Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

Substance Misuse in Pregnancy (GUIDELINE FOR MANAGEMENT OF – includes care of woman and neonate)

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Barking Havering & Redbridge Hospitals NHS Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

1. INTRODUCTION

1.1 The main aims of these guidelines are twofold:

- Firstly to achieve the cooperation and involvement of women and their families in a negotiated package of care
- Secondly, to develop robust strategies that enable parents and professionals to provide supportive care for women and their babies.

We hope that a negotiated individualised care pathway, using a multi-professional team approach, will facilitate the identification of the multiple and complex needs of drug using families and provide opportunities to reduce any negative impact on parenting abilities.

1.2 Outcomes

- Pregnant women who misuse drugs and / or alcohol will seek and engage with maternity services.
- Maternity services will act and respond to the complex needs of women and their families.
- Families receive accurate information regarding the risks associated with drug and alcohol use in pregnancy.
- Women feel they are being listened to and their opinions are respected.
- Individual care pathways based on the harm reduction approach are negotiated with the woman (Beaumont, 2004).
- Babies receive supportive care and remain with their mother unless medical reasons indicate otherwise.
- Strategies to support effective communication are in place.
- Any concerns about the mother or baby are identified and acted upon.
- Normal psychological and physiological aspects of pregnancy, rather than drug use, remain the primary focus of care.

2. IMPLEMENTATION

2.1 Electronic copies will be distributed to midwives, obstetricians, paediatricians and anaesthetists

2.2 The guideline will be available via the Trust Intr@net

3. ROLES AND RESPONSIBILITIES

3.1 All maternity staff have a responsibility to ensure that they are aware of this guideline.

3.2 Matrons and managers have a responsibility to ensure that systems are in place so that all staff, including temporary staff, have access to this guideline.

4. ASSESSING SUBSTANCE MISUSE

Experimental	Uses once or rarely. No impact on health and social functioning
Recreational	Illegal drugs are used regularly. Low risk to health and social functioning
People who use legal substances	Alcohol, tobacco and prescription drugs. Can be to a level which impairs health and social functioning
Dependency on illegal drugs and/or alcohol	Significant impairment of health and social functioning.

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 law
- Increased risk of contracting drugs related infections, eg 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. There are serious negative consequences of a physical, psychological, social, interpersonal, financial and legal nature for users, and those around them. Drug use will usually be heavy, involving features of dependency that can lead to a chaotic and unpredictable lifestyle (Complete assessment - Appendix 1).

5. ANTENATAL

See Appendix 5 for all useful contact numbers and e-mails

5.1 At booking all women should be asked if they have previously used or are currently using recreational drugs, and to quantify their weekly alcohol intake.

The discussion between the woman and the midwife is an essential element of the referral process; to gain accurate information and to facilitate the opportunity to make changes in the family's lifestyle. An assessment is taken noting:

- Current drug misuse including type, frequency and route of use
- Current involvement with Drugs and Alcohol Services, identifying if referral is necessary
- Social network and available family support
- Financial and legal issues
- Any current issues regarding care of existing children
- Previous drug use, but stopped prior to conception (e.g. 1 year ago) - no referral required. Inform the woman of availability of support if required.
- Recent (less than 1 year) drug use disclosed (including cannabis), but the woman advised that she has now stopped. Encourage continued abstinence from drugs and alcohol. Seek consent to send routine urine for toxicology screening for confirmation.

5.2 An initial plan of care is agreed with the woman which can include:

- Referral back to midwife led care in the case of non-problematic drug use (see spectrum of psycho-active substance use). Documentation in maternity records of recommended care plan.
- A short series of appointments with the Drugs and Alcohol team to support the woman in reducing intake e.g. cannabis or alcohol
- Giving information regarding the effects of drug / alcohol use on the pregnancy and unborn baby (appendix 2)
- For most women the routine anomaly scan is sufficient. 'High risk' women may need extra scans at 28; 32; 36 weeks, to be decided at appointment with consultant.
- Referral to Drugs and Alcohol services who will allocate a key worker.

- Urine sample for toxicology as per quick reference flow chart (appendix 3) (white top bottle).

- Advising the woman that a referral will be made to Children and Families Social Work Team using multi agency referral form (MARF).

- If history of IV drug screen for Hepatitis C, following discussion with Consultant Obstetrician. Aim to avoid invasive procedures e.g. amnio/CVs if Hepatitis C positive.

- Negotiated antenatal appointments should follow NICE guidelines with flexibility to meet any additional needs.

- Fear of being judged by professionals, previous Social Services involvement or secondary amenorrhoea may mean that some women access services late or intermittently in pregnancy. However, pregnancy may be a catalyst for change and midwives are ideally placed to support the woman with appropriate information and interventions.

- Women who are using illicit opiates should be offered Methadone whilst in hospital, and a referral to the Wednesday afternoon substance misuse ANC at KGH **(code AAZSA)**. Pregnant drug and / or alcohol using women who are not in treatment will be offered priority appointments by relevant services e.g Drugs and alcohol services.

- Sharing information is essential not only to meet the outcomes and work to best practice but also to address issues raised by 'Hidden Harm' (2003) and 'Why Mothers Die' (2004). If a woman does not keep antenatal appointments, action may need to be taken to change her initial care plan.

- A detailed birth plan should be written with the woman. The midwife should discuss and document relevant issues in the maternity notes e.g analgesia in labour, length of stay, visit to NICU.

- If an antenatal admission is required the ward staff should liaise with the drugs and alcohol service (Appendix 5). This is important to ensure continuity of prescribed medication and also ensure that the drugs and alcohol service can amend current outpatient prescriptions. It is essential that there is no gap in provision and if discharge takes place unexpectedly policy for dispensing Methadone should be followed.

- e-mail neonatal referral form to alert the neonatologist of pending birth.

6. REFERRAL TO SAFEGAURDING

6.1 The threshold for referral and assessment from the health professional should be extremely low. Recent or current drug and alcohol abuse is a clear criterion for referral.

6.1.1 If uncertain regarding referral please liaise with the deputy named midwife/named midwife for Safeguarding children or in their absence the Matron on duty.

6.1.2 Alternatively the Duty Social Worker via switchboard.

6.1.3 All referrals are to be made by completing and faxing a MARF to appropriate social services.

7. INTRAPARTUM CARE

7.1 Care in labour (including pain relief) should follow the women's preferences, hospital guidelines and the agreed care plan. Methadone if prescribed should continue through labour. It will not produce significant analgesic effect and should not replace other forms of pain relief. Normal psychology and physiology should remain the primary focus of care.

7.2 As with all admissions, determine if any drugs or prescribed medications have been taken. Elicit the dose, time, mode of administration, explaining why this information is necessary. If a mother has been prescribed Buprenorphine as it is an opioid blocker this needs to be taken into account when managing pain relief in labour. Referral to an anaesthetist antenatally is recommended for discussion around pain relief management.

7.3 Liaise with Drug and Alcohol services to ensure that there is no gap in the provision of prescribed medication and community prescriptions are not collected whilst the woman is in hospital. Inform the lead midwife (substance misuse) on ext 8284 or a member of the team of admission (between 9-5). You can also leave a message on the answer phone if the message is non-urgent.

7.4 Narcan should not be used in the resuscitation of a baby born to an opiate drug user as this could precipitate an immediate, severe withdrawal syndrome.

7.5 Mother and baby should be transferred to the postnatal ward unless legal or medical reasons indicate otherwise – the plan should be documented in the maternity notes/tracer.

7.6 The Children and Families Social Work Team should be informed of the baby's birth at the earliest opportunity.

8. UNBOOKED DRUG USING WOMEN

8.1 If substance misuse is suspected during labour or immediately post partum, consent should be obtained for urine toxicology screening on mother and baby. (If refuses – observe baby - and follow quick reference flow appendix 3).

8.2 Inform the woman of urgent referral to the Children and Families Social Work Team, or Duty Team if out of hours.

8.3 Discuss with Social Worker the immediate safety issues of the baby and possible management, i.e. risk of mother absconding.

8.4 If a woman is opiate dependant and not on a methadone programme the Obstetric Team should liaise with the Duty Doctor in the Drug and Alcohol Service regarding short term prescribing, and a referral should be made (Appendix 4).

8.5 Refer to guidelines for concealed, denied and unbooked women on the Intr@net.

9. MANAGEMENT OF THE NEWBORN

9.1 The baby should be assessed by the paediatrician soon after/within 24 hours of birth. The midwife should commence assessment for withdrawal signs and symptoms of the neonate on labour ward (these should continue on transfer to the postnatal ward).

High pitched cry	Vomiting	Nasal stuffiness	Sweating	Fist sucking
Sneezing	Temperature >38 C	Convulsions	Tremors	Diarrhoea
Respiratory rate >60	Hypertonic	Restlessness / irritability / Wakefulness	Yawning or hiccoughs	Respiratory depressions

9.1.1. One point should be given for each symptom **(document on neonatal withdrawal chart).** Observe and record at least 4hrly, regularity of observations may need to be increased dependent on the score. Act upon observations according to individual needs, to ensure that babies are able to feed, settle between feeds and medically worrying signs of withdrawal are acted upon by requesting urgent paediatric review. **A management plan must be documented in the neonatal health records.**

9.1.2. Ensure the mother understands the purpose of observation, is involved in the process and facilitated to provide a suitable environment for her baby.

9.2 Commence medical treatment if:

9.2.1 Score of 5 (inform paediatrician for review)

9.2.2 Score of 6 or above (these babies also require further investigations and should be admitted to NICU)

9.2.3 If convulsions occur summon emergency assistance 2222 request neonatal team

9.3 A urine sample should be obtained from the baby within 24hrs for toxicology screening. It is good practice to gain the mother's co-operation for this. If results of toxicology is required urgently from baby, please call biochemist on ext. 2839, 3963, 3961 who can ensure URGENT dispatch to outside lab.

The paediatrician is responsible for obtaining the results prior to the baby's transfer home where possible (a documented plan should be put in place to obtain the results if the baby is transferred home prior to this).

9.4 Check postnatal management plan on E3 regarding admission, social services involvement and other relevant information.

9.5 General guidance regarding samples for toxicology:

- Maternal consent MUST be obtained
- Urine sample not required if mother positive for cannabis only and no other concerns or social care involvement. Discuss with Substance Misuse Midwife Ext 8284 / 8211
- Urine sample for toxicology preferably within 24 hours and not later than 72 hours
- Though less reliable, urine sample can be collected after 24 hours if not obtained on day one.
- Inform biochemist (Ext 2839, 3963, 3961) of all urine samples sent for toxicology, as all should be considered as urgent requests. State that the result is required <24hours (prior to baby's discharge).
- Check mother's HIV, hepatitis B & C status and act accordingly

9.6 LOW RISK INFANTS (defined as: term infant with protective maternal serology and no other concerns)

- Can stay in postnatal ward with the mother if Neonatal Abstinence Syndrome (NAS) scores is 4 or less
- Maintain NAS scoring, feeding and weight charts
- Chase urine toxicology □1) if negative: can go home after paediatrician review, if no other child protection concerns.

□2) If positive: stay in the hospital for at least 4 days, inform social services & consider predischarge meeting.

- Babies in this category will require midwifery discharge summary only

- If the baby has symptoms to a degree requiring treatment (i.e. scoring 5, inform neonatal team for review; score of 6 baby should be admitted to the Neonatal Unit)

HIGH RISK (defined as: Un-booked mother or unknown HIV/hepatitis status with chaotic history) OR UN-WELL INFANTS

- Admit to NICU (NAS scores 6 or more warrants admission)
- Inform neonatal consultant, social services, and the mother
- Urgent urine toxicology (with maternal consent)
- Duration of stay will depend on clinical condition and delayed risk of withdrawal (admission can be as long as 10 days)
- Pre discharge meeting to be arranged on a mutually convenient date & time by midwife / nurse and social worker
- All babies will need a written discharge summary under a named neonatal consultant and letter copied to all relevant agencies including GP

Breast feeding: should be encouraged unless the mother is a poly-user or she is known to be HIV positive or if HIV status is unknown; known or suspected to be an intravenous drug user. If in doubt, discuss with registrar or consultant.

Naloxone: Should not be used as it may provoke a serious or even fatal withdrawal reaction.

USS head: If the mother has been on cocaine, a cranial u/s scan should be done. Cocaine is a potent vasoconstrictor and can lead to cerebral infarcts in the foetus with various other anomalies

'Baby's drug withdrawal and how to reduce symptoms' parent information sheet to be given to the parents or carer of baby and explained to by M/W and signed in the baby notes of low and high risk infants

10. POSTNATAL PERIOD

10.1 Ensure that normal psychological and physiological aspects of parenthood rather than drug use remain the focus of care.

10.2 Breastfeeding is encouraged except for chaotic/polysubstance users (to help with withdrawal).

10.3 Any woman and/or their partner who use drugs and/or alcohol should be strongly advised against co-sleeping with the baby.

10.4 Midwife should document in the maternity records observation and assessment of parenting skills as this is an important aspect of planning

discharge from the maternity unit. The mother may require additional support as the baby may well be unsettled.

10.5 Staff should remember that analgesia requirements may be higher for women with opiate dependency. Liaison with the Medical staff re: dosage is necessary.

10.6 Inform the lead midwife for substance misuse/community midwife and other agencies identified in the care plan that the mother is on the ward.

10.7 If methadone is required following discharge, liaise with the named worker at the drugs and alcohol service, and e-mail the hospital referral form in time for a prescription to be generated. If discharge occurs unexpectedly, follow local hospital policy, which usually allows for up to 3 days of Methadone to be prescribed.

10.8 If it has been identified in the care plan to organise a discharge planning meeting.

10.9 Ward midwife or NICU nurse to inform all appropriate agencies of transfer home.

11. DISCHARGE PLANNING

11.1 The Children and Families Social Work Team will advise on the need for a Discharge Planning Meeting. If the baby remains well this should occur within 4-5 days after the birth. This meeting should include the ward Midwife, community midwife, Neonatal Paediatrician, Nursing staff from SCBU if admitted, Drugs & Alcohol Worker, Health Visitor, GP and other services involved. The Parents are also encouraged to attend and be 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 areas 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.

All babies who required treatment for significant withdrawal should receive paediatric follow-up, the consultant on the neonatal unit will decide this. The Neonatal

Consultant responsible should ensure that the GP and Social Worker are informed of any non-attendance.

References

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Appendix 1

Drug/Alcohol Assessment – enter on E3

Substance:

Frequency:

Amount/Cost:

Route of Administration:

Date last used:

Prescribed Drugs:

Name of Prescriber:

Do you suffer from any type of withdrawal symptoms?

History of Drug/Alcohol use in any previous pregnancies:

Outcomes:

Previous Drug/Alcohol Treatment:

Does Partner use Drugs/Alcohol?

Yes/No

If yes give brief details:

Refer to Drug/Alcohol Service

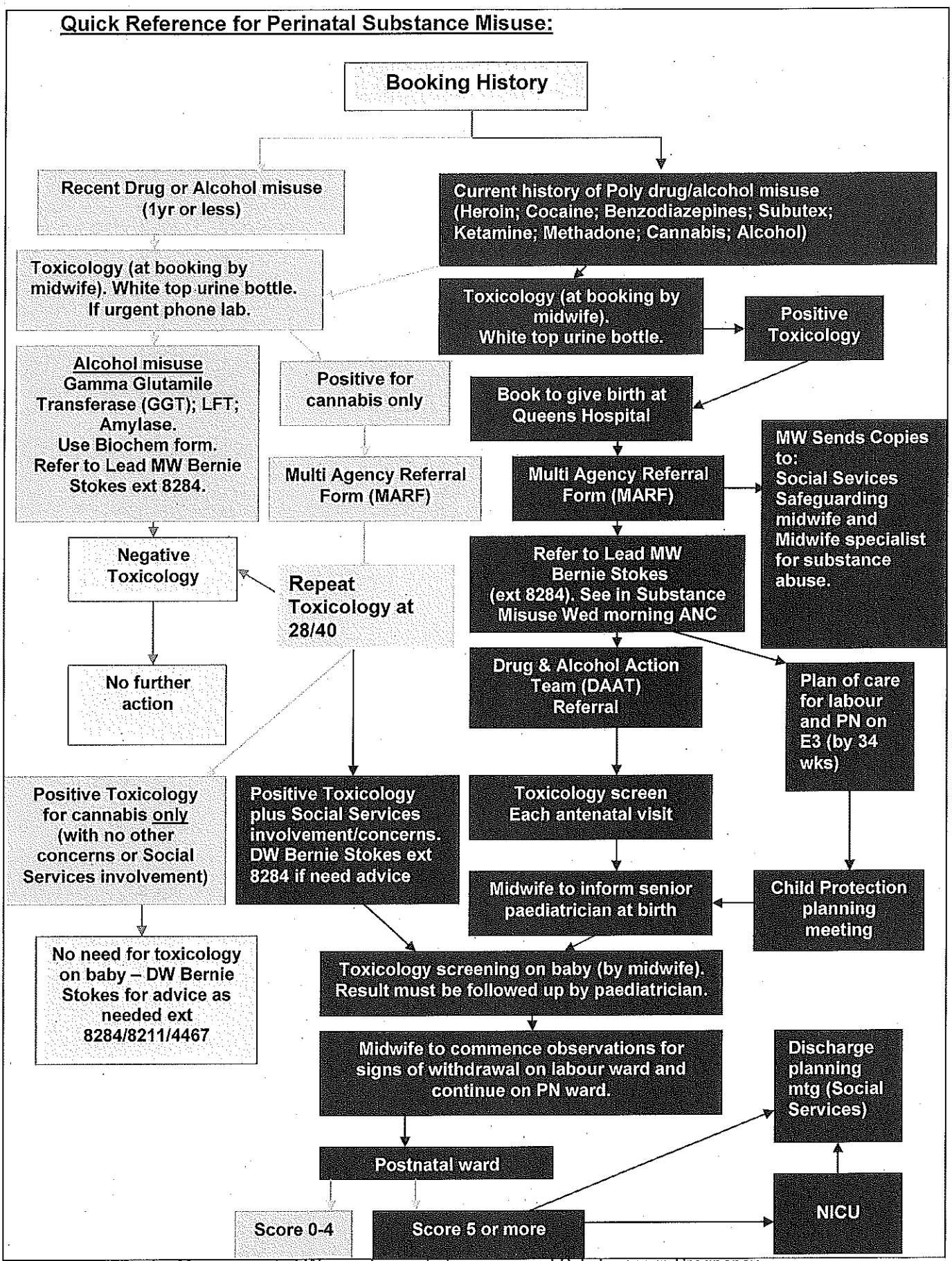
Urine Test: Yes/No

Appendix 2

Effects of maternal drug abuse on the fetus and newborn infant

- Placental abruption
- Stillbirth and neonatal death
- Preterm delivery and intrauterine growth retardation
- Low birth weight and sudden infant death syndrome
- Neonatal abstinence syndrome
- Physical and neurological damage
- Fetal alcohol syndrome

Appendix 3


Quick Reference for Perinatal Substance Misuse:
Booking History
Recent Drug or Alcohol misuse (1yr or less)
Current history of Poly drug/alcohol misuse (Heroin; Cocaine; Benzodiazepines; Subutex; Ketamine; Methadone; Cannabis; Alcohol)
Toxicology (at booking by midwife). White top urine bottle. If urgent phone lab.
Toxicology (at booking by midwife). White top urine bottle.
Positive Toxicology
Alcohol misuse Gamma Glutamile Transferase (GGT); LFT; Amylase. Use Biochem form. Refer to Lead MW Bernie Stokes ext 8284.
Positive for cannabis only
Book to give birth at Queens Hospital
Multi Agency Referral Form (MARF)
Multi Agency Referral Form (MARF)
MW Sends Copies to: Social Sevices Safeguarding midwife and Midwife specialist for substance abuse.
Negative Toxicology
Repeat Toxicology at 28/40
Refer to Lead MW Bernie Stokes (ext 8284). See in Substance Misuse Wed morning ANC
No further action
Drug & Alcohol Action Team (DAAT) Referral
Plan of care for labour and PN on E3 (by 34 wks)
Positive Toxicology for cannabis only (with no other concerns or Social Services involvement)
Positive Toxicology plus Social Services involvement/concerns. DW Bernie Stokes ext 8284 if need advice
Toxicology screen Each antenatal visit
Midwife to inform senior paediatrician at birth
Child Protection planning meeting
No need for toxicology on baby – DW Bernie Stokes for advice as needed ext 8284/8211/4467
Toxicology screening on baby (by midwife). Result must be followed up by paediatrician.
Midwife to commence observations for signs of withdrawal on labour ward and continue on PN ward.
Discharge planning mtg (Social Services)
Postnatal ward
NICU
Score 0-4
Score 5 or more

Appendix 4

Suggested medication regime for women not in treatment, or where treatment cannot be confirmed

- Women who use opiates on a daily basis will start to exhibit signs and symptoms of withdrawal when their supply ceases. The timing and severity of these symptoms will differ according to the woman's drug history.

- Signs and symptoms of Heroin withdrawal usually start after approximately 6 hours and peak at approximately 48 hours, whereas Methadone symptoms start at approximately 12 hours and reach a peak at approximately 72-96 hours.

- Features of withdrawal included craving, irritability, restlessness, muscle cramps, diarrhoea and vomiting.

- If treatment cannot be confirmed, or if the woman is not in treatment, this suggested regime may be commenced until advice from Drug and Alcohol service can be obtained:

- 10mls Methadone (1mg in 1ml) may be given 4 hourly until the optimum dose to control symptoms is reached. The maximum dose is 60mls in the first 24 hours, with the proviso that the woman is requesting medication and that she is not drowsy or intoxicated. After 24 hours the required dose may be given as a daily dose, either as a single dose or a divided dose.

Appendix 5

Telephone Numbers

Mon-Fri 9-5:

[redacted] – Lead Midwife (substance misuse) ext [redacted].
[redacted] – Consultant Neonatologist
[redacted] - Deputy Named Midwife – [redacted]
01708503892 DECT 6322 Safeguarding office
Toxicology Results – Biochemistry or HOMERTON HOSPITAL – 0208 510 7189/7888/7887
Out of hours – Contact paediatrician via NICU.

Redbridge

Recovery[R3] – 0208 221 7600 E MAIL EL-TR.R3@NHS.NET
Alcohol services –See above

Havering WDP

Email: havering@wdp.org.uk
Address: Ballards Chambers 26 High Street
Romford RM1 1HR Telephone: 01708747614

Barking & Dagenham CRI 38 George Street Barking IG11 8FE

Drugs (CGL] – 0208 507 8668
Community alcohol service – 0208 595 1375 St Lukes Dagenham Road RM10

Subwise for young people 0208 227 5019

Brentwood

Drugs (Community ALCOHOL SERVICE 01277 655662

Also open Road Basildon which works with more complex cases 01268 531 435

Thurrock 01375 37441