

The Snuggle ME Guidelines: Tools for Caring for Women with Addiction and Their Babies

2nd Edition

Purpose: The purpose of the Snuggle ME guidelines is to give Family Medicine, Obstetric, Pediatric and Addiction Medicine providers' evidence informed tools to care for pregnant women with substance use disorders and their newborns.



Paul R. LePage, Governor

Department of Health
and Human Services
Maine People Living
Safe, Healthy and Productive Lives

Ricker Hamilton, Commissioner

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

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

Screen for Substance Use @
 First Prenatal Visit/Intake:
 Tools: 4P+ or CRAFFT or CAGE-AID
Women should be screened privately
 • Assess and address psychiatric co-morbidities (PHQ-9)
 • Assess social risk factors: Domestic violence/homelessness (PVS or WAST)

Negative Screen
 Re-screen at 24 to 28 Weeks

Brief intervention (should be done privately)

Positive Screen for Substance Abuse

Denies Need for Treatment

Willingness to Accept Treatment

- Provide information about perinatal risks
- Assess/address psychiatric co-morbidities
- Assess/address social risks including domestic violence and homelessness
- Close interval follow-up appointments including motivational interviewing

Signs of acute withdrawal

YES

NO

Go to Emergency Department

Probable Physiologic Dependence

Unclear or Unlikely Physiologic Dependence

Refer to Counselor Trained in Addiction

- Consider in-patient stabilization or referral to experienced outpatient addiction provider:
- Alcohol (detox required if physically dependent)
- Opiates/benzodiazepines (management may vary based on level and type of use)
- Amphetamines (residential treatment recommended)

***Withdrawal Symptoms May Include:**

Maternal	Fetal
*Dilated Pupils	*Fetal Distress
*Anxiety	*Fetal Tachycardia
*Hypertension, Tachycardia	*Late decelerations (EFM)
*Muscle spasms, tremors	
*Sweating chills, flushing	
*GI Distress: Vomiting, Diarrhea	

Referral to residential or intensive outpatient treatment
 Or
 Step down to office-based buprenorphine or methadone program
 And
 Weekly counseling by substance abuse counselor
 And
 Sign consents to coordinate substance abuse treatment plans with OB Provider

***Chapter 1: Screening for Substance Use During Pregnancy**

Why screen for substance abuse during pregnancy:

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

Women are more likely to participate in health care while they are pregnant.

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

Who should be screened?

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

When should screening occur?

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

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

How to screen:

Universal verbal screening for substance abuse allows the health care provider to discuss the risks of alcohol, drug, and tobacco use with every pregnant woman and eliminates provider bias in determining who is screened. Screening all patients using a validated instrument increases the chance that prenatal substance abuse will be identified, addressed, and potentially reduced by introducing the option for intervention (Chasnoff et al., 2005, Chang et al., 2011).

Screening should be done with women in a private setting. Screening can be performed using interview-based or self-administered questionnaires. A number of instruments have been developed and tested for use

with pregnant women. These include the 4Ps Plus, CRAFFT, CAGE-AID, TACE, and TWEAK (see Appendix B) (Chang et al., 2011; Burns et al., 2010; Chasnoff et al., 2005; Gavin et al., 1987; Humeniuk et al., 2008; Yonkers et al., 2010).

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

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

Brief Intervention:

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

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

Motivational Interviewing:

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

Referral to Treatment:

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

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

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

Referral to the emergency department is recommended if a pregnant woman is in acute withdrawal and unable to access immediate treatment. Unless trained to do so, obstetrical providers should not attempt to treat a woman who is withdrawing from drugs in the outpatient setting. Providers should not prevent withdrawal by prescribing opioids.

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

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

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

Pain Control:

Pain control, both in labor and after surgery is a particular challenge for opioid dependent obstetrical patients and is often a source of particular anxiety. When possible, an anesthesia consultation is recommended in the

third trimester. The various pharmacologic and non-pharmacologic options to manage pain in labor and their effectiveness should be discussed with the patient prior to labor onset.

Toxicology Testing:

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

Toxicology tests may be medically indicated in patients who have:

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

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

Resources related to substance abuse screening and intervention:

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

1. **SBIRT:** <http://www.sbirtraining.com/SBIRT-core>. This program has been developed through collaboration between the American Society of Addiction Medicine (ASAM) and the National Institute for Drug Abuse (NIDA)
 - On-line, on-demand program
 - Cost: \$75
 - AMA PRA Category 1 CME (4 hours)
2. The University of New England College of Osteopathic Medicine is hosting an ongoing, online CME course: Domestic Violence Response Initiative: Screening for Abuse. This course is taught by Daniel Oppenheim, MD and Karen Wentworth, Domestic Violence Community Educator. To register, go to: http://aicme.com/catalog_class.asp?clid=167
 - Cost is \$29
 - CEU 1
3. Training in Motivational Interviewing is available through on-line programs: <http://www.motivationalinterview.org/>
4. **Links to a few of the SAMHSA TIPS:**

Buprenorphine guidelines TIP 40: <https://store.samhsa.gov/shin/content/SMA05-4003/SMA05-4003.pdf>

Opioid maintenance therapy Quick Guide to TIP 43: <https://store.samhsa.gov/shin/content/QGCT43/QGCT43.pdf>

SAMHSA Collaborative approach to care of pregnant women with opioid use disorder: <https://store.samhsa.gov/shin/content/SMA16-4978/SMA16-4978.pdf>
5. **Other:**

World Health Organization Guidelines: http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/

American Society for Addiction Medicine Guidelines: [https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24#search="pregnant"](https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24#search=)

*Chapter 2: Quick Reference Checklists

➤ Antepartum Care Recommendations ◀

First Trimester

- ❑ Do SBIRT screening (Screening, Brief Intervention, Referral to Treatment)
<http://www.maine.gov/dhhs/mecdc/documents/Snuggle-ME-Screen-tool.pdf>
 - CRAFFT, 4 Ps, CAGE-AID are all acceptable standardized tools to use. See Appendix A
 - If positive, ask if patient is enrolled in a treatment program and obtain appropriate consents for coordination of care. See Appendix F for treatment program options.
- ❑ Check patient's record in the Prescription Monitoring Program (PMP)
<http://www.maine.gov/dhhs/samhs/osa/data/pmp/index.htm>
 - Patient receiving prescriptions for chronic pain should have a drug agreement in place (see Appendix H).
 - At first prenatal visit, consider bowel regimen of stool softeners, fluids, fiber products and hemorrhoid cream for opiate-associated constipation.
 - At first prenatal visit, assess need for anti-emetics and antacids for reflux/morning sickness which can mimic or confound withdrawal symptoms.
- ❑ Testing
 - Add HIV, Hepatitis C, and Sexually Transmitted Infections to routine lab panel.
 - Perform Risk screening for tuberculosis (TB).
 - Do Dating ultrasound upon entry to care.
 - EKG if on methadone to assess for prolonged QT.

Patient Resources...

- ✓ Enroll in www.text4baby.org for anticipatory guidance during pregnancy and first year of life.
- ✓ Consider referral to Public Health Nursing, case management, or social worker.
- ✓ Make additional referrals such as Maine Families, legal services, child protective services, education and career building support, adoption, domestic violence counseling, WIC, public assistance, food stamps (SNAP), transportation, mental health services.
- ✓ Provide patient information about smoking cessation maternal drug use/effect on infants:
<http://www.maine.gov/dhhs/samhs/osa/help/fadebrochure2012.pdf> and
<http://www.maine.gov/dhhs/samhs/osa/help/fasddab/pubs/MJ-PGT%20FINAL.pdf>
- ✓ Give family trifold about newborn care and NAS. See *Appendix J Section B*.
- ✓ For more detailed information provide families with booklet about newborn care. See *Appendix J Section C*
- ✓ Review breastfeeding guidelines with mothers:
<http://www.maine.gov/dhhs/samhs/osa/help/fasddab/pubs/BFandSubstanceUse.pdf>
- ✓ AAP recommended resource for medication safety during lactation is:
<http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

Second and Third Trimesters

- Testing
 - Order a 18-20 week ultrasound for anatomic abnormalities.
 - Consider monthly ultrasounds starting at 24 weeks to monitor fetal growth, fluid, and placental function.
 - Repeat labs (Hep C/HIV/STI/RPR panel) at 28 weeks as indicated by continued use of illicit drugs, multiple sexual partners, other high risk behaviors, or social situation.
 - Perform toxicology testing when clinically indicated. Positive toxicology tests should be sent for confirmation.
 - Mothers and providers should be aware that marijuana can be positive in the urine for up to 2 months. Discourage use of marijuana in pregnancy.
- Planning for Labor Pain & Medication Management
 - Work with patient to develop pain management plan in the second trimester. Patients will most likely need an epidural for adequate pain control in labor.
 - Consider anesthesia consultation in the third trimester if IV access is difficult or severe anxiety, or coexisting medical issues could prevent spinal analgesia.
 - Refer for childbirth education.
 - Confirm that hospital has buprenorphine available on formulary or that patient may bring her own medication.
 - Consider Maternal Fetal Medicine (MFM) referral as needed.
- Planning for Newborn Assessment and Care
 - If delivering hospital is not able to provide care for infant with NAS, discuss patient preference for transfer of care in last trimester of pregnancy vs. transfer of newborn after birth if pharmacologic management (required).
 - Facilitate **prenatal appointment with neonatologist/pediatric care provider** who will care for infant after birth.
 - Inform families that the law requires a **Drug Affected Baby (DAB) notification** to DHHS after birth of the baby. <http://www.mainelegislature.org/legis/bills/getDoc.asp?id=15193>
 - Advise families that length of stay for newborns is 5-7 days for observation and that NAS scoring will be done.
- Consider referral to **Public Health Nursing** at any time during pregnancy

➤ Intrapartum Recommendations ◀

- ❑ Anesthesia consult
- ❑ Consider acute withdrawal in the differential diagnosis of a woman with intractable nausea, vomiting or abdominal pain.
- ❑ If a woman discloses illicit substance use during her hospitalization, which was not identified during pregnancy, consider phone consultation with an addiction specialist, treatment center, or a MMC Maternal Fetal Medicine physician at (800) 499-8344.
- ❑ Confirm woman's dose of methadone or buprenorphine and notify treatment provider of OB admission.
 - These medications should be continued at their normal dose and time during labor and/or a cesarean section.
 - An attending may legally prescribe buprenorphine and methadone to maintain a woman's usual dose during her hospitalization. Federal regulation available at:
http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm
- ❑ Review newborn testing recommendations with patients privately.
- ❑ PICC or central line may be needed when peripheral venous access is too difficult due to history of IV drug use.
- ❑ Pain Management in Labor
 - A woman with substance use disorder may require higher and more frequent dosing of narcotic pain medications during labor.
 - Methadone or buprenorphine do not provide adequate pain relief during labor.
 - ***Do not use Nubain or Stadol for pain control during labor in women with opioid dependence.***
 - ***All*** women should be asked about substance use history prior to use of these medications, and informed that these drugs can cause acute withdrawal in women with dependence on opioids.
 - If Nubain or Stadol is given inadvertently, withdrawal symptoms can be reversed with IV Fentanyl or Morphine.
 - ***Neuraxial analgesia (spinal or epidural) may be the most safe and effective way to control pain for vaginal births and cesarean sections.***
 - Surgical patients delivered with general anesthesia will usually need a PCA with morphine or Dilaudid to control post cesarean section pain.

➤ Postpartum Recommendations ◀

Vaginal Birth

- ❑ A woman with substance use disorder may require higher and more frequent dosing pain medications; approximately 75% require scheduled doses of NSAIDS and acetaminophen for mild to moderate pain. Short acting opioids can be added as needed.
- ❑ Maintain woman's buprenorphine and methadone usual dose during her hospitalization, including while in labor and delivery. Re-evaluate dose with the addiction treatment provider after the baby's birth.

Cesarean Sections

- ❑ Maintain woman's buprenorphine and methadone usual dose during her hospitalization. Re-evaluate dose with the addiction treatment provider after the baby's birth.
- ❑ Pain Management for the first 24 hours post-op
 - Patient controlled IV analgesia and/or neuraxial analgesia.
 - Oral opioids can be added for break-through pain.
 - Anticipate scheduled dosing of 1.5 times the normal dose every 3 hours.
- ❑ Pain Management after 24 hours post-op
- ❑ Scheduled doses of NSAIDS or acetaminophen for mild to moderate pain. Short acting opioids can be added as needed.

General Postpartum

- ❑ Hospital breastfeeding guidelines should be reviewed with mothers. Women who are stable in treatment on buprenorphine or methadone and do not use illicit drugs can be encouraged to breastfeed. Caution should be advised against the abrupt cessation of breastfeeding, particularly in patients maintained on methadone.
- ❑ Each hospital should have a clear policy regarding breastfeeding and marijuana use. Go to: <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT> for medication and breastfeeding recommendations.
- ❑ Breastfeeding is contraindicated in women who are HIV positive or who have herpetic lesions on the breast.
- ❑ If infant is on an opioid for treatment of NAS, consider maintaining mother on buprenorphine as opposed to Suboxone because of the potential risk of acute withdrawal in the newborn due to the Naloxone component.
- ❑ Skin to skin contact and rooming in should be encouraged.
- ❑ Complete drug affected baby (DAB) notification as required by law.

- ❑ Work with social workers or nursing staff to complete newborn referral sheet to public health nursing and Child Development Services, in collaboration with the newborn's primary care provider.
- ❑ Notify the addiction treatment provider upon discharge to confirm the patient has a follow up appointment. Give patient a list of medications administered during hospitalization as well as those prescribed at discharge. Be sure to indicate the timing of the last dose. Treatment providers will re-evaluate the patient's dose postpartum and provide all outpatient prescriptions.
- ❑ Some methadone clinics close by early afternoon. Check hours of methadone clinic prior to discharge so that the patient does not miss a dose.
- ❑ Be alert for symptoms of overmedication. When a patient appears somnolent, consider decreasing either pain medication or patient's regular dose of buprenorphine or methadone. It is best to consult with the addiction treatment provider prior to adjusting the dose of the medication assisted treatment.
- ❑ A postpartum visit should be scheduled for two weeks postpartum, which should include making a reproductive plan, screening for postpartum depression, and connecting patient to a primary care provider for continued follow through a Cradle ME referral.

**Chapter 3: Antepartum Management of Patients with Opioid Use Disorder*

TREATMENT PROGRAMS FOR PREGNANT PATIENTS WITH OPIOID USE DISORDER:

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

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

This link will take you to the state website and webinar, PowerPoint and PA document:

<http://www.maine.gov/dhhs/oms/provider/addiction.html>

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

Providers should facilitate access to appropriate services:

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

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

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

BARRIERS TO TREATMENT:

The major barriers to methadone treatment are the restricted hours of operation at clinics and the distance patients have to travel every day. These issues are particularly problematic for women in school, working, or with small children at home. Access to medication and the ability to realistically comply with a treatment program must be considered in the ultimate decision making regarding medication choice. Due to limitations in the number of providers of buprenorphine and the limited availability of methadone clinics, patients often cannot choose the medication they prefer. Prior to accepting patients maintained on buprenorphine or methadone, obstetric providers must be sure that newborn providers in their hospitals can properly care for

neonates with NAS – or when local care is not available, there must be planned transition late in gestation to an institution with providers trained to care for both the opioid-dependent mother and the substance exposed neonate.

PRENATAL CARE OF WOMEN WITH HISTORY OF DRUG USE:

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

ULTRASOUND TESTING:

Pregnancy dating should be confirmed with early ultrasound as oligomenorrhea and irregular cycles are associated with opioid dependence. All patients should have complete ultrasound examinations for anatomical abnormalities by 18-20 weeks. Neither methadone nor buprenorphine are known to cause anomalies. However, lifestyle variations such as smoking, poly-substance use, diet, chaotic social environment, work or exercise have an impact on fetal growth. Recommend every 4 week ultrasounds for growth starting at 24 weeks gestation. Doppler flow studies should be added to assess placental function when intrauterine growth restriction or oligohydramnios is suspected. Cocaine, amphetamines and tobacco particularly predispose the fetus to growth restriction and placental disruption. Alcohol exposure may also cause growth restriction. Patients still using illicit drugs, or whose lifestyles, toxicology tests, or physical signs and symptoms are concerning will require more frequent ultrasound surveillance to determine fetal wellbeing.

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

Women should receive adequate psychiatric treatment to address comorbid post-traumatic stress disorder (PTSD), depression, anxiety, and eating disorders. Patients on opioid agonists often request psychotropic medications like benzodiazepines to treat anxiety symptoms, however, the risk and benefits of additive therapy must be carefully considered. Many clinics discourage the use of benzodiazepines concurrently with opioid replacement therapy due to concerns about drug-drug interactions for the mother and increased rate and severity of abstinence symptoms in the newborn (SAMHSA TIP 43, Cleary 2012).

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

DENTAL ISSUES:

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

MUSCULOSKELETAL PAIN:

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

GASTROINTESTINAL PROBLEMS:

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

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The Outpatient Treatment Manual for the Care of Opioid-Dependent Pregnant Women with Buprenorphine

Introduction

For more than 40 years, methadone has been the standard of care in the treatment of pregnant women with opioid use disorders. However, a growing body of evidence suggests that buprenorphine is a safe and effective alternative and many now advocate that it should also be a first line therapy during pregnancy (Alto & O'Connor, 2011; Jones et al., 2010). In contrast to methadone, buprenorphine is associated with fewer maternal medical complications and overdoses and a shorter duration of infant hospitalization (Bell et al., 2009; Holbrook et al., 2012; Jones et al., 2005; Jones et al., 2010). Infants of mothers treated with buprenorphine during pregnancy have a similar or lower frequency and/or severity of neonatal abstinence syndrome (NAS) when compared to those born to mothers maintained on methadone during pregnancy (Bell et al., 2009; Fischer et al., 2006; Gaalema et al., 2012; Jones et al., 2005; Jones et al., 2010; Lejeune et al., 2006).

http://www.mainedartmouth.org/wp-content/uploads/2015/12/OConnorAltoOutpatientTreatmentManualOpioidDependentPregnant_V2.pdf

***Chapter 4: Intrapartum Management**

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

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

Some patients and providers fear that using opioids for pain management will lead to a loss of control and fear re-addiction. Patients can be reassured that the methadone or buprenorphine will block the euphoric effects of opioid analgesia which will still provide pain relief. If nausea and vomiting is a problem, patients should be pre-medicated with anti-emetics so that they can tolerate oral medications and food. Patients on methadone maintenance who have developed a prolonged Q-T interval should be treated with Phenergan rather than Zofran. Patients who cannot tolerate oral medication can be treated parentally. Central lines or PICC lines may be needed in patients with a history of IV drug use with sclerotic veins.

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

➤ Pain Management of Patients on Opioid Agonist Therapy (OAT) ◀

Paralleling a nationwide trend, there have been an increasing number of parturients on OAT (methadone or buprenorphine, also known as Subutex) presenting for delivery at Maine hospitals. This has led to questions about how to manage these patients. It is widely accepted that the best course of management is to maintain these medications (to address the patient's baseline opioid requirement for their addiction) rather than abruptly discontinue them around the time of delivery. It is also recognized that these medications do not themselves provide analgesia for labor or after surgery and that the patient's pain needs to be effectively treated.

For laboring patients, management does not differ from patients not on OAT. Thus, parenteral opioids and epidural analgesia can both be offered as well as supportive care if the patient desires.

Patients presenting for cesarean delivery on OAT should have their doses of these medications continued throughout the peripartum period with additional medication provided to control their acute pain. A multimodal pain control approach is recommended using opioids, NSAIDs and acetaminophen. Use of intravenous patient-controlled analgesia (PCA) is frequently cited as an effective management strategy in these patients as part of this approach. In addition, these patients may benefit from post-operative epidural analgesia or transverse abdominal plane (TAP) block if these modalities are available in a given institution.

While buprenorphine monotherapy is generally recommended during pregnancy to prevent the fetal risk of acute withdrawal if the buprenorphine/naloxone combination product (Suboxone) is misused, if the patient is maintained on Suboxone when she becomes pregnant, it is not urgent to swap her to the monotherapy if she is not misusing the medication. A reasonable approach is to transition her to monotherapy at the time of her next prescription refill. This will allow the provider to complete the required prior authorization (if the patient is on MaineCare) without any interruption in medication.

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Guideline for the Management of Labor, Delivery and the Newborn in the Opioid Dependent Pregnancy, Northern New England Perinatal Quality Improvement Network, March 2014

The following is a link to the ACOG Committee Opinion on management of these patients (will likely need to copy and paste in browser) <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy>

* *Chapter 5: Postpartum Management*

MANDATORY NOTIFICATION TO DHHS AND INSTITUTIONAL POLICIES:

Whenever possible, patients should be advised prior to admission for delivery that a notification will be made to DHHS in compliance with federal and state laws regarding drug affected neonates. Patients, who are late registrants, or those who have had no prenatal care, may need to be informed after delivery. Patients benefit from meeting with the social worker in the antepartum period to alleviate their fears and prepare them for DHHS notification. Patients should also be informed of their institution's policy on breast feeding and marijuana use earlier in pregnancy, but may need to have protocols explained again after delivery. It may be helpful to mothers to be educated about NAS scoring – how it works, how it impacts length of stay for their neonate, whether or not they will be able to breastfeed or not, whether they will be able to stay at the hospital or an “off campus” facility. Mothers should be advised that the infant going through NAS may be very difficult to soothe.

BREASTFEEDING:

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

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

POSTPARTUM PAIN CONTROL:

After a vaginal delivery, acetaminophen and non-steroidal anti-inflammatory agents should be used for mild to moderate pain. Short-acting opioid analgesics can be added on an as needed basis. Opioids for pain control should not be needed following discharge for a routine vaginal delivery, except in special cases, (i.e. third and fourth degree tears). In cases of cesarean section deliveries, patient controlled IV analgesia or duramorph added to the spinal can assist with pain for the first 24 hours. Oral opioids can be added for break-through pain and can be utilized for the next week or longer in addition to the maintenance medication (methadone or buprenorphine). Upon discharge, patients will often need a written letter from their provider that documents what medications they received in the hospital, including dose, date, and time.

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

* **Chapter 6: Compassion Fatigue and Caring for Ourselves**

Compassion Fatigue and Compassion Satisfaction:

Carla Joinson first coined the term, "compassion fatigue", when she noticed a decrease in empathy among emergency room personnel that she was working with (1992). Coupled with previous work done by Charles Figley, the definition has shifted to "a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress" (1995). Since the 1990's, compassion fatigue has been used to describe these feelings of depletion that is often experienced by anyone who works with those who are suffering: medical personnel, mental health clinicians, veterinarians, etc. In 1999, Beth Stamm introduced the term, "compassion satisfaction", to discuss the feelings of "pleasure you derive from being able to do your work well". Providers can measure their compassion satisfaction by asking themselves, "Did I bring my most compassionate, kind and empathic self into the interactions I had with others and did I bring this for them and myself?" Even if the situation did not turn out the way the provider had hoped – if the answer to the above question is, "Yes", then they are in a place of compassion satisfaction.

Prevalence of compassion fatigue:

Research shows compassion fatigue is high among medical workers, especially those working with pediatric critical care patients. In a study that focused on 464 neonatal nurses, 35% reported moderate to severe levels of compassion fatigue (Beck & Gable, 2012). Another study (Garcia, Garcia, Molon, et al., 2014) showed the prevalence of compassion fatigue among doctors working in pediatric critical care, was 71%, more than twice the rate found in pediatricians with a general focus. While some of the reasons, for the higher levels of compassion fatigue cited within the studies, were related to working with infants who were suffering, numerous reasons specifically related to working with parents who are experiencing addiction were also reported as major stressors.

Risk Factors:

In 1999, James Munroe began talking about compassion fatigue as an "occupational hazard" of caring for others. This delineation works towards changing the mindset from "If I experience this maybe it means I can't do the work" to "This is something I am at risk of experiencing *because* I do the work well". Providers working in pediatric critical care are at risk of experiencing compassion fatigue because of exposure, interaction and working in an often emergent and crisis survival mode. Working in pediatric critical care often means working with, and being *exposed* to, the most vulnerable population during a time when they are experiencing suffering. Additionally, providers are not only working with the patient but they are also *interacting* with the families, who often times are managing their own feelings of guilt, shame, and fear related to the suffering of their child and/or who may be experiencing reactions related to their own trauma histories. In fact, in a qualitative study to investigate the experiences of NICU nurses working with infants with NAS, completed by Murphy-Oikonen, Brownlee, Montelpare, and Gerlach (2010), nurses reported their roles felt significantly more

demanding due to the needs of the parents vs. the needs of the infants. Parents who have children in the NICU often experience it as stressful; however this level of stress is often exacerbated when the parent is using substances, especially when the substance use may have led to the infant needing the NICU resources. Nurses also noted that they anticipated their work would involve the additional skills needed to take care of critically ill infants and instead are finding what is needed is time and love, something they often don't have the manpower to adequately provide. Finally, frequently working in an *emergent and crisis driven environment* (monitors may be making noises a lot of the time; infants may be crying, inconsolably, if not held most of the time; parents ineffectively expressing their fear, guilt and/or shame; etc.), means providers' fight, flight or freeze response is being repeatedly activated; however, providers are often not able to respond to this activation. The more the body and brain go into survival mode, the harder it is to distinguish real emergencies from non-real emergencies and that alone, can be draining.

Managing Reactions and Building Resilience:

There are skills that can be utilized to help manage compassion fatigue related reactions and build personal resilience. For quick, in the moment relief, take a deep belly breath, imagining there is a balloon inside the stomach and with every inhale, the balloon is being blown up and with every exhale the air is being let out of the balloon. This can be done alone or a quick grounding technique can be added in. To do this, simply place both feet flat on the floor, close the eyes (or lower the gaze to the floor), inhale to a count of 4, pause and exhale to a count of 5. There are also ways to manage reactions on a more continuous basis. Studies have shown that medical practitioners, who reported positive relationships with other staff, colleagues, and administrators, were more likely to report higher levels of compassion satisfaction (Linzer, et al., 2009; Karsh, Beasley & Brown, 2010). Seeking out ways to strengthen connections with colleagues and utilizing managers and supervisors for support are just a couple of ways to increase positive professional relationships. Just as connection within the work is a protective factor for compassion satisfaction, disconnection from the work, is also a protective factor. Allowing time for disconnection and developing ways to "leave the work at the office" gives providers the space to recharge their battery and connect to the people, places and activities that help build personal resilience.

Another important step in building personal resilience is increasing awareness about the self and others. How well a provider understands what led to an adverse situation, what they brought (and what others may have brought) to the situation and how it impacted them influences how the situation is managed. Additionally, interacting with others, with a trauma-informed lens can help alleviate challenges when working with parents and families. Recognizing that substance use is often a coping skill for people experiencing trauma related reactions allows for the acknowledgment that it is not as simple as someone making a choice that harms their child but rather a complex process that includes the caregiver utilizing a survival skill that providers may not understand. When working with others becomes challenging, providers often question what they are doing wrong and/or why the patient (or their family) can't just do what is being asked of them and this can lead to thoughts of inadequacy on the part of the provider. Being able to change those thoughts from "What am I

doing wrong?” to “What is happening in this situation and/or what has happened in this person’s life that is making it hard for the patient/family to effectively work with us?” can decrease those negative feelings providers may have about their work, which is another way to manage compassion fatigue.

Finally, knowing how to effectively recover from an adverse situation can help build personal resilience. Knowing what coping skills work and what coping skills don’t work will allow for easier access to the helpful techniques during the stressful time.

Positive Outcomes of Identifying and Managing Compassion Fatigue Reactions:

Managing reactions and positive outcomes have a cyclical effect on each other. When a provider experiences compassion satisfaction, there is a greater ability to empower parents, which leads to improved parent-child attachment and improved outcomes for parents and child, which can lead to increased compassion satisfaction among providers, which continues the cycle. Additionally, compassion satisfaction is a protective factor for providers sustaining themselves in the work. Flight attendants tell passengers, “If the cabin air pressure changes and the oxygen masks come down, even if you have someone sitting next to you who needs help...put your own oxygen mask on first” because they know that if a passenger tries to help someone else, the risk for both to run out of air is greater than if the passenger gets their own mask on and then offers help. The same is true for providers who are exposed to pain and suffering – identifying and managing compassion fatigue and employing resilience building techniques is the “oxygen mask” that can increase provider sustainability.

How and When To Reach Out for Additional Support:

An often asked question is when should a provider reach out for additional support? Building awareness about the self and others is critical in understanding what reactions are typical and what reactions may be signs of something bigger manifesting and in understanding when additional help may be needed. Utilizing a self-scoring measure (see Appendix) is one way to begin building this awareness and allows for the provider to capture a baseline of current thoughts, feelings and reactions. If a provider is experiencing negative reactions that are on-going (typically for more than a couple of weeks) and/or if a manager or leader notices reactions that are not subsiding after a couple of weeks, then reaching out for additional supports could be beneficial. Additional support could range from increasing the utilization of coping skills to working on ways to disconnect from the work to seeking professional support through EAP and/or other mental health services. This chapter includes a self-scoring assessment measure and two handouts with quick, in the moment coping skills that can be utilized to manage compassion fatigue related reactions.

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Compassion Satisfaction and Fatigue (CSF) Test

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-test.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

	Items About You:
	1. I am happy.
	2. I find my life satisfying.
	3. I have beliefs that sustain me.
	4. I feel estranged from others.
	5. I find that I learn new things from those I care for.
	6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
	7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
	8. I have gaps in my memory about frightening events.
	9. I feel connected to others.
	10. I feel calm.
	11. I believe that I have a good balance between my work and my free time.

	12. I have difficulty falling or staying asleep.
	13. I have outburst of anger or irritability with little provocation
	14. I am the person I always wanted to be.
	15. I startle easily.
	16. While working with a victim, I thought about violence against the perpetrator.
	17. I am a sensitive person.
	18. I have flashbacks connected to those I help.
	19. I have good peer support when I need to work through a highly stressful experience.
	20. I have had first-hand experience with traumatic events in my adult life.
	21. I have had first-hand experience with traumatic events in my childhood.
	22. I think that I need to "work through" a traumatic experience in my life.
	23. I think that I need more close friends.
	24. I think that there is no one to talk with about highly stressful experiences.
	25. I have concluded that I work too hard for my own good.
	26. Working with those I help brings me a great deal of satisfaction.
	27. I feel invigorated after working with those I help.
	28. I am frightened of things a person I helped has said or done to me.
	29. I experience troubling dreams similar to those I help.
	30. I have happy thoughts about those I help and how I could help them.
	31. I have experienced intrusive thoughts of times with especially difficult people I helped.

	32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
	33. I am pre-occupied with more than one person I help.
	34. I am losing sleep over a person I help's traumatic experiences.
	35. I have joyful feelings about how I can help the victims I work with.
	36. I think that I might have been "infected" by the traumatic stress of those I help.
	37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
	38. I remind myself to be less concerned about the well-being of those I help.
	39. I have felt trapped by my work as a helper.
	40. I have a sense of hopelessness associated with working with those I help.
	41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
	42. I wish that I could avoid working with some people I help.
	43. Some people I help are particularly enjoyable to work with.
	44. I have been in danger working with people I help.
	45. I feel that some people I help dislike me personally.
	Items About Being a Helper and Your Helping Environment:
	46. I like my work as a helper.
	47. I feel like I have the tools and resources that I need to do my work as a helper.
	48. I have felt weak, tired, run down as a result of my work as helper.
	49. I have felt depressed as a result of my work as a helper.
	50. I have thoughts that I am a "success" as a helper.
	51. I am unsuccessful at separating helping from personal life.
	52. I enjoy my co-workers.
	53. I depend on my co-workers to help me when I need it.

	54. My co-workers can depend on me for help when they need it.
	55. I trust my co-workers.
	56. I feel little compassion toward most of my co-workers
	57. I am pleased with how I am able to keep up with helping technology.
	58. I feel I am working more for the money/prestige than for personal fulfillment.
	59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
	60. I find it difficult separating my personal life from my helper life.
	61. I am pleased with how I am able to keep up with helping techniques and protocols.
	62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
	63. I have thoughts that I am a "failure" as a helper.
	64. I have thoughts that I am not succeeding at achieving my life goals.
	65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
	66. I plan to be a helper for a long time.

Scoring Instructions

Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information.

1. Be certain you respond to all items.
2. Mark the items for scoring:
 - a. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.
 - b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.
 - c. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.
3. Add the numbers you wrote next to the items for each set of items and note:
 - a. *Your potential for Compassion Satisfaction (x)*: 118 and above=extremely high potential; 100-117=high potential; 82- 99=good potential; 64-81=modest potential; below 63=low potential.
 - b. *Your risk for Burnout (check)*: 36 or less=extremely low risk; 37- 50=moderate risk; 51-75=high risk; 76-85=extremely high risk.
 - c. *Your risk for Compassion Fatigue (circle)*: 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.

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These publications are great resources for child death and related materials:

1. Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma (PDF)
<https://www.childdeathreview.org/wp-content/uploads/NCRPCD-Docs/GuidanceVicariousTrauma.pdf>
2. Vicarious Trauma Toolkit
<http://www.atthereadymag.com/site/misc/VTTFactSheet.pdf>
3. Compassion Satisfaction and Fatigue Scale: measures compassion fatigue and compassion satisfaction.
4. https://www.researchgate.net/profile/David_Hemsworth/publication/51898163_Understanding_Compassion_Satisfaction_Compassion_Fatigue_and_Burnout_A_survey_of_the_hospice_palliative_care_workforce/links/5588925808aeb716bccffdf.pdf
5. Self-Care Strategies: Quick guide to helpful self-care techniques on the next page.
6. What you can do in: grounding techniques that can be done in 2 – 5 minutes on next page.

Self-Care Strategies

Aromatherapy

Scents like lavender, citrus and sage have a calming effect on our nervous system.

Taking a time out; stretching; regrounding; using humor

Taking a moment to stretch, change your body position, and reground ourselves allows for a pause.

Breathing

Taking some deep breaths allows us to slow down our heart rate, decrease our blood pressure and allows oxygen to flow to our muscles, which helps relax them.

Knowing your limits

Setting boundaries helps us take some control during an overwhelming experience.

Professional supervision and/or support from co-workers

Accessing support from supervisors and co-workers allows increases connection and support.

Transition to home – leave it at the office

Finding a way to transition from work to home provides disconnection from the work and related stressors, which allows us to connect to other areas in our lives that are resilience building.

Exercise and eat healthy

Extensive research shows eating healthy and getting exercise helps improve our mood and how we react to a given situation.

Support from family and/or friends

Accessing support from family and/or friends helps us disconnect from work and connect with other areas in our lives that are resilience building.

Humor

Humor has a great ability to allow for connection with others. Laughter has significant positive effects on our ability to cope and improve functioning.

Professional counseling

Use professional support, if needed.

What Can You Do In 2 Minutes?

Stretch

Take your stress temperature

Compliment yourself

Take a deep breath

Look out the window and make note of something beautiful

Share a joke

Compliment someone else

Color

Take a sip of water

Smile

5 minutes:

Listen to a favorite song

Chat with a co-worker

Attend to personal needs

Step outside and take a deep breath

Walk around the building or your office/work area

Write down an affirmation and hang it up

Enjoy a healthy snack

Straighten/organize an area of your office/desk/work area

Appendix A: Screening Tools

Screening instruments specifically validated for use during pregnancy:

- 4P's (alcohol and drug use) Page 37
- CRAFFT (valid for use in adolescents, piloted in pregnancy) Page 38
- CAGE-AID (joint screening for alcohol and drug use) Pages 39-40
- PHQ9 (depression and mental health questionnaire) Pages 41-42
- Edinburgh-postpartum depression screening Pages 43-45
- WAST (domestic violence screening) Page 46
- PVS (domestic violence screening) Page 46

4P's

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

Administration Time: 3 to 5 min.

1. Parents

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

2. Partner

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

3. Past

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

4. Present

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

Scoring: Any "yes" should trigger further questions

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

CRAFFT*

- C** – Have you ever ridden in a car driven by someone (including yourself) that were “high” or had been using alcohol or drugs?
- R** – Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
- A** – Do you ever use alcohol or drugs while you are by yourself, alone?
- F** – Do you ever forget things you did while using alcohol or drugs?
- F** – Do your family or friends ever tell you that you should cut down on your drinking or drug use?
- T** – Have you ever gotten into trouble while you were using alcohol or drugs?

Scoring Instructions:

CRAFFT Scoring: Each “yes” response scores 1 point.

A total score of 2 or higher is a positive screen, indicating a need for additional assessment

CRAFFT is available in multiple languages by going to:

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

CAGE-AID – Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

CAGE-AID – Overview

The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include alcohol and other drugs.

Clinical Utility

Potential advantage is to screen for alcohol and drug problems conjointly rather than separately.

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited ¹ :	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

1. Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wisconsin Medical Journal. 1995;94(3) 135-140.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

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

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

Edinburgh Postpartum Depression Screening

The Edinburgh Post Natal Depression Scale (EPDS)

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

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

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

In the past 7 days:

1. I have been able to laugh and see the funny side of things-
 - a. As much as I always could
 - b. Not quite so much now
 - c. Definitely not so much now
 - d. Not at all
2. I have looked forward with enjoyment to things -
 - a. As much as I ever did
 - b. Rather less than I used to
 - c. Definitely less than I used to
 - d. Hardly at all
3. I have blamed myself unnecessarily when things went wrong-
 - a. Yes, most of the time
 - b. Yes, some of the time
 - c. Not very often
 - d. No, never
4. I have been anxious or worried for no good reason-
 - a. No, not at all
 - b. Hardly ever
 - c. Yes, sometimes
 - d. Yes, very often
5. I have felt scared or panicky for no good reason-
 - a. Yes, quite a lot
 - b. Yes, sometimes
 - c. No, not much
 - d. No, not at all
6. Things have been getting on top of me -
 - a. Yes, most of the time I haven't been able to cope at all
 - b. Yes, sometimes I haven't been coping as well as usual

- c. No, most of the time I have coped quite well
- d. No, I have been coping as well as ever

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

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

8. I have felt sad or miserable -

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

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

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

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

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

How to score the Edinburgh Postnatal
Depression Scale:
For Providers:

Scoring the English Scale:

- 0 point
- 1 point
- 2 points
- 3 points

0 – 8 points: Low probability of depression

8 – 12 points: Most likely just dealing w/ a new baby or the “baby blues”

13 – 14 points: Signs leading to possibility of PPD; take preventative measures

15 + points: High probability of experiencing clinical depression

Scoring the Spanish Scale:

Questions 1, 2, & 4

***Questions 3, & 5 -10

0 = 0

0 = 3

1 = 1

1 = 2

2 = 2

2 = 1

3 = 3

3 = 0

*** Please note these questions are reverse scored in order to maintain consistency in the scale for the client.

Total score still has meanings as outlined with in the English scale.

Domestic violence screening tools

WAST

1. In general, how would you describe your relationship—a lot of tension, some tension, no tension?
2. Do you and your partner work out arguments with great difficulty, some difficulty, or no difficulty?
3. Do arguments ever result in you feeling down or bad about yourself?
often, sometimes, never
4. Do arguments ever result in hitting, kicking or pushing?
often, sometimes, never
5. Do you ever feel frightened by what your partner says or does?
often, sometimes, never
6. Has your partner ever abused you physically?
often, sometimes, never
7. Has your partner ever abused you emotionally?
often, sometimes, never
8. Has your partner ever abused you sexually?

A score of 4 indicates exposure to IPV

PVS

1. Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?
If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Scoring: Positive response to any question denotes abuse

Appendix B: *Intrapartum Guidelines, Testing for Substance Abuse*

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

Purpose:

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

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

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

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

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

1. Present with preterm labor, fetal distress, IUGR (intrauterine growth restriction), preterm birth, or placental abruption, unexplained onset hypertension (significant change in baseline blood pressure), stroke, heart attack, multiple episodes of nausea and vomiting, anxiety, and/or abdominal pain.
2. Are currently participating in an opiate replacement program depending on the availability of previous drug screening and/or communication with the substance abuse treatment program.
3. Has a child in DHHS custody if a previous history of substance abuse is documented.

Guidelines:

1. The healthcare provider will inform the pregnant woman who meets these criteria of the medical indication for a urine drug test and this notification should be documented in the patient's medical record. The patient will have the ability to decline testing. A social work consult should be considered if this is the case and the newborn's provider should be notified.
2. A urine drug test should include assays for Opiates, Oxycodone, Methadone, Hydrocodone, Benzodiazepines, Marijuana, Cocaine, Amphetamines, and Buprenorphine. Ethyl Glucuronide should be considered if alcohol intake within 72 hours is suspected. *If a provider is uncertain how to interpret the results of a urine drug screen, he/she should contact the hospital's laboratory and/or pathologist as needed. When lab results from a urine drug test will not be available until more than 24 hours, the newborn's provider should be notified to allow a meconium sample for drug testing.*
3. Providers should be aware that a negative urine drug test does not rule out the possibility of drug use during pregnancy. In addition, false positives can occur which must be ruled out by confirmatory testing
4. If a pregnant woman has a urine drug test that is positive for illicit substances that she did not disclose, a confirmatory test should be sent. If the urine test was not done upon first arrival to the maternity unit, the women's medical record should be reviewed to see what medications were administered prior to the urine screen.
5. If a woman's urine drug test is positive, the newborn's provider should be notified and a social services consult should be ordered.
6. If mother refuses testing, see Appendix C.

Appendix C: *Screening & Notification of Newborn Drug Exposure*

Policy Title: Drug Screening and Notification of Newborn Drug Exposure

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

Purpose:

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

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

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

1. The newborn manifests signs and symptoms consistent with withdrawal from exposure to drugs in utero.
2. Maternal urine toxicology screen is positive of substances not prescribed or the mother meets criteria for substance use and urine drug screen was not sent.
3. Unexplained intrauterine growth restriction (IUGR) and/or head circumference less than 10th percentile (ACOG 2007).
4. If a mother has been tested for substance use during the admission for delivery of the newborn, a urine drug screen on the baby is not indicated, as the results are not expected to be different than those of the mother. If the mother has not been tested during the admission for delivery of the newborn and meets screening criteria, the newborn provider should consider ordering a urine toxicology screen for prompt identification of recent substance exposure in addition to a meconium testing.

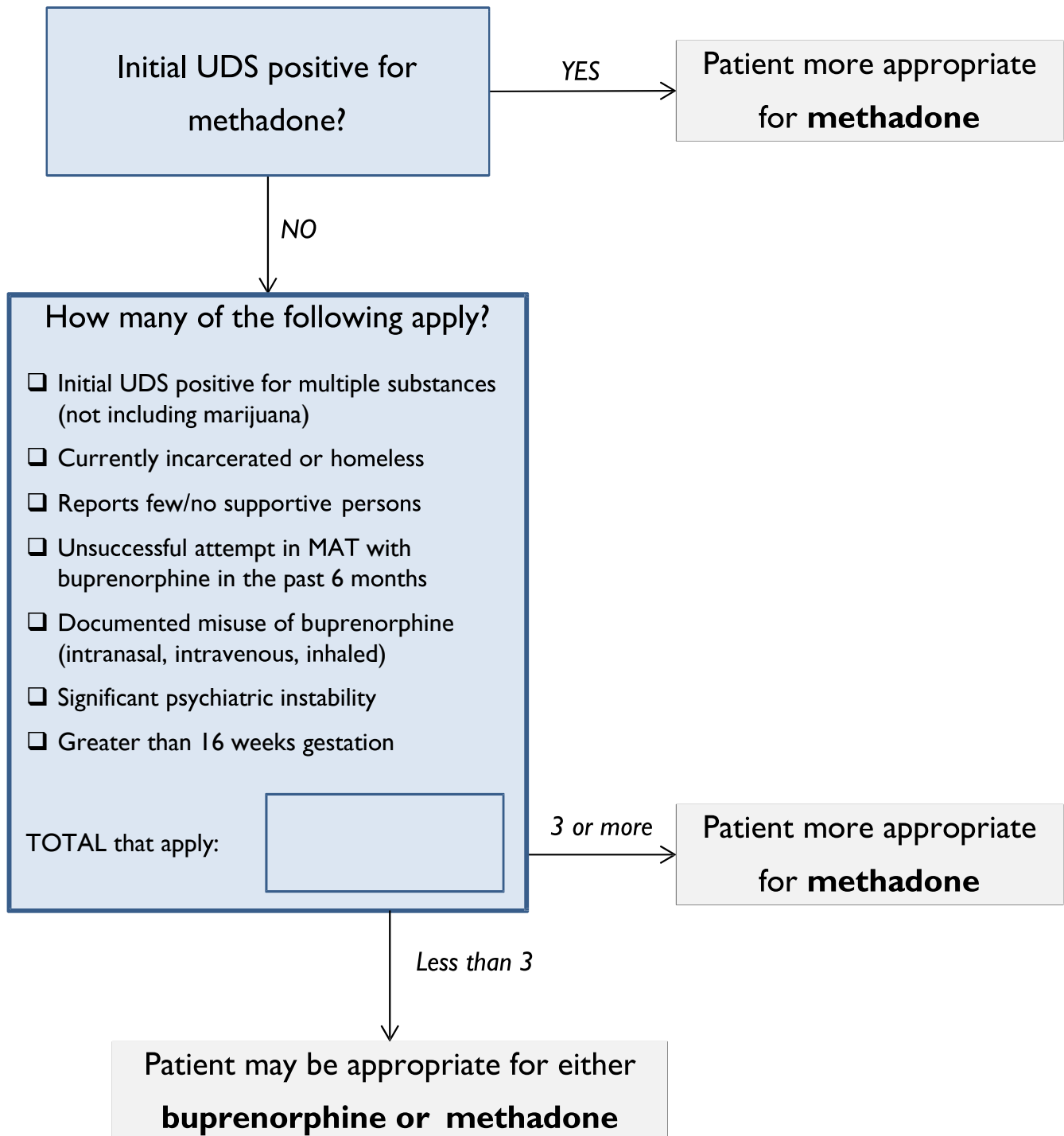
Guidelines:

1. The health care provider or nurse reviews the prenatal record, admission assessment and lab results for an indication of maternal drug use during the prior year, with or without a prescription, or that the mother has 3 or less prenatal visits, entry to care later than 24 weeks, or no prenatal care.
2. The health care provider, nurse or social worker informs the mother of the need to obtain a drug screen on the baby "...according to our policy." The provider should explain the rationale for the testing, which should include, but not necessarily be limited to, proper medical management of the newborn, as well as identification of the need for and referral to early intervention services based on substance exposure. This notification should be documented in the newborn's medical record.
3. If a parent refuses the recommended testing on the baby after being notified of the policy for such testing, they should be informed that their refusal will be noted but the test will still be completed. Testing the baby after parental refusal is deemed acceptable given that the testing involves no risk of harm to the baby and the best interests of the baby are being served through proper identification and intervention for factors that will have an impact on the child's physical and developmental well-being both in the acute care setting and post-discharge.
4. The nurse initiates drug screen order set and obtains first available meconium (urine as needed).
5. Urine and meconium drug screens should test for Oxycodone, Buprenorphine, Methadone, Hydrocodone, Opiates, Benzodiazepines, Marijuana, Amphetamines and Cocaine not necessarily in that order. *Every institution will need to explore what drugs are tested for in their drug screening panel and may need to specifically ask for the certain tests. If the health care provider is not familiar with interpreting these tests, he/she should contact the hospital's lab and/or pathologist as needed.*
6. The nurse will inform the newborn's health care provider that a meconium (and urine as needed) has been obtained because of maternal drug use, status of prenatal care, or newborn withdrawal symptoms. A system should be set up on the newborn unit to track results of meconium screening once ordered. If a urine toxicology screen is ordered because a maternal urine screen is not available and the result is positive, a confirmatory urine toxicology screen should be sent if the mother denies using the illicit substance.
7. If the newborn is at risk of narcotic withdrawal or demonstrates withdrawal symptoms, the nurse will initiate the clinical practice guidelines around Neonatal Abstinence Syndrome (NAS) including an objective scoring system such as Finnegan within 2 hours of birth. *Of note, the Finnegan Scoring system was developed for use in assessing babies with narcotic withdrawal in the first month of life. If the tool is used at greater than one month of age, consideration must be made for developmental norms, such as decreased amounts of sleep and improving muscle tone over time. It has not been validated for infants exposed to antidepressants or other substances that may cause a withdrawal syndrome in infants.*
8. Newborns should be hospitalized for at least 5 days after birth to observe for withdrawal symptoms and determine if further treatment is necessary. While observing infant in hospital, symptomatic care

should be provided case-by-case including rooming in as much as possible, swaddling, holding, skin to skin contact with parents, decreased stimulation (light, noise, tactile), and the use of pacifiers as desired. If the infant receives pharmacologic treatment, refer to hospital treatment guidelines.

9. The nurse will report NAS scores to the newborn's health care provider.
10. The newborn's health care provider will report the results to the mother and review the treatment plan if intervention is necessary.
11. When either maternal or neonatal factors are present to indicate a need to test for substance use/exposure, a social services or clinical counselor consult should be ordered. A social worker or clinical counselor will complete a psychosocial assessment of the family and provide recommendations to the medical team for safe discharge planning. This may include notification by the social worker (or health care provider in the absence of a social worker) to the Department of Health and Human Services (DHHS) regarding the baby having been affected by one or more drugs during the pregnancy according to Maine State Law Infants Born Affected by Substance Abuse or After Prenatal Exposure to Drugs (2003) Department of Health and Welfare, Title 22, Chapter 1071, Section 4004B and 4011B. Additional intervention by the social worker may be offered and will be based on an assessment of the parent's present stage of change. If there are any signs of child abuse and neglect, a report should be made to DHHS.
12. Referrals to Child Development Services (CDS), Public Health Nursing (PHN), and to the newborn's primary care provider should be initiated to inform them of infant's medical care in hospital and need for future services. A referral should also be considered to the Maine Families network.

Methadone vs. Buprenorphine Referral Algorithm for Pregnant Women



Patient preference of medication is important, but does not supersede other objective indicators, even if patient endorses unwillingness to enter treatment with methadone.

Specific drug of abuse and/or amount of opiate use is often an unreliable indicator of whether a patient will succeed in a specific treatment program.

APPENDIX D:

Finnegan Neonatal Abstinence Scoring Tool(FNAST)

Patient ID: Name: Today's Weight: DOB: Date:

Signs & Symptoms	Time	Score	A				PM				Comments
Central Nervous System Disturbances											
Crying: Excessive High Pitched Crying: Cont. High Pitched		2									
Sleeps < 1 Hr. After Feeding		3									
Sleeps < 2 Hr. After Feeding		2									
Sleeps < 3 Hr. After Feeding		1									
Hyperactive Moro Reflex		2									
Markedly Hyperactive 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 (Specific Area)		1									
Myoclonic Jerk		3									
Generalized Convulsions		5									
Metabolic, Vasomotor And Respiratory Disturbance											
Sweating		1									
Fever < 101 (37.2-38.3c)		1									
Fever > 101 (38.4c)		2									
Frequent Yawning (> 3)		1									
Mottling		1									
Nasal Stuffiness		1									
Sneezing (>3)		1									
Nasal Flaring		2									
Respiratory Rate (> 60/Min)		1									
Respiratory Rate (>60/Min With Retractions)		2									
Gastrointestinal Disturbances											
Excessive Sucking		1									
Poor Feeding		2									
Regurgitation		2									
Projectile Vomiting		3									
Loose Stools		2									
Watery Stools		3									
Score											
Total Score											
Average Daily Score											
Inter-Observer Reliability %											
Initials Of Scorer 1											
Initials Of Scorer 2											

Adapted from Finnegan, L.P., Kaltenbaach. K. The assessment and management of Neonatal Abstinence Syndrome. Primary Care, 3rd editions, Hoekelman + Nelson (eds.), C.V. Mosby Company, St. Louis, MO., pp. 1367-1378, 1992. The FINNEGAN NEONATAL ABSTINENCE SCORE is for the assessment of infants exposed in utero to psychoactive drugs, particularly Opioids/Opiates. Evaluator should check signs or symptoms observed at various time intervals and add the scores to obtain a total score. Observation of the scores over the time interval provides the progression/diminution of symptoms. Copyright, 2007

Appendix E: Drug Affected Baby Reports

****DAB Mandated Referral - Email Format****

Date/Time:

Referent information:

Family/Caregiver Information:

*Remember to ask if there is a separate mailing address for the primary caregiver.

Directions:

Out of home parents:

*Screen the father of the baby into the profile on all DAB reports. If this report is not going to have allegations, you do not need to screen in out of home parents for the other children.

Presenting problem:

Any concerns about the mother's prenatal care?

What, if any, prescribed substances were used during pregnancy?

What, if any, illicit substances or non-prescribed medications were used during pregnancy?

What, if anything, has the mother said about her substance use? Does she have any concerns about the impact it may have on the infant?

What information, if any, is known about the mother's substance abuse history prior to pregnancy?

What were the results of any prenatal drug screens (including admission)?

Has the meconium been gathered for testing?

Was the infant full term?

What, if any, withdrawal symptoms have been observed so far?

Is the child scoring, if so, what are the current scores?

Does the infant have any additional known health concerns?

What care, if any, is the infant now receiving?

Does the mother plan to breastfeed? Are there any concerns or difficulties with breastfeeding?

When is the estimated discharge date for the infant?

Did the family accept Public Health Nursing or is PHN already involved? Who will make the referral?

Did the family accept Maine Families or is MF already involved? Who will make the referral?

Who will the infant's pediatrician be?

Has the family been educated about Safe Sleep practices?

Yes/ Will be prior to discharge No

If no, please explain:

Any concerns for co-sleeping/bed sharing?

Yes No

If yes, please explain:

Has the family been educated about The Period of Purple Crying?

Yes/ Will be prior to discharge No

If no, please explain:

Insurance: MaineCare No insurance Unknown Private Insurance

If private: What company?

What observations have been made of the parent's interactions with the infant and each other? Any concerns?

Are there any concerns about the parents' emotional or cognitive ability to provide needed infant care?

Are there any concerns about the parents' preparations for the infant's care?

Domestic Violence: (Please indicate if parents were spoken to separately)

Mental Health Problems:

Substance abuse: (Dads or anyone else in the home? For mom, see above)

What are the family's protective strengths?

Are there any other services for anyone in the family that were offered or are already in place? What additional supports are available to the infant and parents (family, church, community based services)?

Primary Language:

Native American heritage (ICWA):

Prior CPS History and impact on current Decision:

*End here if this will be a DAB with no allegations. If there are going to be allegations then:

Work information:

School/Childcare information:

Bureau of Motor Vehicle (when indicated):

Sex Offender Register Information (when indicated):

Reported Harm Statement:

Signs of Danger:

Collaterals:

****DAB Mandated Referral - Phone Format****

Referent (person sending report):

Hospital:

Address:

Phone:

Requesting Confidentiality?

Child:

DOB:

MaineCare#:

Birth Weight:

Gestational Age:

Mother:

DOB:

Address:

Phone:

Siblings:

1)

DOB/Age:

2)

DOB/Age:

3)

DOB/Age:

Father:

DOB:

Address:

Phone:

Fax to...

Infant's Primary Care Provider:

Fax Number:

PHN: fax number: (207) 561-4467

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

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

➤ Prenatal Care ◀

(To be completed in Obstetric Care Providers Office)

Provider Name:

Address:

Phone:

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

Pregnancy complications (if yes, describe):

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

Did the mother self-disclose her drug use?

**Did the mother have a urine drug screen?
If positive, was confirmatory testing completed?**

Enrolled in narcotic treatment program?

Provider Name:

Address:

Phone:

➤ Newborn Care ◀

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

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

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

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

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

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

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

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

Is the mother breastfeeding? Lactation Support in Hospital? Lactation support needed at home?

➤ Family Assessment ◀

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

What observations have been made of the parent's interactions with the infant? What are the current living arrangements?

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

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

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

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

Mental Health Issues (if yes, describe):

In treatment?:
Provider Name:
Address:
Phone:

Household member substance abuse (if yes, describe):

Treatment Location:
Provider Name:
Address:
Phone:

Service Providers:

Provider Name:
Address:
Phone:

Relative resources:

Relative Name:
Relationship:
Address:
Phone:

Native American heritage (ICWA):
If yes, please indicate tribal affiliation:

Primary Language:
Was an interpreter used in the hospital?

****DAB Mandated Referral - Adapted Format****

Mother of Baby:

Father of Baby:

Estimated Due Date:

Living Situation:

Date patient entered buprenorphine treatment:

Gestational age at entry into treatment:

Has patient attended most office visits?

Have urine drug screens been appropriate?

Has patient been enrolled in substance abuse counseling?

Pertinent information pertaining to father of baby:

Previous involvement with DHHS (if known):

Other children in the home:

Children out of the home:

Services in place:

Services offered:

Family Support/Strengths:

Domestic violence related concerns:

Mental health related concerns:

Addiction history:

Concerns about social situation:

Other comments or concerns:

Based on the information available to me:

- I have no concerns about the patient caring for her infant.
- I have some concerns the patient caring for her infant and these include:
- I have significant concerns about the patient caring for her infant and these include:

****DAB Mandated Referral – Completed Example****

Mother of Baby: Laura Williams.

Father of Baby: David Reynolds.

Estimated Due Date: 12/4/16.

Living Situation: Lives with partner, David and her two children. Laura and David have been together for 7 years.

Date patient entered buprenorphine treatment: May 2011 until April of 2013. She then re-entered treatment at MDFP on 7/11/13 until the present time.

Has patient attended most office visits? Yes.

Have urine drug screens been appropriate? July 13, 2016 positive for Opiates (Morphine and Codeine). Pt. denied using. All other drug screens have been appropriate.

Has patient been enrolled in substance abuse counseling? MDFP OB Group every 2 weeks.

Pertinent information pertaining to father of baby: Laura reports that she and David started using drugs together, but he has been clean for a long time now.

Other children in the home: Casey Reynolds (6)-Father is David Reynolds.

Chris Chase (8)-Father is Charles Chase who is involved.

Children out of the home: None.

Previous involvement with DHHS (if known): DHHS was involved when Laura was arrested in 2008. Laura states that she signed over guardianship of Casey to her in-laws and Chris went to live with his father. Laura regained custody of her children in 2009 upon her release from jail.

Services in place: Laura has private insurance through her mother. She is a stay at home mom. Laura's partner is employed full time at True Value. Laura applied for MaineCare and Food Stamps and was found to be over income.

Services offered: Maine Families, Laura declined. She is not interested in WIC at this time.

Family Support/Strengths: Laura identifies her mother, Leslie Bradshaw and her father, Michael Williams as being her biggest support system.

Domestic violence related concerns: In the past, providers have had concerns regarding partners controlling behaviors however Laura has denied any abuse. February 4, 2016 office visit note states that David would not allow Laura to come to group because he was not able come with her. No recent concerns noted.

Mental health related concerns: Anxiety, Depression, and Panic Attacks with agoraphobia. Laura states that she feels that she is stable at this time and his not prescribed any medications for this.

Addiction History: Laura began addiction treatment at MDFP in May 2011 until April 2013. She voluntarily ended treatment at MDFP due to pressure from her partner and her family about getting off of Suboxone. She was able to remain sober for a few weeks but then started buying Suboxone off the street. She reentered treatment at MDFP in July of 2013.

Concerns about social situation: as stated above

Other comments or concerns:

Based on the information available to me:

- **I have no concerns about the patient caring for her infant.**
- **I have some concerns the patient caring for her infant and these include:**
- **I have significant concerns about the patient caring for her infant and these include:**

Appendix F: Maine Office of Substance Abuse and Mental Health Services

Maine Office of Substance Abuse and Mental Health Services

11 State House Station
41 Anthony Avenue, Augusta Maine 04333-0011
Phone: (207) 287-2595
TTY: 1-800-606-0215
Online: <http://www.maine.gov/dhhs/samhs/>

Maine Office of Substance Abuse Programs

<http://www.maine.gov/dhhs/samhs/>

State of Maine Resources and Hotlines:

<http://www.maine.gov/dhhs/hotlines.htm>

SAMHSA Buprenorphine Physician & Treatment Program Locator (by State)

The Locator is a non-line resource designated to assist States, medical and addiction treatment communities, potential patients, and/or their families in finding information on locating physicians and treatment programs authorized to treat opioid addiction with buprenorphine (Suboxone® and Subutex®)
<http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>

The Women's Project/The Opportunity Alliance

<http://www.opportunityalliance.org/programs/adult-mental-health-services/>
Central Intake: [207-523-5049](tel:207-523-5049)

2-1-1 Maine

A comprehensive statewide directory of over 8,000 health and human services available in Maine.
Dial 211 from a Maine phone number

24-Hour Statewide Crisis Hotline

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

Sample Forms/Confidentiality

<https://lac.org/resources/substance-use-resources/confidentiality-resources/sample-forms-confidentiality/>

An overview of the release requirements can be found at:

<https://www.law.cornell.edu/cfr/text/42/2.31>

The Prohibition on Re-disclosure requirement can be found at:

<https://www.law.cornell.edu/cfr/text/42/2.32>

Appendix G: Treatments

Treatment Definitions

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

Co-Occurring (Integrated) Treatment:

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

DSAT (Differential Substance Abuse Treatment):

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

Detoxification "Detox":

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

Detoxification Management:

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

Emergency Shelter:

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

Extended Care:

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

Halfway House:

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

Intensive Outpatient Services:

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

Outpatient Services:

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

Medication Assisted Treatment for Addiction:

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

Other:

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

Residential Rehabilitation:

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

Residential Rehabilitation – Adolescent:

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

Residential Rehabilitation 1:

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

Appendix H: Release Form

WELLSPRING
98 Cumberland Street
Bangor, ME 04401

Name _____
DOB _____
SS # _____

Authorization to Release/Receive Information

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1966 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. These rules prohibit the recipient of confidential information from further disclosure of it, unless that disclosure is expressly permitted by your written consent or as otherwise permitted by 42 C.F.R. Part 2. I understand that generally Wellspring may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I will be given a copy of this form if I request it.

I, _____, authorize Wellspring and

(name, agency, address, phone)

to communicate with and disclose to one another the following information:

- | | | | |
|-----------------------|--------------------------------------|-----------------------|-------------------|
| Admission status | Bio-psychosocial History | Medical Consultation | Aftercare Plan |
| Presence in Treatment | Clinical Assessment | Treatment Plan | Discharge Summary |
| Admission Summary | Psychological/Psychiatric Evaluation | Progress in treatment | Recommendations |

Other _____

The purpose of this disclosure is to:

- Schedule appointments
- Plan or coordinate treatment and services
- Facilitate meeting legal obligations
- Obtain/maintain employment, government, other benefits

Other _____

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken on it. Unless revoked, this consent will expire automatically:

(Specify date, event, or condition, not to exceed one year from date of signing)

- I do not authorize information to be faxed. I understand that there are confidentiality risks in fax transmissions.
- I do not authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse.
- I do not authorize disclosure of information that refers to treatment or diagnosis of Psychiatric illness.
- I do not authorize disclosure of information that refers to treatment or diagnosis of HIV, ARC or AIDS.
- I do not authorize re-disclosure of this information to_____.
- I do not wish to review my Wellspring records before their release. If I do, a program director or designee will supervise my review and document the supervision below.

Client Signature_____Date _____

Parent/Guardian_____Relationship _____

Witness Signature_____Date _____

To be valid, all sections above must be completed.

Office: The records were reviewed as required above:

Date of Review: _____

Client Signature: _____

Supervisor Signature: _____

Revocation: by phone in person other_____Date_____

Date written confirmation received _____



Authorization for Release of Confidential Information

Clinic name and address
DISCOVERY HOUSE CENTRAL MAINE
40 AIRPORT RD
WATERVILLE, ME 04901

NAME: _____ DOB: _____

ADDRESS: _____

I hereby authorize DISCOVERY HOUSE to:

OBTAIN FROM: RELEASE TO: VERBALLY SPEAK WITH:

Name: _____

Title: _____

Address: _____

THE FOLLOWING INFORMATION: _____

THE PURPOSE OF DISCLOSURE AUTHORIZED HEREIN IS SPECIFICALLY FOR:

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent verbally or in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

DATE/EVENT OF EXPIRATION:

(Specification of the date, event or condition upon which this consent expires)

I understand that generally Discovery House may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

(If Relevant) I voluntarily consent to disclose the above information, which also includes HIV-related information.

Patient's Signature

Date

Witness/Counselor's Signature

Date

Did patient receive a copy Yes No Initial _____

Signature of parent, guardian or authorized representative where required.

Appendix I: References

Professional Organization Resources

AAP Committee on Drugs and Committee on the Fetus and Newborn. Neonatal Drug Withdrawal. 2012, *Pediatrics*, 129 (2), e540-e560.

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ACOG Committee Opinion #496, 2011. At Risk Drinking and Illicit Drug Use: Obstetrical and Gynecologic Implications.

ACOG Committee Opinion # 524. Opioid Abuse, Dependence, and Addiction in Pregnancy. May 2012, reaffirmed 2016.

ACOG Committee Opinion # 518. Intimate Partner Violence. February 2012.

ACOG Committee Opinion # 630. Screening for Perinatal Depression. May 2015.

ACOG Committee Opinion # 473. Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician Gynecologist. January 2011, reaffirmed 2014.

ACOG Committee Opinion # 627. Marijuana Use during Pregnancy and Lactation. July 2015.

ACOG Committee Opinion # 471. Smoking Cessation during Pregnancy. November 2010, reaffirmed 2015.

ACOG Committee Opinion # 423. Motivational Interviewing: A tool for behavior change. January 2009, reaffirmed 2016.

ACNM, Position statement: Addiction in pregnancy, May 2013.

<http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000052/Addiction%20in%20Pregnancy%20May%202013.pdf>

National Addiction Guidelines

American Society of Addiction Medicine. The National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. June 2015.

<http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npq>

Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: <http://store.samhsa.gov/>.

National Institute on Drug Abuse. Chart of evidence based screening tools for adults and adolescents. Revised September 2015. <https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults>

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Burns, E, Gray, R, Smith, L. Brief screening questionnaires to identify problem drinking during pregnancy: a systematic review. (2010). *Addiction*, 105, 601-614.

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Chang, G, Orav, E, Jones, J, Buynitsky, T, Gonzalez, S, & Wilkins-Haug, L. (2011) Self reported alcohol and drug use in pregnant young women. *J Addict Med* 5(3) 221-226.

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Chasnoff, I, McGourty, R, Bailey, G, Hutchins, E, Lightfoot, S & Pawson, L (2005). The 4Ps Plus Screen for substance use in pregnancy. *J. Perinataology* (25). 368-374.

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Appendix J: *Patient Education Resources*

- A. Information for Pregnant Women
- B. Marijuana and Pregnancy
- C. Neonatal Abstinence Syndrome (NAS) Information for New Parents
- D. Marijuana: Is It Safe When Breast Feeding?

The following appendices may be edited to reflect individual facility variation. When making modifications, please give credit to the original authors and maintain the original intent of the materials.

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Maine Resources

INFORMATION ON NAS

- March of Dimes
 [www.marchofdimes.org/complications/neonatal-abstinence-syndrome-\(nas\).aspx](http://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-(nas).aspx)

SUBSTANCE ABUSE RESOURCES

MaineHealth Learning Resource Center
 1 (866) 609-5183

www.mainehealthlearningcenter.org/resources/treatment-for-drug-addiction

Maine Alliance for Addiction Recovery (MAAR)

Free recovery support program and recovery housing help.
 (207) 621-8118

Office of Substance Abuse
Information & Resource Center
 1 (800) 499-0027

Substance Abuse & Mental Health
Services Administration
 www.samhsa.gov

The Woman's Project
 (207) 523-5049

RESOURCES FOR NEW PARENTS

Public Health Nursing in Maine
(Statewide Central Referral)
 1 (877) 763-0438

Text4Baby

Free smartphone app that sends you tips and helpful information.

www.text4baby.org

Maine Families

Free visits from child development professionals and parent educators.

(207) 624-7900

www.maineamilies.org

Lactimed

Free app and website providing information about taking medications or supplements while breastfeeding.

Classes at MMC

www.mmc.org/childbirth-parenting-education

MMC New Parent Website

www.mmc.org/parent-resources

Exhibit J A: Prenatal

Information for Pregnant Women

Neonatal Abstinence Syndrome(NAS)



Most babies who are exposed to certain medicines or drugs in the womb will have Neonatal Abstinence Syndrome (NAS). These medicines include methadone, Subutex, OxyContin, Vicodin, and codeine. NAS can be caused by prescribed and unprescribed medicines as well as drugs like heroin. This booklet will tell you how we will work together to care for your baby.

What are the signs of NAS?

- High-pitched cry and crankiness
- Excessive weight loss
- Muscle stiffness and tightness
- Sneezing
- Trouble sleeping
- Shaking and jitters
- Vomiting and/or diarrhea
- Difficulty feeding
- Fast breathing
- Fever

What can I do to help before my baby is born?

There are things you can do now to help your baby have the healthiest start.

- Attend all of your doctor's appointments.
- Please do not drink alcohol. Do not use tobacco or marijuana. If you have used marijuana recently, please tell your doctor and read the handout about marijuana use.
- Keep yourself healthy and take your vitamins.
- If you take drugs that are not prescribed to you, please consider medication-assisted therapy (MAT). MAT involves taking prescribed medication to reduce cravings and withdrawal. MAT helps your baby grow safely.

What will happen after my baby's birth?

- NAS is treatable.
- The nurses will watch your baby closely at birth.
- They will use a form to track your baby's withdrawal symptoms and give him or her a score every 3 to 4 hours.
- The higher your baby's score is, the more signs and symptoms of withdrawal he or she has.
- You may stay with your baby wherever he/she is in the hospital.

Maternal state laws require health care providers to notify the Office of Child and Family Services when a baby has been born with symptoms from a prenatal substance exposure.

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

- Your baby will need to stay in the hospital for at least 7 days.
- If your baby is still showing signs of withdrawal, he or she may need to stay longer.
- Please remember: all babies are different. Withdrawal happens in different ways for different babies.

Will my baby need medicine?

We may need to give your baby medicine like morphine or phenobarbital to help with withdrawal. Your baby's doctor will talk with you to about what medicine is best for your baby.

Can I breastfeed my baby?

- We encourage you to breastfeed your baby.
- If you are using marijuana, your breast milk may not be safe for your baby. Please do not use marijuana during your pregnancy or during breastfeeding.

Should I still take my prescription opioids?

- Please do not try to wean off of your medicines on your own.
- It is important for you to take your prescription medicines as your doctor prescribed.
- The amount of NAS symptoms a baby has is not related to the dose of the mom's prescription opioids.

WHAT YOU CAN DO

- Spend as much time as possible with your baby by rooming with your baby ("rooming-in").
- Hold your baby as much as possible using **skin to skin**.
- Swaddle your baby.
- Keep your room quiet with the lights dim.
- Limit activity around your baby.
- Ask visitors not to disturb your baby if sleeping.
- Feed your baby whenever he/she is hungry.

WHAT WE CAN DO

- Give your baby fortified milk or formula to add calories and help your baby gain weight.
- **Give your baby** medicines like morphine, if needed.
- Answer questions and offer support.

Marijuana

Is it safe to use
while pregnant?



When you are pregnant and use marijuana, so does your baby.

Marijuana passes through the placenta into a baby's bloodstream.

Studies suggest marijuana use during pregnancy can harm a growing baby.

- It may cause your baby to be born before his or her body and brain are ready. This can mean health problems at birth and throughout life.
- It could change how your baby's brain develops, causing life-long problems with:
 - Paying attention and following rules
 - Learning and memory
 - Doing well in school

Make the safest choice for you and your baby. Do not use marijuana when pregnant or breastfeeding.

Should I use marijuana if I breastfeed?

- NO, women who breastfeed should not use marijuana.
- Marijuana is found in the breast milk of nursing mothers who use the drug.
- Talk to your baby's health care provider about the risks of marijuana use compared to the benefits of breastfeeding, so you can make the best decision for you and your baby.

Still have questions?

Talk to your health care provider. Even if you have been using marijuana, stopping now will help lower the risks to your baby.

Do you need help quitting?

Reaching out for help is a sign of strength.

For resources dial 2-1-1

Visit www.211maine.org or

TEXT your zip code to 898-211

SOURCES:

Marijuana Use During Pregnancy and Lactation. American College of Obstetricians and Gynecologists Committee on Obstetric Practice, *Obstet Gynecol*. 2015

Behnke, M. & Smith, V. (2013). Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus. *Pediatrics*, *131* (3), e1009-e1024.

Brown, H. & Graves, C. (2013). Smoking and Marijuana Use in Pregnancy. *Clinical Obstetrics and Gynecology*, *56* (1), 107-113.

Goldschmidt, L. et al. (2008). Prenatal Marijuana Exposure and Intelligence Test Performance at Age 6. *Journal of American Academy of Child and Adolescent Psychiatry*, *47* (3), 254-263.

Gray, T. et al. (2010). Identifying Prenatal Cannabis Exposure and Effects of Concurrent Tobacco Exposure on Neonatal Growth. *Clinical Chemistry*, *56* (9), 1442-1450.

Hayatbakhsh, M. et al. (2012). Birth Outcomes Associated With Cannabis Use Before and During Pregnancy. *Pediatric RESEARCH*, *71* (2), 215-218.

Sachs, H. et al. (2013). The Transfer of Drugs and Therapeutics Into Human Breast Milk: An Update on Selected Topics. *Pediatrics*, *132* (3), e795-e809.



Maine Resources

INFORMATION ON NAS

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- www.text4baby.org

Maine Families

Free visits from child development professionals and parent educators.

- (207) 624-7900

- www.maineamilies.org

Lactimed

Free app and website providing information about taking medications or supplements while breastfeeding.

- www.lactimed.com

Classes at MMC

- www.mmc.org/childbirth-parenting-education

MMC New Parent Website

- www.mmc.org/parent-resources

Exhibit J C: Postnatal
Information for New Parents

Neonatal Abstinence Syndrome (NAS)



Most babies who are exposed to certain medicines or drugs in the womb will have Neonatal Abstinence Syndrome (NAS). These medicines include methadone, Subutex, OxyContin, Vicodin, and codeine. NAS can be caused by prescribed and unprescribed medicines as well as drugs like heroin. This booklet will tell you how we will work together to care for your baby.

What are the signs of NAS?

NAS symptoms usually develop 1–3 days after birth, but may take 5–7 days to appear.

These symptoms are:

- High-pitched cry and crankiness
- Excessive weight loss
- Muscle stiffness and tightness
- Sneezing
- Fast breathing
- Trouble sleeping
- Shaking and jitters
- Fever
- Vomiting and/or diarrhea

What is the treatment for NAS?

You are the most important part of your baby's treatment. We will show you how you can help your baby feel better while in the hospital.

Will my baby need medicine?

We may need to give your baby medicine like morphine or phenobarbital to help with withdrawal. Your baby's doctor will talk with you to about what medicine is best for your baby.

What is Finnegan scoring?

- Your baby's nurses will use a Finnegan scoring form to track your baby's withdrawal symptoms every 3–4 hours.
- The higher your baby's score is, the more signs and symptoms of withdrawal he or she has.

Maine state law requires health care providers to notify the Office of Child and Family Services when a baby has been born with symptoms from a prenatal substance exposure.

Where will my baby stay in the hospital?

- If your baby is healthy at birth, you and your baby will stay in your room in the East Tower.
- If your baby shows many withdrawal signs, you and your baby may be moved to the Continuing Care Nursery (CCN) or the Neonatal Intensive Care Unit (NICU), both in the East Tower.
- You may stay with your baby wherever he or she is in the hospital.

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

- Your baby will need to stay in the hospital for at least 7 days.
- If your baby is still showing signs of withdrawal, he or she may need to stay longer.
- Please remember: all babies are different. Withdrawal happens in different ways for different babies.

What happens when my baby is ready to go home?

- Your baby may still show some symptoms of NAS, even after being discharged to home.
- Before discharge, we will show you how to continue to help your baby feel better at home.
- A visiting nurse may come to your home and make sure you and your baby are adjusting well at home.
- It is important that you bring your baby to all of his or her doctor appointments.

WHAT YOU CAN DO

- Spend as much time as possible with your baby by rooming with your baby ("rooming-in").
- Hold your baby as much as possible using **skin to skin**.
- Swaddle your baby.
- Keep your room quiet with the lights dim.
- Limit activity around your baby.
- Ask visitors not to disturb your baby if sleeping.
- Feed your baby whenever he/she is hungry.

WHAT WE CAN DO

- Give your baby fortified milk or formula to add calories and help your baby gain weight.
- Give your baby medicines like morphine, if needed.
- Answer questions and offer support.

Marijuana

Is it safe when breastfeeding?



Using marijuana if you breastfeed is not healthy for your baby and it is not recommended.

(American Academy of Pediatrics and The Academy of Breastfeeding Medicine)

What are the Risks?

- The active ingredient, THC, gets into your breast milk and your baby's system
- It may create feeding problems by:
 - Lowering your milk supply
 - Making your baby sleepy so he/she is less willing to eat
- It increases the risk of SIDS (Sudden Infant Death Syndrome)

**Make the safest choice for your baby.
Choose to breastfeed and
not use marijuana.**

Benefits of breastfeeding

For Babies:

- Protects against colds and ear infections
- Lowers the chance of allergies, asthma, obesity, cancer, and type 2 diabetes
- Provides the perfect food for your baby

For Moms:

- Heal from childbirth more quickly
- The hormones released while breastfeeding can help you feel less stressed
- Lower rates of breast and ovarian cancer and type 2 diabetes later in life
- Breastfeeding is free and without the hassle of using bottles or mixing formula

Still have questions?

Talk to your baby's health care provider about the risks of marijuana use compared to the benefits of breastfeeding. This will help you make the best decision for you and your baby.

Need help quitting?

Reaching out for help is a sign of strength.

For resources dial 2-1-1

Visit www.211maine.org or

TEXT your zip code to 898-211

SOURCES:

- Marijuana Use During Pregnancy and Lactation. American College of Obstetricians and Gynecologists Committee on Obstetric Practice, *Obstet Gynecol*. 2015
- Breastfeeding Benefits Your Baby's Immune System. (n.d.). Retrieved October 14, 2014, from <http://www.healthychildren.org/English/ages-stages/baby/breastfeeding/Pages/Breastfeeding-Benefits-Your-Baby's-Immune-System.aspx>
- Jaques, S.C. et al. (2014). Cannabis, the pregnant woman and her child. *Journal of Perinatology*, 34 (6), 417-424.
- Miller, C. (2012). Marijuana use and breastfeeding. *Clinical Lactation*, 3 (3), 101-107.
- Sachs, H. et al. (2013). The Transfer of Drugs and Therapeutics Into Human Breast Milk: An Update on Selected Topics. *Pediatrics*, 132 (3), e795-e809.
- Why Breastfeeding is Important. (n.d.). Retrieved October 16, 2014, from <http://www.womenshealth.gov/breastfeeding/breastfeeding-benefits.php>



Public Health Nursing in Maine

Statewide Central Referral

(During pregnancy and for newborns)

1-877-763-0438

Care for
You and Your Baby:

NAS



Patient Education Handbook

NEONATAL ABSTINENCE SYNDROME (NAS): *A Guide for Families*

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

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INTRODUCTION

Congratulations on the birth or upcoming birth of your baby!

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

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

How do I use this book?

This guide has three parts:

Part One: What to Expect Before You Deliver

Part Two: Care in the Hospital

Part Three: Transition to Home.

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

PART ONE: What to expect before you deliver

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

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

Neonatal Abstinence Syndrome (NAS) is a term to refer to the symptoms babies may have when withdrawing from contact with narcotics. Heroin, Morphine, Codeine, Oxycodone Oxycontin or Percocet, Hydrocodone (Vicodin), Meperidine, (Demerol) or Fentanyl, are just a few of the drugs that may cause NAS to occur in a baby. Withdrawal also may occur if the mother has been on methadone or buprenorphine (Subtex) treatment during pregnancy.

How can I help?

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

I seem to be very emotional. Is this normal?

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

Office of Substance Abuse Information and Resource Center:

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

Or 207-287-8900

Public Health Nursing

1-877-763-0438

[Division of Community Based Care Services](#) Bureau of Behavioral Health

(New Hampshire)

105 Pleasant Street

Concord, NH 03301

Phone: 603-271-5000

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

Emergency Mental Health

(New Hampshire)

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

Fax: 603-271-5058

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

➤ *Signs and symptoms of NAS...*

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

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

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

How soon will we see signs of NAS?

- Most babies who have NAS will show signs 24 to 72 hours, or as late as five to seven days after birth.
 - This depends on the dose of Subutex, methadone or other opiates
 - Exposure to prescribed medications, including some psychiatric medications

- Exposure to other drugs – such as Opiates (Heroin), Amphetamines, Marijuana, and Tobacco- particularly in the days just before the birth
- The type of childbirth (vaginal or C-section)
- Your baby's gestational age

What signs will we see?

The potential signs of NAS include:

- High-pitched cry
- Tremors/jitters
- Stuffy nose
- Hard time feeding and sucking
- Poor weight gain
- Increased breathing rate
- Irritability or fussiness and difficult with comforting
- Trouble sleeping
- Sneezing
- Tight muscles (arms & legs seem stiff)
- Vomiting, diarrhea
- Skin irritation
- Hyperactive reflexes (very big response to being startled)

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

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

How long can the signs and symptoms of NAS last?

Many babies need treatment even after they have gone home.

PART TWO: Care in the hospital

What will happen after my baby is born?

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

When will my baby show signs of NAS?

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

Does my baby need any special care?

- After birth, your baby will usually go with you to the mother/baby unit.
- We will care for you and your baby in the same way as we care for any other new mom and baby.
- You will be encouraged to care for your baby in the hospital as much as possible.
- Please look at your hospital's guide for information on the basic care of yourself and your newborn.

Will my baby be tested for drugs?

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

Other things to expect:

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

➤ Feedings and Weight Gain...

Why do you need to watch my baby?

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

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

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

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

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

Can I breastfeed my baby?

- While breastfeeding is an excellent way for a mother to feed and bond with a baby, the decision to support breastfeeding must be made on a case-by-case basis.
- Talk to your baby's health care provider to decide if it is safe for you to breastfeed.
 - Be open and honest with your baby's health care provider.

Is there anything about the stools I need to watch?

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

Is there anything else my baby will be watched for?

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

➤ **NAS Scoring...**

How will my baby be checked for signs of withdrawal?

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

What is the Finnegan Score?

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

What score would show my baby has NAS?

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

➤ **Medications...**

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

How much medication will my baby be given?

The dose given will depend on:

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

How will the doctors know my baby is getting enough?

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

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

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

➤ *Providing Supportive Care for your Baby...*

Can I spend time with my baby?

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

Suggestions:

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

Safe Sleep:

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

PART THREE: *Transition to home*

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

- Most infants have an amazing ability to recover from early problems. This includes babies with NAS.
- Once at home, your baby may have mild signs of withdrawal for several weeks or months. The symptoms slowly become less severe.

Is my baby fussy because of NAS?

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

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

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

➤ *Establishing a routine...*

Is getting my baby into a routine a good thing?

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

What should I know about feeding my baby?

Feeding times may be difficult in the beginning

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

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

How often should my baby eat?

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

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

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

➤ *Sleep...*

How long should my baby sleep?

- Most babies with NAS will go home from the hospital when they are one to six weeks old. At this age, infants usually sleep 16 to 20 hours a day.
- Falling asleep and staying asleep are important things for your baby to know how to do. Setting a routine for daytime naps and nighttime sleeping is an important developmental step for your baby.
- It may be 6-9 months for NAS babies to develop a good sleep routine.

How can I help my baby sleep better?

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

➤ *Awake time...*

What should I do when my baby is awake?

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

- Babies need to be in different positions during the day to learn about their world, and develop muscle control. Try things like holding the baby facing you or facing out, on your shoulder or on your hip, or secured in a swing or seat. Many babies like swings and vibrating seats but some babies with NAS may find them too stimulating.

- “Tummy time” is very important. Although your baby should always sleep on his or her back, when awake he or she should spend 10 to 20 minutes on the tummy on a firm surface (a blanket on the floor is best) while you are watching. This will strengthen the back and shoulder muscles, and your baby will learn to move around.
- Cuddle up with a book or a song. Rhythmic, soft music can be soothing for both of you, especially when your baby is restless or tired. Reading to your baby has the same effect.

➤ *Daily Schedule...*

How should I touch my baby?

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

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

➤ *Daily Schedule...*

Why does my baby cry?

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

What should I check when my baby cries?

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

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

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

The Period of PURPLE Crying:

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

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

➤ Other resources...

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

Other resources that offer help include:

Maine Association of Alcoholism and Drug Abuse Counselors (MAADAC)

maadac2001@yahoo.com

(207) 548-2877 (fax)

Maine Association of Substance Abuse Programs (MASAP)

www.masap.org

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

(207) 621-8118

The Woman's Project

Southern Maine - 1-800-611-1588

Northern Maine - 1-800-611-1779

1-800-452-6457

Helping women affected by substance abuse

www.propeople.org/women.html

Maine Statewide Crisis Hotline

1-888-568-1112

Maine Families

Augusta, ME 04333-0011

(207) 624-7900

www.maineamilies.org

BEHAVIOR CALMING SUGGESTIONS...

- Difficult or poor feeding
- Your baby may need more time to feed than others
 - Feed your baby with the same nipple type as was used in the hospital
 - Feed small amounts more often. You may need to use a special formula to make sure the baby is taking in enough calories.
 - Feed in a quiet, calm place with little noise and interruptions.
 - Swaddle baby to keep arms and hands close to midline and reduce extra movement.
 - Be alert to your baby's cues. They may include searching or pulling away from nipple or needing to pause to swallow or burp.
- Sneezing, stuffy, nose
- Call your pediatrician, especially if your baby is working to breathe.
 - Keep your baby's nose and mouth clean.
 - Do not overdress or wrap your baby too tight.
 - Keep your baby in a position where the head is above the heart, well supported and supervised.
 - Do not let your baby sleep on his or her tummy.
 - Ask your baby's doctor about saline drops.
- Spitting up
- Feed your baby slowly. Let your baby rest between feeds.
 - Feed your baby less but more often.
 - Burp your baby often.
 - After feeding, keep your baby upright in your arms for 20 minutes to help with digestion.
- Trembling
- Keep your baby in a warm quiet room.
 - Swaddle your baby snugly.
 - When positioning your baby, move slowly and carefully to not startle him or her.
 - Gently and slowly, massage your baby's arms and legs.

GLOSSARY

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

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

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

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

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

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