questioning by the health care worker will help to facilitate full disclosure by pregnant women.**

2. Discuss in a collaborative way the benefits/risks of smoking and deciding to stop smoking for the mother and baby. Also discuss the options and support available for quitting smoking.
3. Complete a comprehensive (or brief) assessment, which may include information about their degree of nicotine dependence, motivation to quit and barriers to cessation.
4. Assess willingness to quit and appropriate intervention. The type of intervention will depend on the woman's willingness to quit and their current tobacco use. Interventions include psychosocial (e.g., the '5 As' program) and

pharmacotherapy (e.g., Nicotine Replacement Therapy [NRT])

**Consider pharmacotherapy only after psychosocial intervention has failed.**

5. Continue to reinforce the pregnant woman's decision to quit smoking, and encourage her partner and family to also quit smoking to reduce the environmental tobacco.

### Breastfeeding

- If the mother is smoking:
  - Encourage the mother to breastfeed while encouraging her to also cease smoking.
  - Mothers should not smoke the hour before feeding to reduce the amount of nicotine in breast milk.
  - Babies should be fed and settled before the mother has a cigarette.
  - Smoking should occur away from the baby, and preferable outside of the house.
- If the mother is on NRT:
  - Encourage the mother to breastfeed.
  - As soon as possible after feeding, advise the mother to use one of the intermittent delivery methods of NRT (e.g., gum, lozenge, inhalator, mouth spray) to reduce the baby's exposure to nicotine.

### More information

- QUIT Helpline offers support services and information packs. Phone 13 7848 or visit <[www.quitnow.gov.au/](http://www.quitnow.gov.au/)>.
- Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599.

# Opioids Summary

## Background information

Possible harmful effects of using opioids:

During pregnancy	For the child
Miscarriage	Withdrawal in the newborn
Premature birth	Death from SIDS
Stillbirth	Reduced growth

## Clinical implications

- Withdrawal from opioids and opioid substitution treatment (i.e., methadone or buprenorphine maintenance) during pregnancy is not recommended.

## Opioid Substitution Treatment

- Opioid Substitution Treatment (OSTs) are safe and effective during pregnancy for both mother and neonate.
- An opioid-dependent pregnant woman should be offered a place within an OST, combined with drug and alcohol counselling and psychosocial support.

Methadone (MMT)	Buprenorphine (BMT)
<ul style="list-style-type: none"> <li>May have better retention rate in treatment</li> <li>No risk of precipitating withdrawal</li> <li>Patients with very high tolerance to opioids</li> </ul>	<ul style="list-style-type: none"> <li>Probably less severe NAS</li> <li>Reduced risk of overdose during induction</li> <li>Possibly reduced risk of overdose in women who also use sedatives</li> <li>Reduced risk of overdose if children exposed to take-away doses</li> </ul>

- Vomiting is a serious concern in pregnant women on MATOD, as vomiting of a MMT dose may lead to withdrawal in both mother and fetus. If a pregnant woman on MMT is vomiting, staff should follow protocols in place. If there is no protocol, then the prescriber should be notified.
- Transfer of a pregnant woman already on MMT to BMT is strongly advised against, but the transfer from BMT to MMT is a possibility if BMT is not proving a suitable treatment option.
- The safety and efficacy of buprenorphine-naloxone in pregnancy is not established.

**Consider whether the woman could be weaned off the opioid or if the dose could be reduced. After birth, babies must be screened for withdrawal (same period as for heroin: 7 days).**

## Breastfeeding

- Mothers who are stable on OST (both MMT and BMT) should be supported if they choose to breastfeed.
- The National Infant Feeding Guidelines recommend that not using illicit substances is the safest option when breastfeeding.
- Women who are stable on an OST, but occasionally use heroin in a 'one-off' pattern, should be advised that not using illicit substances is the safest option when breastfeeding. If they choose to use illicit substances, they should be advised to express and discard breast milk for a 24 hour period afterwards, then return to breastfeeding. They should also be encouraged to have a 'safety plan' in place for the infant on such occasions.
- Mothers who are unstable, continuing to use opioids such as heroin, or using multiple drugs, should be encouraged not to breastfeed, and attention should be paid to assisting them to stabilise their lifestyle.

## More information

- NSW Department of Health website offers information about heroin and its potential harms. Visit <[www.health.nsw.gov.au/factsheets/drugAndAlcohol/heroin.html](http://www.health.nsw.gov.au/factsheets/drugAndAlcohol/heroin.html)>. Methadone Advice & Conciliation Service (MACS) telephone helpline provides opiate pharmacotherapy information (including methadone and buprenorphine), referrals, advice and a forum for pharmacotherapy concerns. Phone 1800 642 428 (toll free) from Monday to Friday 9.30am-5.00pm.
- Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599.
- Prescription opioids, such as morphine, oxycotin, tramadol and hydrocodone, as well as illicit heroin, can be used for non-medical purposes (i.e., for their intoxicating effects). Codeine is an opioid that is available over the counter at pharmacies. Individuals who are dependent on any of these substances may benefit from Opioid Substitution Treatment (OST).

## Cannabis Summary

### Background information

Possible harmful effects of using cannabis

During pregnancy	For the child
Respiratory problems for mothers	Some evidence of developmental delays
Mood and other psychological problems for the mother	Some evidence of reduced memory and performance
Premature birth	
Longer labours	

### Clinical implications

- Women should be advised to stop using cannabis prior to, and during, pregnancy.
- Women should be offered support for cessation and relapse prevention early in pregnancy, and as a routine part of each antenatal, child health or clinic visit.

**Women who are heavily dependent on cannabis and report physical and psychological symptoms when they try to stop their drug use should be referred to their GP or specialist D&A agency.**

**Women with mood or perceptual disturbances, either from continued use or since stopping cannabis, should be referred to their GP or mental health facility.**

### Brief intervention

- As a minimum, women should be offered:
  - feedback relating to their presentation and where their cannabis use fits in
  - education regarding the impact of cannabis use
  - education regarding the short- and long-term harms to mother and fetus from cannabis use.
- If possible, it is also important to:
  - assist the woman to identify problems areas and high risk situations
  - discuss reasons and strategies for change
  - discuss withdrawal and coping with cravings
  - discuss goal setting.
- The 5 As of Intervention (Ask, Advise, Assess, Assist, Arrange) may encourage patients to quit cannabis. Psychosocial interventions should also be made available to these women.

### Breastfeeding

- There is evidence that cannabis is excreted in breast milk.
- Rather than interrupting plans to breastfeed, women should be advised that they should not take cannabis while they are breastfeeding.
- While the benefits of breastfeeding may outweigh the potential risk, in certain cases women should consider not breastfeeding if they plan to continue their high level use of cannabis.
- Further advice to women and others should be not to be intoxicated around baby and as for tobacco: that is, smoke away from the infant, out of the house, and not in the car.

### More information

- The National Cannabis Information and Helpline is a confidential information and support line for cannabis users that provides counselling, information and referrals. Phone 1800 30 40 50 (toll free).
- Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599.

# Benzodiazepines Summary

## Background information

Possible harmful effects of using benzodiazepines:

For pregnancy	For the child
Preterm birth	Low birth rate
	Withdrawal in the newborn
	Death from SIDS
	Poor neonatal outcomes

## Clinical implications

- Ideally, benzodiazepines should be avoided during pregnancy.

**For pregnant women with mood disorders or other health problems, conduct a risk-benefit assessment and consult the guidelines for the use of benzodiazepines in the general population.**

- Long-acting benzodiazepines should be avoided as much as possible.
- For severely anxious pregnant women, short-acting benzodiazepines may be considered while awaiting the onset of action of a safer drug
- The goal for benzodiazepine-using pregnant women is to be substance-free at, or before, birth.
- Polydrug use is common for people taking benzodiazepines.

**It is recommended that benzodiazepine-dependent pregnant women are transferred to a single long-acting benzodiazepine (e.g., diazepam) and their dose is gradually reduced, while receiving psychosocial support.**

- The modified Finnegan scale can be used to identify if a newborn is in withdrawal.

**Babies born to benzodiazepine-dependent women should be observed for at least one week in hospital before discharge, and have an outpatient review weekly during the first month of life.**

- During the hospital stay, parents should be educated to watch for signs of withdrawal after discharge, and encouraged to present the newborn back to the hospital if concerned.

## Breastfeeding

- The safety of benzodiazepines in breast milk is not known.
  - Short-acting benzodiazepines may be considered while awaiting the onset of action of a safer medication, but long-acting benzodiazepines should be avoided.
  - The National Infant Feeding Guidelines advise that benzodiazepines through breast milk can sedate the baby.

**Conduct a risk-benefit assessment of breastfeeding when the mother is using benzodiazepines.**

- Mothers taking benzodiazepines and wishing to breastfeed should be advised:
  - to undergo supervised gradual withdrawal of benzodiazepines rather than abruptly stopping.
  - not to breastfeed immediately after taking a dose because of the risk of her falling asleep and smothering the infant
  - if breastfeeding while drowsy, the mother should be securely seated in a chair, with the baby also well supported, so that if she falls asleep the baby will be safe.

## More information

- NSW Department of Health website offers information about benzodiazepines and its potential harms. Visit <[www.health.nsw.gov.au/factsheets/drugandalcohol/benzodiazepines.html](http://www.health.nsw.gov.au/factsheets/drugandalcohol/benzodiazepines.html)>.
- Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599

## Amphetamine-Type Stimulants Summary

### Background information

Possible harmful effects of using amphetamine-type stimulants (ATS):

During Pregnancy	For the child
Miscarriage	Reduced growth
Premature birth	Stroke or heart failure in newborn
Stillbirth	Withdrawal in the newborn
Woman may develop nutritional deficiencies (e.g., anaemia) or psychiatric illnesses	Delays in motor development
	Cognitive problems
	Death

### Clinical Implications

- Aim to identify and engage ATS exposed mothers early on in pregnancy.

**Pregnant women using ATS are likely to be polydrug users and not be engaged in D&A services.**

- Provide health education to women on the risks/benefits of ATS use and cessation, as well as other important information such as breastfeeding and safe sleeping guidelines.

**Pregnant women with a history of recent ATS use may require a medically supported inpatient setting to assist them in stopping their drug use.**

- Health professional should familiarise themselves, and other members of the team, on the adverse consequences of ATS use in pregnancy and the ongoing risk of relapse.

**Re-screen for blood-borne viral infections near birth if the woman injected drugs during pregnancy.**

- Case manage women's care and be assertive in follow-up when women fail to attend for antenatal care, including alerting clinical areas/hospitals and the partner if appropriate.

**Use of ATS are associated with mental illness, so mental health should be monitored and managed.**

- Address child safety concerns as early as possible (for both newborn and siblings).

- After birth, discourage early discharge, assess the physical and psychological health of mother and newborn, provide midwifery support, and have family/social supports in place.

### Breastfeeding

- Mothers who are stable and not using ATS should be supported if they choose to breastfeed.
- Breastfeeding mothers who use ATS rarely, or in binges, should be:
  - recommended to abstain from substance use
  - informed of the risks
  - educated in how to minimise the harmful effects to the baby, that is:
    - to express and discard the breast milk after ATS use (not to simply stop breastfeeding)
    - to have a back-up feeding plan ready for such events
    - advised not to breastfeed for 24-48 hours after the use of ATS.
- Mothers who are regular ATS users or are unstable should be advised against breastfeeding.

### More information

Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599.

# Cocaine Summary

## Background information

Possible harmful effects of using cocaine:

For the mother	For the child
Miscarriage	Reduced growth
Premature birth	Cognitive difficulties
Detrimental effects on the cardiovascular systems of the mother and fetus	Withdrawal in the newborn
	Stroke or heart failure in newborn

## Clinical implications

- The use of cocaine may be associated with increased exposure to HIV, hepatitis and syphilis from intravenous drug use and unprotected intercourse with multiple partners.
- A recent history of cocaine use, particularly intravenous use, should be taken as a marker of a high risk pregnancy.
- A pregnant woman using cocaine should be advised of the potential health risks to herself and to her baby. Women seeking further support should be provided with counselling and substance abuse treatment integrated with antenatal care.
- Children who have been exposed to cocaine in utero often respond positively to early interventions, educational interventions, and a stimulating and responsive care environment.

## Breastfeeding

- Mothers who are stable and not using cocaine should be supported if they choose to breastfeed.
- Breastfeeding mothers who use cocaine rarely, or in binges, should be:
  - recommended to abstain from substance use
  - informed of the risks
  - educated on how to avoid the harmful effects to the baby, that is:
    - to express and discard the breast milk after cocaine use (not to simply stop breastfeeding)
    - to have a back-up feeding plan ready for such events

- advised not to breastfeed for 24-48 hours after the use of cocaine, as it may be mixed with other unknown substances.

- Mothers who are regular cocaine users or are unstable should be advised against breastfeeding.

## More information

- NSW Department of Health website offers information about cocaine and its potential harms. Visit <[www.druginfo.adf.org.au/drug-facts/cocaine](http://www.druginfo.adf.org.au/drug-facts/cocaine)>.
- Alcohol and Drug Information Service (ADIS) is a 24-hour confidential information, advice and referral telephone service for all substances. If in Sydney, call 02 9361 8000. If in regional NSW, call 1800 422 599.

## Inhalants Summary

### Background information

Inhalants are household, industrial or medical products that are inhaled to produce psychoactive (mind-altering) effects. Although research is limited, possible harmful effects of using inhalants:

During pregnancy	For the child
Premature birth	Low birth weight
	Developmental delays
	Growth delays

### Clinical implications

- Health care workers undertaking antenatal screening must be aware of the risk level of inhalant use in their local community and screen accordingly.
- An abstinence syndrome has been observed in infants born to mothers known to be volatile substance users during their pregnancy. This consisted of a characteristic odour (reflecting pulmonary excretion of the volatile substance), excessive and high-pitched crying, sleeplessness, hyperactive Moro reflex, tremor, hypotonia and poor feeding.

**Neonates born to mothers abusing volatile substances should be monitored for withdrawal as scored with the Finnegan Neonatal Abstinence Scoring (FNAS) system.**

TWENTY ONE

## Management of Neonatal Abstinence Syndrome (NAS) Summary

### Detecting NAS

- Infants of all mothers taking opioids or other drugs of dependence associated with NAS for a prolonged period during pregnancy should be monitored for NAS (hospital stay of at least 5 days after birth).

### Measuring opioid NAS

- Use the Finnegan or the modified Finnegan scale to assess opioid NAS.

### More information

For more information, see the Neonatal Abstinence Syndrome Guidelines GL 2013\_008  
[http://www0.health.nsw.gov.au/policies/gl/2013/GL2013\\_008.html](http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_008.html)









