Whole-family treatment of neonatal abstinence syndrome

The title of Vogel's article[1] captures very well the urgent need for a change in clinical practice regarding neonatal abstinence syndrome. The Fetus and Newborn Committee of the Canadian Paediatric Society (CPS) addressed clinical concerns about the increase in neonatal abstinence syndrome as a result of drug withdrawal in newborns from maternal opioid use in Canada today.[2] The suggestions from the CPS are an important step forward in supporting a more holistic approach to the management of neonatal abstinence syndrome by advocating a model of "rooming-in" care for parents and families, advising less emphasis on pharmacotherapy, and highlighting the need for comprehensive discharge planning in this situation. The CPS document does not elaborate on the requirements involved in implementing changes in perinatal care to make these suggestions a reality.

This rooming-in model of care for mothers who use opioids and newborns at risk of neonatal abstinence syndrome was described in Canada in 2007 and 2010 by Abrahams and colleagues.[3,4] This program has been running for more than a decade in Vancouver, and yet its principles and practice have not been adopted by the perinatal community across Canada. The implementation of this model of care as suggested by the recent CPS document requires a lengthy process of education and changing attitudes of health professionals toward these pregnant women and their families. The support of families in this situation requires a deep commitment by health care professionals to a nonjudgmental, broad-based team approach to care during pregnancy, childbirth and the postpartum period. This team approach should include health care professionals supporting the above attitude to care, comprising family practice, obstetrics, neonatology, pharmacies specializing in opioid prescribing, methadone clinics, and local social and economic support groups familiar with the pregnant women using opioids in the community.

The intrapartum and postpartum caregivers must be educated in a harm-reduction approach to care for these pregnant women and their newborns. This harm-reduction focus in education is traditionally absent from the standard medical and nursing educational programs. Harm reduction–based care, relating to an understanding of previous life experiences involving neglect and abuse, may be a foreign concept in tertiary care hospital settings, where opioid-exposed neonates are likely to be born. This education requirement is in sharp contrast to the traditional perinatal and neonatal intensive care approach of medically monitoring and treating newborns with neonatal abstinence syndrome only when they are in frank drug withdrawal. This approach removes the mother from the centre of care, thereby reinforcing many of these mothers' previous negative experiences with institutions and people in authority.[5]

A nonjudgmental approach by care providers is essential to foster the basic trust necessary to support opioid-using mothers during pregnancy, childbirth and drug withdrawal in the newborn. Important aspects of this type of care may be easily overlooked in the traditional approach of treatment, which separates mother and baby. For example, the mother will require ongoing opioid medication after the neonate's birth. If this daily requirement is not met, her ability to care for her newborn will be compromised. Understanding this aspect of care and acting on it is a leap of faith for many health professionals working in delivery rooms and perinatal wards in hospitals in Canada today. It contrasts sharply with the previous experience of mothers discharging themselves against medical advice in order to obtain their daily opioid requirement, resulting in almost certain legal apprehension of the infant.

Although the CPS document indicates that careful discharge planning is "essential," it does not highlight the importance of early frequent follow-up of mother and infant together. This care must be undertaken by practitioners who are clinically experienced and trusted within the opioid-using community. The ongoing care of both the mother and the infant in this situation requires considerable expertise, a trusting relationship, and willingness of health care professionals to be flexible in their expectations of family dynamics, appointment scheduling, timetables and so on.

Finally the success of the rooming-in model requires strong financial and infrastructure support in the birthing hospital to allow mothers, babies and other family members to remain central to care in hospital for 7 to 10 days. This duration of care is a considerable increase over the usual postpartum stay of a day or two currently available after birth. Strong leadership and institutional administrative support of the program is key to success in dealing with the myriad obstacles that need to be overcome. As the rooming-in model is based on a substantial change in focus, with the mother and family being primary caregivers during the entire drug-withdrawal phase, strong institutional support is key to success in implementation.

In 2014, we established a rooming-in program for mothers using methadone at the Grey Nuns Hospital in Edmonton. We received combined funding from the Government of Alberta and Covenant Health to support the program. The program involved identifying mothers using methadone in the community and arranging prenatal care, admission for delivery and postnatal care at our hospital. We also organized the renovation of two postpartum rooms to be available for the family members to stay in and provide 24-hour care within the program. The extensive staff education outlined above was a major undertaking. To date, our program has cared for 43 mothers and 46 infants. Almost all infants have remained in the care of family, without pharmacotherapy or admission to the neonatal intensive care unit. Preliminary results have been presented locally and at a national bioethics conference.[6]

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