1. Introduction and who the 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.

Background:

These guidelines are aimed at community, maternity and neonatal staff to ensure that babies at risk of neonatal abstinence syndrome are identified and receive appropriate medical, nursing and social management in the neonatal period.

It is also intended to provide guidance in the support of the parents and other caregivers in conjunction with maternity and social services so that the optimal outcome may be achieved.

- To minimise the harm caused by the mother’s drug use on the pregnancy and the unborn baby.
- To provide an accessible, welcoming, flexible and integrated approach to health and social care, in a non-judgement way.
- To involve the woman in the decision making process.
- To reduce poly-drug use, and to promote stabilisation and engagement during pregnancy.
- To manage the newborn at risk of neonatal abstinence syndrome in a holistic family-centred way advocating non-pharmacological management where possible.
<table>
<thead>
<tr>
<th>Section</th>
<th>Heading</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessing Substance Use/Misuse</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Antenatal Care</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Specialist Substance Misuse Clinics</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Referral to Safeguarding Care for Children and Families</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Safeguarding Issues Whilst an Inpatient</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Labour &amp; Birth</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Unbooked Pregnancy</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Withdrawal Signs &amp; Symptoms in the Woman</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Postnatal Care</td>
<td>8</td>
</tr>
<tr>
<td>10</td>
<td>Neonatal Abstinence Syndrome: Care of the Term &amp; Near Term Infant</td>
<td>9</td>
</tr>
<tr>
<td>11</td>
<td>Discharge Planning</td>
<td>16</td>
</tr>
<tr>
<td>12</td>
<td>Discharge Care by Community Midwife/Specialist Midwife</td>
<td>17</td>
</tr>
<tr>
<td>13</td>
<td>Contacts List</td>
<td>18</td>
</tr>
<tr>
<td>14</td>
<td>Monitoring of Guidelines</td>
<td>19</td>
</tr>
<tr>
<td>15</td>
<td>References</td>
<td>20</td>
</tr>
<tr>
<td>A1</td>
<td>Appendix 1 Drug History Assessment</td>
<td>22</td>
</tr>
<tr>
<td>A2</td>
<td>Appendix 2 Pregnant Substance Misuse Pathway</td>
<td>24</td>
</tr>
<tr>
<td>A3</td>
<td>Appendix 3 Treatment/Prevention of Withdrawal in Antenatal/Postnatal Women</td>
<td>25</td>
</tr>
<tr>
<td>A4</td>
<td>Appendix 4 Substance Misuse Midwife Referral</td>
<td>27</td>
</tr>
<tr>
<td>A5</td>
<td>Appendix 5 Audit C – Alcohol Screening Tool</td>
<td>29</td>
</tr>
<tr>
<td>A6</td>
<td>Appendix6 Effects of Maternal Drug Abuse on the Fetus and Newborn Infant</td>
<td>31</td>
</tr>
<tr>
<td>A7</td>
<td>Appendix 7 Model Care Pathway – Substance Misuse in Pregnancy</td>
<td>32</td>
</tr>
<tr>
<td>A8</td>
<td>Appendix 8 Breastfeeding and Neonatal Abstinence Syndrome</td>
<td>33</td>
</tr>
<tr>
<td>A9</td>
<td>Appendix 9 SMC Information and Contact Numbers</td>
<td>34/15</td>
</tr>
</tbody>
</table>
2. Guidance:

## 1. ASSESSING SUBSTANCE USE/MISUSE

<table>
<thead>
<tr>
<th>Type of Use</th>
<th>Description</th>
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<tbody>
<tr>
<td>Experimental</td>
<td>Uses once or rarely. No impact on health and social functioning.</td>
</tr>
<tr>
<td>Recreational</td>
<td>Illegal drugs are used regularly. Low risk to health and social functioning.</td>
</tr>
<tr>
<td>People who use legal substances</td>
<td>Alcohol, tobacco and prescription drugs. Can be to a level which impairs health and social functioning.</td>
</tr>
<tr>
<td>Dependency on illegal drugs and / or alcohol</td>
<td>Significant impairment of health and social functioning.</td>
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Substance Misuse is the stage at which the use of drugs and/or alcohol 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 trouble with the Police 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 protocol will focus on the ‘problematic’ drug/alcohol user. 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.

## 2. ANTENATAL CARE

- **Screening**
  Refer to the Maternity Management Guidelines (DMS No: 18774). All women are asked to report their alcohol intake, smoking, and use of recreational drugs at booking.
  Provision of brief interventions by midwife at booking, identifying to the patient the following:
  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). See Appendix 5 - AUDIT C.
  What a binge is? (More than 4 units in pregnancy can impact on the developing fetus).
  Information, advice and referral onto specialist services are provided as appropriate.
• **Partner**
  Information regarding partner 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, this should be referred to the appropriate services and information provided regarding pregnant partner. The specialist midwife can liaise with these services as required.

• **Previous drug use, but stopped within 1 year prior to conception**
  If there is a past history of dependency, offer referral to the Specialist Midwife in Substance Misuse for assessment/support as required? Encourage continued abstinence from drugs and alcohol. If past illicit drug use please take toxicology on booking with patient’s consent and in each trimester. If alcohol use more than 14 units per week pre pregnancy please ensure referral. Identification of use in early stages is vital to assess risk of Fetal Alcohol Syndrome (FAS).

• **Current drug use disclosed:**
  Ascertain the level of drug use, drug used, frequency, amount & route of administration. Discuss with Client, partner’s use and whether they are on a treatment programme. Please take toxicology on booking with patient’s consent and each trimester. If class A drugs identified please take each time patient is seen. Refer to the Specialist Midwife in Substance Misuse for further assessment for the woman and her partner, if one or both of them has a drug dependency. Complete Referral form to Specialist Midwife and complete social service referral (A Form).

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

  - Substance misuse is ongoing and 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.

Ensure a leaflet on “Reducing Risk of Harm to Children in Your Household” is provided.
3. SPECIALIST SUBSTANCE MISUSE CLINICS

These are as follows:

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Clinic Details</th>
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<tbody>
<tr>
<td>Tuesday</td>
<td>13.30 – 17.00</td>
<td>Substance Misuse Clinic – ANC, LRI Weeks 1, 3 &amp; 5 with consultant</td>
</tr>
<tr>
<td>Tuesday</td>
<td>13.30 – 17.00</td>
<td>Substance Misuse Clinic – ANC, LRI Weeks 2 &amp; 4 with specialist midwife</td>
</tr>
<tr>
<td>Wednesday</td>
<td>13.30 – 17.00</td>
<td>Substance Misuse Clinic – ANC, LGH Weeks 1 &amp; 3 with specialist midwife</td>
</tr>
</tbody>
</table>

This is a multi-disciplinary Antenatal clinic between Consultant & Specialist Midwife Substance Misuse and any other Co-opted Healthcare Professional as required e.g. Health Visitor, Community Drug Team, Social Services (County & City), Anaesthetist and other Specialist Midwives. The Clinic is every Tuesday afternoon from 13.30hrs – 17.00hrs. Referral from Midwives or hospital staff can be made via fax using referral form Appendix 1, outside agencies or patient's can self refer using the mobile number below.

Tel: 0116 258 5990  
Mobile: 07966 558 286  
Fax: 0116 258 7262 or 0116 258 7774

Please include:

- The patient and referrer details
- Information about the pregnancy
- The reason for referral
- The patient’s consent for referral

The outcome of the substance misuse midwife’s assessment may be:

- Brief intervention by providing information and access to support via clinic appointments.
- Continued care by the Community Midwifery/Consultant team for women with recreational but not problematic drug use/or are engaging well with midwifery care. OR
- Or case-held by Specialist Midwife for Substance Misuse to address the risks posed by substance misuse to the pregnancy and to the infant. Care will be documented in the hand held records and on E3, Intrapartum care plan will be filed in hospital notes by 36 weeks. CMW will be informed if client is case-held within the specialist team.
- Drug dependency may lead to poor engagement with services. Refer to the management of missed antenatal appointments guidelines should this occur.
- Patients that frequently Do Not Attend (DNA) appointments should be followed up with a home visit and referred to Social Services. The Community Midwife will be informed if patients fail to engage with substance misuse clinic and require follow up. If safeguarding issues increase then please re-refer to specialist midwifery team for further consideration for case-holding.
- If history of IV drug use screening for Hepatitis C, following discussion and consent by client. If positive refer to Care Pathways for the management of Blood Borne Infections (BBI's), (see UHL Guideline Register No: C100/2006).
Inform Specialist Midwife for Safeguarding who will send an alert notice via Leicester, Leicestershire and Rutland Local Safeguarding Children Board, Bridge Park Plaza, Leicester, (Tel 0116 260 0004) to other maternity units.

Specialist Midwife for Safeguarding to ensure alert notice and up to date information is placed on E3 system.

Specialist Midwife to continue trying to engage client in care.

Social Service Referral and follow up their involvement, including attendance at initial child protection conference and core groups as required.

Liaise with Community Drug Team, Community Midwife and General Practitioner and Health Visitor.

4. REFERRAL TO SAFEGUARDING SOCIAL CARE FOR CHILDREN AND FAMILIES

The threshold for referral and assessment from the health professional should be extremely low. Recent or current drug and alcohol abuse is a clear criteria for referral. If uncertain, contact Specialist Midwife in Substance Misuse or Specialist Midwife for Safeguarding.

5. SAFEGUARDING ISSUES WHILST AN INPATIENT

Concerns with clients who may still be using illicit intravenous drugs will be informed in the antenatal period by the Specialist Midwife that this is not acceptable within the trust premises.

Any client or partner that is observed using illicit drugs whilst on hospital premises should not be approached by staff, but security or police should be contacted.

6. LABOUR AND BIRTH

- 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.

- 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.

- If the woman is on an opiate substitute prescription (Methadone or Buprenorphine, commonly known as Subutex®) the dosage should be verified by the information in her hospital notes and confirmed by contacting the Specialist Midwife in Substance Misuse Mobile: 07966558286 – (Mon-Fri 9am-5pm) on admission. If unable to contact please confirm with the original prescribing
7. UNBOOKED

- If substance misuse is suspected antenatally, during labour or immediately postpartum consent should be obtained for urine toxicology screening on mother.
- Ensure completion of Drug History Assessment.
- Observation and documentation of potential intravenous sites used, consider body map if available.
- If a woman is opiate dependant 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 instant test if available). Inform Specialist Midwife for Substance Misuse on 07966 558286.
- 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 30mls in any 7 day period, i.e. 10mls increased up to a maximum of 3 times in a 7day period). Usually prescribed by community drug team. The non compliant or patient with nausea/vomiting preventing adequate replacement, may need admission for stabilisation and above protocol to be followed.
- *Cyclizine is contraindicated in IVDU and if on Methadone.*
- The woman may be unable to cope with hospital admission; if she is experiencing withdrawal symptoms then an urgent referral should be made to the Specialist Midwife & Turning Point.
8. WITHDRAWAL SIGNS & SYMPTOMS IN THE WOMAN

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<tr>
<th>WITHDRAWAL SIGNS AND SYMPTOMS IN THE WOMAN</th>
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<tbody>
<tr>
<td>Diarrhoea</td>
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<tr>
<td>Feeling Hot &amp; Cold</td>
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<tr>
<td>Generalised Aches &amp; Pains</td>
</tr>
</tbody>
</table>

9. POSTNATAL CARE

- 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, and consideration to split dosing the current methadone prescription to help with pain relief. DO NOT PRESCRIBE METHADONE PRN FOR ADDITIONAL PAIN RELIEF.

- Staff should ensure that prescribed analgesia is effective and request review by the Obstetric Team if not, regular review should occur.

- 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.

- The mother needs to be reminded that the aim is to detect, and if necessary treat significant signs and symptoms of neonatal abstinence syndrome, 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 review on a daily basis. A management plan should be documented in the notes.

- Neonatal observations should be undertaken 4-hourly and when baby is awake.

- Symptoms of methadone withdrawal may take several days to present, for this reason a minimum of 72 hours monitoring of the infant is recommended. All observations and actions taken must be documented on NEWS charts and in the notes as appropriate.

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

- Specialist Midwife in Substance Misuse and Specialist Midwife for Safeguarding to be informed of admission and will visit whilst on the ward to co-ordinate care and discharge as required.
• Breastfeeding should be encouraged. Please see guidance on page 13.

• 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. Ensure that whilst an in patient this practice does not occur.

• A urine sample should be obtained with consent on Day 2 for toxicology and alternate days until discharged.

• The midwife should document in the maternity records, observation and assessment of parenting skills (complete parenting skills log documentation) as this is an important aspect of planning discharge from the unit. 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.

10. NEONATAL ABSTINENCE SYNDROME: CARE OF TERM & NEAR TERM INFANT

Key Points:
1. A paediatric alert form should have been completed on each mother where there is known, habitual substance misuse and who are under the care of the specialist midwife for substance misuse. This should be sent to the neonatal unit and a copy filed in the patient’s hospital notes.

2. It is important to note the results of antenatal serology testing and social circumstances as well as the drugs and dosages to which the fetus was exposed during pregnancy

3. Infants should be managed on the postnatal wards where at all possible

4. All at risk infants should remain in hospital for at least 72 hours of 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.

5. Little is known about NAS in preterm babies and responses are likely to be different from those in term infants. As yet there is no recognised method of identifying signs and symptoms or defining severity of withdrawal.

6. Note that there may be additional diagnoses in NAS infants – Do Not Assume.

See appendix 6 below

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.

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.

**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 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, ongoing research regarding effects on babies.

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.

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 [23] [24]:

**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 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.

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.

Breast Feeding
Breastfeeding may reduce the severity and length of neonatal abstinence syndrome in some situations and the universal benefits of breastfeeding must also be considered when counselling these women. This is particularly true when the mother is on a methadone or buprenorphine replacement programme.

However it is important to balance the benefits of breastfeeding for the mother and baby with the risk of harm from maternal substance misuse in certain circumstances. The only absolute contraindication to breast feeding is in a mother that is HIV positive (see HIV policy).

Breast feeding is in not recommended for a mother that is HIV positive (see HIV policy), although there may be some circumstances where it might be possible the safest way to feed the baby is with formula as there is an on-going risk of HIV exposure after birth.
(British HIV Association (BHIVA) guidelines on the management of HIV in pregnancy and postpartum)

In the following situations breast-feeding would not be recommended due to risk of harm to the infant. The mother should be made aware of the risks of breastfeeding in these situations but if she still wishes to breastfeed and a clinical decision is made that the effects on the infant are minimal then this should be supported:
1. Where there has been a history in pregnancy of unstable illicit drug use and there is concern about the substances that the infant may have been exposed to. There have been batches of crack that have been cut with anthrax for instance. It may be possible to introduce breastfeeding if a urine toxicology screen from mother is reassuring.

2. If the mother has been on high dosage benzodiazepines (>10mg)

3. Binge drinking of alcohol (>4 units on a single occasion). Levels peak 30-90 mins after consuming alcohol so breastfeeding should be avoided for at least 3 hours or longer. As maternal blood alcohol returns to normal so does the level in breastmilk. It may be that a mother needs to express for comfort, so that she can maintain her supply or to avoid the possibility of blocked ducts or mastitis, however, she may not be in a fit enough state to do this.

   If she is so drunk she is vomiting she should avoid breastfeeding until the following morning. (The Breastfeeding Network “Alcohol and Breastfeeding”)

4. If heroin is injected then a 24 hour period of breast feeding cessation should begin (due to concerns about other substances that may be cut with the batch). In this time Mum should be advised to express milk and discard. There may be occasions where mothers that are generally stable on an opiate replacement programme illicitly use heroin around the time of delivery to manage pain. In this instance giving colostrum is not contraindicated as the volume is very small and hence the amount of heroin that the baby would be exposed to is likely to be minimal.

5. Cocaine taken by the mother does transfer into breastmilk and as it is metabolised in the gut the baby will absorb the cocaine which can have harmful effects on the baby including seizures, hypertension and tachycardia. Mothers who wish to breastfeed but continue to use cocaine should be advised to leave at least 24 hours for drug elimination before resuming breastfeeding.

Mothers who have been drinking alcohol, misusing substances etc. should never let themselves be in a situation where they might fall asleep with the baby particularly while breastfeeding.

Investigations
Routine urine testing of the infant is not advocated and should only be done with the mother’s consent. The exception to this is if the infant is clinically unwell and NAS is suspected. In this instance it would be appropriate to test without consent, but best practice would be to inform the mother this is happening. Urine for toxicology should be sent to the lab.

Symptoms and signs
NB Never assume that all symptoms and signs are the result of NAS. Assess all infants on an individual basis, especially in the case of seizures.

- The parents should be included in the assessment of their child in order to encourage their involvement and knowledge of the signs of withdrawal
- Infants should be assessed for ‘signs of normality’ – i.e. Is the baby feeding? Is the baby sleeping? Scoring charts are not used
- The infant should be assessed after feeds by parents with the support of perinatal staff
- The aim of pharmacological treatment is to prevent seizures and this should be considered in an infant with poor feeding and/or unable to sleep and/or major signs

**Non pharmacological treatment**
- This should be the mainstay of treatment
- Nurse in quiet environment with reduced lighting where possible
- Minimal handling and use of prone position [26]
- Vestibular stimulation including rocking and patting the back
  - Physical boundaries including swaddling and use of pacifiers with parental consent
  - Demand feeding little and often
  - Encourage breast feeding (unless contraindicated)

**Pharmacological Treatment**
One of the aims of pharmacological treatment is comfort *not* sedation and it *should be avoided unless absolutely necessary* as it will require admission of the infant to NNU and may delay discharge. It should be considered if *major* signs are present e.g. seizures.

**Drug treatment for opiate abuse**
- Start morphine sulphate (oromorph) at 0.04mg/kg (e.g. 120mcg in a 3 Kg infant) and give 4 hourly
- Increase to a maximum of 200mcg 4 hourly if signs not controlled
- Maintain the effective dose for 48 hours
- Once clinically stable reduce every 24-48 hours
  - 0.03mg/Kg 4 hourly
  - 0.02mg/Kg 4 hourly
  - 0.01mg/Kg 4 hourly

**Drug treatment for polydrug use**
- Load with phenobarbitone at 10mg/Kg
- Consider a further dose of 10mg/Kg if signs continue
  - Maintenance phenobarbitone should be commenced 24 hours after the loading dose at 2.5mg/Kg bd (5mg/kg/day)
  - Phenobarbitone levels should be monitored

**Immunisations (Hepatitis B and BCG)**
Review maternal serology
- If Hep C or Hep B positive consult pharmacist regarding immunisation
- Hep B immunisation should be *offered* to all infants that are thought to be at postnatal risk
- BCG vaccination should also be *offered* - this is done in the community at St Peters Health Centre
Social Issues
The social situation should be clear from the paediatric alert form including the name of
the social worker (antenatal liaison information). The mother should have been made
aware that an early discharge is not possible, but if she insists, the emergency duty
social work team must be informed.

If the social situation is not clear or additional concerns arise, the midwifery or neonatal
teams (depending where the infant is being cared for) should contact the social services
department. **The parents must be informed that this is happening.** A case discussion
should be organised prior to discharge if the infant is felt to be at risk of neglect.

There are a number of centres that run drug or alcohol reduction programs and some
GP practices also run their own programs.

The liaison midwife should be contacted in the first instance (tel. 07966 558 286).
Other important phone numbers are below:
Turning Point: 0330 303 6000
Social Services: 0116 454 1004 (city)
Social Services: 0226 305 0005 (county)

Discharge
The social situation and result of any case conferences should be clarified prior to
discharge and issues around storage of methadone etc should have been discussed.

- Hepatitis B immunisation has been discussed and the infant referred onwards to
  Dr Bandi for further immunisations if Hepatitis B immunisation was given
- In most cases the infant will be discharged 48 hours after the morphine has been
  stopped.
- In some cases the infant may be discharged on oromorph where the Mum is the
  primary care giver, there are no social concerns and the outreach team has been
  involved.
- These infants are not routinely followed up in outpatients but may require follow
  up in specific situations:
  - Fetal alcohol syndrome – 6/52 clinic; consider referral to genetics and
    neurodevelopmental follow up
  - Crack / Cocaine – 6/52 clinic; head scan as out-patient if required

11. DISCHARGE PLANNING

- The Children and Young People’s Services will liaise with the specialist midwife
  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 ward prior to discharge to ensure robust plans are in
  place to support safe discharge. This meeting should include the ward Midwife,
  Specialist Midwife, Neonatal Paediatrician, Nursing staff from Neonatal Unit if
  admitted, Social Worker, Health Visitor, GP, CDT and any other services
  involved.
• The purpose of this meeting is:

1. To share information including any treatment for withdrawal that has taken place and plans for medical follow-up and review.
2. For the social worker to discuss the outcome of the assessment which has been carried out, highlighting any area of concern.
3. To ensure that community services are aware of the baby’s planned discharge from hospital and that appropriate support is available.
4. To make decisions and recommendations for community and social work follow-up and support as appropriate.
5. Identify support needs and mechanisms.

12. DISCHARGE CARE BY COMMUNITY MIDWIFE / SPECIALIST MIDWIFE

• Community Midwives will provide routine Post Natal Care for all women in their care, discharge care of the mother and baby to the Health Visitor and inform the Specialist Midwife in Substance Misuse.

• For the women who have written agreements or where there is a child protection plan in place, the community midwife will provide routine Post Natal Care up to 10 days and transfer care to Specialist Midwife who will continue to review up to 28 days and discharge care of the mother and baby to the Health Visitor when indicated.

13. CONTACTS LIST

<table>
<thead>
<tr>
<th>Name</th>
<th>Ext</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela Geraghty, Specialist Midwife (Mon-Fri 9-5)</td>
<td>0116 258 ____</td>
<td>07966 558286</td>
</tr>
<tr>
<td>Sonia Agarwal, Consultant Obstetrician (Secretary-Jo Ayres &amp; Claire Richards)</td>
<td>5990 7773</td>
<td>7770 6086</td>
</tr>
<tr>
<td>Louise Robinson, Midwifery Matron – Safeguarding Lead (Mon-Thu 9-5)</td>
<td>6086 07867 525097</td>
<td></td>
</tr>
<tr>
<td>Specialist Midwife – Safeguarding (Mon-Fri 9-5)</td>
<td>6432 07876 475318</td>
<td></td>
</tr>
<tr>
<td>Jo Behrsin, Consultant Neonatologist</td>
<td>7595/7729</td>
<td></td>
</tr>
<tr>
<td>Community Drug Team – Turning Point</td>
<td>0330 303 6000</td>
<td></td>
</tr>
<tr>
<td>Children and Families Social Work Team (City) Grey Friars</td>
<td>0116 454 1004</td>
<td></td>
</tr>
<tr>
<td>Children and Families Social Work Team (County)</td>
<td>0116 305 1005</td>
<td></td>
</tr>
<tr>
<td>The Neonatal Unit, Kensington Building</td>
<td>6464 6464</td>
<td>6464</td>
</tr>
<tr>
<td>Drug Advisory Service</td>
<td>0116 222 9522</td>
<td></td>
</tr>
<tr>
<td>Infant Feeding Co-ordinator Office:</td>
<td>5990 07833 642147</td>
<td></td>
</tr>
<tr>
<td>Ann Raja – Specialist Midwife</td>
<td>07770 580455</td>
<td></td>
</tr>
<tr>
<td>Jane Friend - Maternity Support Worker</td>
<td>07500 127803</td>
<td></td>
</tr>
<tr>
<td>National Drugs Helpline</td>
<td>0800 776600</td>
<td></td>
</tr>
</tbody>
</table>
3. Training and Education:
None

4. Monitoring Compliance

<table>
<thead>
<tr>
<th>What will be measured to monitor compliance</th>
<th>How will compliance be monitored</th>
<th>Monitoring Lead</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement of client</td>
<td>DNA monitoring</td>
<td>A Geraghty</td>
<td>Annually</td>
<td>Annual Report</td>
</tr>
<tr>
<td>Outcomes for Mother &amp; Baby</td>
<td>Delivery information &amp; Safeguarding outcomes</td>
<td>A Geraghty</td>
<td>Annually</td>
<td>Annual Report</td>
</tr>
</tbody>
</table>

5. Supporting References


RCOG Green Top Guidance, Statement Number 5 – Alcohol Consumption and the Outcomes of Pregnancy. March 2006

Substance Misuse in Pregnancy. A Resource Book for Professionals. Drugscope 2005

6. Key Words

List of words, phrases that may be used by staff searching for the Guidelines on PAGL. If none – state none.

CONTACT AND REVIEW DETAILS

Guideline Lead (Name and Title) A Geraghty and S Agarwal

Executive Lead C Fox

Details of Changes made during review:
Changes to community drug team provider to Turning Point.
Caseload criteria amended in line with current working.
Minor amendments to wording and terminology.
References amended to maximum of 3

Guideline development:

October 2010 Guideline originally written by A Geraghty, Specialist Midwife - Substance Misuse

Sept 2011 Review by Neonatal Guidelines Group and Maternity Governance Group
## APPENDIX 1: DRUG HISTORY ASSESSMENT

### DRUG HISTORY ASSESSMENT

- **Pattern of current substance use**
  - Problem Drugs
  - Prescribed Y/N
  - Frequency
    - < once a week
    - No. of days per week
    - Daily
    - More than once daily
  - Dose/Amount (weight)
  - Route
  - If injecting, 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
    -Physostigmine
    - Subutex
    - Codeine
    - DFI 18
    - Morphine
    - LSD
    - Amphetamine
    - Cocaine
    - Methamphetamine
    - Crack
    - Glue
    - Aerosol
    - Fuels
    - Others:
    - Mushrooms
    - Ecstasy
    - Cannabis
    - Anti-depressants
    - Cyclizine
    - Ketamine
    - Tranx (eg: Valium, Temazepam, Sleepers)
    - Tobacco (how much)
    - Nitrates/poppers
    - GHB
    - Steroids
    - Paracetamol
    - Alcohol
    - Khat

- **Prescribed medication**
  - Drug Name
  - What For
  - Prescribed by:

---

Angela Geraghty
Specialist Midwife Substance Misuse 0796158286

1
**DRUG HISTORY ASSESSMENT**

### HARM REDUCTION

<table>
<thead>
<tr>
<th>Ever Injected?</th>
<th>Y / N</th>
<th>Currently injecting (last 4 weeks)</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcutaneous (skin popping)?</td>
<td>Y / N</td>
<td>Intramuscular?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Age 1st injected?</td>
<td></td>
<td>Site(s) Used</td>
<td></td>
</tr>
<tr>
<td>Any Problems with injecting? (e.g. venous access, infections, abscesses, cellulitis etc)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know of the needle exchange schemes in the area? (if no give details)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where do you get your kit from?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Injecting, Snorting & Smoking

<table>
<thead>
<tr>
<th>Prompt – all injecting, cocaine and crack use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever Shared?</td>
</tr>
<tr>
<td>Have you Ever Overdosed?</td>
</tr>
</tbody>
</table>

### Other Information:

### TESTS / VACCINATIONS:

<table>
<thead>
<tr>
<th>Hep A</th>
<th>Vaccinated?</th>
<th>Y / N</th>
<th>Antibody Test?</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep B</td>
<td>Vaccinated?</td>
<td>Y / N</td>
<td>Antibody Test?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Hep C</td>
<td>Antibody Test?</td>
<td>Y / N</td>
<td>Positive / Negative / Not Known</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>Antibody Test?</td>
<td>Y / N</td>
<td>Positive / Negative / Not Known</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2: PREGNANT SUBSTANCE MISUSE PATHWAY

PREGNANT SUBSTANCE MISUSE PATHWAY

Referral from CDT via CDT referral form

Referral from AAA/PAS and checking of Antenatal notes following booking

Referral from Other Specialist / Community Midwife via referral form/telephone call

Referral received by the Specialist Midwife in Substance Misuse. Case loading identified

High Risk – Chaotic clients Methadone Programme with use on top

Medium Risk – Methadone Programme and stable

Low Risk – Recreational use prior to pregnancy, no longer using drugs

High Risk – Case Load Client

Medium Risk – Care by CMW and seen in Antenatal Clinic by Specialist MW/Consultant

Low Risk – Assess in clinic and refer back to CMW Re-refer if need identified
APPENDIX 3: 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 drug chart crossing out doses 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 discharge medication/resumption of normal supplies.

Women unknown to CDT or Substance Misuse clinic
- Aim to take the edge off symptoms thus allowing woman to remain in hospital
- Complete Drug History Assessment
- Confirm illicit drug taken by sending urgent Toxicology screen (Use instant test if available)
- Symptoms and signs of opiate withdrawal
  - Sweating / Gooseflesh
  - Lachrymation & Rhinorrhea
  - Yawning
  - Feeling hot and cold
  - Anorexia & abdominal cramps
  - Nausea, vomiting & diarrhoea
  - Tremor
  - Insomnia & restlessness
  - Generalised aches & pains
  - Tachycardia & hypertension
  - Dilated pupils
  - Increased bowel sounds
- After delivery contact CDT/CJIT/Specialist Midwife.
- ONLY PRESCRIBE DISCHARGE MEDICATION FOLLOWING AGREEMENT WITH CDT/CJIT/GP PRESCRIBING.

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.
- Rest
- Calm environment, consider single room.
## SPECIALIST MIDWIFE REFERRAL

<table>
<thead>
<tr>
<th>Substance Misuse / Homeless &amp; Asylum / Teenagers / Mental Health (please circle)</th>
</tr>
</thead>
</table>

### CLIENT DETAILS

Name:  
DOB or Hospital No:  
Address:  
Telephone:  
LMP:  
EDD:  

### YOUR DETAILS

Name & Position:  
Address:  
Contact Details:  
Planned Follow up with this client: YES/NO  
Referral discussed with client: YES/NO  
Domestic Abuse: YES/NO  
Date:  

### 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  
Fax to: 0116 258 7262  
Telephone: 0116 258 5990  
Substance Misuse: 07966 559295  
Teenagers: 07717694420 / 07795646158  
Homeless & Asylum: 07876216934  
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 or 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 Condut 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 5: AUDIT C ALCOHOL SCREENING TOOL

This is one unit of alcohol...

- Half pint of regular beer, lager or cider
- 1 small glass of wine
- 1 single measure of spirits
- 1 small glass of sherry
- 1 single measure of aperitif

...and each of these is more than one unit

- Pint of Regular Beer/Lager/Cider
- Pint of Premium Beer/Lager/Cider
- Alcopop or carbohydrate of Regular Lager
- Can of Premium Lager or Strong Beer
- Can of Super Strength Lager
- Glass of Wine (175ml)
- Bottle of Wine

AUDIT – C

Questions                                                                 Scoring system          Your score
How often do you have a drink containing alcohol? 0 1 2 3 4      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 - 5 7 - 9 10+             1 - 2 3 - 4 5 - 5 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

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

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

TOTAL Score equals
AUDIT C Score (above) + Score of remaining questions
### Appendix 6: EFFECTS OF MATERNAL DRUG ABUSE ON THE FOETUS AND NEWBORN INFANT

#### EFFECTS OF MATERNAL DRUG ABUSE ON THE FETUS AND NEWBORN INFANT

<table>
<thead>
<tr>
<th>Drug</th>
<th>Possible Effect(s) on Fetus</th>
<th>Possible Effect(s) on Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis, LSD, magic mushrooms</td>
<td>No significant harmful effects</td>
<td>But known harmful effects if smoked with tobacco</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Fetal Alcohol Syndrome or Fetal Alcohol Spectrum Disorder</td>
<td>Increased risk of miscarriage, major structural malformations, low birth weight and pre-term labour</td>
</tr>
<tr>
<td>Amphetamines and Ecstasy</td>
<td>Small for dates; increased risk of cleft palate and heart defects</td>
<td></td>
</tr>
<tr>
<td>Cocaine (crack cocaine may have less side effects than cocaine)</td>
<td>Placental abruption, fetal hypoxia/death; meconium aspiration; preterm birth. Small for dates IUGR; increased incidence of various intracranial haemorrhage and ischaemic lesions inc haemorrhage, infarction; random ischaemic lesions, e.g. gut atresia, limb reduction, myocardial ischaemia etc.</td>
<td>Poor feeding and difficult to settle</td>
</tr>
<tr>
<td>Opiates (heroin) and Opiodes (methadone)</td>
<td>Preterm and low birth weight</td>
<td>Withdrawal Neonatal abstinence syndrome</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Use in 1st trimester increases risk of cleft palate</td>
<td>Withdrawal Neonatal abstinence syndrome (see below)</td>
</tr>
<tr>
<td>Solvent Abuse</td>
<td>Little available evidence</td>
<td>Theoretical risk of reducing oxygen supply to infant</td>
</tr>
</tbody>
</table>

#### WITHDRAWAL SIGNS AND SYMPTOMS IN THE NEONATES

<table>
<thead>
<tr>
<th>Hiccups</th>
<th>Vomiting</th>
<th>Nasal stuffiness</th>
<th>Sweating</th>
<th>High pitched cry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sneezing</td>
<td>Hyperthermia</td>
<td>Convulsions of under/overfeeding</td>
<td>Tremors</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Salivation</td>
<td>Hypertonicity</td>
<td>Dehydration</td>
<td>Yawning</td>
<td>Tachyapnoea</td>
</tr>
</tbody>
</table>

Seizures non-responding to anticonvulsants – (morphine required)
APPENDIX 7: MODEL CARE PATHWAY – SUBSTANCE MISUSE IN PREGNANCY

<table>
<thead>
<tr>
<th>Pre-conceptual Care</th>
<th>Advice on reproductive health, contraception and sexual health.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advice on pregnancy care.</td>
</tr>
<tr>
<td></td>
<td>Establish type and amount of drug intake</td>
</tr>
<tr>
<td></td>
<td>Discuss with team for potential support</td>
</tr>
<tr>
<td>Confirmation of pregnancy</td>
<td>Pregnancy &amp; Birth Book. Refer to Midwifery Team/Specialist Midwife (referral form - Substance Misuse)</td>
</tr>
<tr>
<td></td>
<td>Infants Up</td>
</tr>
<tr>
<td></td>
<td>Arrange scan</td>
</tr>
<tr>
<td></td>
<td>Refer to team with CDT Team—early intervention as required</td>
</tr>
<tr>
<td></td>
<td>Early Assessment of drug use (including tobacco and alcohol)</td>
</tr>
<tr>
<td></td>
<td>(T-ACE - alcohol questionnaire)</td>
</tr>
<tr>
<td></td>
<td>Leaflet: Pregnant...and using alcohol and drugs.</td>
</tr>
<tr>
<td></td>
<td>Consent form for multidisciplinary/multi-agency working</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8-10 weeks Booking appointment Hospital / Community Multidisciplinary Assessment</th>
<th>DNT Screening between 16 – 18+6GD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss and confirm management of drug/alcohol use</td>
</tr>
<tr>
<td></td>
<td>Identify lead professional / care co-ordinator</td>
</tr>
<tr>
<td></td>
<td>New patient record.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 weeks Antenatal appointment</th>
<th>DNT Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor progress of care &amp; drug/alcohol use</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20-22 weeks Antenatal appointment Hospital</th>
<th>Detailed Scan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss infant feeding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25 weeks Antenatal appointment</th>
<th>Monitor progress of care &amp; drug/alcohol use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss breastfeeding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28 weeks Antenatal appointment Hospital Review care plan</th>
<th>Case discussion / care plan review meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reassess social circumstances / risk</td>
</tr>
<tr>
<td></td>
<td>Growth scan / fetal monitoring</td>
</tr>
<tr>
<td></td>
<td>NDUO for referral to Sheffield Obstetrics</td>
</tr>
<tr>
<td></td>
<td>Antenatal/ Labour &amp; Delivery</td>
</tr>
<tr>
<td></td>
<td>Repeat Blood test - FBC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31 weeks Antenatal appointment Home</th>
<th>Home visit by Midwife – assess needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ensure all entitled benefits have been claimed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>34 weeks Antenatal appointment Hospital</th>
<th>Start preparation for parenthood &amp; discuss birth plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss Neonatal Abstinence Syndrome (NAS) and plan parent information leaflet</td>
</tr>
<tr>
<td></td>
<td>Ask about Domestic Abuse and offer support if identified</td>
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<td></td>
<td>Child protection case conference if needed</td>
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<td></td>
<td>Growth scan / fetal monitoring</td>
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</tbody>
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<table>
<thead>
<tr>
<th>36 weeks Antenatal appointment</th>
<th>Preparation for parenthood</th>
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<tbody>
<tr>
<td></td>
<td>Assess fetal growth</td>
</tr>
<tr>
<td></td>
<td>Discuss labour and delivery (include protocol re prescription)</td>
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<table>
<thead>
<tr>
<th>38 weeks Antenatal appointment</th>
<th>Preparation for parenthood</th>
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<tbody>
<tr>
<td></td>
<td>Monitor drug/alcohol use – update antenatal liaison form</td>
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<table>
<thead>
<tr>
<th>40 weeks Childbirth</th>
<th>Pregnancy outcome liaison form</th>
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<tbody>
<tr>
<td></td>
<td>NAS assessment and care</td>
</tr>
<tr>
<td></td>
<td>Discharge plan (include prescription arrangements)</td>
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<tr>
<td></td>
<td>Discharge pack – discuss info on SIDS (cot death)</td>
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<td></td>
<td>Follow postnatal care pathway</td>
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<thead>
<tr>
<th>41 weeks Antenatal appointment Hospital</th>
<th>Book Induction of Labour</th>
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<tr>
<td></td>
<td>Gain consent &amp; Perform membran sweep if able</td>
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<table>
<thead>
<tr>
<th>10 days Post delivery Up to 28 days Postnatal care Review care plan</th>
<th>Continue multidisciplinary support / postnatal care plan</th>
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<tbody>
<tr>
<td></td>
<td>Continue NAS assessment and care (if needed)</td>
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<tr>
<td></td>
<td>Monitor drug / alcohol use</td>
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<tr>
<td></td>
<td>Relapse prevention support</td>
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<td></td>
<td>Midwife hands over (15–25 days)</td>
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<td></td>
<td>Home visit by Health Visitor</td>
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<tr>
<td></td>
<td>Specialist Midwife in Substance Misuse can be contacted by client up to 28 days for Support &amp; Advice</td>
</tr>
</tbody>
</table>
Appendix 8: Breastfeeding and Neonatal Abstinence Syndrome

Breastfeeding may reduce the severity and length of neonatal abstinence syndrome in some situations and the universal benefits of breastfeeding must also be considered when counselling these women. This is particularly true when the mother is on a methadone or buprenorphine replacement programme.

However it is important to balance the benefits of breastfeeding for the mother and baby with the risk of harm from maternal substance misuse in certain circumstances. The only **absolute** contraindication to breast feeding is in a mother that is HIV positive (see HIV policy).

In the following situations breast-feeding would not be recommended due to risk of harm to the infant. The mother should be made aware of the risks of breastfeeding in these situations but if she still wishes to breastfeed and a clinical decision is made that the effects on the infant are minimal then this should be supported:

1. Where there has been a history in pregnancy of unstable illicit drug use and there is concern about the substances that the infant may have been exposed to. There have been batches of crack that have been cut with anthrax for instance. It may be possible to introduce breast feeding if a urine toxicology screen from mother is reassuring or if the benefits outweigh the risks and or Consultant Neonatologist has been consulted.

2. If the mother has been on high dosage benzodiazepines (>10mg)

3. Binge drinking of alcohol (>4 units on a single occasion). It may be possible to “express and dump” for 24hours and resume breast feeding at a later time.

4. If heroin is injected then a 24 hour period of breast feeding cessation should begin (due to concerns about other substances that may be cut with the batch). In this time Mum should be advised to express milk and discard. “Pump and Dump”. There may be occasions where mothers that are generally stable on an opiate replacement programme illicitly use heroin around the time of delivery to manage pain. In this instance giving colostrum is not contraindicated as the volume is very small and hence amount of heroin that the baby would be exposed to is likely to be minimal. For further advice please consult Consultant Neonatologist on the Neonatal Unit or Specialist Midwife.
Prescribing in women who are on METHADONE

- Check the dose that she is on & whether she has taken a dose at home on day of admission
- Titrating the dose will be done by Community Drug Worker or Specialist midwife
- Do not increase the dose
- Do not prescribe PRN dose!
- Do not prescribe opiates for analgesia
- Do not prescribe CYCLIZINE
Community Drug Teams

Specialist Midwife Substance Misuse
Angela Geraghty
07966 558286
(Mon–Fri 8.30–5pm)

Turning Point
0330 303 6000
(open – Mon–Fri 9–5, Sat 9–1)