

Substance use in pregnancy

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General principles

"This section draws on National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn (2006) published by the Australian Government, and is used with permission. The text has been revised to take into account South Australian circumstances, and the new text may not necessarily reflect the views of the Australian Government".

Drug use information for all women of child bearing age

The adverse effects on fetal development of alcohol and other drugs such as tobacco, psychostimulants and opioids are well known. Women who are pregnant or who may become pregnant are therefore a high priority for interventions to reduce drug use. It is also possible that women may be more prepared to change drug using behaviour if they are pregnant or may become pregnant, which can improve the success of appropriate interventions. Prevention programs should target all women of child-bearing age, including those still at school. All women need to know the risks associated with drug use. In assessing a young, pregnant woman, where episodic binge use or regular drug use may be an issue, it is important to consider the woman's social supports and emotional well-being as well as drug use. Information about drug use and its effects may be provided by a range of services, including general practitioners, women's health providers, maternity services, Aboriginal health services, public health information services or schools.

Level of evidence: Consensus

Care of all drug-dependent women of child bearing age

These guidelines are intended for use by all health care practitioners working with pregnant women who have a drug or alcohol use problem, particularly drug dependency, but including other drug uses such as bingeing. The guidelines recommend that pregnant women with problematic drug or alcohol use will benefit from:

- > appropriate referral to specialist assessment and help, such as a drug and alcohol specialist, in addition to midwifery and obstetric care
- > appointment of a case manager and care team who remain consistent throughout the pregnancy
- > specific treatments for their drug use, which may include counselling, pharmacotherapies and relapse prevention.

Contraception

Exposure to drugs and alcohol may have a serious effect on the fetus in the very early stages of pregnancy, particularly before the first missed period. Therefore, all women with problematic drug or alcohol use should be provided with advice on contraception. This will facilitate planned rather than unplanned pregnancies, and reduce harm to the unborn child.

Vertical transmission of blood-borne viruses

Before pregnancy it is important that all drug-dependent women of child-bearing age receive information about vertical transmission of blood-borne viruses, specifically:

- > preventing transmission
- > management after infection
- > implications for pregnancy
- > implications for breastfeeding

Mental health issues

ISBN number:
Endorsed by:

UNKNOWN

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Mental health in women who use drugs or alcohol is important at all stages of pregnancy. The two most important responses from health care workers are to:

- > recognise signs of mental illness (particularly psychosis, suicide risk, risk of harm to fetus or baby, postnatal depression) and
- > refer appropriately to specialist services. See coexisting mental health and drug and alcohol use issues

Confidentiality

Confidentiality is a fundamental right of all people using health care services. In all communications it is important to work within the privacy legislation and local guidelines to ensure privacy and confidentiality are maintained. In regard to people who use drugs or who have infectious diseases (especially blood-borne viruses), confidentiality takes on a particular significance because of the social stigma attached to these conditions.

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. Professionals with the requisite knowledge and supervised experience in this work may include social workers, psychologists, drug and alcohol clinicians and counsellors, Aboriginal health workers, child protection workers, medical staff, nurses and midwives who work in specialist maternity units of drug treatment services. The contact details of specialist support services should be readily available for pregnancy care providers, including after hours contact details, especially where multidisciplinary pregnancy care is not available. Refer to multi-agency collaboration.

Child protection

All State and Territory jurisdictions have specific legislation with regard to child protection. Although drug and alcohol use alone may not be an indicator for a child protection report or notification, child protection is a consideration in all drug and alcohol interventions for pregnant women. Legislation requires that the safety and well-being of the child is a paramount consideration. Refer to child protection issues.

Specific drugs in pregnancy

ISBN number:
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UNKNOWN

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Alcohol

Harmful effects of alcohol

Alcohol is known to have teratogenic effects. Drinking alcohol while pregnant increases the risk of problems in fetal development, but the level of drinking which causes significant fetal problems is not known. In this document, the term 'fetal alcohol spectrum disorder' (FASD) is used to indicate the full range of possible effects of fetal exposure to alcohol, while the term 'fetal alcohol syndrome' (FAS) will be used to indicate the severe effects, characterised by brain damage, facial deformities, and growth deficits.

Advice on drinking alcohol in pregnancy

All pregnant women should be given information on the risks associated with drinking alcohol during pregnancy and advised that no completely safe level of alcohol consumption has been determined for the fetus.

Level of evidence: Consensus

Comment: The Australian Alcohol Guidelines note that the first few weeks after conception, before the first missed period, are probably the most crucial in relation to alcohol. At that time it is unlikely the woman will know she is pregnant, particularly if the pregnancy is unplanned. For this reason, there is a strong need for education about safe drinking for all women of child bearing age, including young women still at school. This education should include a discussion of the risks of binge drinking as well as other patterns of drinking. From Australian Alcohol Guidelines: Health Risks and Benefits (NHMRC, 2001, p.16). Available from URL: http://www.nhmrc.gov.au/publications/synopses/_files/ds9.pdf

NH&MRC GUIDELINE 11: Women who are pregnant or might soon become pregnant

- > may consider not drinking at all.
- > most importantly, should never become intoxicated.
- > if they choose to drink, over a week, should have less than 7 standard drinks, AND, on any one day, no more than 2 standard drinks (spread over at least two hours).
- > should note that the risk is highest in the earlier stages of pregnancy, including the time from conception to the first missed period.

See also Appendix 8: Australian Alcohol Guidelines: pregnancy and breastfeeding for more information.

Comment: These guidelines currently concur with the national guidelines developed by the NHMRC for alcohol consumption by pregnant women, although it is noted that the NHMRC guidelines do not classify a level of evidence to support its recommendations. An abstinence-based approach is not recommended, in part because it could result in disproportionate anxiety among women with an unplanned pregnancy, many of whom consume some alcohol before they know they are pregnant, but usually without harmful consequences for the infant. Anxiety about alcohol consumption has sometimes resulted in precipitous decisions to terminate

a pregnancy (National Report Fetal Alcohol Syndrome National Workshop 2002). The 'standard drink' measure of 10 g of alcohol should be used in assessing the level of alcohol consumption. This measure should be explained to the woman and her partner if present.

Level of evidence: Consensus

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Antenatal care

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Continuity of care and of carers

Continuity of care and of carers is now accepted in Australia as best practice for all pregnant women. All pregnancy care providers and maternity services should be aiming to provide continuity of care for all pregnant women, regardless of their background. Multidisciplinary teams working collaboratively can achieve optimal pregnancy, birth and parenting outcomes for each woman and her family. A multidisciplinary team can include 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 regardless of the venue for providing this care. Continuity of care, and of caregivers, takes on added importance for vulnerable groups, such as women with drug and alcohol use issues. Continuity of care is established by:

- > effective engagement skills, including cultural awareness skills
- > an effective system which 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.

Level of evidence: Consensus

Comment: Pregnant women with drug and alcohol use issues do not always engage easily with mainstream health care. Continuity of care and of carers during and after pregnancy will assist in ensuring adequate care. This will minimise the number of women and infants being lost to follow up within complex health services. Aboriginal and Torres Strait Islander 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.

Level of evidence: Consensus

It is recommended that clinical interventions with Aboriginal and Torres Strait Islander pregnant women be guided by the six common principles identified by the Ministerial Council on Drugs Strategy (2003–2006) for addressing substance use by Aboriginal and Torres Strait Islander peoples. These are:

- > 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 wellbeing, community development and capacity building.
- > Local planning is required to develop responses to needs and priorities set by local Aboriginal and Torres Strait Islander communities.
- > Culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples must be developed, implemented and evaluated.

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- > Aboriginal and Torres Strait Islander peoples must be centrally involved in planning and implementing strategies to address use of alcohol, tobacco and other drugs in their communities.
- > Aboriginal and Torres Strait Islander 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 and Torres Strait Islander peoples. (Ministerial Council on Drugs Strategy 2003–2006)

Level of evidence: Consensus

Engagement

The first antenatal presentation, wherever and whenever that may occur (including in Accident and Emergency after hours, or presenting for the first time in labour), is an opportunity to engage the pregnant woman and her family in pregnancy care that will ideally continue through the birth to postnatal and early childhood care.

Level of evidence: Consensus

Comment: Drug-dependent pregnant women, like other vulnerable populations, may be difficult to engage and maintain in pregnancy care. Each presentation of a drug dependent pregnant woman to a health care service, including after hours presentations, is an opportunity to engage the woman effectively in care. The aim of engagement is to establish a professional, trusting and empathetic relationship in which the woman will feel encouraged to continue pregnancy care. Successful engagement may rest on the quality of the relationship established with the woman by the health care providers she meets.

Level of evidence: Consensus

Comment: The aim of this relationship is for the woman to feel safe, to build trust in the health care providers, and to empower her to seek what is best for her health and the health of her unborn baby. The maxim to ‘inform and advise about risks’ may not be a sufficient intervention for a drug-dependent pregnant woman. The quality of the relationship between the woman and the health care provider is a very significant factor in maintaining the woman in care. While information must still be provided, a ‘partnership model’ is considered more appropriate in the relationship between a drug-dependent pregnant woman and her health care providers.

Level of evidence: Consensus

Engagement is a prerequisite to care being provided. Failure of engagement may result in loss of that woman to follow-up, with less than optimal outcomes for the woman and infant. Engagement of vulnerable groups into care requires specific skills and experience of clinicians. All clinicians need training in the specific skills required to engage vulnerable groups in care.

Level of evidence: Consensus

Engagement skills

Engagement skills include:

- > An understanding of one’s own values and beliefs in a way that results in non-judgemental attitudes to people in care.
- > An awareness that drug and alcohol use is not isolated from other psychosocial and cultural factors.
- > Commitment to providing optimal and timely health care for every individual.

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- > An understanding of addiction as a health care issue and not an issue for moral, social or other judgements.
- > An ability to create an environment that is safe and ensures privacy and confidentiality.
- > An understanding of potential barriers to the woman accepting pregnancy care, and strategies for overcoming them.
- > Acknowledgement of the woman's feelings and perceptions.
- > An understanding that disclosing drug and alcohol use in pregnancy is difficult.
- > An understanding of the significance of establishing and sustaining a sound and trusting professional relationship with women with drug and alcohol issues.
- > Awareness that women with drug and alcohol issues often have a number of service providers involved in their lives.

Aboriginal and Torres Strait Islander women

Priority should be given to providing Aboriginal and Torres Strait Islander cultural awareness training to all maternal and child health care providers and drug and alcohol service providers. This is fundamental to the delivery of respectful and effective health care and should address the impact of colonisation and dispossession on the health status of Aboriginal and Torres Strait Islander people.

Level of evidence: Consensus

Comment: Cultural sensitivity and awareness are key skills of engagement, particularly when engaging Aboriginal and Torres Strait Islander Peoples in care. Training is required to develop these skills in the health care workforce.

Literacy

Health care workers need to be aware that low literacy reduces access to health information and this in turn affects people's ability to practise a healthy lifestyle. Many (although by no means all) women with drug or alcohol use issues have other social disadvantages, and this may include low literacy. Therefore all information should be provided verbally as well as in writing, and discussed with the woman (and her partner) to ensure understanding.

Level of evidence: Consensus

Women from culturally and linguistically diverse (CALD) backgrounds are not necessarily literate in their first language. The extent to which a woman received school education may depend on the country of origin and the age at which she emigrated. Therefore it is not enough to provide information brochures in the spoken language. A professional health care interpreter should also be used.

Level of evidence: Consensus

Screening

General screening for drug and alcohol use should be included in the usual antenatal history. All pregnant women should be asked for their current and previous history of drug and alcohol use at initial assessment (time of confirmation of pregnancy, at first booking-in visit, or first presentation), to help decide the appropriate model of pregnancy care or provider. This screening should be repeated at periodic re-assessment. Simple questions about what drugs have been used from the time of conception (or earlier if possible) are appropriate for screening. Ask specifically about:

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- > prescribed medications (including opioid replacement therapies)
- > over the counter medications e.g. paracetamol
- > alcohol
- > tobacco
- > other substance use (this may include cannabis, stimulants (speed, ecstasy, cocaine), opioids, inhalants and unprescribed use of benzodiazepines).

It is important to establish the pattern and frequency of use, determining whether each substance is used occasionally, on a regular recreational or non-dependent basis or whether there is habitual, regular or dependent use. From a child protection perspective, regular, daily or near daily use and binge use are of most concern (see Child protection issues). It is also important to establish whether there are patterns of concurrent or serial use of different substances. In this interaction with the woman, clinicians should avoid expressions that may be interpreted as judgemental, such as 'addict', as these may undermine the trust and openness crucial to obtaining an accurate history and for retaining the woman in continuing care.

Level of evidence: Consensus

Comment: The information provided about drug and alcohol use as much as three months before conception provides insight in regards to the maternal drug use at conception, and is particularly relevant in the development of fetal alcohol syndrome.

Information about most prescribed medications may be obtained from designated agencies in each State or Territory (see Appendix 2: Advice for consumers on drugs, alcohol and medications)

Screening for alcohol

All pregnant women should be asked about their level of alcohol consumption. If women are drinking over the recommended NH&MRC levels during pregnancy, then a full assessment of alcohol intake should be undertaken and appropriate referrals should be made. A validated screening tool such as T-ACE, TWEAK or AUDIT should be used.

Level of evidence: Consensus

Comment: Incorporating a validated alcohol screening tool into antenatal assessment is likely to substantially increase the detection rate of women using excessive amounts of alcohol. No specific screening tool is recommended, but if one is used, it should be a validated and reliable tool. T-ACE and TWEAK are validated and reliable tools that have been developed for use with pregnant women. However, they may not be useful with lower levels of drinking that may still be risky in pregnancy (as defined in the Australian Alcohol Guidelines). AUDIT is a validated tool, but is not designed specifically for use during pregnancy. The relationship established between the pregnant woman and the health care worker may influence the woman's willingness to disclose alcohol use and hence health care workers should seek this information in a sensitive and empathetic manner.

Screening for tobacco

The first step in treating tobacco use and dependence is to identify tobacco users and recent quitters. Identifying smokers itself increases rates of clinical intervention. Effective identification of smoking status guides clinicians to identify appropriate interventions based on the individual's current tobacco use and willingness to quit.

Level of evidence: Consensus in Fiore et al 2000

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

Level of evidence: I (Cochrane review: Lumley et al 2001)

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Comment: Smoking during pregnancy carries a social stigma, and clinicians must bear this in mind when asking pregnant women about smoking. Effective engagement skills and sensitive questioning by the health care worker are believed to facilitate accurate disclosure by pregnant women. There is strong evidence that written questionnaires that provide the opportunity for multiple-choice responses to the question about smoking status, rather than simple yes/no options, including the options 'I used to smoke' and 'I have cut down', are more likely to provoke accurate disclosure of smoking status.

Level of evidence: II (Melvin et al 1994)

Screening for inhalants

Routine screening for inhalant use is recommended for all pregnant women identified as being at risk of inhalant use. Risk level varies between urban, rural and remote communities. Health care workers undertaking antenatal screening must be aware of the risk level in their local community, and screen accordingly.

Level of evidence: Consensus

Urine drug screening for illicit drugs

Pregnant women should have urine drug screens no less often than other women in similar circumstances (e.g. when in an opioid treatment program).

Level of evidence: Consensus

Comment: The efficacy of urine drug testing for pregnant women is unclear. There is some evidence that within a trusting professional relationship, self-disclosure of drug use may be reliable.

Screening for blood-borne viruses

It is cost effective to screen all drug-dependent pregnant women for blood-borne viral infections early in pregnancy, particularly where evidence supports the benefits of interventions to reduce the risk of vertical transmission to the newborn.

Level of evidence: Consensus

All screening for blood-borne viruses must be conducted with the informed consent of the woman, and with appropriate pre-test and post-test counselling.

Level of evidence: Consensus

Screening for human immunodeficiency virus (HIV)

It is cost effective to screen for HIV infections, even in a low prevalence population such as Australia's.

Level of evidence: III-3

Screening for hepatitis C virus (HCV)

Routine testing for blood-borne viruses including HCV is recommended for all pregnant women identified as having been at risk of transmission. The main risk factor is a history of injecting drug use, even when this has been infrequent or a long time in the past. Other risk factors include being born or raised in countries with high prevalence of HCV, blood transfusion before 1990, tattooing, and occupational exposure.

Level of evidence: IV

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Comment: HCV may be transmitted from mother to baby during childbirth. No strategies have yet been shown to reduce this risk. The risk is increased by HIV co-infection, although HIV antiretroviral therapy can mitigate this effect. At the present time, HCV cannot be treated during pregnancy. Accordingly, the benefits of identifying this infection during pregnancy are indirect. Pregnancy is a point of contact with the health care system, during which women receive blood tests and medical review. If an HCV antibody test is positive, further investigation is required to determine viral status (e.g. HCV PCR test). Liver function tests should also be conducted.

Screening for hepatitis B virus (HBV)

Irrespective of drug history, all pregnant women should be tested for hepatitis B surface antigen. Passive immunisation of the infant is particularly effective in reducing the risk of vertical transmission.

Level of evidence: Consensus

Clinical considerations

Liver disease and cirrhosis place severe stress on mother and baby. Regardless of viral hepatitis status, patients with clinically evident liver disease should be referred to an appropriate liver specialist or centre for management.

Level of evidence: Consensus

Comprehensive drug use assessment and treatment planning

If there is a history of drug use, referral to a skilled provider may be required for a comprehensive assessment to:

- > Ascertain whether the woman is or may be drug dependent.
- > Inform the woman of the known risks in pregnancy of the particular drug(s) used, emphasising the potential for harm.
- > Inform the woman about her options for specialist care, drug and alcohol counselling and treatment options. Initiate referrals according to her decision.

Level of evidence: Consensus

Comment: If it is possible and will not compromise engagement, these issues can be discussed at the first presentation. If it is not possible at that visit — for example, if the woman is intoxicated or distressed by symptoms of withdrawal — a full assessment of drug use must be undertaken early in the pregnancy, over the next one or two visits. Clinicians will use their skills and experience in making decisions about the most appropriate timing for gathering this information.

See Appendix 3: Examples of drug use assessment tool.

Partner / support person

From the first visit the partner (or support person and family if relevant) will be included in all stages of care, including discussions about drug use, provided that the woman's informed consent has been obtained before any discussions in front of others. Informed consent requires full disclosure of what will be discussed with others.

Level of evidence: Consensus

Comment: It is appropriate to offer interventions to the woman's partner if that person has problematic drug or alcohol use. A partner's drug use increases the woman's risk of continuing or relapsing to drug use.

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Psychosocial assessment

Planning for discharge should commence at the first antenatal visit. Psychosocial assessment for discharge planning should consider:

- > financial issues and poverty
- > inadequate or inappropriate housing (or homelessness)
- > domestic and intimate partner violence
- > sexual abuse and assault
- > relationship issues
- > legal issues
- > previous history of child protection issues
- > a history of mental illness.

The woman must be supported to address psychosocial issues that may affect outcomes of the pregnancy or result in an avoidable separation of mother and baby due to child protection requirements. Support needs are likely to vary according to the stage of pregnancy or parenting and may include material assistance, practical support, emotional support and support to establish non-drug using networks, as well as drug use interventions. Counselling and other support should be initiated early in pregnancy.

Level of evidence: Consensus

Coexisting mental health and drug and alcohol use issues

All health care workers involved in pregnancy care must be able to recognise signs of serious mental health problems, specifically:

- > anxiety and depression
- > psychosis (including delusions and hallucinations)
- > suicidal or self-harming ideation or planning
- > unsafe ideas, plans or behaviour towards the fetus, infant or other person.

In such cases, the health care worker must

- > Refer urgently to a specialist psychiatric service for assessment and advice (for example, a liaison psychiatry team).
- > Where urgent referral is not an available option (such as in remote areas), seek expert advice from a specialist psychiatric service. Such services are available in each State and Territory by telephone.
- > Ensure that the woman is safe while awaiting consultation. This may include a staff member remaining with the woman to ensure her safety and the safety of the fetus or infant.

Health care services should ensure that these procedures are familiar to all clinicians working with pregnant women.

Level of evidence: Consensus

Comment: 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

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after the birth. It may require drug information be included in the woman's medical chart (especially for women who are on antipsychotic, mood stabilising or antidepressant medications). Symptoms of mental health problems may not be obvious without a mental health assessment or questioning, in which not all midwives may be skilled. (This is an area suitable for workforce development)

Ongoing assessment and treatment planning at each visit

As the pregnancy progresses, the following issues must be reviewed at each appointment:

- > compliance with care and counselling
- > maternal and fetal wellbeing
- > drug, alcohol and tobacco use
- > drug, alcohol and tobacco use of partner and others in the same house
- > socioeconomic circumstances and psychosocial issues (poverty, homelessness, domestic violence)
- > mental health
- > (if relevant:) withdrawal symptoms and dose of pharmacotherapy.

Level of evidence: Consensus

Comment: The quality of antenatal care may significantly affect neonatal outcomes. Refer to Management of neonatal abstinence syndrome (NAS).

Multidisciplinary team

A skilled multidisciplinary team is ideal to provide care for the drug-dependent pregnant woman. Such a team consists of specialists and generalists relevant to each woman's situation. These might include (but are not limited to) a general practitioner, midwife, obstetrician, anaesthetist, social worker, drug and alcohol specialist doctor, psychologist, psychiatrist, mental health worker, drug and alcohol worker, dietician, Aboriginal health worker, paediatrician, early childhood worker, lactation consultant, or probation and parole officer. Where such multidisciplinary care is not available, women with complex drug and alcohol use issues will require transfer to a centre able to provide such care or liaison with a specialist under a shared care arrangement.

Level of evidence: Consensus

Aboriginal and Torres Strait Islander women

In both urban and remote areas, Aboriginal health workers, Aboriginal liaison officers and Aboriginal health education officers are integral members of the primary health care team providing clinical care, health education and liaison services between Aboriginal women, hospital services and community-based services.

Level of evidence: Consensus

Multi-agency collaboration

In some circumstances, a collaborative response from more than one agency may be of benefit to mother and family. The multi-agency response may include drug and alcohol services, family support services, child protection services, Aboriginal medical services, general practitioners, probation and parole services, and community welfare organisations.

Level of evidence: Consensus

Comment: Such an approach requires coordination which can be undertaken by the case manager.

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Aboriginal and Torres Strait Islander women

Wherever possible, Aboriginal and Torres Strait Islander pregnant women with drug dependencies should be referred to an Aboriginal Medical Service (AMS), or a primary health care service which provides culturally appropriate care. This will assist in ensuring that multidisciplinary care is provided before, during and after pregnancy, and during the early childhood years. Where women choose care or require care in a maternity service or tertiary centre, shared care should be considered, with referral to an Aboriginal support worker.

Level of evidence: Consensus

Allocating case manager or care coordinator

To ensure continuity of care and adequate risk management, a case manager should be appointed to oversee the woman's care and liaise with other members of her care team. There must be absolute clarity about who is the primary case manager. It must be clear to the woman, to the rest of the team, and to the case manager. The woman must be provided with contact details for the case manager and care team. Refer to Communication.

Level of evidence: Consensus

Comment: Without a definite case manager, continuity and consistency of care is difficult to achieve. Variations occur in different State and Territory jurisdictions with regard to the discipline of the case manager, who may be a midwife, nurse, general practitioner, Aboriginal health worker, psychologist, social worker, or private obstetrician. Variations also occur in how the case manager is allocated. The case manager should be proactive in the care of the woman, for example, following her up assertively (but respectfully) if she does not attend appointments. The case manager participates in regular team meetings and case conferences and provides a formal hand-over to those caring for the woman and infant during the birth and postnatal period. If the woman is in an opioid treatment program, there should be close liaison with the pharmacotherapy prescriber and / or dosing point.

Written care plan

A plan of care will be formulated in conjunction with the woman (and partner or support person if relevant). The plan should be written and readily available to other health workers (such as in the case notes), particularly if the woman presents out of hours. The plan must be reviewed regularly with mother, who should have a copy.

Level of evidence: Consensus

Comment: The woman must be involved in formulating and reviewing the plan for it to be meaningful to her, and for her to be committed to participate in it.

Communication

Pregnant women who engage in risky drug or alcohol use may access pregnancy care only intermittently. To support the woman to remain in care, systematic communication strategies and protocols should be established between members of the pregnancy care team. The woman and all the team members need to know each person's role and contact details. The case manager will play a key role in keeping everyone informed (see Allocating case manager or care coordinator).

Level of evidence: Consensus

Comment: Regular case conferences are an example of a systematic communication strategy.

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Preparation for discharge

Discharge planning with the woman and her identified support people must begin at the first antenatal presentation. Involving the woman and the family in the care plan will facilitate progress in the postnatal period. The potential need for postnatal residential care for some mothers and babies should be considered and planned before the birth as residential care places may be in short supply.

Level of evidence: Consensus

Comment: Some pregnant drug-dependent women may have immediate issues or a chaotic lifestyle that make discharge planning seem irrelevant. In these situations the priority must be to help such women stabilise their lives to enable planning for the future.

Preparation for the birth and the postnatal period

Preparing for the birth and the postnatal period will include the usual antenatal preparations and childbirth education, with particular consideration of the following issues:

Birth

- > options for pain relief, particularly for opioid dependent women (see Labour and birth)
- > timing and mode of birth, taking account of the risk indicators present, such as presence of HIV (see Vertical transmission of blood-borne viruses)
- > advisability of presenting early in labour to minimise the need for self medication and to monitor drug use.

Postnatal period

- > choices for infant feeding
- > risks and benefits of breastfeeding, taking into account drug and alcohol use, medications, and the presence of blood-borne viruses (refer to Breastfeeding)
- > neonatal abstinence syndrome and treatment options (particularly for the opioid-dependent mother)
- > possibility of extended hospital stay for the infant and mother
- > safe sleeping practices and risk factors for sudden infant death
- > the effects of environmental tobacco smoke (refer to Environmental tobacco smoke and Breastfeeding)
- > parenting education, and the option of participating in classes tailored for drug-dependent women
- > issues around the safety of the home environment, particularly with regard to safe storage of any medications kept in the home, including methadone take away doses.

Level of evidence: Consensus

Late presentations

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. Although each individual's situation is unique, and may not include drug or alcohol use, if possible the preferred management is:

- > Admit to hospital (regardless of drugs used).
- > Undertake comprehensive assessment, including history of drug and alcohol use.
- > Develop a detailed management plan including liaison with the general practitioner or community health professional and plans for discharge.

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- > If indicated by the woman's history (such as dependence or binge use), initiate or refer for drug and alcohol treatment (including pharmacotherapy) or counselling (according to the woman's wishes).

Opioid-using women presenting for the first time in labour require an urgent assessment of their level of opioid tolerance and dependence, as this will have immediate significance for managing analgesia during labour and for managing neonatal withdrawal syndrome. Reassuring the woman that she will be treated in a non-judgemental, compassionate manner is of great importance and may assist in securing her willing participation in antenatal care.
Level of evidence: Consensus

Comment: There is a relationship between antenatal care and infant well-being. Late presentation in pregnancy may indicate an infant at risk of neonatal abstinence syndrome (see Management of neonatal abstinence syndrome (NAS)).

Oral health and risk of preterm birth

There is some evidence that periodontal disease may increase the risk of preterm birth. For this reason, and until conclusive evidence becomes available, pregnant women should be given priority access to dental care. Dental infections during pregnancy should be treated aggressively by the health service dental health team.

Routine dental scraping is not recommended as this may release bacteria into the circulation.
Level of evidence: Consensus

Comment: Opioid-dependent pregnant women may be unaware of pain associated with caries or infection and hence not present for treatment of dental problems until infection is established.

Child protection issues

Child protection is governed by the States and Territories, not the Commonwealth. Health professionals in each jurisdiction are advised to consult their relevant local legislation.

Assessing infant safety

An assessment of risk to the fetus or infant should be made by the health care professional working with the family, according to the mandated notification system in each State or Territory. This assessment should be made early in the pregnancy and continue throughout the pregnancy and postnatally.

Level of evidence: Consensus

Comment: While operating within the statutory framework of each State or Territory jurisdiction, clinicians should bear in mind that fear of possible intervention by child protection authorities can be a significant obstacle to the willing participation in antenatal and postnatal care of women with a history of drug use. Whatever reassurances and involvement can be honestly given to the woman will be useful in maintaining trust and in alleviating anxiety.

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Reasons to notify

Child protection agencies are notified when there is considered to be risk of harm or neglect to a fetus (in jurisdictions where legislation supports reporting before birth) or infant. Reasons for notification will be itemised in the legislation and protocols in each jurisdiction, but generally include one or more of the following:

- > late presentation for antenatal care
- > polydrug use (including women not using any illicit drugs, but risky levels of tobacco and alcohol)
- > ongoing drug and alcohol use with severe mental illness
- > unstable living arrangements or homelessness
- > suspected abuse
- > suspected domestic violence
- > concerns regarding parenting practices such as being in care of an infant when substantially affected by drugs or alcohol.

Level of evidence: Consensus

Comment: All health and service providers should be alert to the need for intervention, including possible child protection notification, if the baby or developing child is considered to be at risk of harm. Risk may become more evident after discharge from hospital. Providers also need to consider the wellbeing of other children of the mother and her partner. If the statutory child protection agency is notified of a child at risk, the health care team should liaise closely with the agency throughout the pregnancy and the postnatal period. The mother should be informed of the notification unless doing so would increase the risk of harm to the infant. At appropriate points (such as before discharge), case meetings should be conducted. These meetings will aim to establish an agreed plan of care for the infant, and will include the mother/parents and their advocates (such as an Aboriginal health worker), as well as the child protection worker, health care providers, and representatives of all agencies involved in the care of the family. At each meeting, a time frame for review of the plan should be determined.

Level of evidence: Consensus

Families about whom no notification has been made will be followed up as usual by the early childhood services in each State or Territory.

Level of evidence: Consensus

Labour and birth

Obstetric care for women with drug and alcohol use issues is provided by midwives and obstetricians who are part of the multidisciplinary team providing overall care for these women during their pregnancy

Monitoring fetal growth

There is an increased risk of reduced fetal growth (intrauterine growth restriction) in women who use drugs and alcohol. Standard assessment by measuring symphysis fundal height in centimetres is an adequate measure of fetal growth. If that measure indicates inadequate fetal growth, then the usual obstetric protocols for biophysical monitoring of reduced fetal growth should be followed.

Level of evidence: Consensus

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Out of hours emergency presentations

It is not unusual for pregnant women who use drugs or alcohol to present in crisis to emergency services after hours, either intoxicated, or in withdrawal, or for social reasons such as homelessness or violence. Each health care service requires clear protocols to manage these situations so that women are not lost to follow-up. The protocols should include which practitioner is to be notified, and clear guidelines on stabilisation and psychosocial management. Jurisdictional legislation and guidelines to ensure safety must be adhered to.

Level of evidence: Consensus

The comments below on managing withdrawal and intoxication in pregnancy should guide protocol development. They are also intended to guide practitioners in the absence of local protocols.

Withdrawal

In the event that the woman is withdrawing from drugs, the protocol should specify the following steps:

- > Admit the woman as an inpatient.
- > Undertake thorough assessment, including drug use history and physical signs and symptoms of withdrawal.
- > If the woman is withdrawing from heroin or other opioid drugs, a thorough recent drug use history must be taken because of the risk of overestimating or underestimating opioid tolerance. The history taken also informs decisions about opioid replacement therapy (if indicated).
- > Ascertain whether the woman is in an opioid treatment program. If so, contact the prescriber, clinic or dosing point to find out:
 - > the woman's current dose
 - > whether she has had her dose that day yet
 - > whether she has received takeaway doses.
- > If it is confirmed that the woman is opioid dependent but not in an opioid treatment program, and if, after discussion, she gives her informed consent, she should be inducted into methadone maintenance according to the local State or Territory policy for inpatient induction. This protocol should allow for more rapid induction than outpatient induction, but with close monitoring.
- > Legislation and protocols of the local State or Territory must be followed.
- > Commencing the woman onto methadone maintenance should be done in consultation with a drug and alcohol medical specialist.
- > Methadone is always administered in liquid when treating addiction.
- > The dose of methadone should be titrated to the woman's symptoms with rapid increases. The starting dose (inpatient) should be 20 mg, reviewed at 4 hourly intervals. At each review, if the woman has objective signs of withdrawal (e.g. pupils big, restless; see Appendix 4: Examples of assessment scales for opioid withdrawal in adults), then give an additional 10 mg. If there are no signs of withdrawal, no extra dose is given until the next scheduled review. The maximum dose in the first 24 hours should not exceed 50 mg. Thirty (30) mg should be more than enough for most women, but rarely higher doses will be necessary, and up to 40 mg or even 50 mg could be required in exceptional cases on day 1. Extreme caution should be exercised when assessing the patient's requirements on subsequent days if a dose of over 30 mg is used on day 1, in order to prevent accumulation and possible toxicity from methadone on subsequent days, when this is most likely to occur.
- > The same process should be repeated on Day 2 (when the woman will almost certainly require less methadone), commencing again with 20 mg in the morning, and giving additional aliquots of 10 mg as required up to a maximum of 50 mg. If at any

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time the woman becomes sedated (small pupils, drowsiness), increase frequency of observation and ensure that no methadone is administered until sedation is reversed. By Day 3, a reasonable idea of the required total daily dose will have been established. If prescribing the dose as a split dose, give 2/3 in morning, 1/3 in afternoon.

- > Depending on local protocols, the assessment of opioid withdrawal may be undertaken by a specialist, a nurse, or a junior medical officer. Health care staff without experience in assessing opioid withdrawal should, in the first instance, seek expert advice, including telephone advice. Staff who are unable in the short term to access expert assistance should refer to Appendix 4: Examples of assessment scales for opioid withdrawal in adults.
- > In rural areas, rapid inpatient induction to methadone treatment as described above should be used as an acute measure until a review can be arranged by the local drug and alcohol unit. Ideally this should take no longer than 3 days. When the delay in full assessment will be longer than 3 days, services should consider transporting the woman to a unit with the appropriate expertise to provide this care.

Intoxication

In the event that the woman is intoxicated, the progress of the pregnancy and the condition of the fetus should be assessed by the obstetric team. If possible, initial assessment of the fetus should be by auscultation of the fetal heart and cardiotocograph (CTG), with followup ultrasound as considered appropriate. A decision to admit will depend on circumstances, including the gestation (how late in the pregnancy it is), whether there has been any antenatal care or investigations, potential domestic violence, homelessness, concurrent health issues and other risk factors. If the service cannot assess and manage the woman, she should be transferred

to a centre which can. If the woman is not admitted, appropriate support services and referrals, including pregnancy care follow-up, should be arranged.

Level of evidence: Consensus

Early admission in labour

It is suggested that women be advised to attend hospital early in spontaneous labour. If elective induction of labour or caesarean section is planned and the woman has complex or unstable drug or alcohol use, the time of admission will need to allow for assessment and stabilisation before the surgery or induction.

Level of evidence: Consensus

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

Women on an opioid treatment program

When a woman on a methadone (or buprenorphine) program presents to give birth, local State or Territory laws with regard to prescribing and administering the drugs must be met. Some jurisdictions may require transfer of the permit to prescribe opioids from the usual

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prescriber to the hospital. It is important that the labour unit (or other relevant staff) know the correct protocol, which must include the following:

- > Inform the usual dosing point (whether clinic or pharmacy) that the woman is an inpatient and will not be attending the clinic for dosing.
- > Ascertain whether the woman has had her dose for that day or is in possession of take-away doses.
- > If not, arrangements should be made for her to be given her usual daily dose.
- > Obtain faxed copies of
 - > Confirmation of identity (birth date, address, photo, etc)
 - > Confirmation of last dose (time and size of dose)
 - > Copy of current prescription for reference by hospital prescriber.
- > Observe for signs of withdrawal or overdose.
- > Before administering the dose, exclude recent opioid use by taking a recent drug use history.

On discharge, the unit/prescriber and pharmacy should be informed by hospital staff of the date of the woman's discharge, and the date and size of the last dose given. This is particularly important on discharge if the dose has been adjusted and is different to the dose on admission. In some jurisdictions, the permit to prescribe opioids must be transferred on discharge.

Level of evidence: Consensus

Induction of labour

There is no indication for an induction of labour if the baby is showing normal growth. Induction of labour is indicated for the normal obstetric and social indications (including remoteness and access to transport).

Level of evidence: Consensus

Appropriate forms of pain relief

All forms of pain relief, including non-pharmacological means, should be offered in labour. Options may include TENS machine, water, paracetamol, nitrous oxide, regional anaesthesia and epidural, with regard to the usual obstetric contraindications for each. All forms of pain relief should be escalated as required.

Level of evidence: Consensus

Comment: There is a tendency to underestimate the amount of pain relief needed by drug-dependent women during labour. Total analgesic requirements may be increased in women with a history of drug use. Analgesic doses should be individually titrated. Carefully assessing the woman's needs and providing adequate and appropriate pain relief is essential. Continuity of midwife care and particularly of a known carer has been shown to reduce interventions and improve birthing outcomes for all women.

Intrapartum analgesia may be non-pharmacological (e.g. water, hypnotherapy, TENS machine), pharmacological (nitrous oxide and oxygen, intramuscular or intravenous opioid based) or regional (epidural and combined spinal-epidural procedures). If all options have been discussed early in pregnancy, informed choices can be made at this time. All forms of pain relief should be escalated as required.

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Total analgesic requirements may be increased in women with a history of drug use. Analgesic doses should be individually titrated, and analgesia may be escalated as required. Women who use non-opioid substances (with the exception of cocaine) will require standard doses of opioids. Women on opioid replacement therapies, heroin users and cocaine users may be tolerant to the analgesic effect of opioids and may benefit from regional analgesia. Where regional techniques are contraindicated alternative analgesic strategies may include titrated opioids in an appropriately monitored setting. Drugs with respiratory depressant effects such as benzodiazepines should be used with caution in opioid tolerant women.

Careful assessment of the woman's needs and the provision of adequate and appropriate pain relief is essential. Continuity of midwife care (particularly with a known carer) has been shown to reduce interventions and improve birthing outcomes for all women.

Women on a methadone program in labour

For women in methadone maintenance, the usual methadone dose will not relieve the pain of labour. Women must receive their methadone dose on time (in liquid, not tablet form), but pain must be assessed as a separate issue. Dose of analgesic drugs should be titrated to response, bearing in mind the tolerance to opioids developed during methadone maintenance treatment. Pethidine may be ineffective in women who are opioid or cocaine dependent, due to changes in the opiate receptors. Therefore, if nonpharmacological means of analgesia, or Entonox gas, have been ineffective, regional anaesthesia may be more appropriate and should be discussed with the anaesthetic team on call for labour ward.

Level of evidence: Consensus

Comment: The woman's methadone dose merely inhibits the onset of opioid withdrawal symptoms; it is not sufficient to alleviate the pain of child birth.

Women on a buprenorphine program in labour

There are no distinctive issues in relation to buprenorphine in comparison with methadone. Women receiving buprenorphine maintenance should be managed as for those on methadone maintenance — that is, continue the buprenorphine, and give other analgesia (including simple analgesics such as paracetamol, and opioids, if indicated) to manage pain. Full opioid agonists (e.g. pethidine) may be less effective due to the pharmacology of buprenorphine. The use of regional anaesthesia should be considered for the management of pain in labour. For further details on managing pain in labour, see Clinical Guidelines for the use of buprenorphine in pregnancy at URL: http://www.turningpoint.org.au/library/CTG_Bup_Pregnancy_060104.pdf or Clinical Guidelines for the use of buprenorphine in the treatment of opioid addiction at URL: <http://buprenorphine.samhsa.gov/publications.html>

Level of evidence: Consensus

Intractable pain

Women in whom pain is difficult to control should have pathological causes of pain excluded by well-directed investigations.

Level of evidence: Consensus

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Comment: Pain caused by an unknown pathology may be masked by drug 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.

Difficulty with venous access

Some drug-dependent women have damaged veins, making venous access difficult. Central venous access may be required. If long term intravenous therapy is required a peripherally inserted central venous catheter (PICC line) may be appropriate.

Awareness of the potential for the misuse and contamination of intravenous lines in women who continue to use intravenous drugs is required.

Level of evidence: Consensus

Anaesthesia

Anaesthetic services may be required for:

- > pain relief in labour, e.g. epidural analgesia in labour
- > the provision of anaesthesia for instrumental or caesarean deliveries
- > assistance with gaining intravenous access (by either peripheral or central route)
- > antenatal and post-partum pain management
- > assistance in the management of medical and obstetric emergencies, sometimes precipitated or exacerbated by acute intoxication
- >

Other issues relevant to anaesthesia include:

- > a lack of antenatal care
- > dietary deficiencies
- > coexisting diseases (e.g. cellulitis / poor dentition / respiratory infections / abscesses / endocarditis)
- > difficulties with intravenous access
- > acute intoxication
- > potential exposure to blood borne infectious diseases
- > There is significant potential for drug interaction between ingested substances and anaesthetic agents. It may be difficult to predict the exact nature of these interactions in a given individual

Anaesthetic Assessment

Anaesthetic review in the third trimester is recommended as part of the multidisciplinary planning for the peripartum period. This is particularly important where operative delivery is planned or likely.

This review provides the opportunity for:

- > Assessment of the type of substance use, the implications for anaesthesia in terms of interactions with anaesthetic, analgesic and vasoactive drugs, and the presence of other significant comorbidities
- > Education and discussion regarding the options for analgesia in labour and anaesthesia for caesarean section may occur, with a clear plan documented.
- > Establishing rapport with the anaesthetic team

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- > Subsequent liaison with obstetricians, drug and alcohol services and midwives as necessary

Regional anaesthesia

- > Standard doses of local anaesthetic and intrathecal opioids are recommended for spinal anaesthesia
- > There is an increased need for supplementation of regional anaesthesia for caesarean section in substance using women. Conversion to general anaesthesia may be required
- > Platelet levels should be checked in cocaine users before establishing regional anaesthesia

General anaesthesia

General anaesthesia has issues of the effects of both acute and long term drug use on anaesthetic requirements, the potential for haemodynamic instability, significant drug interaction, and high requirements for analgesia. Invasive haemodynamic monitoring may be appropriate, including into the post-operative period. As both acute and long term substance use affects the MAC (minimum alveolar concentration) of volatile anaesthetic agents and a depth of anaesthesia monitor should be considered. The duration of action of anaesthetic drugs may be altered due to pharmacokinetic changes.

In non-opioid substance users cardiovascular problems are more common in and may include hypertension, myocardial ischaemia, myocardial infarction and arrhythmias. Hypotension and myocardial depression may also occur. Ketamine should be used with caution in this group of patients. Sympathomimetic agents should be used with caution as both depletion of endogenous catecholamines and increased sensitivity to exogenous sympathomimetics can occur.

Hypertension at laryngoscopy should be prevented. Beta-blockers may be inappropriate due to unopposed alpha-adrenoreceptor stimulation. Magnesium sulphate or potent opioids may be used.

Respiratory problems may occur in women using inhaled substances with potential for oropharyngitis, uvular swelling, and elevated carboxyhaemoglobin levels.

Intraoperative analgesia will require titration of opioid doses with adjunctive agents used as required.

Specific anaesthetic issues and drug interactions related to opioid and non-opioid substance use in pregnancy are reviewed by Ludlow et al. in *Anaesthesia and Intensive care* 2007;35: 881-893

Postoperative and postpartum pain

Post-operative pain management may be difficult with an increased incidence of inadequate post operative analgesia

Specialists with experience in acute pain management should be involved in consultation with the drug and alcohol service

A plan for post-operative analgesia should be developed

Multimodal analgesic plans should include paracetamol and NSAIDs (unless contraindicated)

Intrathecal and epidural opioids should be used at standard doses with the caveat that supplemental intravenous opioids may be required

Intravenous and oral opioids will require dose titration, and high doses may be required

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Regional techniques such as epidural infusion of local anaesthetic/ opioid solutions and or transversus abdominal plane (TAP) blocks may be very useful

In situations where analgesia is inadequate adjuncts such as ketamine and clonidine may be considered

There should be appropriate processes for postoperative monitoring

Level of evidence: Consensus

Breastfeeding

Breastfeeding is encouraged. High doses of methadone i.e. > 80 mg / day may signal other substances being used. This should be considered.

Level of evidence - Consensus

Useful references:

Clinical Guidelines for the use of buprenorphine in pregnancy available from URL: http://www.turningpoint.org.au/library/CTG_Bup_Pregnancy_060104.pdf

Clinical Guidelines for the use of buprenorphine in the treatment of opioid addiction available from URL:

<http://buprenorphine.samhsa.gov/publications.html>

Postnatal care

"This section on Postnatal care draws on National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn (2006) published by the Australian Government, and is used with permission. The text has been revised to take into account South Australian circumstances, and the new text may not necessarily reflect the views of the Australian Government".

Timing of discharge

Early discharge is not usually appropriate for drug dependent women. Opioid and sedative-dependent women should be prepared for a postnatal stay of five or more days to allow assessment of neonatal abstinence syndrome. See also Criteria for safe discharge of infants home.

Level of evidence: Consensus

Contraception

As for all women, options for contraception should be discussed before discharge and information should be provided. It is suggested that the means of contraception be reliable and easy to use.

Level of evidence: Consensus

Sudden unexpected deaths in infancy

Sudden unexpected deaths in infancy (SUDI) is the death of an infant less than 12 months of age, where the death was sudden, and was unexpected at the time. The term 'unexpected' indicates that the cause of death was not recognised before the event, although it may be

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diagnosed at autopsy . SUDI usually includes death due to SIDS and to other ill-defined causes (such as sleeping accidents).

SIDS and tobacco

Both maternal smoking during pregnancy and environmental exposure of the infant to tobacco smoke (ETS) are associated with an increased risk of sudden infant death syndrome (SIDS). All parents should be advised of the association between environmental tobacco smoke and SIDS. Mothers who smoke tobacco (or cannabis mixed with tobacco), or who live with smokers, should be advised of these risks, and specifically:

- > not to smoke during feeding (whether breastfeeding or bottle feeding)
- > not to smoke in the house or the car with the baby
- > that partners, family and friends should not smoke in the house or the car.

In addition, mothers should be offered support with smoking cessation.

Level of evidence: Consensus

An infant's most harmful exposure to tobacco is through environmental tobacco smoke. Smoking outside the home and away from the infant reduces the infant's exposure. Contamination by environmental tobacco smoke is not limited to the indoor air, it includes surfaces and dust in living rooms and bedrooms and on skin. Infants are at risk of exposure to the toxic components of environmental tobacco smoke through these sources, so it is important that parents are given this information. Refer to Environmental tobacco smoke.

Level of evidence: IV

Sleeping practices

Cosleeping, or 'bed-sharing' refers to the infant sleeping in the same space as an adult — whether bed, lounge or floor. There is a risk of

- > accidental smothering of the infant
- > injury to the infant
- > the adult not waking if the infant becomes distressed.

All women should be informed of these risks and about safe sleeping practices before discharge.

Level of evidence: Consensus

Aboriginal and Torres Strait Islander women

All health care workers should be aware that mothers or other family members sleeping with infants is a common practice in Aboriginal and Torres Strait Islander communities. Culturally appropriate education should be provided in relation to the risks. Sids and Kids provide an Indigenous brochure on safe sleeping practices at

http://www.sidsandkids.org/safe_sleeping-parents.html

Level of evidence: Consensus

Sedating substances and sleeping accidents

In particular, if an adult has used any form of sedating substance which might result in them sleeping heavily (including prescription medications, methadone and alcohol), there is an increased risk to the infant. A woman who drinks alcohol or takes sedating substances before sleeping should be advised

- > not to have the baby sleep with her
- > that if she is heavily sedated, she may not wake for the baby's next feed, or if the baby becomes distressed
- > to consider arranging a 'safety plan'. That is, to have another responsible adult to take care of the infant if the mother decides to use drugs or alcohol.

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Any other person responsible for caring for the baby should also be informed about these risks and about safe sleeping practices.

Level of evidence: Consensus

Comment: Information will ideally be given both verbally and in writing. For an example of a parent education brochure on safe sleeping practices for women using drugs, alcohol or sedating medication, see Appendix 5: Examples of safe sleeping practices information. Refer also to Environmental tobacco smoke.

Safe sleeping practices

All women should be provided with a general SIDS brochure as well as information related to drug and alcohol use and sleeping practices. More detailed information on safe sleeping practices can be found on the Sids and Kids website at http://www.sidsandkids.org/safe_sleeping-parents.html

Advice to parents should include the following:

- > Put baby on the back to sleep.
- > Sleep baby with face uncovered.
- > Baby sleeps in own sleeping space, not an adult bed.
- > Baby should have a safe cot, safe mattress, and safe bedding.
- > Put baby's feet at the bottom of the cot, tuck bedclothes in firmly.
- > Tobacco smoke is bad for baby.

Level of evidence: Consensus

Preparation for discharge

A timely and thorough written discharge plan, initiated during pregnancy, must be reviewed with the woman and care providers before discharge. The plan must take into account assessments commenced in the antenatal period:

- > parenting ability
- > stability and psychosocial issues
- > mental health
- > environmental issues including safe storage of medications in the home
- > material goods and preparation for the baby
- > child protection issues.

Copies of the plan are placed in the mother's notes, the infant's notes and given to the mother. The plan needs to include appointment dates and contact details, which are given to the mother and forwarded to community providers.

Level of evidence: Consensus

For examples of two discharge checklists, see Appendix 6: Examples of discharge assessment checklist.

Assertive follow-up

Inpatient services

Babies of mothers with a history of problematic drug or alcohol use need the same support and follow-up as other babies. The mother may require support to access appointments with the baby, such as help with transport or finances. At the time of 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. The provider who is referring should actively follow up with community services to ensure that the woman has engaged with the service. Where engagement has not occurred, the referring provider should follow up with the woman / family.

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Community services

In accepting the referral, the community provider / service should be aware that families with drug and alcohol use issues may be difficult to engage in care. Community services must be active in engaging these families and ensuring arrangements are followed up. These arrangements might include appropriate assessment, care and support services to ensure the wellbeing of the mother and baby, and to identify ongoing developmental issues.

Level of evidence: Consensus

Comment: At all points of contact, there should be ongoing risk assessment regarding the wellbeing and safety of the infant and / or other children. This may involve referral to child protection services (see Child protection issues).

Home visiting

An in-home assessment may be required before discharge, but most families will not receive home visiting on an ongoing basis. Families should be assessed individually as to the appropriateness and likely benefits of in-home visits.

Level of evidence: Consensus

Comment: Although there is currently insufficient evidence regarding the efficacy of sustained home visiting in women with serious substance misuse, in-home visits are one method of providing care and support to mothers and families, particularly those who do not engage well with community and hospital services.

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Breastfeeding

"This section on Breastfeeding draws on National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn (2006) published by the Australian Government, and is used with permission. The text has been revised to take into account South Australian circumstances, and the new text may not necessarily reflect the views of the Australian Government".

Refer to the South Australian Perinatal Practice Guideline "Breastfeeding guidelines for women with alcohol, tobacco or other drug dependencies" for South Australian recommendations.

General principles

- > Most drugs diffuse into breast milk
- > The "dose" received by the baby is usually very low
- > Most drugs diffuse back from the milk to the mother's bloodstream as serum levels fall and this should be considered in relation to the timing of breastfeeding

Mothers who are drug dependent should be encouraged to breastfeed with appropriate support and precautions. In addition, it is now recognised that skin-to-skin contact is important regardless of feeding choice and needs to be actively encouraged for the mother who is fully conscious and aware and able to respond to her baby's needs.

Level of evidence: Consensus

Comment: Breastfeeding is recognised as the best nutrition for the infant. It is also inexpensive and easier to prepare and deliver than other options. As with all mothers of newborns, breastfeeding is recommended, where possible, for drug-dependent mothers, with the cautions described in the following statements.

A harm minimisation approach to breastfeeding is recommended in these guidelines. Encouraging breastfeeding is preferred to avoiding breastfeeding, provided that:

- > The woman is informed about the likely effects on the infant of the drugs she is using (or may use) and
- > The woman is assisted to plan minimum exposure of the infant to the effects of these drugs.

Level of evidence: Consensus

Comment: In these guidelines, a 'harm minimisation approach' does not mean that the woman should be advised against breastfeeding. In advising drug-dependent women with regard to breastfeeding, the specific potential risks in each woman's individual circumstances should be weighed against the benefits of breastfeeding, and she should be informed of them.

Level of evidence: Consensus

Mothers who present with an ongoing unstable pattern of drug use should not be encouraged to breast feed. Ongoing frequent intravenous substance use, polysubstance use, intoxicated presentations, and failure to engage in treatment plans may compromise the safety of the infant. A review regarding child protection concerns may also be indicated.

Comment: There is very little evidence about the effects of most drugs, prescription and

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Vertical transmission of blood-borne viruses



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"This section on Vertical transmission of blood-borne viruses draws on National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn (2006) published by the Australian Government, and is used with permission. The text has been revised to take into account South Australian circumstances, and the new text may not necessarily reflect the views of the Australian Government".

General considerations

Confidentiality

Confidentiality of information must be assured to women and partners.

Level of evidence: Consensus

Occupational health and safety of staff

Issues affecting the occupational health and safety of staff should be considered in the management of people with blood-borne viruses.

Level of evidence: Consensus

Comment: Normal body fluid precautions should be taken; bearing in mind that infectivity may be related to viral load.

Education

In line with the national strategy on drug use, education about safe sex and risk reduction practices is vital in preventing blood-borne viral infections.

Level of evidence: Consensus

Comment: This applies to all people using health services. All women of childbearing age should be given information about blood-borne viral infections in relation to pregnancy.

Screening

For more information refer to PPG: Screening for blood-borne viruses.

Breastfeeding

For more information refer to PPG: Breastfeeding and blood-borne viruses.

Human immunodeficiency virus

Antiretroviral therapy

Antiretroviral therapy reduces the risk of vertical (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. Consult an infectious diseases specialist for further detail.

Level of evidence: II

Comment: Evidence suggests micro-transfusion may occur during fetal life. The risk of HIV vertical transmission is significantly reduced if zidovudine is given during pregnancy (from 25 per cent risk in the placebo group to 8 per cent in the zidovudine group). It is further reduced by combination therapy. There is concern regarding the teratogenicity of some antiretroviral drugs during early gestation. Consult an infectious diseases specialist for the management of antiretroviral therapy in pregnancy.

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Promoting risk at birth

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Version control and change history

PDS reference: OCE use only

Specific drugs in pregnancy

Version	Date from	Date to	Amendment
1.0	27 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	Current	

Antenatal care

Version	Date from	Date to	Amendment
1.0	22 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	Current	

Labour and birth

Version	Date from	Date to	Amendment
1.0	22 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	30 Nov 09	Reviewed
3.0	30 Nov 09	Current	

Postnatal care

Version	Date from	Date to	Amendment
1.0	27 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	Current	

Breastfeeding

Version	Date from	Date to	Amendment
1.0	18 Mar 04	03 Mar 09	Original version
2.0	03 Mar 09	Current	

Vertical transmission of blood-borne viruses

Version	Date from	Date to	Amendment
1.0	22 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	Current	

Management of neonatal abstinence syndrome (NAS)

Version	Date from	Date to	Amendment
1.0	22 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	Current	

Glossary

Version	Date from	Date to	Amendment
1.0	27 Jul 04	28 Oct 08	Original version
2.0	28 Oct 08	Current	South Australian Paediatric Clinical Guidelines Reference Committee; South Australian Child Health Clinical Network

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Appendix 1: Advice for health care workers on drugs and alcohol

National Quitline number	13 7848 (cost of local call)
Australian Capital Territory Alcohol and Drug Service (ADIS)	02 6207 9977
New South Wales NSW Drug and Alcohol Specialist Advisory Service (DASAS) (24-hour health professionals telephone service)	02 9361 8006 1800 023 687 (outside Sydney)
Northern Territory Drug and Alcohol Clinical Advisory Service (Dacas-NT)	1800 111 092
Queensland Queensland Drug Information Centre Therapeutic Advice and Information Service Alcohol and Drug Information Service (ADIS) (24-hour counselling, information and referral)	07 3636 7098 1300 138 677 07 3236 2414 1800 177 833 (outside Brisbane)
South Australia Alcohol and Drug Information Service (ADIS) in SA	1300 13 13 40
Tasmania Drug and Alcohol Clinical Advisory Service (Dacas)	1800 630 093
Victoria The Women's Alcohol & Drug Service (pregnancy care and professional support) DirectLine (24 hour counselling and referral) Quit Victoria	03 9344 3631 1800 888 236 03 9663 7777
Western Australia Antenatal Chemical Dependency Clinic (ACDC) Women's and Children's Health Service	08 93401379

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Appendix 2: Advice for consumers on drugs, alcohol and medications

National Quitline number	13 7848 (cost of local call)
Australian Capital Territory	
Alcohol and Drug Service (ADIS) (24-hour counselling, information and referral)	02 6207 9977
New South Wales	
MotherSafe: the Statewide Medications in Pregnancy and Lactation Advisory Service The Royal Hospital for Women, Barker Street, Randwick 2031	02 9382 6539 Freecall 1800 647 848
Alcohol and Drug Information Service (ADIS) (24-hour counselling, information and referral)	02 9361 8000 1800 422 599 (outside Sydney)
Poisons' Information Centre	13 11 26
Northern Territory	
ADIS NT (24-hour counselling, information and referral)	1800 131 350
Drug and Poisons Information Centre Royal Darwin Hospital Specialty Tropical Medicine	08 8922 8424
Pregnancy Drug Information Centre, Royal Darwin Hospital	08 8922 8424
Queensland	
National Prescribing Service Limited (NPS) Medicines Line Monday to Friday, 9am to 6pm EST	1300 888 763
Alcohol and Drug Information Service (ADIS) (24-hour counselling, information and referral)	07 3236 2414 1800 177 833 (outside Brisbane)
South Australia	
Alcohol and Drug information Service (ADIS) (24-hour counselling, information and referral)	1300 131 340
Drugs in Pregnancy Service Women's and Children's Hospital, 9am – 5pm Monday to Friday	08 8161 7222
Tasmania	
Alcohol and Drug Information Service (ADIS) (24-hour counselling, information and referral)	1800 811 994
Victoria	
Drug information Centre The Royal Women's Hospital, Melbourne, 9am – 5pm Monday to Friday	03 9344 2277
Western Australia	
Antenatal Chemical Dependency Clinic (ACDC) Women's and Children's Health Service	08 93401379

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Appendix 3: Examples of drug use assessment tools

Example 1: The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

WHO - ASSIST V3.0

CLINICIAN ID	<input type="text"/>	CLINIC	<input type="text"/>
PATIENT ID	<input type="text"/>	DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

INTRODUCTION (Please read to patient. Can be adapted for local circumstances)

(Many drugs & medications can affect your health. It is important for your health care provider to have accurate information about your use of various substances, in order to provide the best possible care.)

The following questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT

Question 1

In your life, which of the following substances have you <u>ever used?</u> (NON-MEDICAL USE ONLY)	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

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Question 2

In the <u>past three months</u> , how often have you used the substances you mentioned (<i>FIRST DRUG, SECOND DRUG, ETC</i>)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the <u>past three months</u> , how often have you had a strong desire or urge to use (<i>FIRST DRUG, SECOND DRUG, ETC</i>)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

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Question 4

During the <u>past three months</u> , how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the <u>past three months</u> , how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

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Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you <u>ever</u> tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

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Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> used any drug by injection? <i>(NON-MEDICAL USE ONLY)</i>	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING

Once weekly or less or

Fewer than 3 days in a row

INTERVENTION GUIDELINES

Brief Intervention including "risks associated with injecting" card

More than once per week or

3 or more days in a row

Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

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WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

- a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
- b. Alcoholic beverages (beer, wine, spirits, etc.)
- c. Cannabis (marijuana, pot, grass, hash, etc.)
- d. Cocaine (coke, crack, etc.)
- e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
- f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
- g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
- h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
- i. Opioids (heroin, morphine, methadone, codeine, etc.)
- j. Other - specify:

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

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Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST V3.0) Feedback REPORT CARD for Patients

Name _____ Test Date _____

Specific Substance Involvement Scores

Substance	Score	Risk Level
a. Tobacco products	0-3 4-26 27+	Low Moderate High
b. Alcoholic Beverages	0-10 11-26 27+	Low Moderate High
c. Cannabis	0-3 4-26 27+	Low Moderate High
d. Cocaine	0-3 4-26 27+	Low Moderate High
e. Amphetamine type stimulants	0-3 4-26 27+	Low Moderate High
f. Inhalants	0-3 4-26 27+	Low Moderate High
g. Sedatives or Sleeping Pills	0-3 4-26 27+	Low Moderate High
h. Hallucinogens	0-3 4-26 27+	Low Moderate High
i. Opioids	0-3 4-26 27+	Low Moderate High
j. Other - specify	0-3 4-26 27+	Low Moderate High

What do your scores mean?

- Low:** You are at low risk of health and other problems from your current pattern of use.
- Moderate:** You are at risk of health and other problems from your current pattern of substance use.
- High:** You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

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a. tobacco	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	Regular tobacco smoking is associated with:			
	Premature aging, wrinkling of the skin			
	Respiratory infections and asthma			
	High blood pressure, diabetes			
	Respiratory infections, allergies and asthma in children of smokers			
	Miscarriage, premature labour and low birth weight babies for pregnant women			
	Kidney disease			
	Chronic obstructive airways disease			
	Heart disease, stroke, vascular disease			
	Cancers			

b. alcohol	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	Regular excessive alcohol use is associated with:			
	Hangovers, aggressive and violent behaviour, accidents and injury			
	Reduced sexual performance, premature ageing			
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure			
	Anxiety and depression, relationship difficulties, financial and work problems			
	Difficulty remembering things and solving problems			
	Deformities and brain damage in babies of pregnant women			
	Stroke, permanent brain injury, muscle and nerve damage			
	Liver disease, pancreas disease			
	Cancers, suicide			

c. cannabis	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	Regular use of cannabis is associated with:			
	Problems with attention and motivation			
	Anxiety, paranoia, panic, depression			
	Decreased memory and problem solving ability			
	High blood pressure			
	Asthma, bronchitis			
	Psychosis in those with a personal or family history of schizophrenia			
	Heart disease and chronic obstructive airways disease			
	Cancers			

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d. cocaine	Your risk of experiencing these harms is:..... Regular use of cocaine is associated with: Difficulty sleeping, heart racing, headaches, weight loss Numbness, tingling, clammy skin, skin scratching or picking Accidents and injury, financial problems Irrational thoughts Mood swings - anxiety, depression, mania Aggression and paranoia Intense craving, stress from the lifestyle Psychosis after repeated use of high doses Sudden death from heart problems	Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
---------------	---	--

e. amphetamine type stimulants	Your risk of experiencing these harms is:..... Regular use of amphetamine type stimulants is associated with: Difficulty sleeping, loss of appetite and weight loss, dehydration jaw clenching, headaches, muscle pain Mood swings –anxiety, depression, agitation, mania, panic, paranoia Tremors, irregular heartbeat, shortness of breath Aggressive and violent behaviour Psychosis after repeated use of high doses Permanent damage to brain cells Liver damage, brain haemorrhage, sudden death (from ecstasy) in rare situations	Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
--------------------------------------	--	--

f. inhalants	Your risk of experiencing these harms is:..... Regular use of inhalants is associated with: Dizziness and hallucinations, drowsiness, disorientation, blurred vision Flu like symptoms, sinusitis, nosebleeds Indigestion, stomach ulcers Accidents and injury Memory loss, confusion, depression, aggression Coordination difficulties, slowed reactions, hypoxia Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys) Death from heart failure	Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
-----------------	---	--

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g. sedatives	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
Regular use of sedatives is associated with:	
	Drowsiness, dizziness and confusion Difficulty concentrating and remembering things Nausea, headaches, unsteady gait Sleeping problems Anxiety and depression Tolerance and dependence after a short period of use. Severe withdrawal symptoms Overdose and death if used with alcohol, opioids or other depressant drugs.

h. hallucinogens	Your risk of experiencing these harms is:..... Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
Regular use of hallucinogens is associated with:	
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory Difficulty sleeping Nausea and vomiting Increased heart rate and blood pressure Mood swings Anxiety, panic, paranoia Flash-backs Increase the effects of mental illnesses such as schizophrenia

i. opioids	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
Regular use of opioids is associated with:	
	Itching, nausea and vomiting Drowsiness Constipation, tooth decay Difficulty concentrating and remembering things Reduced sexual desire and sexual performance Relationship difficulties Financial and work problems, violations of law Tolerance and dependence, withdrawal symptoms Overdose and death from respiratory failure

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g. sedatives	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
Regular use of sedatives is associated with:	
	Drowsiness, dizziness and confusion Difficulty concentrating and remembering things Nausea, headaches, unsteady gait Sleeping problems Anxiety and depression Tolerance and dependence after a short period of use. Severe withdrawal symptoms Overdose and death if used with alcohol, opioids or other depressant drugs.

h. hallucinogens	Your risk of experiencing these harms is:..... Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
Regular use of hallucinogens is associated with:	
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory Difficulty sleeping Nausea and vomiting Increased heart rate and blood pressure Mood swings Anxiety, panic, paranoia Flash-backs Increase the effects of mental illnesses such as schizophrenia

i. opioids	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
Regular use of opioids is associated with:	
	Itching, nausea and vomiting Drowsiness Constipation, tooth decay Difficulty concentrating and remembering things Reduced sexual desire and sexual performance Relationship difficulties Financial and work problems, violations of law Tolerance and dependence, withdrawal symptoms Overdose and death from respiratory failure

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WHO-ASSIST Risks of Injecting Card – Information for Patients

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- The substance
 - If you inject any drug you are more likely to become dependent.
 - If you inject amphetamines or cocaine you are more likely to experience psychosis.
 - If you inject heroin or other sedatives you are more likely to overdose.
- The injecting behaviour
 - If you inject you may damage your skin and veins and get infections.
 - You may cause scars, bruises, swelling, abscesses and ulcers.
 - Your veins might collapse.
 - If you inject into the neck you can cause a stroke.
- Sharing of injecting equipment
 - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

❖ It is safer not to inject

- ❖ If you do inject:
 - ✓ always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
 - ✓ always use a new needle and syringe
 - ✓ don't share equipment with other people
 - ✓ clean the preparation area
 - ✓ clean your hands
 - ✓ clean the injecting site
 - ✓ use a different injecting site each time
 - ✓ inject slowly
 - ✓ put your used needle and syringe in a hard container and dispose of it safely
- ❖ If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.
 - ✓ avoid injecting and smoking
 - ✓ avoid using on a daily basis
- ❖ If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.
 - ✓ avoid using other drugs, especially sedatives or alcohol, on the same day
 - ✓ use a small amount and always have a trial "taste" of a new batch
 - ✓ have someone with you when you are using
 - ✓ avoid injecting in places where no-one can get to you if you do overdose
 - ✓ know the telephone numbers of the ambulance service

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Example 2: Women's Alcohol and Drug Client Assessment Tool

The Royal Womens Hospital
Women's Alcohol And Drug Service (WADS)
132 Grattan Street, Carlton 3053, Australia,
Telephone (03) 9344 3631 www.rwh.org.au/wads



Women's alcohol and drug service worker:

Date of screening:

Client: Past New

Client details

Name:

Address:

Telephone:

Mobile:

UR:

DOB: Age:

Country of birth:

Cultural background:

Occupation:

Language used at home:

Interpreter needed: YES NO

Level of education:

Aboriginal or Torres Strait Islander: YES NO

Literacy difficulties: YES NO

Date of referral:

Referee:

Address:

Telephone:

General practitioner details

Name:

Address:

Telephone:

Fax:

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Pharmacotherapy prescriber

Name:

Address:

Telephone:

Fax:

Current pharmacy details

Name:

Address:

Telephone:

Fax:

Support service details

Contact person:

Agency:

Address:

Telephone:

Fax:

Previous Pregnancies

1. Year _____ Outcome _____

Gestation _____ F/M _____

Delivery mode _____

2. Year _____ Outcome _____

Gestation _____ F/M _____

Delivery mode _____

3. Year _____ Outcome _____

Gestation _____ F/M _____

Delivery mode _____

Current Pregnancy

Have you had a positive pregnancy test: YES NO

Expected date of delivery: _____

Gestation (in weeks): _____

Was this pregnancy planned: YES NO

Have you had antenatal care: YES NO

If yes with whom: _____

Commencement date: _____

Medical/psychiatric history

Past medical/psychiatric history:

Current medical/psychiatric history:

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Drug use history

Heroin

Age at first use: _____

Method of use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

Age when you first sought to reduce/address your drug use: _____

- self detox
- home detox/supervised help
- pharmacotherapy
- specialist AOD counselling service
- self-help support group
- general practitioner
- AOD treatment residential
- general counselling

Other: _____

Current heroin use

Amount used: _____ How many times a day: _____

Method of use: _____

Has your use changed recently? YES NO

Reason for change:

- pregnancy
- relationship
- financial hardship
- legal issues
- desire to change

Other: _____

Date and time last used: _____

Injecting drug use history

Do you share injecting equipment?

Present: YES NO

Past: YES NO

Have you shared injecting equipment with a partner: YES NO

Have you shared injecting equipment with people other than your partner: YES NO

Alcohol use history

Age at first use: _____

Age at heaviest use: _____

Amount used at this time: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

Alcohol current use

Amount used: _____

Has your use changed recently: YES NO

Reason for change:

- pregnancy
- relationship
- financial hardship
- legal issues
- desire to change

Other: _____

Date and time last used alcohol: _____

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Amphetamines use history

Age at first use: _____

Method of use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

peer pressure

relationship/family breakdown

financial hardship

abuse/domestic violence

Other: _____

Amphetamine current use

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

pregnancy

relationship

financial hardship

legal issues

desire to change

Other: _____

Date and time of last use: _____

Cannabis use history

Age at first use: _____

Method of use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

peer pressure

relationship/family breakdown

financial hardship

abuse/domestic violence

Other: _____

Cannabis current use

Amount used: _____

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

pregnancy

relationship

financial hardship

legal issues

desire to change

Other: _____

Date and time of last use: _____

Benzodiazepines use history

Age at first use: _____

Method of use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

peer pressure

relationship/family breakdown

financial hardship

abuse/domestic violence

Other: _____

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Benzodiazepines current use

Benzo names: _____

Amount used: _____

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

- pregnancy
- relationship
- financial hardship
- legal issues
- desire to change

Other: _____

Date and time of last use: _____

Ecstasy use history

Age at first use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

Ecstasy current use

Amount used: _____

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

- Pregnancy
- Relationship
- Financial hardship
- Legal issues
- Desire to change

Other: _____

Date and time of last use: _____

LSD use history

Age at first use: _____

Age at heaviest use: _____

Method of use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

LSD current use

Amount used: _____

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

- pregnancy
- relationship
- financial hardship
- legal issues
- desire to change

Other: _____

Date and time of last use: _____

Inhalants use history

Age at first use: _____

Method of use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

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Inhalants current use

Names: _____

Amount used: _____

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

- pregnancy
- relationship
- financial hardship
- legal issues
- desire to change

Other: _____

Date and time of last use: _____

Tobacco use history

Age at first use: _____

Age at heaviest use: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

Tobacco current use

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

- pregnancy
- relationship
- financial hardship
- legal issues
- desire to change

Other: _____

Cocaine use history

Age at first use: _____

Age at heaviest use: _____

Amount used at this time: _____

How many times a day did you use: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

Current cocaine use

Amount used: _____

Method of use: _____

How many times a day: _____

Has your use changed recently: YES NO

Reason for change:

- Pregnancy
- Relationship
- Financial hardship
- Legal issues
- Desire to change

Other: _____

Date and time of last use: _____

Other substance use

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Pharmacotherapy

(methadone, buprenorphine, naltrexone)

Age at first use: _____

How many times daily: _____

Method of use: _____

Amount used at this time: _____

Were there any precipitating factors: YES NO

- peer pressure
- relationship/family breakdown
- financial hardship
- abuse/domestic violence

Other: _____

Current pharmacotherapy

Amount used: _____

Method of use: _____

Has your use changed recently: YES NO

Reason for change:

- Pregnancy
- Relationship
- Financial hardship
- Legal issues
- Desire to change

Other: _____

Date and time of last use: _____

Prescription medication

History

Current medication

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Partner details

Name: _____

Address: _____

Age: _____ DOB: _____

Is your partner the father of the baby: YES NO

Is the baby's father aware of the pregnancy:

- YES NO

How long have you and your partner been together:

Does your partner use drugs: YES NO

Partner's current drug use: _____

Method: _____

Amount: _____

How many times a day: _____

Is your partner's drug use a problem for you:

- YES NO

Has your partner's use changed recently and reasons for change: _____

Is he/she in treatment: _____

Partner's legal issues

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> none | <input type="checkbox"/> bond |
| <input type="checkbox"/> cfo | <input type="checkbox"/> parole |
| <input type="checkbox"/> lco | <input type="checkbox"/> remand |
| <input type="checkbox"/> drug treatment order | <input type="checkbox"/> prison |
| <input type="checkbox"/> bail/charged | <input type="checkbox"/> court order |
| <input type="checkbox"/> combined custody and community treatment | |
- Other: _____

Partners previous children

Does your partner have any other children:

- YES NO

Children details

Name: _____

DOB: _____

Name: _____

DOB: _____

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Have DHS/child protection been involved:

YES NO

Details (order): _____

supervision order

unknown

Further information: _____

Partner's history with DHS/child protection

Details: _____

Clients history with DHS/child protection

Have you been a client of child protection as a child:

YES NO

Details: _____

Clients legal situation

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> none | <input type="checkbox"/> bond |
| <input type="checkbox"/> cbo | <input type="checkbox"/> parole |
| <input type="checkbox"/> ico | <input type="checkbox"/> remand |
| <input type="checkbox"/> drug treatment order | <input type="checkbox"/> prison |
| <input type="checkbox"/> bail/charged | <input type="checkbox"/> court order |
| <input type="checkbox"/> combined custody and community treatment | |

Other: _____

Further information: _____

Previous incarceration

Details: _____

Financial

Income:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> employed full-time | <input type="checkbox"/> pensioner |
| <input type="checkbox"/> self employed | <input type="checkbox"/> student |
| <input type="checkbox"/> employed part-time | <input type="checkbox"/> home duties |
| <input type="checkbox"/> sickness benefits | <input type="checkbox"/> unemployment |

Other: _____

Referral to: _____

Housing

What type of housing are you currently in:

Living arrangement:

- | | |
|--|--|
| <input type="checkbox"/> alone | <input type="checkbox"/> spouse/partner |
| <input type="checkbox"/> alone with child(ren) | <input type="checkbox"/> spouse/partner and child(ren) |
| <input type="checkbox"/> friend(s) | <input type="checkbox"/> parent(s) |
| <input type="checkbox"/> relatives | <input type="checkbox"/> group household |

Other: _____

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Accommodation

- house/flat – owned house/flat – rented
 rooming/boarding hostel (supported)
 psychiatric home/hostel shelter/refuge
 AOD treatment service no fixed abode
 caravan park

Other: _____

How long have you been there: _____

Have you been homeless in the past 12 months:

- YES NO

Do you plan to move to more suitable housing:

- YES NO

Do you need housing assistance: YES NO

Details: _____

Do you have a housing worker: YES NO

Name: _____

Address: _____

Phone: _____

Referral made to housing worker: YES NO

Details: _____

Genogram

Significant relationship: _____

Abuse and domestic violence issues

In the past have you been exposed to:

Verbal abuse, physical trauma,
sexual assault and/or emotional trauma:

What age were you at the time: _____

Further information: _____

Worker access issues for home visits

Type of housing:

- house flat apartment

Access issues (stairs, parking):

Details: _____

Pets at the home:

- unknown no yes type:

Are pets restrained: no yes

Weapons in the home:

- unknown no yes type:

Past/current violence towards workers:

- no yes

Details: _____

Past/current violence in the home:

- unknown no yes

Details: _____

Suicide risk history

Past

Attempt: _____

Self harm: _____

Ideation: _____

Treatment: _____

Current

Attempt: _____

Self harm: _____

Ideation: _____

Treatment: _____

Individual treatment plan

Short term goals: _____

Medium term goals: _____

Long term goals: _____

Source: Women's Alcohol and Drug Service (WADS),
The Royal Women's Hospital, Melbourne, Victoria.

SA/CP/10 National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn.

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Appendix 4: Examples of assessment scales for opioid withdrawal in adults

Example 1: The short opiate withdrawal scale

Please put a check mark in the appropriate box if you have suffered from any of the following conditions in the last 24 hours:

	None	Mild	Moderate	Severe
Feeling Sick				
Stomach Cramps				
Muscle Spasms/Twitching				
Feelings of Coldness				
Heart Pounding				
Muscular Tension				
Aches and Pains				
Yawning				
Runny Eyes				
Insomnia/Problems Sleeping				

Scoring: None = 0 Mild = 1 Moderate = 2 Severe = 3

Gossop M. 'The development of a Short Opiate Withdrawal Scale (SOWS)'. *Addictive Behaviors*. 15(5), pp.487-90, 1990.


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Example 2: a. The subjective opiate withdrawal scale (SOWS)

Date: _____ Time: _____

Please score each of the 16 items below according to how you feel now (circle one number)

	Symptom	not at all	a little	moderately	quite a bit	extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are tearing	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

Total score range 0-64.

Example 2: b. Objective opioid withdrawal scale (OOVS)

Date: _____ Time: _____

Observe the patient during a 5 minute observation period then indicate a score for each of the opioid withdrawal signs listed below (items 1-13). Add the scores for each item to obtain the total score

	Sign	Measures		Score
1	Yawning	0 = no yawns	1 = ≥ 1 yawn	
2	Rhinorrhoea	0 = < 3 sniffs	1 = ≥ 3 sniffs	
3	Piloerection (observe client's arm)	0 = absent	1 = present	
4	Perspiration	0 = absent	1 = present	
5	Lacration	0 = absent	1 = present	
6	Tremor (hands)	0 = absent	1 = present	
7	Mydriasis (pupil dilation)	0 = absent	1 = ≥ 3 mm	
8	Hot and Cold flushes	0 = absent	1 = shivering / huddling for warmth	
9	Restlessness	0 = absent	1 = frequent shifts of position	
10	Vomiting	0 = absent	1 = present	
11	Muscle twitches	0 = absent	1 = present	
12	Abdominal cramps (Holding stomach)	0 = absent	1 = Holding stomach	
13	Anxiety	0 = absent	1 = mild - severe	
	TOTAL SCORE			

Total score range 0-13

Handelsman L, Cochrane K, Aronseon M, Ness R, Rubinstein K, Kanof P 1987 'Two new rating scales for opiate withdrawal' American Journal of Drug and Alcohol Abuse 13 (3), p. 293-308.

Source: Women's Alcohol and Drug Service (WADS), Royal Women's Hospital, Melbourne Victoria.

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Appendix 5: Examples of safe sleeping practices information

Example 1: Women's Alcohol and Drug Service Safe Sleeping brochure

SAFE SLEEPING FOR YOUR BABY

Support and Information

Important

Change your own habits by reading this facts for your baby

- Follow the SIDS and Kids guidelines.
- Don't smoke in the house.
- Don't have baby sleeping in the same bed as you, but have her/him sleeping in the same room.
- Have a responsible adult available to care for your baby if you decide to use drugs or alcohol.

Women's Alcohol and Drug Service Women's Alcohol and Drug Service

If you use drugs or alcohol you need to be aware of the increased risk of SIDS

Contact details

Phone: 1300 766 387
Ph: 03 9622 9611 - 24 hr service.
Quarantine Ph: 131 848 - 24 hr service.
ServiceLine Ph: 1800 800 236 - 24 hr service, freecall.
Maternal and Child Health Line Ph: 132 239 - 24 hr service, freecall.

The Royal Women's Hospital

Women's Alcohol and Drug Service Women's Hospital

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What is SIDS?

SIDS is short for Sudden Infant Death Syndrome. In the past, this was called 'cot death.' It means the sudden unexpected death of a baby from no known cause. It is the most common cause of death for infants in Australia between the ages of one month and twelve months. More babies die of SIDS in winter than in summer.

How to put your baby to sleep safely

Clean air
Cot firm unclustered bedding
Head and face uncovered
Securely tucked in
Lying on back, feet to foot of cot

Follow the safe sleeping recommendations from SIDS and Kids

- Always have your baby sleeping in their own cot.
- Ensure the cot has a firm well fitted mattress and clean bedding.
- Never put your baby to sleep on a waterbed, bean bag, sofa or mattresses on the floor. They are not safe sleeping places and your baby may suffocate or overheat.
- At night time have your baby in their cot in the room where you sleep.
- Be sure that other people who care for your baby know how to put them to sleep safely.

Belly sharing baby should not share your bed

It is not recommended that your baby shares your bed for sleeping, feeding or comforting. Drugs such as methadone, heroin and sedatives, tranquilizers and antidiuretics can cause you to sleep heavily. This may lead to you being less aware of where your baby is in the bed. There have been occasions when parents have accidentally smothered their babies under these circumstances.

Belly with adult bedding

If you are having difficulty getting safe bedding, contact your Social Worker or Midwife. There are services available to help you obtain baby goods.

Belly to your baby's bedding

To make sure your baby's sleeping environment is safe, ask the Domiciliary Midwife or Maternal & Child Health Nurse to check when they visit.

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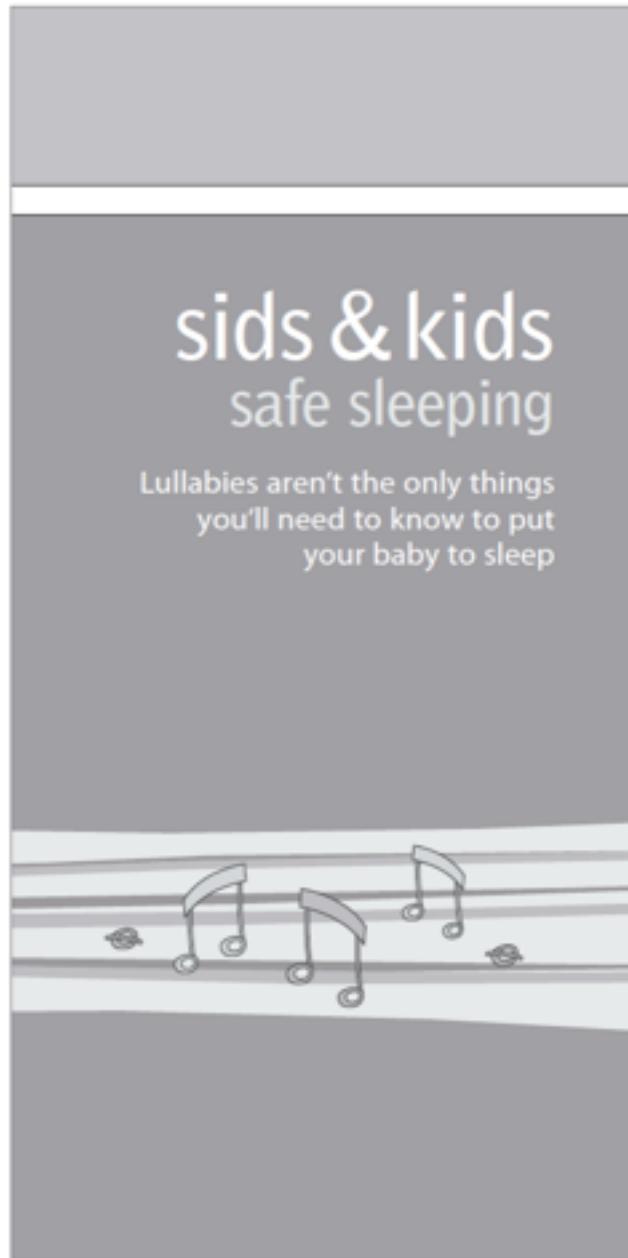
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Example 2: *Sids and Kids Safe Sleeping brochure*



Source: SIDS and Kids: Safe sleeping www.sidsandkids.org/safe_sleeping.html.

For more information, see SIDS and Kids www.sidsandkids.org/home.html
Or you can contact National Health Promotion Manager Tel. 02 6287 4255

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Appendix 6: Examples of discharge assessment checklists

Example 1: The Royal Women's Hospital Assessment for Infant Home Based Withdrawal

THE ROYAL WOMEN'S HOSPITAL		(Affix Label Here)	
Assessment for Infant Home Based Withdrawal (IHBW)			
ANTENATAL ASSESSMENT For completion by social worker at 36/40 weeks gestation			
Name of provider: _____		EDC: _____	
Signature: _____		Date: _____	
INDICATOR	NO CONCERN	CONCERN	PLAN
Mother stable and/or infant's Primary care			
Ongoing illicit drug use or alcohol abuse (mother)			
Severe mental illness			
Poor or non-attendance for antenatal care; refused or dropped out of care			
Unstable living arrangements; inadequate or temporary accommodation			
Current history of domestic violence or abuse – physical or emotional			
Unstable drug or alcohol use by others in the household			
Current Child Protection concerns that preclude the infant from IHBW			
Demonstrated absence of commitment to infant			
Non-acceptance of referrals and supports			
Recent history of non-compliance with services			
Unable to access hospital and M&CH or GP service for weekly appointments			
Absence of agreement to home based management			
Comments: _____ _____ _____			
Original sheet to be retained in mother's medical record Forward duplicate sheet to the Case Manager, SCN			

ASSESSMENT FOR IHBW

MR190629A

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Assessment for Infant Home Based Withdrawal (IHBW) SPECIAL CARE NURSERY ASSESSMENT			
Baby's DOB:			
Name of provider:			
Signature:			
Date:			
INDICATOR	NO CONCERN	CONCERN	PLAN
Mother stable and/or Infant's Primary carer			
Ongoing illicit drug use or alcohol abuse (mother)			
Severe mental illness			
Poor or non-attendance for antenatal care; refused or dropped out of care			
Unstable living arrangements; inadequate or temporary accommodation			
Current history of domestic violence or abuse – physical or emotional			
Unstable drug or alcohol use by others in the household			
Current Child Protection concerns that preclude the infant from IHBW			
Demonstrated absence of commitment to infant			
Non-acceptance of referrals and supports			
Recent history of non-compliance with services			
Unable to access hospital and M&CH or GP service for weekly appointments			
Absence of agreement to home based management			

Retain in baby's medical record

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Example 2: Chemical Use in Pregnancy Discharge Checklist

Chemical Use in Pregnancy (CUPS) Discharge Checklist

(tick appropriate boxes)

- Administration of medication
- Signs and symptoms of NAS
- Completed Medicare form
- Emergency contact numbers
- SIDS information and safe sleeping for under 2s
- Parentcraft Skills
 - Sleep and settling
Independent / Supervised / Assisted
 - Bottle sterilisation
Independent / Supervised / Assisted
 - Breastfeeding
Independent / Supervised / Assisted
- Provisions for baby
- CUPS clinic appointment / Early childhood clinic appointment
- Blue Book
- Discharge summary
- Child at risk identification
Referral / No referral

Other agencies family referred to

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Appendix 7: Categorisation of drug risks in pregnancy and breastfeeding

Australian categorisation of risk of drug use in pregnancy

Category A

Drugs which have been taken by a large number of pregnant women and women of childbearing age without any proven increase in the frequency of malformations or other direct or indirect harmful effects on the fetus having been observed.

Category C

Drugs which, owing to their pharmacological effects, have caused or may be suspected of causing, harmful effects on the human fetus or neonate without causing malformations. These effects may be reversible. Accompanying texts should be consulted for further details.

Category B1

Drugs which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human fetus having been observed. Studies in animals have not shown evidence of an increased occurrence of fetal damage.

Category B2

Drugs which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human fetus having been observed. Studies in animals are inadequate or may be lacking, but available data show no evidence of an increased occurrence of fetal damage.

Category B3

Drugs which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human fetus having been observed. Studies in animals have shown evidence of an increased occurrence of fetal damage, the significance of which is considered uncertain in humans.

Category D

Drugs which have caused, are suspected to have caused or may be expected to cause, an increased incidence of human fetal malformations or irreversible damage. These drugs may also have adverse pharmacological effects. Accompanying texts should be consulted for further details.

Category X

Drugs which have such a high risk of causing permanent damage to the fetus that they should not be used in pregnancy or when there is a possibility of pregnancy.

Source: Therapeutic Goods Administration, Australian Drug Evaluation Committee, 1999, *Prescribing medicines in pregnancy: an Australian categorization of risk of drug use in pregnancy* 4th edition, Australian Department of Health and Ageing, Canberra, [inside front cover, no page number].

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Hale's categorisation of breastmilk drug risks

L1 Safest

Drug which has been taken by a large number of breastfeeding mothers without any observed increase in adverse effects in the infant. Controlled studies in breastfeeding women fail to demonstrate a risk to the infant and the possibility of harm to the breastfeeding infant is remote or the product is not orally bioavailable in an infant.

L2 Safer

Drug which has been studied in a limited number of breastfeeding women without an increase in adverse effects in the infant. And/or the evidence of a demonstrated risk which is likely to follow use of this medication in a breastfeeding woman is remote.

L3 Moderately Safe

There are no controlled studies in breastfeeding women; however, the risk of untoward effects to a breastfed infant is possible or controlled studies show only minimal non-threatening adverse effects. Drugs should be given only if the potential benefit justifies the potential risk to the infant.

L4 Possibly Hazardous

There is positive evidence of risk to a breastfed infant or to breastmilk production by the benefits from use in breastfeeding mothers may be acceptable despite the risk to the infant (eg if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective).

L5 Contraindicated

Studies in breastfeeding mothers have demonstrated that there is significant and documented risk to the infant based on human experience or it is a medication that has a high risk of causing significant damage to an infant. The risk of using the drug in breastfeeding women clearly outweighs any possible benefit from breastfeeding. The drug is contraindicated in women who are breastfeeding an infant.

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Appendix 8: Australian Alcohol Guidelines: pregnancy and breastfeeding

NH&MRC GUIDELINE 11: Women who are pregnant or might soon become pregnant

11.1 may consider not drinking at all.

11.2 most importantly, should never become intoxicated.

11.3 if they choose to drink, over a week, should have less than 7 standard drinks, AND, on any one day, no more than 2 standard drinks (spread over at least two hours).

11.4 should note that the risk is highest in the earlier stages of pregnancy, including the time from conception to the first missed period.

Rationale: Alcohol in a woman's blood stream enters that of her unborn child, and this may affect the child from conception onwards. It is difficult to identify exactly the lower levels of drinking at which alcohol may cause harm to the child and, for this reason, a woman may consider not drinking at all.

Nevertheless, while more high quality research is needed, the limited available evidence indicates that averaging less than one drink per day has no measurable impact on children's physical and mental development.

The evidence indicates that episodes of drinking above the guideline levels considerably increase the risk to the unborn child, including the risk of miscarriage, low birth weight, cognitive defects and congenital abnormalities. Heavy bouts of drinking maximise that risk.

The evidence base is discussed on page 77. See also pages 23 and 46.

Comment: The most important consideration for women is to avoid a high blood alcohol level at any time during the pregnancy. The first weeks after conception

are probably the most critical in relation to alcohol, and the woman is usually unaware of the pregnancy at this stage. The guideline is therefore important not only for women who are pregnant, but for those who may soon become pregnant.

The literature review undertaken for these guidelines found no definite evidence that low-level drinking causes harm to the unborn child. Other authorities have, nevertheless, recommended no drinking during pregnancy. Women may choose not to drink at all, out of caution, especially if relevant risk factors are present: for example, if the mother has health problems such as high blood pressure or poor nutrition. Good antenatal care and good diet, including folate and vitamin B supplements, and not smoking are also very important.

BREASTFEEDING—A Prudent Approach

Women who are breastfeeding are advised not to exceed the levels of drinking recommended during pregnancy, and may consider not drinking at all.

Comment: Alcohol in the blood stream passes into breast milk. There is little research evidence available about the effect that this has on the baby, although practitioners report that, even at relatively low levels of drinking, it may reduce the amount of milk available and cause irritability, poor feeding and sleep disturbance in the infant. Given these concerns, a prudent approach is advised.

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Appendix 9: Fagerström test for nicotine dependence

Fagerstrom Test for Nicotine Dependence*

Score

Your score was _____

Your level of dependence on nicotine is

- | | | |
|---|-----|---------------------------|
| 1. How soon after you wake up do you smoke your first cigarette? | | Score |
| After 60 minutes | (0) | 0-2 Very low dependence |
| 31-60 minutes | (1) | 3-4 Low dependence |
| 6-30 minutes | (2) | 5 Medium dependence |
| Within 5 minutes | (3) | 6-7 High dependence |
| | | 8-10 Very high dependence |
| 2. Do you find it difficult to refrain from smoking in places where it is forbidden? | | |
| No | (0) | |
| Yes | (1) | |
| 3. Which cigarette would you hate most to give up? | | |
| The first in the morning | (1) | |
| Any other | (0) | |
| 4. How many cigarettes per day do you smoke? | | |
| 10 or less | (0) | |
| 11-20 | (1) | |
| 21-30 | (2) | |
| 31 or more | (3) | |
| 5. Do you smoke more frequently during the first hours after awakening than during the rest of the day? | | |
| No | (0) | |
| Yes | (1) | |
| 6. Do you smoke even if you are so ill that you are in bed most of the day? | | |
| No | (0) | |
| Yes | (1) | |

Source: *Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addictions* 1991;86, p.1119-27

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Appendix 10: Examples of neonatal abstinence syndrome scoring scales

Example 1: Royal Prince Alfred Hospital modified Finnegan's Scale

Modified Finnegan's scale

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

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

System	Signs and symptoms	Score
CNS	High-pitched cry	2
	Continuous high-pitched cry	3
	Sleeps <1 hour after feeding	3
	Sleeps <2 hours after feeding	2
	Sleeps <3 hours after feeding	1
	Mild tremors disturbed	1
	Mod-severe tremors disturbed	2
	Mild tremors undisturbed	3
	Mod-severe tremors undisturbed	4
	Increased muscle tone	2
	Excoriation (specify area)	1
	Myoclonic jerks	3
	Generalised convulsions	5

System	Signs and symptoms	Score
Metabolic/ Vasomotor/ Respiratory	Fever (37.3-38.3 deg C)	1
	Fever (>38.3 deg C)	2
	Frequent yawning (>3-4 times)	1
	Nasal snuffiness	1
	Sneezing (>3-4 times)	1
	Nasal flaring	2
	Respiratory rate > 60/min	1
	Respiratory rate > 60/min + retractions	2
Gastrointestinal disturbances	Excessive sucking	1
	Poor feeding	2
	Regurgitation	2
	Projectile vomiting	3
	Loose stools	2
	Watery stools	3

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

For more information on Neonatal Abstinence Syndrome from the Royal Prince Alfred Hospital Department of Neonatal Medicine Protocol Book see www.cs.nsw.gov.au/rpa/neonatal/html/newprot/nas.htm.

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

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Example 2: Women's Alcohol and Drug Service NAS Scoring System

Neonatal Handbook

Neonatal Abstinence Scoring System

Infants at risk of narcotic withdrawal are assessed for signs of withdrawal % to 1hr after each feed. Infants who display signs of withdrawal will score from signs in each of the three sections of the scoring chart. The scoring chart is designed for term infants who are fed 4 hourly. Allowances must be made for infants who are preterm or beyond the initial newborn period.

SYSTEM	SIGN	SCORE			
C.N.S.	Excessive cry	2			
	Continuous cry	3			
	Sleeps <1hr after feed	3			
	Sleeps <2hrs after feed	2			
	Sleeps <3hrs after feed	1			
	Over active Moro reflex	2			
	Very over active Moro reflex	3			
	Mild tremors disturbed *	1			
	Mod/severe tremors disturbed *	2			
	Mild tremors undisturbed *	3			
	Mod/severe tremors undisturbed *	4			
	Increased muscle tone	2			
	Excoriation *	1			
	Myoclonic jerks	3			
	Generalised convulsions	5			
G.I.T.	Excessive Sucking	1			
	Poor Feeding *	2			
	Regurgitation *	2			
	Projectile Vomiting	3			
	Loose Stools	2			
	Watery Stools	3			
OTHER	Sweating	1			
	Fever 37.3 to 38.3 C	1			
	Fever 38.4 C and above	2			
	Frequent yawning (>3-4 in 1/2hr)	1			
	Mottling	1			
	Nasal Stuffiness	1			
	Sneezing (>3-4 in 1/2hr)	2			
	Nasal flaring	1			
	Respiratory rate >60/min.	1			
	Respiratory rate >60/min. & retraction	2			
TOTAL SCORE					

Adapted from L.P.Finnegan (1986)

Explanation of Signs

- Tremors – infants should only get one score from the four options in this category
- Excoriation – score when presents, rescore only if it increases or appears in another area
- Poor Feeding – score if slow to feed or baby takes inadequate amounts
- Regurgitation – score if it occurs more frequently than usual in a newborn

Neonatal Handbook - http://www.wch.org.au/nets/handbook/index.cfm?doc_id=622#Guidelines

Source: Women's Alcohol and Drug Service (WADS), Royal Women's Hospital, Melbourne Victoria.

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Appendix 11: Example of parent information brochure on NAS

Caring for your Baby with NAS

The brochure on the following pages is laid out for photocopying, collation and folding to create an A5 booklet.

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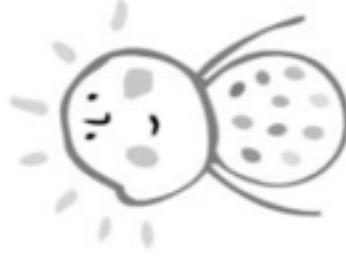
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CARING FOR YOUR BABY WITH NAS



NEONATAL ABSTINENCE CHART		Baby's Time	Score
SYSTEM	STROKES & SYMPTOMS		
OBSTETRICAL	High pitched cry	1	
MICROBIAL	Gastritis, high pitched cry	2	
SYSTEM	Shivering + 2 or more of:	3	
SYMBIOTIC	Shivering + 2 or more of:	3	
SYSTEM	Shivering + 2 or more of:	3	
SYNTERISTICS	Shivering + 2 or more of:	3	
	and/or more where determined whether infant has been treated when first noted	1	
	Child has been stabilized	2	
	Abdominal distension/tension	1	
	Decreased muscle tone	1	
	Excessive (specify area)	1	
	Respiratory (specify area)	1	
	Endocrinological manifestations	1	
	Fever (10°2–38°3°C)	1	
	Fever (38°4°C and higher)	2	
	Persistent vomiting > 4 times	1	
	Head shiffling	1	
	Seizuring > 4 times	1	
	Head flinging	1	
	Respiratory rate > 60/min with respiratory distress	2	
	Respiratory distress	1	
	Extremities jerking	1	
	Fever (rectal)	1	
	Inguinal hernia	1	
	Thigh/leg cramping	1	
	Lance pustules	1	
	Malformations	1	
	TOTAL SCORE	1	
	SCORING INITIALS		

Perinatal & Family Drug Health 2003
Drug Health Services
RPA Women's and Babies
PH: 02 9515 6111

EMERGENCY CONTACT NUMBERS:
Emergency Services Number 000
Nursery 9515 8894/8897
Perinatal & Family 9515 7611 (8:30am – 5pm) Mon – Fri

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NEONATAL ABSTINENCE SYNDROME

It is important that your newborn baby has a safe place to sleep. Bed sharing with your baby or nursing your baby in your arms whilst being effected by any substance could put your baby at risk of dying from either suffocation or overheating. It is important to provide a cot for your baby to sleep in to prevent the risk of sudden infant death syndrome (SIDS). To further reduce the risk of SIDS place your baby on his/her back to sleep, don't smoke around your baby, position your baby at the base of the cot, put your baby in clothes that may prevent overheating like cotton and don't cover your babies head, these are some things you can do as a parent to reduce the risk of SIDS (SIDS pamphlet 2001). If you have any further questions on how to reduce SIDS ask your midwife or contact the SIDS foundation on 1300 308 307.

The information in this booklet is to help you understand how to manage drug withdrawal in newborn babies. This withdrawal is known as Neonatal Abstinence Syndrome (NAS).

Once a baby has been born, the baby will no longer be exposed to the substances taken during pregnancy. This can result in a baby developing signs of withdrawal.

It is impossible to predict which babies will experience NAS, or how it will effect them. Every baby and every withdrawal is different.

Every baby will have an unsettled period each day and they tend to have a least one unsettled day per week. We need to keep this in mind so that we do not confuse normal newborn behaviour with NAS signs.

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Safe Sleeping For Under 2's.

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PARENTS' FEELINGS WHEN THEIR BABY EXPERIENCES NAS

Having a baby with NAS can often put you on an emotional roller coaster. Your emotions may range from guilt, anxiety, fear, anger, sadness, loss, grief, disappointment, relief, hope and a need to be seen as a good parent. These feelings are even stronger when you are separated from your baby. The staff acknowledge and understand that this is a very stressful and emotional time. Together we have the same goal - to help you and your baby through the withdrawal and to get your baby home with you as soon as possible.

GOING HOME

When you and your baby are getting ready to go home, you will meet with the DIPS social worker, DIPS team and RPA staff to talk about:

- ❖ Referral to Neonatal Early discharge & Family Support Program
- ❖ Your baby's Blue Book
- ❖ Postnatal clinic or Early Childhood Health Centre
- ❖ Giving your baby's medication for NAS
- ❖ Linking in with community resources
- ❖ Medicare, birth registration and Centrelink forms
- ❖ Emergency contact phone numbers (see back page)
- ❖ STDS and safe sleeping for under 2's

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-2-

SIGNS OF NAS

Is your baby experiencing any of these signs?

- ❖ High pitched cry
- ❖ Irritability
- ❖ Tremors/Jittering
- ❖ Sleeping difficulties
- ❖ Snuffy nose
- ❖ Sneezing
- ❖ Feeding difficulties due to sucking problems
- ❖ Tense arms, legs and back
- ❖ Poor weight gain
- ❖ Vomiting/Diarrhoea
- ❖ Increased breathing rate
- ❖ Convulsions
- ❖ Skin irritation
- ❖ Increased temperature, sweating



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NAS is when your baby displays a combination of these signs:

Babies may also experience these signs for other reasons, so your baby will be closely monitored to exclude other problems such as a fever.

Most babies who experience NAS show signs within 24-72 hours after birth. Sometimes however, signs don't appear until 7 days after your baby is born, and for this reason all babies exposed to alcohol or other drugs during pregnancy need to stay in hospital for at least 5 - 7 days to be monitored.



-3-

The dose of medications prescribed for your baby will depend on:

- ❖ The NAS scores (the higher the scores, the higher the dose needed).
- ❖ Your baby's weight (the more your baby weighs, the higher the dose needed).

The dose is adjusted according to your baby's response to treatment. The process of scoring, assessing and reducing the medication continues until the signs of withdrawal have stopped. Sometimes your baby's medication needs to be increased if they suddenly put on a large amount of weight.

Babies can be discharged home on these medications and medical follow up will be arranged prior to your baby leaving hospital. Staff will teach you how to administer the medication and what times to give it.

The midwives will help you with some techniques that may assist you and your baby. These involve things like positioning to aid feeding, wrapping your baby, massage, bathing and settling techniques.

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The time it takes for signs of NAS to begin to show depends on:

- ❖ The combination of drugs or alcohol used in pregnancy, particularly in the last three days before the birth.
- NAS can last from one week to six months. The length of the withdrawal process can depend on:
 - ❖ The amount of drugs or alcohol a baby has been exposed to.
 - ❖ Multiple drug use eg: using methadone with either speed, heroin, benzodiazepines, alcohol &/or cocaine.

MEDICATION

The medications that are used to treat NAS are morphine and phenobarbitone. They are used either separately or as a combination of both.

MORPHINE

Morphine is an opiate-based medication and a depressant. Morphine is prescribed to treat your baby for opiate withdrawal, for example if your baby has been exposed to methadone, heroin, morphine, ponazaine forte etc.

Other medication may be considered if the morphine dose cannot be increased further and your baby remains unsettled.

PHENOBARBITONE

Phenobarbitone (phenobarb) is an anticonvulsant and a barbiturate. Phenobarb is prescribed to treat your baby for withdrawal from substances such as benzodiazepines and alcohol. Some babies need a combination of morphine and phenobarb to settle their symptoms. For example, if your baby has been exposed to multiple drug use such as methadone and benzos or if we have reached the maximum dose of morphine and your baby remains unsettled with NAS.

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The reduction or elimination of drug use other than methadone will help to decrease the likelihood and/or severity of any withdrawal symptoms experienced by your baby.

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NAS MAY OCCUR DIFFERENTLY DEPENDING ON THE SUBSTANCE YOUR BABY WAS EXPOSED TO:

Amphetamines - Babies exposed to this drug may become more irritable. Disturbed sleep pattern and feeding patterns are often noticed and settling techniques are encouraged in these babies.

Benzodiazepines - Withdrawal symptoms can be delayed following birth. When used in combination with opiates eg. Methadone/Heroin the withdrawal in the baby is more difficult and stabilisation on medication may take a longer time.

Cocaine - When used in combination with opiates eg. Methadone/Heroin the withdrawal in the baby is more difficult and stabilisation on medication may take a longer time.

Heroin - Withdrawal symptoms can begin to be observed from 2hrs to 48hrs following birth.

Marijuana - Babies exposed to this drug may become more irritable and have a disturbed sleep pattern. Soothing Settling techniques are encouraged in these babies.

Methadone - Withdrawal symptoms can begin to be observed from 48hrs up to 7 days following birth.

MANAGEMENT AND TREATMENT OF NAS

You and the midwife will assess your baby for signs of withdrawal every 4 hours before a feed using the score chart (see back page).

The scores recorded against each sign are added up. If the score comes to 8 three times in a row or above 8 twice in a row your baby will be transferred to the nursery so that your baby can be monitored more closely. If your baby cannot be settled with nursing techniques then your baby will need, for your babies own comfort, to commence on medication to treat NAS.

Your baby will need to stay in the nursery for a minimum of 24-48 hours and will stay in hospital until the NAS is stabilised with medication. This can sometimes take several weeks, depending on your baby and how your baby is coping during this time.

The nursery is staffed by nurses, midwives and doctors who will assist you to care for your baby. They will show you how to give your baby his/her medication. If you find you are feeling substance effected at any stage it may be a good idea to get support from the people around you rather than handling your baby yourself.

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SUGGESTED SETTLING TECHNIQUES FOR YOUR BABY / CALMING SUGGESTIONS	Excessive sucking	Poor feeding	Trembling	Fever
Prolonged crying (may be high pitched)	<ul style="list-style-type: none"> Hold your baby close to your body, perhaps wrapped in a sheet or light blanket. Avoid loud noises, bright lights and excessive handling. Try not to pat your baby, just rub your baby gently. Humming and gentle rocking may help. Able to sleep your baby on his/her back. 	<ul style="list-style-type: none"> This is a sign of NAS. Infants will be normal baby behaviour. 	<ul style="list-style-type: none"> Your baby may require more frequent breastfeeds You may need to feed your baby small amounts, often, using slow-flow teats. Feed in a quiet, calm surrounding with minimal noise and disturbance. 	<ul style="list-style-type: none"> You may need to wrap your baby securely in a sheet/light blanket.
Breastfeeding				
Sleeplessness	<ul style="list-style-type: none"> Your baby needs a quiet environment. If your baby is sleeping after your baby to rest. This may make them sleep more comfortably. If your babies bottom looks irritated, clean with water only, using zinc cream every change. 	<ul style="list-style-type: none"> NAS can make your baby very warm. Try not to use too many blankets or clothes on your baby. Your baby may need to be dressed in cotton clothes or simple like cheese cloth that allows the heat to escape. If your baby has a temperature over 37.5 degrees you should seek medical help. 		
Vomiting	<ul style="list-style-type: none"> Your baby may vomit some times. Hold your baby in an upright position when feeding. Burp your baby after each feed. 			

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Appendix 12: Duration of postnatal hospitalisation required to detect severe NAS

Introduction: Severe neonatal abstinence syndrome (NAS) is a potentially life threatening medical illness. Inpatient observation for 7 to 10 days after delivery is recommended to avoid unsupervised withdrawal. However, prolonged inpatient stay has significant psycho-social and economic implications to both the infant's family and the community.

Aim: To evaluate appropriate duration of hospitalisation sufficient to detect severe NAS prior to discharge.

Methods: We conducted a 2 year retrospective review of all infants born to narcotic dependent women at the Royal Women's Hospital in the time period between January 1998 and December 1999 (inclusive).

All infants were observed as inpatients utilising a modified Finnegan NAS scoring system until a minimum of 7 days of age.

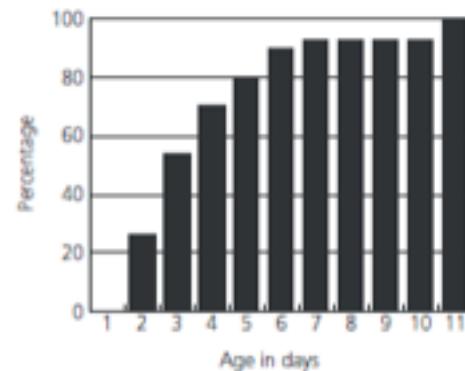
Severe NAS was defined as that requiring medical therapy based on the recommendations of Finnegan et al.

Age in days when each infant first received medication was recorded.

Results: 203 infants exposed to regular maternal narcotic use during pregnancy were born during the study period.

40 (20 per cent) infants received postnatal oral morphine therapy for symptoms of significant narcotic withdrawal.

Cumulative percentage of infants requiring medication for narcotic withdrawal



36 of the medicated infants were exposed to regular antenatal methadone, 4 were exposed to heroin only.

38 infants (95 per cent) experienced peak symptoms of neonatal abstinence syndrome by 7 days of age.

Conclusion: Discharge of infants born to narcotic-dependent women prior to 7 days of life may result in a significant risk of these infants experiencing symptoms of severe neonatal abstinence syndrome in an unsupervised environment.

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