Substance Misuse in Pregnancy Guideline UHL Obstetric Guideline

University Hospitals of Leicester NHS Trust

C44/2010

Contents

1. Introduction and who this guideline applies to:

This guideline is intended for the use of all Medical, Midwifery and Nursing staff. It will also be of relevance to Primary Care and Laboratory staff involved in the care of pregnant women.
These guidelines are aimed at community, maternity and neonatal staff to ensure that:

- Provision for maternity care is accessible, welcoming, flexible and integrated to health and social care, in a non-judgement way for women.
- To involve the woman in the decision making process.
- To minimise the harm caused by the mother's drug/alcohol use on the pregnancy and the unborn baby.
- To reduce poly-drug use, and to promote stabilisation and engagement during pregnancy.

- Babies at risk of neonatal abstinence syndrome (NAS) & Fetal Alcohol Syndrome (FAS) are identified early and receive appropriate medical, nursing and social management in the neonatal period, in a holistic family centred way advocating non-pharmacological management where possible.
- Guidance and support is provided to parents and other caregivers in conjunction with maternity and social services so that the optimal outcome may be achieved.

What's new?

- Antenatal care pathway added
- Antenatal drug/alcohol treatment section including referral to services & support
- Includes misuse of over-the counter & prescription medications
- Added contributory factors for maternity care avoidance
- Acknowledgemnt of women's fears to disclose misuse
- Referral to phoenix team
- Offer one to one consultation and individualise support required
- Folic acid to continue for duration of pregnancy rather than up to 12/40
- Methadone titration now in increments of no more than 3 x 10ml in a 7 day period
- If women are dependant on alcohol they require one Consultant ultrasound scan and then growth scans
- Pain relief in labour section added
- Withdrawal signs in the neonate added
- Actions to be taken if mother is found drowsy or unrousable
- Methadone must not be administered to the newborn

2. Guideline Standards and Procedures

2.1 IDENTIFICATION

Substance Misuse (alcohol and/or drugs) is the stage at which the regular use of recreational drugs, misuse of over-the –counter medications, misuse of prescription medications, alcohol and or misuse of solvents or inhalants is having a harmful effect on a person's life:

- There will be a pre-occupation with obtaining and using their drug of choice.
- The substance is used to cope with daily life.
- Physical and mental health can be adversely affected.
- Loss of relationships, financial problems, and involvement with the Police, Probation, etc.
- Increased risk of contracting drug related infections e.g: HBV, HCV, HIV and Septicaemia.

The effects of drugs are complex and vary enormously depending on both the drug and the user. This guideline will focus on the 'problematic' drug/alcohol user (Table below No's 3&4). There are serious negative consequences of a physical, psychological, social, interpersonal, financial and legal nature for users, family, friends and unborn child. Drug use will usually be heavy, involving features of dependency that can lead to chaotic and unpredictable lifestyle needs of women who are dependent on drugs and/or alcohol.

Table 1: Categorisation

1.Experimental	Uses once or rarely. No impact on health and social functioning.
2.Recreational	Illegal drugs are used regularly. Low risk to health and social functioning. Can stop immediate use.
3.People who use legal substances	Alcohol, tobacco and prescription drugs. Can be to a level which impairs health and social functioning.
4.Dependency on illegal drugs and / or alcohol	Significant impairment of health and social functioning. Struggles to stop use without additional professional support.

Some pregnant substance misusers actively avoid maternity care despite being at high risk of medical and mental health issues (CMACE 2011).

The reasons for this include but not limited to:

- Secondary Amenorrhoea (particularly with Opiate Users / Low BMI).
- Fear of judgemental attitudes from professionals.
- Safeguarding involvement.
- Guilt and inability to change lifestyle away from substance misuse.
- Conflict with partner / domestic abuse.

2.2 ANTENATAL CARE - Screening & Booking

All pregnant women at their booking appointment with their midwife should be asked about their use of prescribed and non-prescribed drugs (legal & illicit), including tobacco use, to determine the quantity and frequency of use. Many drugs used recreationally e.g: Amphetamines, cocaine and ecstasy are discontinued on confirmation of pregnancy by the majority of women.

Pregnant women who misuse substances may be anxious about the attitudes of healthcare staff and the potential role of social services. They may also be overwhelmed by the involvement of multiple agencies. These women need supportive and coordinated care during pregnancy and should include;

- addressing women's fears about the involvement of children's services and potential removal of their child, by providing information tailored to their needs
- addressing women's feelings of guilt about their misuse of substances and the potential effects on their baby.

All women are asked to report their medication, alcohol intake, smoking, and use of recreational drugs at booking.

Identifying: alcohol use/misuse.

- All pregnant women to be asked about their alcohol use, use Audit C tool if any alcohol use identified. (Appendix C).
- Women with problematic alcohol use (Score 16 or above on Audit C tool) should be referred to the Specialist Midwife.

- What a unit is? - half a pint of standard lager/beer/cider, 1 shot of spirit, (A glass of wine 175mls is usually approx 2.5units).

*More than 4 units on one occasion in pregnancy can impact on the developing fetus.

- If significant alcohol use – please use Audit-C tool, if score is more than 16 pre pregnancy please ensure referral to substance misuse clinic. Identification of use in early stages (from 5-6weeks gestation) is vital to assess risk of Fetal Alcohol Syndrome (FAS). http://insitetogether.xuhl-tr.nhs.uk/Divisions/Corporate/CommunicationsandExternalRelations/Documents/CM/Alcohol%20Advice%20Booklet%20-%20UHL%20and%20TP%20Drew%20Jun%202017.pdf

Identify drug use/misuse

- Ascertain the level of drug use, the drug/s of choice, frequency, amount in cost & route of administration on booking.
- Please take **toxicology on booking** with patient's consent and each trimester.
- If class A drugs identified please take each time patient is seen.

Referral at booking

- Safeguarding referral (A form) should be emailed to: Maternity.Safeguarding@uhl-tr.nhs in line with Leicester Safeguarding Children Partnership Board (LSCPB) guidance.
- Complete referral form to the specialist midwife/Phoenix Team (Appendix A) for further assessment for the woman and her partner, if one or both of them has a drug dependency. Please send to: VulnerableMidwifery@uhl-tr.nhs.uk. This referral will be discussed within the allocations meeting as to whether it meets the criteria for Specialist Midwifery case-holding.
- Continue to engage woman in antenatal care until informed otherwise, (Appendix B).

Previous drug use, but stopped within 1 year prior to conception

- If there is a past history of dependency, offer referral to the Phoenix Team for assessment/support via specialist clinic if required?
- Encourage continued abstinence from drugs/alcohol.
- If past illicit drug use please obtain a urine sample for toxicology screen on booking with patient's consent and in each trimester.

Partner

- Information regarding partner/father of baby is required at booking and should include any substance misuse by him, any services he is engaged with and any treatment programme he is undertaking.

- If no treatment programme is identified, but it is felt to be required, encourage self-referral to drug & alcohol services, and referral to the appropriate services ensuring information is provided regarding pregnant partner.

Neonatal Information

A paediatric alert form should be completed antenatally and sent to the Neonatal team for women whose:

- ✓ Substance misuse is ongoing/chaotic.
- ✓ Continues to use illicit substances on top of or instead of prescribed medication (Methadone/Buprenorphine).
- ✓ Significant alcohol use at any stage of pregnancy.
- ✓ Any other concern that identifies a need for one.

In order to facilitate discussion of sensitive issues, offer each woman with a one-to-one consultation, without her partner, a family member or a legal guardian present, on at least one occasion.

Offer the woman information about the potential effects of substance misuse on her unborn baby, and what to expect when the baby is born, for example what medical care the baby may need, where he or she will be cared for and any potential involvement of social services.

Offer information about help with transportation to appointments if needed to support the woman's attendance. The support for travel is: either via social services (if involved), or if on benefits they can claim back. Benefits documentation and bus or train ticket need to be taken over to the cashier's office to for refund. There are, on occasions, where support services will support a patient with getting to appointments and in attending with them where needed.

Offer women information about the services provided by other agencies.

The first time a woman who misuses substances discloses that she is pregnant, offer her referral to an appropriate substance misuse programme.

Use a variety of methods, for example text messages, to remind women of upcoming and missed appointments.

- Offer 5mgs Folic Acid for the duration of the pregnancy as alcohol use delays absorption of vitamins. (talauliker & Arulkumaran, 2011).
- Routine blood tests screening will be offered.
- Repeat Screening for Infectious Diseaase screen at 28weeks should be offered to women who work in the sex trade industry or are current IV drug users.
- Hep C screening to be offered to woman identified as high risk of IV drug use/sex work.
- Screening for Chlamydia & Gonorrhoea can be offered via Haymarket Health (sexual health screening services)
- Referral to Anaesthetic clinic should be advised for woman with:

- ✓ poor venous access
- ✓ history of current heroin/crack cocaine use
- ✓ Intravenous drug use (IVDU) current or past

*Ensure a leaflet on “Mixing, reduce your risk of harm” is provided/available (Appendix D)

https://www.publichealth.hscni.net/sites/default/files/2019-05/Mixing_leaflet_05_2019.pdf

* Ensure a leaflet on “Reducing the risk of harm to children in your household” is provided/available https://lrsb.org.uk/uploads/reducing-the-risk-of-harm-to-children-in-your-home-(july-2017).pdf

*Ensure a leaflet on “Drug and Alcohol use in Pregnancy” is provided/available https://yourhealth.leicestershospitals.nhs.uk/library/women-s-children-s/obstetrics/382-drug-and-alcohol-use-in-pregnancy

2.3. ANTENATAL CARE - UNBOOKED

For women who do not have a booking appointment at the first contact with any healthcare professional:

- discuss the need for antenatal care
- offer the woman a booking appointment in the first trimester, ideally before 10 weeks if she wishes to continue the pregnancy, or offer referral to sexual health services or substance misuse midwife if she is considering termination of the pregnancy, who will refer to Orchid clinic at LRI (gynaecology) or BPAS.
- Is a woman presents unbooked antenatally/during labour or immediately postpartum and is suspected of misusing substances, a toxicology screen should be obtained with consent.
- Substance misuse history (Appendix E) should be obtained and documented by the midwife caring for the woman and referral to specialist services as soon as possible. Safeguarding referral should be telephoned through to the on call social workers for the area the woman lives in. An urgent assessment of her home circumstances and support networks should be made by the multi agency group as soon as possible.
- Observation and documentation of potential intravenous sites used if applicable, consider body map if available.
- If a woman is opiate dependent and not on a methadone programme the Obstetric Team should liaise with the Community Drug Team Duty Doctor at Turning Point 0330 303 6000 (Mon-Sat), office hours only, regarding short term immediate prescribing. (Drug Test is required with consent to confirm positive opiate use – Urine test requested on Chemistry form for urgent toxicology screen or/and instant test if available). Inform Specialist Midwife for Substance Misuse on 07966 558286.
- COMMENCE METHADONE TITRATION -Once confirmed on urine testing that Opiate/Heroin/Methadone positive (instant drug screen if available), a prescription for Methadone titration should be made commencing at 30mls as a daily dose and can increase *10mls/day until saturation is established and no withdrawal effects are felt by the woman. (*No more than an increase of 3 x 10mls in any 7 day period).

*Prescribing is usually by community drug team but can be by the consultant on call when out of hours. The non compliant or patient with nausea/vomiting preventing adequate titration, will need admission for stabilisation and above protocol to be followed.

***Cyclizine is contraindicated in IVDU and/or on Methadone.**

2.4 ANTENATAL CARE PATHWAY

All pregnant women with an identified current substance misuse should be offered routine antenatal care in line with Primigravida criteria/substance misuse care pathway (Appendix B)

These women should be asked about their substance misuse at every contact and this clearly documented in the notes/E3.

Brief interventions by the midwife should be offered at booking and antenatal appointments. This information should be evidence based with up to date information about the risk of their drug/alcohol use on their health and that of their baby's health:

- https://www.nspcc.org.uk/keeping-children-safe/support-for-parents/baby-parenting/
- https://www.drugwise.org.uk/heroin/

Although the majority of antenatal care should be in the community setting by the community midwife, some women require increased specialist care and referral to the Phoenix team to consider allocation to a specialist midwife, if the criteria has been met. Other women identified with current drug use will be reviewed in the specialist clinic for substance misuse and have input from the consultant and specialist midwife. (Appendix F).

Toxicology screening should be requested at every trimester (minimum)for women who are continuing to misuse substances and more frequently if required or identified.

Women who are physically dependent on alcohol should be advised to avoid sudden cessation of alcohol consumption as this may lead to seizures due to alcohol withdrawal; pharmacological treatment and supervised withdrawal may be required and this should be supported by the drug and alcohol services and communicated to the obstetrician and specialist midwife for substance misuse.

Any identified increase in substance misuse/alcohol use during the pregnancy should be highlighted to maternity safeguarding team and the specialist midwife.

All women currently misusing substances and/or alcohol in pregnancy should be offered growth scan at 26-28weeks gestation. If women are dependant on alcohol they require one Consultant ultrasound scan and then growth scans

Paediatric Alert Form to be completed by 36weeks regarding any risks and ongoing drug/alcohol misuse or any other identified concern.

Care provision

- Consider initiating a multi-agency needs assessment, including safeguarding issues, so that the woman has a coordinated care plan.
- Respect the woman's right to confidentiality and sensitively discuss her fears in a non-judgemental manner.Tell the woman why and when information about her pregnancy may need to be shared with other agencies.
- Progress is tracked through the relevant agencies involved in her care & notes from the different agencies involved in her care are combined into a single document and E3
- There is a coordinated care plan

2.5 ANTENATAL CARE - DRUG/ALCOHOL TREATMENT

- The pregnant woman and/or partner should be advised and encouraged to self refer to the Drug & Alcohol Services in Leicester, Leicestershire & Rutland (Turning Point) if not currently ustilising these services. https://www.turning-point.co.uk/services/leicestershire or call: 0330 300 6000.
- Or the woman can be referred by the midwife and "fast tracked" for assessment using the below link: https://tp-opa.custhelp.com/tp_opa/owda/0/investigate/Professional%20Referral/en-US/ScreenOrder~Main~qs%24cf63214e-894c-4279-bc1a-cd1da1a35af5%24global%24global.
- Harm reduction and stabilisation of drug/alcohol use is the priority. The woman and their partner should be encouraged to engage with all services. Substance misuse monitoring will be carried out by the drug & alcohol services, however, toxicology screening on the mother should be sent to the lab as identified above.
- Treatment options will be discussed by drug and alcohol services and their prescribing team. Maintenance, partial reduction, and drug/alcohol withdrawal will be offered with ongoing support and counselling.
- To ensure a good outcome for mother & baby they should be encouraged to continue to attend all appointments with all professionals.
- Continuity of regular good antenatal care is paramount in reducing the risks for mother and baby.
- Many women struggle to stop using drugs particularly with additional stresses of pregnancy and poor socio-economic circumstances.
- Women should be advised and supported to reduce their substance misuse slowly in order to ensure stability in the pregnancy and promote lifestyle changes that can be maintained, this can reduce any unknown risks to fetal growth and development.
- https://www.sciencedirect.com/science/article/abs/pii/S1751721420301615

2.6 ANTENATAL CARE - LABOUR & DELIVERY

All staff involved should be aware of the current status of the woman's drug usage/treatment. Liaison with the anaesthetic team is likely to be required to ensure effective analgesia. Entonox can be used unless contraindicated as a form of analgesia in labour. Epidural is recommended as the most effective form of pain relief for women with opiate dependency.

Toxicology screen should be requested on admission in labour or immediately postnatal with consent and documented if declined.

If the woman is on an opiate substitute prescription [Physeptone (Methadone) or Buprenorphine, (Subutex®)] the dosage should be verified by the information in her hospital notes and confirmed by contacting the dispensing pharmacy or the original prescribing doctor/nurse at Turning Point (Mon-Sat Tel: 0330 303 6000). If the admission is out of hours the information from the woman and her hand held notes should be used and verified at the first opportunity. The Specialist Midwife in Substance Misuse should be informed of admission as soon as possible. (Mobile: 07966558286: Mon-Fri 8am-4pm).

Opiate substitution treatment should be continued as normal when admitted in labour

The newborn infant exposed to opiates antenatally MUST NOT receive Naloxone as this could precipitate immediate acute and severe withdrawal symptoms including seizures resistant to anticonvulsants.

Social services and the specialist midwife should be informed of the baby's birth at the earliest opportunity. Staff to inform relevant professionals and/or agencies following the delivery, in order to ensure that the Family Support Plan, written agreements or Child Protections Plans are adhered to and followed.

If the woman has a history of IVDU there may be difficulty in venous access – advice from the Anaesthetist should be sought antenatally and a plan provided in the notes.

Women with dependency issues can be offered all analgesic options for labour and delivery, unless there are specific contraindications. The analgesia management may be more challenging if opiates are used, especially for women on buprenorphine. The default position should be standard opioid administration. It is recommended that pre-existing doses of prescribed opiate substitute medication (Methadone or Buprenorphine) are not altered to achieve pain relief but additional opioids are prescribed as required. The aim should be to achieve adequate analgesia with the lowest dose of additional opioids for the shortest period of time.

Epidural analgesia may be useful for 2 main reasons:

- ✓ Can avoid the use of additional IV opioids particularly if this reminds the woman of any past IVDU.
- ✓ Can be useful when women are taking high doses of opiates antenatally and in whom it may be difficult to control pain with standard opioid analgesia.

2.7 POSTNATAL CARE OF MOTHER & BABY

Most babies of substance misusing mothers are cared for on the postnatal wards. Admission to the neonatal unit (NNU) is rare; where this occurs the mother should be encouraged to stay with her baby.

Staff should remember that analgesia requirements may be higher for women with opiate dependency and **MUST NOT** be withheld unless there is a medical indication, however, wherever possible opiates should not be given, Paracetamol and non-steroidal anti-inflamatory pain relief should be offered in the first instance; additionally, consideration to split dosing the current methadone prescription to aid pain relief may also help especially where the woman has any nausea and vomiting .

***DO NOT PRESCRIBE METHADONE PRN FOR ADDITIONAL PAIN RELIEF** any changes to prescription should be sanctioned by the drug & alcohol services prescribing team.

Staff should ensure that prescribed analgesia is effective and request review by the obstetric team daily. Opioid analgesia should be reduced/stopped as soon as is appropriate. See treatment/prevention of withdrawal in AN & PN women - Appendix G

The mother and baby once transferred to the Post Natal ward should be located in an open ward so as staff are able to observe and monitor for symptoms of withdrawal.

WITHDRAWAL SIGNS AND SYMPTOMS IN THE WOMAN				
Diarrhoea	Nausea & Vomiting	Sweating	Yawning	Lachrymation & Rhinorrhea
Feeling Hot & Cold	Anorexia	Abdominal Cramps	Tremor	Insomnia & Restlessness
Generalised Aches & Pains	Tachycardia & Hypertension	Gooseflesh	Dilated pupils	Increased bowel sounds

The mother should be advised that the aim is to detect, and if necessary treat significant signs and symptoms of NAS/FAS, and prevent the worst case scenario of neonatal seizures.

The baby must be referred for review by the neonatal team at delivery who will then reviewed daily. A management plan should be documented in the notes.

Neonatal observations should be undertaken 4-hourly and when baby is awake. All observations and actions taken must be documented on NEWS charts and in the mother's notes as appropriate. It is important to document in maternal and on any baby records any signs of baby's withdrawal as this may be required should the child show any developmental signs or symptoms in their later life to support a potential NAS/FAS diagnosis.

Symptoms of methadone withdrawal may take several days to present, for this reason a minimum of 72hours monitoring of the infant is recommended, these symptoms may last up to 2 weeks with opiates and longer with other drugs such as Benzodiazepines. See Table below and Appendix H

WITHDRAWAL SIGNS AND SYMPTOMS IN THE NEONATE				
Jitteriness / Tremors / Seizures	Rigidity in limbs	Nasal stuffiness & sneezing	High pitched cry	Diarrhoea / excoriation nappy region
Tachyapnoea	Salivation	Vomiting	Dehydration	Poor feeding
Hiccups	Hypertonicity	Yawning	Hyperthermia /Sweating	Weightloss

If the baby has symptoms to a degree that requires treatment, he/she may require admission to the Neonatal Unit for further management.

Specialist midwife in substance misuse and safeguarding midwives to be informed of admission and will visit whilst on the ward to support care and discharge planning as required.

Management of the neonate on the ward should be non pharmalogical.

- ✓ Nurse in quiet environment with reduced lighting where possible
- ✓ Minimal handling and use of prone position
- ✓ Vestibular stimulation including rocking and patting the back
- ✓ Physical boundaries including swaddling and use of pacifiers with parental consent

- ✓ Demand feeding, little and often
- ✓ Breastfeeding should be encouraged. Please see further guidance on page 12.

Any women or their partners who use drugs and/or alcohol should be strongly advised against co-sleeping with the baby as there are significant risks to the baby. .

A urine sample should be obtained from the mother with consent on **Day 2** for toxicology and alternate days until discharged.

The parents should be included in the assessment of the baby in order to encourage their involvement and knowledge of the care of the newborn. The midwife should document in the maternity records, observation and assessment of parenting skills (**complete parenting skills log documentation**) this is an important aspect of planning discharge from the unit and maybe required for Court reporting if requested.

The mother may require additional support as the baby may well be fractious and unsettled.

If the mother is observed leaving the ward for long periods, the midwife should enquire as to the reason for the absence and to challenge the woman if the midwife suspects the use of illicit substances or alcohol. If suspected of using illicit substances a urine sample should be taken for toxicology screen and the specialist midwife for substance misuse & safeguarding should be informed ASAP.

If the mother is drowsy or unrousable, observations and refer to Dr for review, consider may require rescuitation and or Naloxone for Opiate overdose. (separate paragraph)

2.8 NEONATAL ABSTINENCE SYNDROME/FETAL ALCOHOL SYNDROME – CARE OF INFANT

Key Points:

- A paediatric alert form should have been completed on each mother where there is known, habitual substance misuse. This should be sent to the neonatal unit and a copy filed in the patient's hospital notes by 36 weeks.
- It is important to document the results of antenatal serology testing, toxicology screening and social circumstances as well as the drugs and dosages to which the fetus was exposed during pregnancy.
- Infants should be managed on the postnatal wards where at all possible.
- All **at risk** infants should remain in hospital for at least 72 hours for observation following birth and a NEWS chart completed. This **does not** apply for mothers and babies where there are no ongoing concerns about substance misuse e.g. those who may have used in the past, but are not doing so currently and not taking any medication that require monitoring of the newborn.
- Little is known about NAS/FAS in preterm babies and responses are likely to be different from those in term infants. As yet there is no definitive method of identifying signs and symptoms or defining severity of withdrawal.
- Note that there may be additional diagnoses in infants with NAS/FAS symptoms - **Do Not Assume.**
- **Methadone must not be administered to a newborn infant under any circumstances as it is extremely toxic to the infant and potentially fatal, parents/carers must be reminded of this prior to discharge (appendix D).**

2.8% of pregnant women report having used illicit drugs and it is estimated that up to 75% of infants exposed in-utero will show signs of withdrawal. In addition the proportion of young women aged between 16 and 24 that drink heavily increased to 33% in 2002/2003. Polydrug use is also increasingly common.

The types of drugs used as well as the pattern of use during pregnancy will affect the length and severity of withdrawal in the newborn infant as well as the gestation at birth.

It is important to be aware that not all drug use is incompatible with being a good parent. There is evidence that effective support and treatment for the parent can reduce the risk of harm to the infant (Advisory Council on the Misuse of Drugs 2003). It must also be remembered that some mothers may be on opiate derivatives for the control of pain.

2.9 BREASTFEEDING

Breastfeeding should be encouraged as with any mother. The only contraindication to breast feeding is in a mother that is HIV positive (see HIV policy for further guidance if breastfeeding is desired by the mother) or being treated with certain antipsychotic medication.

If the mother has continued to use illicit drugs in pregnancy then they are advised of the risk of harm from maternal substance misuse and to abstain should they wish to breastfeed.

If a mother wishes to breastfeed and has used an illicit substance recently or prior to delivery then it is recommended that the mother waits for 24 hours to elapse since her drug/alcohol use, before commencing or continuing breastfeeding. Expressing and discarding breastmilk should be encouraged to support maternal milk supply.

In general the benefits of breastfeeding far outweigh the disadvantages (SCODA, 1997). Although the risks and benefits should be considered before using any drug when breastfeeding, it should be noted that most drugs pass through the breast milk in very small quantities with a milk-to-plasma ratio <1% (American Academy of Paediatrics, 2001), (The Breastfeeding Network, 2002) and can support a natural detox for the infant. However, there maybe contraindications in some medication/drug use, including some antipsychotics used in the case of dual diagnosis/severe enduring mental health issues. https://www.choiceandmedication.org/leicspart/ and/or https://www.medicinesinpregnancy.org

2.10 DISCHARGE FROM HOSPITAL

Discharge planning should start prior to admission in labour.

Safeguarding issues should have been identified during the pregnancy and any referrals to social care actioned, social worker should be identified and a child in need (CIN) or child protection (CPP) identified, these can be found on E3, Nerve Centre & a copy in the maternal notes.

A pre-birth safe discharge meeting should have been completed and the plan attached to E3, Nerve Centre & a copy in the maternal notes.

The mother should have been made aware that a minimum stay of 72 hours is required to monitor her baby and that an early discharge is not possible if there has been any substance misuse or significant alcohol use in pregnancy, but if she insists, the emergency duty social work team must be informed.

If no safeguarding issues have been identified antenatally, any new safeguarding concerns during labour or postnatally should be acted on immediately. Safe guarding referral (A form) to be completed, this should be phoned through to the duty social worker on:

- Social Services: 0116 454 1004 (city)
- Social Services: 0226 305 0005 (county)

Parents should be informed that this is happening.

On discharge consideration to the following should be discussed with the mother:

- Storage of methadone and a methadone prescription arranged with the drug & alcohol services prescribing team should have been arranged.
- Specialist midwives for blood borne infections (BBI) should have seen the woman antenatally if baby at high risk/maternal IVDU. Hepatitis B immunisation are offered to baby prior to discharge and a referral to Dr Bandi for further immunisations if Hepatitis B immunisation given.
- These infants are not routinely followed up in outpatients but may require follow up in specific situations e.g: FAS - 6/52 clinic; consider referral to genetics and neurodevelopmental follow if identified; or for unrelated substance misuse issues.
- Children and Young People's Services will liaise with the specialist midwifery (Phoenix) team and following the professional pre-birth planning meeting, develop a robust antenatal and safe discharge plan. In a high risk case a discharge planning meeting will be convened on the ward prior to discharge to ensure robust plans are in place to support a safe discharge. This meeting should include the Mum and any support networks she has, ward midwife, specialist midwife, neonatologist, nursing staff from NNU if admitted, social worker, health hisitor, GP, CDT and any other services involved. The purpose of this meeting is:
  - To share information including any treatment for withdrawal that has taken place and plans for medical follow-up and review.
  - For the social worker to discuss the outcome of the assessment which has been carried out, highlighting any area of concern.
  - To ensure that community services are aware of the baby's planned discharge from hospital and that appropriate support is available.
  - To make decisions and recommendations for community and social work follow-up and support as appropriate.
  - Identify support needs and mechanisms.

2.11 DISCHARGE CARE BY COMMUNITY MIDWIFE / SPECIALIST MIDWIFE

- Community Midwives will provide routine post natal care for all women they case-hold, discharge care of the mother and baby to the Health Visitor when appropriate and inform the specialist midwife in substance misuse if.
- For the women who have written agreements or where there is a child protection plan in place, the case-holding community midwife/specialist midwife will provide routine post natal care up to 10 days and continue to review weekly as required up to 28 days before discharging care of the mother and baby to the Health Visitor when appropriate.

- Complete Substance Misuse Audit form and email to specialist midwife substance misuse: VulnerableMidwifery@uhl-tr.nhs.uk. (Appendix J)

2.12 CONTACT LIST

Name	0116 258 **Ext** (-1 if dialling from outside UHL)	
Angela Geraghty, Specialist Midwife (Mon-Fri 8-4)	15990/17773	07966 558286
Sarah Stone, Specialist Midwife (Mon-Fri 8-4)		O7717694341
Sonia Agarwal, Consultant Obstetrician (Secretary)	15923/17770	
Flo Cox, Midwifery Matron (Mon-Thu 8-4)	16086	07867 525097
Specialist Midwives – Safeguarding (Mon-Fri 8-4)	16432	07876 475318
Jo Behrsin, Consultant Neonatologist	17595/17729	
The Neonatal Unit, Kensington Building	16464	
Infant Feeding Co-ordinator Office:	15990	
Ann Raja – Specialist Midwife		07833 642147
Diana Matthew - Maternity Support Worker		07770 580455
Jane Friend - Maternity Support Worker		07500 127803
Community Drug Team – Turning Point		0330 303 6000
Children and Families Social Work Team (City)		0116 454 1004
Children and Families Social Work Team (County)		0116 305 1005
National Drugs Helpline		0800 776600
Drug Advisory Service		0116 222 9522
Websites of use: www.drugscope.org.uk; www.nta.nhs.uk; www.alcoholconcern.co.uk; www.nofas-uk.org.uk		

3. Education and Training

Healthcare professionals should be given training on the social and psychological needs of women who misuse substances.
Attend mandatory safeguarding training day every 3 years.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Outcomes for Mother & Baby	Audit Form	Specialist RM	Each Casehold	Safeguarding lead for maternity

5. Supporting References

Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110) NICE GUIDANCE 22 September 2010 reviewed 2018(ACCESSED 22/02/2022)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832459/user-guide-to-drug-misuse-statistics.pdf

https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

6. Key Words:

Alcohol, Fetal Alcohol Syndrome, Neonatal abstinence syndrome, Recreational drugs, Solvent, Withdrawal

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) A Geraghty – Specialist midwife S Agarwal - Consultant			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
October 2010	**1**		Original authors: A. Geraghty & P. Ryan
September 2011	**2**	Neonatal Guidelines Group & Maternity Governance Group	
XXXXXXX 201?	**3**	S/Midwife,(Angela Geraghty), Consultant (S.Agarwal) & Neonatologists	
January 2019	**4**	Consultant – S Agarwal,Neonatologists, Infant Feeding Co-ordinator	

February 2022 – March 2022	**5**	Specialist Midwife - Angela Geraghty, Floretta Cox - Matron Consultant Obstetrician - Dr S.Agarwal Maternity Governance Group	Antenatal care pathway added, appendix updated. Antenatal drug/alcohol treatment section incl referral to apt services & support, pathway flow cahrt in appendix updated Included misuse of over-the counter & prescription medications Added contributory factors for maternity care avoidance Acknowledgemnt of women's fears to disclose misuse Referral to phoenix team Offer one to one consultation and individualise support required Folic acid to continue for duration of pregnancy rather than up to 12/40 Require one Consultant ultrasound scan and then growth scans Methadone titration now in increments of no more than 3 x 10ml in a 7 day period Pain relief in labour section added Withdrawal signs in the neonate added Actions to be taken if mother is found drowsy or unrousable Methadone must not be administered to the newborn

Appendix A: Specialist M/W Referral

SPECIALIST MIDWIFE REFERRAL

Substance Misuse / Homeless & Asylum / Teenagers / Mental Health (please circle)

CLIENT DETAILS

Name:
DOB or Hospital No:
Address:

Telephone:
LMP: **G** **P** **EDD:**

YOUR DETAILS

Name & Position:
Address:

Contact Details:
Planned Follow up with this client: YES/NO **Date:**
Referral discussed with client: YES/NO
Domestic Abuse: YES/NO

REASON FOR REFERRAL

Please provide as much information as possible on referral

Please Post to: Specialist Midwives Office
Jarvis Building,
Leicester Royal Infirmary, Leicester, LE1 5WW
Email: **vulnerablemidwifery@uhl-tr.nhs.uk**
Telephone: ***0116 258 5990/7773***
Substance Misuse: 07966 558286/07717694341 ***Homeless & Asylum: 07500 959280***
Teenagers: 07717694420 ***Mental Health: 07717694373***

Guidance on for referral to Specialist Midwives

Substance Misuse:

- Anyone with a current significant alcohol intake
- Anyone on Methadone or Subutex
- Anyone taking illicit substances regularly
- Anyone with a recent drug or alcohol issue within the last year prior to pregnancy
- Anyone on a drug rehabilitation order
- Anyone with a drug or alcohol history that are involved with Social Care or on a Child in Need or Child Protection Plan

Homeless

- Women and their partners who are homeless
- Women and their partners who are living in hostels/ Bed and breakfast
- Women and their partners who are living on the streets
- Women and their partners who are sofa surfing
- Women living in a refuge
- Women living in supported accommodation
- Women who have recently been liberated from prison
- Women registered with Homeless Health Care at the Dawn Centre Conduit Street Leicester

* NO MEMBERS OF THE TRAVELLING COMMUNITY

Asylum

- Women and their partners who are seeking Asylum in the U.K.
- Women and their partners who are destitute and have been refused asylum in the U.K.

* NO EUROPEAN NATIONALS

Teenagers

- Teenagers under the age of 18 years

Mental Health

- Anyone with a history of mental health issues
- Anyone who displays current mental health issues
- Anyone who is currently under Consultant psychiatric care
- Referral to Psych Liaison must also be completed

If you are unsure whether to refer a patient to a particular specialist midwife please contact them on the appropriate mobile number overleaf to discuss the case. Please note completion of a referral form MUST be sent.

Appendix B: Substance misue in pregnancy pathway

SUBSTANCE MISUSE IN PREGNANCY PATHWAY

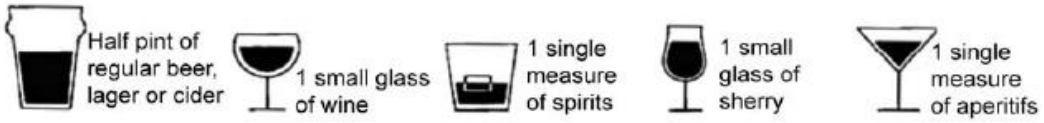
	Pre-Conceptual Care	- Advice on reproduction health, contraception & sexual health - Advice on pregnancy care - Establish substance misuse - Discuss support with drug & alcohol services
	Confirmation of pregnancy	- Pregnancy submission form once confirmed pregnant - Inform GP - Arrange Booking appointment
8-10 weeks	Booking Appointment	- Complete Booking on E3 and hand help notes - Complete substance misuse history on E3, check if on Opiate substitute programme - Assess alcohol use using AUDIT-C where possible - Discuss and agree management of drug/alcohol misuse - Take booking bloods & Hep C screening if at high risk - Toxicology screen with consent - Offer Hep C screening if past or current IVDU - Send referral to specialist midwives VulnerableMidwifery@uhl-tr.nhs.uk - Assess social circumstances and risk - Complete safeguarding A form Maternity.Safeguarding@uhl-tr.nhs.uk - Referral taken to Phoenix team allocations meeting to discuss criteria for case-holding - Refer/Liaise with community drug team (CDT) – early intervention as required - Discuss smoking and complete CO monitoring for all women - Discuss infant feeding / encourage breastfeeding and cessation of substance misuse
11-14 weeks	NT Scan	- Woman to attend USS - Woman offered NT screening
15-16 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Give Booking blood results to woman – if Rh-ve, book clinic appt for 28/40 - Ensure Substance misuse clinic appointment is booked if required - Give urine test results - Check NT screening completed if not offer DRT screening
19-22 weeks	Anomaly Scan	- Woman attends anomaly scan - Antenatal check & CO monitoring for smokers
24-25 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Monitor drug/alcohol use, engagement with CDT, social care etc - Discuss any concerns/safeguarding involvement - Check opiate substitute programme - Send toxicology screen with consent - Discuss Infant feeding
28 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Re check FBC & Rhesus antibody blood test - Fundal height assessment or Growth scan if on pathway - Listen to Fetal Heart - Toxicology screen with consent - Check engagement with all services - Check opiate substitute programme - Reassess social circumstances/risk & follow up any safeguarding concerns

31 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Fundal height assessment or Growth scan if on pathway - Listen to Fetal Heart - Check opiate substitute programme - Send toxicology screen with consent - Preparation for parenthood
34 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Fundal height assessment or Growth scan if on pathway - Listen to Fetal Heart - Check opiate substitute programme - Send toxicology screen with consent
36 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for all women - Fundal height assessment or Growth scan if on pathway - Listen to Fetal Heart - Check opiate substitute programme - Send toxicology screen with consent - Discuss Pain relief, labour & delivery & 36/40 risk assessment
38 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Fundal height assessment or Growth scan if on pathway - Listen to Fetal Heart - Check opiate substitute programme - Send toxicology screen with consent - If still misusing substances book IOL by 40/40
40 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Fundal height assessment or Growth scan if on pathway - Listen to Fetal Heart - Check opiate substitute programme - Send toxicology screen with consent - Discuss membrane sweep and if consents - agree date & time
41 weeks	Antenatal Appointment	- Antenatal check & CO monitoring for smokers - Fundal height assessment - Listen to Fetal Heart - Check opiate substitute programme - Send toxicology screen with consent - Perform membrane sweep if consent obtained & book IOL if not previously booked
Up to 28 days	Postnatal	- Continue MDT support/PN care plan - Continue NAS/FAS assessment on new-born - Monitor drug & alcohol use - Relapse prevention support - Midwife discharges care to GP & HV (10-28 days) depending individual needs

Appendix C: Audit - C

AUDIT-C

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

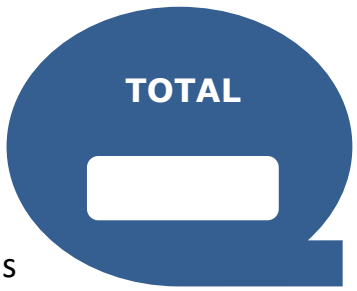
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions

Appendix D: Information leaflets/websites

*Ensure a leaflet or web link on “Mixing, reduce your risk of harm” is provided/available

https://www.publichealth.hscni.net/sites/default/files/2019-05/Mixing_leaflet_05_2019.pdf

* Ensure a leaflet or web link “Reducing the risk of harm to children in your household” is provided/available https://lrsb.org.uk/uploads/reducing-the-risk-of-harm-to-children-in-your-home-(march-2021).pdf?v=1642521731

*Ensure a leaflet or web link “Drug and Alcohol use in Pregnancy” is provided/available https://yourhealth.leicestershospitals.nhs.uk/library/women-s-children-s/obstetrics/382-drug-and-alcohol-use-in-pregnancy

*Ensure a leaflet or web link on “Mixing, reduce your risk of harm” is provided/available

https://www.publichealth.hscni.net/sites/default/files/2019-05/Mixing_leaflet_05_2019.pdf

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Appendix E: Substance misue history form

Substance Misuse History

PATTERN OF CURRENT SUBSTANCE USE			
Problem Drugs	1.	2.	3.
Prescribed Y/N			
Frequency • < once a week • No. of days per week • Daily • More than once daily			
Dose/Amount (weight/cost)			
Route - oral, sniffing, bombing, IV. If IV sites used			
Age 1st used			
This Use/Episode (How long?)			
Physical Dependency Symptoms Present?			
Last Used?			
Who thinks your drug use is a problem?			

ALCOHOL CONSUMPTION			
How many days in the last month have you drunk alcohol?			
Typically how much did you drink on any one day? ☐ UNITS			
Other Drugs: Which of the following have you used in the last month?			
Heroin Methadone Physeptone Buprenorphine (Subutex) Codeine DF118 Morphine LSD	Amphetamine Cocaine Methamphetamine Crack Glue Aerosol Fuels Others:	Mushrooms Ectasy Cannabis Anti-depressants Cyclizine Ketamine Tranx (eg: Valium, Temazepam, Sleepers) Tobacco (how much)	Nitrites/poppers GHB Steroids Paracetamol Alcohol Khat

Prescribed Medication:

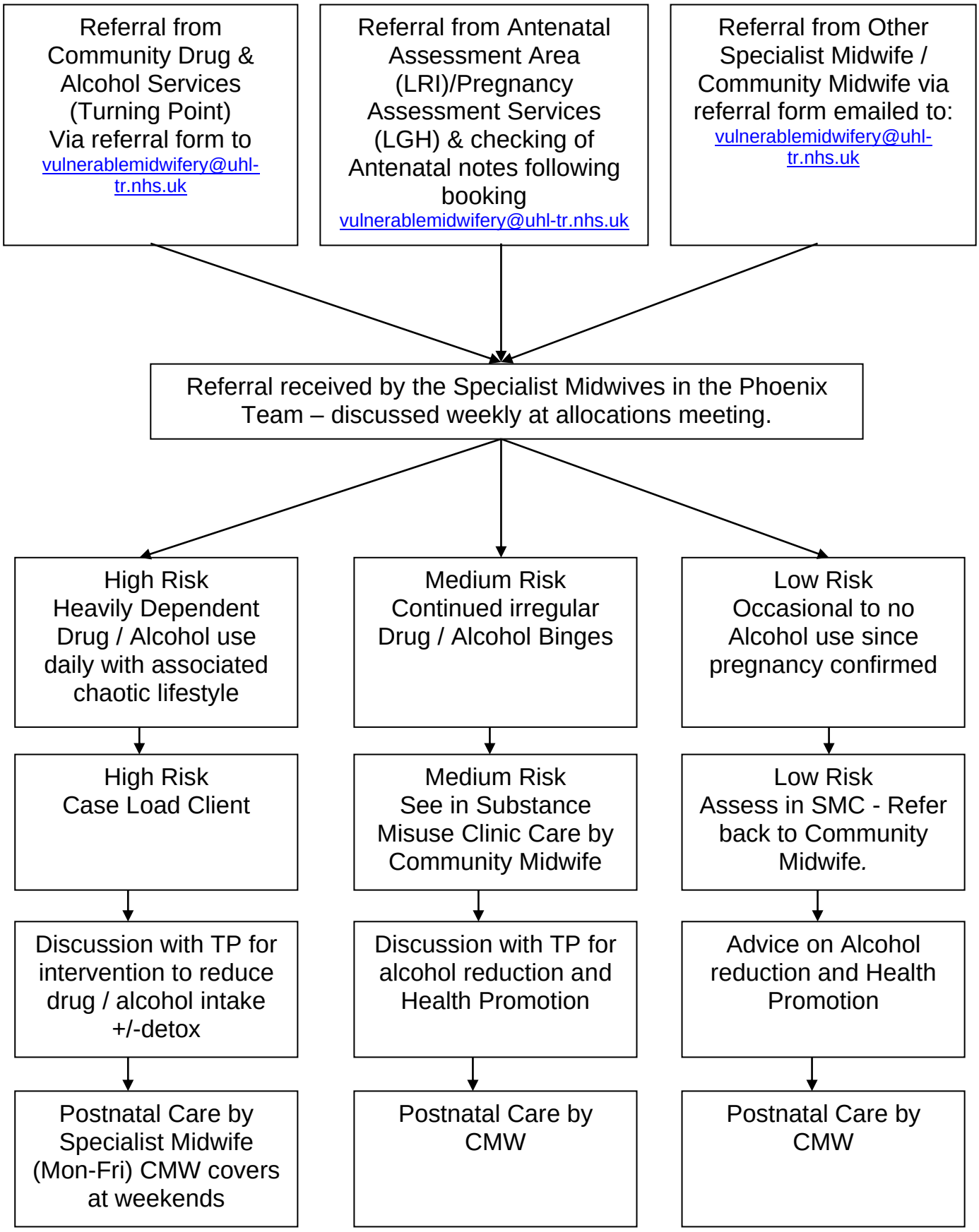
Drug Name	What For	Prescribed by:

Ever Injected?	Y / N	Currently injecting (last 4 weeks)	Y / N
Subcutaneous (skin popping)? Y / N		Intramuscular? Y / N	Intravenous? Y / N
Age 1st injected?	Site(s) Used		
Any Problems with injecting? (e.g. venous access, infections, abscesses cellulitis etc)			Y / N
Do you know of the needle exchange schemes in the area? (if no give details)			Y / N
Where do you get your kit from?			
Injecting, Snorting & Smoking (prompt – all injecting, cocaine and crack use)			
Ever Shared?	Y / N	If Yes, have you shared in the last four weeks	Y / N
Have you Ever Overdosed?	Y / N	When?	
Other Information: (eg, fund habit, accommodation, working, support, children etc)			

TESTS / VACCINATIONS:		
Hep A	Vaccinated? Y / N	Antibody Test? Y / N
Hep B	Vaccinated? Y / N	Antibody Test? Y / N
Hep C	Antibody Test? Y / N	Positive / Negative / Not Known
HIV	Antibody Test? Y / N	Positive / Negative / Not Known

Appendix F: Pregnancy drug & alcohol misuse pathway

PREGNANT DRUG ALCOHOL MISUSE PATHWAY



Appendix G – Treatment / Prevention of Withdrawal in Antenatal / Postnatal women.

Women on a methadone programme:

- Ascertain total daily dosage taken. Women usually bring their own supply with them if they have been prescribed in unsupervised consumption. However to verify the dosage contact the Community Drug Team (CDT) or Specialist Midwife at earliest opportunity.
- Is it taken as single or divided doses?
- How much has already been taken that day?
- Prescribe on EMEDS/Nervecentre ensure dose already taken that day, specifying the strength of the mixture and the volume taken
- Is any other drug taken e.g. hypnotic?
- Liaise with obstetric pharmacist regarding normal supplies of methadone and requirement for TTO medication/resuming of normal supplies.

Women unknown to CDT or Substance Misuse clinic

- Commence titration thus allowing woman to remain in hospital
- Complete Drug History Assessment & Inform drug & alcohol services in A&E Dept
- Confirm illicit drug taken by sending urgent Toxicology screen (Use instant test if available)
- Symptoms and signs of opiate withdrawal:

➢ Sweating / Gooseflesh	➢ Tremor
➢ Lachrymation & Rhinorrhea	➢ Insomnia & restlessness
➢ Yawning	➢ Generalised aches & pains
➢ Feeling hot and cold	➢ Tachycardia & hypertension
➢ Anorexia & abdominal cramps	➢ Dilated pupils
➢ Nausea, vomiting & diarrhoea	➢ Increased bowel sounds

- After delivery contact CDT/ Specialist Midwife.

*ONLY ISSUE TTO MEDICATION FOLLOWING AGREEMENT WITH CDT PRESCRIBING TEAM

Opiate/Heroin users

- Give stat dose of 30ml Methadone 1mg/ml mixture and observe effects.
- Review the need for further doses, increasing 10mls per day (up to an increase of 30mls over a 7 day period). Appropriate dose is when saturation is reached and no withdrawal affects are felt by the patient.
- Intolerance to methadone is unusual. If it induces vomiting or rarely an allergic reaction use Buprenorphine (Subutex®) instead. Suboxone® should not be used due to the Naloxone being contraindicated in pregnancy.
- Should Buprenorphine be prescribed Start dose is 8mgs/day increasing 4mgs/day to a maximum dose of 32mgs/day.

Crack and amphetamine users

- Hydrate and ensure adequate diet is taken.
- Reduce any stimulation / encourage rest
- Calm environment, consider single room if appropriate

Appendix H – Effects of Maternal Drug Abuse on the Foetus & Newborn Infant

Specific Drug Effects

Alcohol

Infants exposed to alcohol may have features of fetal alcohol syndrome - FAS (dysmorphic facies, congenital heart disease, symmetrical growth retardation, mental retardation).

Acute withdrawal occurs between 6 and 12 hours and symptoms include irritability, tremors, spontaneous seizures, opisthotonos, abdominal distension

Phenobarbitone should be used to treat severe cases or seizures

Some FAS symptoms do not show up at birth and will only become noticeable as the baby grows and develops, parents should be advised when assessed in antenatal clinic and again on discharge. This should be documented on the baby's discharge paperwork/Red book where possible.

Amphetamines

Fetal exposure is associated with preterm delivery and placental abruption

Effects are similar to cocaine

Benzodiazepines

Late withdrawal is a feature of benzodiazepine use in pregnancy

Babies of mothers who have a history of long-term benzodiazepine misuse may need observation for more than 72 hours. This will need to be reviewed on an individual basis. The two important consequences of benzodiazepine withdrawal are:

- Late withdrawal occurring beyond 10 days and presenting with features of irritability.
- Infant exposed to benzodiazepines in utero may be hypotonic with depressed respiratory drive

Cocaine/Crack

Cocaine is a powerful vasoconstrictor

- There are reports of it causing fetal vascular disruption sequence
- The recognised cerebral complications are those of sub ependymal haemorrhage, cerebral infarct and periventricular leukomalacia. These complications are rare and are associated with significant high dose cocaine abuse.

Onset of withdrawal symptoms and signs is usually early but may be delayed until 72 hours

Ecstasy

Little is known about the effects of ecstasy on either the mother or infant but it is known to have a hyperthermic effect

Marijuana/pot/cannabis

This is a widely used drug and there are no known neonatal withdrawal phenomena, however on-going research regarding effects on babies continue regarding links with autistic traits.

Opiates (Diamorphine) and Opioids (methadone, buprenorphine)

One of the reasons for commencing methadone or buprenorphine is to reduce the risk associated with intravenous injection of diamorphine.

Withdrawal symptoms are common:

- Onset of symptoms usually occurs by 48 hours (may be < 24 hours with diamorphine) but may be delayed until 6 days (>72 hours with methadone).
- There is debate about the correlation between maternal dose of methadone and neonatal abstinence syndrome but there is correlation between the cord blood levels of methadone and the severity of NAS.
- Buprenorphine withdrawal is less severe than methadone withdrawal
- Treatment with oral morphine is recommended for severe withdrawal from opiates and opioids

Polydrug exposure

This may lead to a biphasic pattern of withdrawal

The use of phenobarbitone is advocated in this situation if required

Volatile gas use

The use of volatile inhaled gases has increased and may lead to increased miscarriage and fetal abnormalities including craniofacial defects

Inhalation of volatile gases may also result in signs of withdrawal which include a specific odour as well as a persistent metabolic acidosis

Signs & Symptoms of Withdrawal

The symptoms and signs of neonatal abstinence syndrome in term or near term infants can be classified as major or minor as below:

Major

Seizures; continuous tremors even when undisturbed; marked irritability even when undisturbed; rigid muscle tone; tachypnoea > 95; profuse watery stools; profuse vomiting; NG feeding required due to uncoordinated swallowing.

Minor

Mild irritability or jitteriness; tremors; shrill cry; sweating; vomiting; diarrhoea; weight loss; sneezing; yawning; hiccoughs.

Other Issues:

There may be long term complications of exposure to drugs in utero and there is also an association with an increased risk of sudden infant death syndrome.

Risk of Congenital Infection:

It is important to be aware that there may be other important issues such as the risk of vertical transmission of viral infections including HIV, hepatitis B/C, chlamydia etc or postnatal risk of exposure. Parents must also be educated in safe storage of methadone etc prior to discharge.

Management

Antenatal History

A thorough antenatal history should be sought to guide further assessment and management this needs to include:

- Details of maternal drug/alcohol use (types and dosage)
- Antenatal Hep B, Hep C, HIV serology
- Social issues identified during pregnancy

Resuscitation at birth

Do **NOT** use Naloxone at resuscitation

- the half life of Naloxone is shorter than the half life of Opiates and respiratory depression / apnoea may result once the naloxone has worn off.
- Support respiration as long as is required and admit to neonatal unit if indicated

Postnatal Care

Following the successful introduction of a pilot scheme in 2004 most babies are now managed on the postnatal wards, only being admitted to the NNU if they have major symptoms and require pharmacological treatment. Parents should be encouraged in skin-to- skin contact and initiation of early breastfeeding (except where contraindicated). All **at risk** infants should be observed in hospital for signs of withdrawal for 72 hours.

Appendix I – Drug & Alcohol Screening

There are arrange of drug testing that are available, these are uring, saliva and hair strand testing. Screening within UHL is via urine testing. This is a plain urine sample sent to the lab with a haematology/chemistry pathology lab form and toxicology screening is requested in the box for stating “other.Regular and/or random sampling can confirm that prescribed drugs are being taken and whether or not illicit substance misuse continues.

Drug screening has its limitations, however, practices change and should not be taken as definitive proof of current sage or abstinence. Whilst current substance use is important it is more useful to focus on a person’s parenting ability and behaviour when assessing the parent/s.

The table below provides information on approximate elimination times for some substances found on urine toxicology.

Drug/Alcohol/Substance Misuse	Approximate Elimination Time
Alcohol (Ethanol)	1 “Unit” per hour
Amphetamines e.g. Ecstasy	1-4days
Barbiturates	4-10days – Phenobarbitone up to 20days
Benzodiazepines	2-30days
Cannabinoids (marijuana) ➢ Single use ➢ Moderate use (4 x a week) ➢ Heavy use (daily) ➢ Chronic heavy use	 3 days 4+days 10-28days 28+days Cannabinoids are stored in subcutaneous fat and can therefore excrete randomly up to 6-8weeks after chronic heavy use.
Cocaine Benzoylecgonine	2-4days 4-5days
Methadone EDDP(Methadone metabolite) Buprenorphine (Subutex)	2-10 2-10 2-10
Heroin as morphine 6-acetylmorphine Opiates (morphine,codeine metabolite)	24hours 5-7days
New Pychoactive Substances (NPS)	Currently unknown – please stipulate NPS on request form.

Appendix J – AUDIT

Substance Misuse Audit Form

DATE:	Click here to enter a date.	Completed by:	
EDD:		Date of Delivery:	Click here to enter a date.
NHS Number:		Gestation at Delivery:	
Gestation at Booking:		Gravida:	
Hospital Booked at:	Choose an item.	Parity:	
Speciality:	Choose an item.	A Form:	Click here to enter a date.
Linked Professional			
Community Midwife		Social Worker:	
Specialist Midwife		Drug/Alcohol Worker:	
Health Visitor		Probation Officer:	
Information			
Did Pt stabilise on one drug in pregnancy	Yes / No	If No how many? Poly drug use	
Did Pt drink Alcohol	Yes / No	Dependent:	Yes / No
Did Pt attend clinic during pregnancy	Yes / No	How many DNA's:	Yes / No
Did Pt have growth scans	Yes / No	How many scans:	Yes / No
Did Pt have any BBI positive results in pregnancy	Yes / No	Which BBI was diagnosed:	Yes / No
OUTCOME FOR BABY			
Did baby go on a Child Protection Plan	Yes / No	COMMENTS:	
Did baby go on a Child in Need Plan	Yes / No		
ICO/Foster	Yes / No		
Family Foster Care	Yes / No		
Home with Family support	Yes / No		
Home with mum	Yes / No		
Was the baby admitted to NNU	Yes / No		
INFANT FEEDING			
Breast feeding	Yes / No	Bottle/Artificial feeding	Yes / No
Mix feeding	Yes / No		
MOTHER ON DISCHARGE			
Was Mother referred to other agencies	Yes / No	Which Agencies	Yes / No
Smoking at booking	Yes / No	Smoking at Delivery	Yes / No
Smoking at Discharge	Yes / No		
COMMENTS:			

Please return to Specialist Midwife Substance Misuse: VulnerableMidwifery@uhl-tr.nhs.uk