MGH Best Practice Guidelines for the Management of Substance Exposed Newborns

Problem Statement:

In 2003 Congress passed the Keeping Children and Families Safe Act, an amendment to the Child Abuse Prevention and Treatment Act (CAPTA), which required each state to develop policies to address the needs of substance exposed newborns. In 2010, a reauthorization of CAPTA expanded legislation to include newborns with fetal alcohol spectrum disorder. This legislation requires that health care providers involved in the delivery or care of substance exposed infants notify the child protective services system of an infant's exposure; in addition, the legislation requires caregivers to determine appropriate medical treatment for substance exposed newborns.

Prenatal exposure to alcohol and prescribed or illicit drugs is a significant problem in Massachusetts, and carries with it many risks to children and families. The national rate of illicit drug use in pregnancy for women from age 15-44 was 5.4% in 2012/2013, with pregnant women between ages 15 and 17 having the highest rate of use (14.6%).[1] These numbers do not take into account alcohol use or abuse of prescription drugs. Alcohol and/or use of prescribed or illicit drugs during pregnancy often occurs in the context of other social risk factors and can lead to severe and permanent developmental and medical problems for newborns.

Although many women who abuse substances are motivated to decrease or stop alcohol and drug use during pregnancy, there is often a resumption of use after childbirth. This may increase the risk of compromised parenting as well as abuse and neglect of infants and other children in the family. Pregnancy provides a unique opportunity to provide substance abuse treatment to women as well as increased access to other social benefits for both mothers and their children.

This document is designed to assist providers at MGH with best practice guidelines about how to respond to positive screening (interviewing) and laboratory testing in women and their newborns around the time of delivery.

(Please see attached Massachusetts Department of Public Health guidelines[2] about how and when to screen pregnant women, as well as suggestions about when to perform laboratory testing of mothers and/or newborns.)

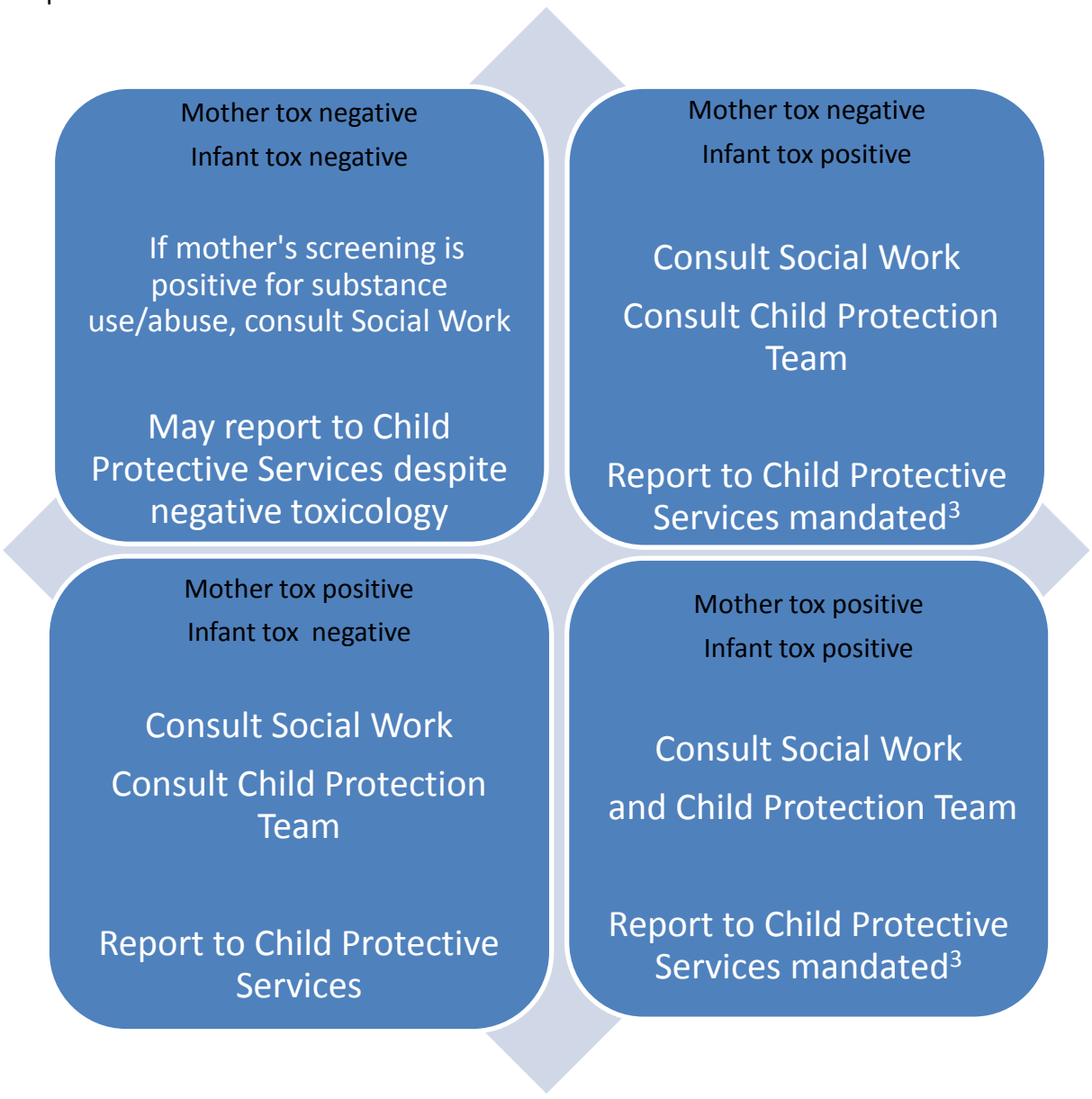
Response to Positive Maternal Screening and Positive Laboratory Testing in Mother or Infant

Terminology:

Screening refers to verbal questioning designed to determine whether an individual is using substances.

Testing refers to a laboratory test, such as urinalysis or meconium testing, that indicates whether alcohol or illicit drugs are present.

- Every woman should be screened for substance use or abuse upon admittance for labor and delivery. The response to a positive screen, as well as other potential risk factors, may result in laboratory testing of both mother and infant for prescription and illicit drugs.
- The response to positive screening about alcohol and/or prescribed or illicit drugs as well as positive laboratory testing of either mother or infant should involve a multidisciplinary team, including clinicians, social work staff, mental health/substance abuse providers, and the Child Protection Team. Decisions should be based not only on a positive screen or laboratory test, but also on providers' assessment of the situation.



Frequently Asked Questions:

- At what point in time should infant urine be collected?
    - The first void of a newborn is much more likely to be positive than subsequent urine samples, so if testing is indicated infants should have a urine bag placed shortly after delivery

- When should meconium also be sent?
    - If a newborn is felt to be a candidate for toxicology screening, both urine and meconium should be sent
        - Newborn urine reflects substance exposure during the preceding one to three days, however, cocaine metabolites may be present for four to five days. Marijuana may be detected in newborn urine for weeks, depending on maternal usage.
        - Meconium in term infants reflects substance exposure during the second half of gestation; preterm infants may not be good candidates for meconium testing. Note, a meconium screen may reveal intrapartum medications given to a mother to control pain. The high sensitivity of meconium analysis for opiate and cocaine and the ease of collection make this test ideal for perinatal drug testing

- If the mother takes a prescription drug, should I test the infant?
    - Maternal use of prescription drugs during pregnancy is associated with increased rates of psychiatric co-morbidity as well as use or abuse of other substances.[4]
    - Because some prescription drugs, such as opiates, may lead to withdrawal symptoms in newborns, it may be important to send a urine screen to determine infant exposure. In addition, mothers may abuse prescription drugs or combine them with alcohol or other illicit substances.
    - The decision to screen a pregnant woman (or her newborn) who is only taking prescription drugs should be made in consultation with both maternal and newborn caregivers, as well as social work, other mental health providers, and possibly the hospital child protection team.

- Will there be criminal action if a mother or infant tests positive?
    - Substance abuse treatment information is protected by federal law under 42 Code of Federal Regulations, Part 2 (42 CFR 2). This federal law prohibits disclosure of information unless it is expressly permitted by the written consent of the person to whom it pertains. The only exception is for child abuse/neglect reporting. [2]

- When do I need to seek consent to perform laboratory testing?
    - Pregnant women need to provide consent for laboratory drug testing under most circumstances. However, testing without permission may be indicated in an unconscious or intoxicated patient, or a patient with signs and symptoms of complications of intoxication (e.g., seizure).
    - In newborns, consent is not required because testing is to provide appropriate medical care for the infant. However parents should be notified of the need to test and of the results

References

1. Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
2. http://www.mass.gov/eohhs/docs/dph/quality/hcq-circular-letters/2013/dhcq-1305586-sen-guidelines.pdf
3. http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section51A
4. Smith MV, Costello D, and Yonkers KA. Clinical correlates of prescription opioid analgesic use in pregnancy, Matern Child Health J 2015. 19(3):548-56.