Frimley Health
NHS Foundation Trust

Substance misuse in pregnancy

Key Points

- Substance misuse should be discussed and documented at booking and any subsequent contacts should a disclosure be made (Antenatal, Intrapartum & postnatal period).
- Urine toxicology should be requested upon any disclosure of current substance misuse, recently stopping and/or significant previous substance misuse.
- Consent should be gained for any request for urine toxicology.

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Abbreviations

AN	Antenatal
CTG	Cardiotocography
HIV	Human Immunodeficiency Virus
IV	Intravenous
IUGR	Intrauterine growth restriction
NNU	Neonatal Unit
SCBU	Special care baby unit

Contents

1. Purpose of the Guideline

'Research shows that the use of tobacco, alcohol, or illicit drugs or misuse of prescription drugs by pregnant women can have severe health consequences for infants. This is because many substances pass easily through the placenta, so substances that a pregnant woman takes also reach the fetus' (National Institute on Drug Abuse 2020a).

The purpose of this guideline is to ensure that the best possible care is offered to women and families who are substance misusers and their unborn babies. This will be achieved by working in partnership with the parents and multi-agency collaboration as per recommendation by NICE [2010]

Women should be reassured that they will not be discriminated against as result of drug or alcohol use and that the overall aim in each service is to provide non-judgemental care. This is essential to achieve engagement of women in services.

The Midwife should discuss the woman's substance misuse throughout her pregnancy to assist in the planning of appropriate care as this can have far reaching implications for her future drug use and the well-being of her baby.

It is hoped that in promoting a positive approach to women who substance misuse, pregnant women will become more confident in reporting and reducing their drug and alcohol use.

In order to reduce harm, it is essential that multi-disciplinary working occurs in the antenatal and postnatal care for pregnant women who misuse drugs and alcohol. This guideline follows the Children Act 1989, which states that the welfare of the child is paramount.

The Guideline

2. Aims of the Guideline

- Ensure the pregnant substance misusing woman is offered appropriate antenatal care
- Identify risks of significant harm to the unborn child from the misuse of substances and ensure appropriate action
- Encourage the pregnant substance user and/or the partner/father to the baby seeks help/support for their substance misuse.
- Stabilise the woman on a safe level of drugs or alcohol for the duration of the pregnancy.
- Establish a comprehensive plan of care to meet the needs of the pregnant substance user and her child and identifies which professional undertakes the responsibility for convening and co-ordinating any meetings
- Ensure that the woman is involved in all aspects of her care planning throughout her pregnancy and postnatally

- Provide information about HIV, Hepatitis B and C and risk reduction to pregnant substance users.

- Provide a flexible service according to client need with due respect to client individuality and culture.

- Establish effective communication between all professionals.

2.1 Implementing the Guideline

The maternity unit has the crystal midwifery team at Wexham Park working with women with substance and alcohol misuse in pregnancy to help and support the women and their midwifery colleagues. Frimley Park Hospital does not have a specialist team.

3. Antenatal care

3.1 Role of the Midwife

- All women should be asked about their use of drugs and/or alcohol when they book care and at all subsequent appointments with midwifery services.
- Ask about any previous drug use any previous addictions and any current substance misuse.
- Following disclosure of previous Class A drug use (Appendix 1), previous addiction and/or any recent or current substance misuse. Gain consent for a urine specimen for toxicology (recent use may be considered as within the past 12 months prior to booking, however midwives should use professional judgement when requesting a urine toxicology for previous use).
- If consent not given, refer to social services if substance misuse in current pregnancy reported or suspected – sample cannot be sent without consent.
- If result is positive, repeat a minimum of 2-3 urine toxicology's in pregnancy. If negative and no concerns about ongoing use, no need to repeat further tests.
- Following disclosure of current substance misuse (at booking / antenatally), **with consent**, referrals should be made to:
    - Local drug treatment agency as soon as possible
    - If Wexham patient, Crystal team midwife with women's consent, via EPIC referral form – if women do not consent these women will continue under the care of the community midwife.
    - Obstetric antenatal clinic by sixteen (16) weeks of pregnancy or ASAP after disclosure/positive toxicology, if after 16 weeks
      (Mr Vathanan at Wexham Park / any obstetrician at Frimley)

- **Compulsory referrals** [Working together to Safeguard Children (2023)]
    - Referral to safeguarding midwife, using the safeguarding referral form on EPIC for 'mother of unborn'
    - Health visitor liaison form for a targeted early visit on the day of disclosure or positive toxicology result
    - Social services department on day of disclosure or positive toxicology result

- All women should be encouraged to access the main antenatal services and receive multidisciplinary antenatal care, which includes routine antenatal screening. IV drug users should be advised to have blood test for Hep C in addition to the routine Hep B and HIV testing and consider retesting at 36/40. Working together to Safeguard Children (2023)
- All women using recreational drugs regularly or intermittently should be referred to the drug and alcohol counselling service contact details in Section 6. Giving up drugs during the pregnancy greatly reduces the likelihood of neonatal withdrawal.
- If late booking/concealed pregnancy, please ensure urgent scan is requested at booking. All concealed pregnancies should be offered urine toxicology at booking. If decline inform social services on the referral being made.
- Consider the specific problems of this group, i.e., harm minimisation through good nutrition and needle exchange. On any admission notify the ward pharmacist of women on treatment programmes, what medication they are on and who their prescribers are.
- Paediatrician will be informed at the Neonatal unit / psychosocial meeting, weekly at Wexham, fortnightly at Frimley, which is chaired by the named midwife for safeguarding. A plan of care will be agreed at these meetings.
- If there is a possibility that the baby may need admission to the Neonatal Unit (NNU), a visit can be arranged for the parents/carers.
- Encourage women to discontinue the use of recreational substances, by discussing the possible impact on pregnancy, e.g., IUGR; Prematurity – see appendix 1. This can be done in conjunction with specialist advice (National Institute on Drug Abuse 2020b)
- If mother is choosing to breastfeed, discuss colostrum harvesting.
- If admitted antenatally, control symptoms of withdrawal (as applicable). Those women receiving substitute medication can continue this medication and must be encouraged to bring in their own supply, they have already collected. **Whilst as an inpatient we can supply the medication, we must liaise with their external prescriber on admission and discharge to continue their usual prescriptions and confirm dosage.** (Those using recreational cannabis should simply be advised to discontinue). Women should be encouraged to bring in their own supply of substitute medication – which should be stored as per ward protocols for storage of controlled drugs.

3.2 Role of Crystal/Named Midwife

General – To be aware of and to develop a good relationship with agencies that are involved with substance misuse treatment within the trust and neighbouring areas.

Specific -To liaise regularly with all agencies/professionals involved in the woman's care to formulate a care plan and to ensure accurate and current knowledge of progress.

- Follow up referrals made by (first contact) midwife to ensure referrals have been received by agencies and appointments allocated.

- Make contact with the mother within two weeks of referral and maintain contact (visit, telephone or text) as frequently as is applicable for each woman at a mutually convenient venue. Confirm with the mother that she is aware of all appointments made for her.

- Obtain informed consent for a sample of urine for toxicology from women with a history of substance misuse (explaining both legal and illegal substances will be screened for) **See above if declines consent**. Screen at booking and on a minimum of two further unannounced appointments as applicable. Requesting on EPIC:
    - access the woman's EPR
    - select 'orders' tab
    - type "Toxicology" in the "name" field
    - press "enter"
    - select "Drug Screen"
    - Complete form as required and send sample in white top urine bottle

- Ensure that the mother has been given an opportunity to discuss her care with the obstetric consultant.

- If there has been a plan for immediate paediatric input at the birth, then offer the mother an opportunity to discuss the care plan for her baby with the paediatric consultant. Offer tour of NNU if baby is likely to be admitted.

- Carry out antenatal/postnatal care according to the women's needs.

- Ensure that the general care plan for the mother and baby covers the antenatal, intrapartum and postnatal period.

- Review care plan regularly to confirm that it remains appropriate to the needs of the women and her baby. Amend as necessary and ensure that the women and all agencies involved in her care are aware of any changes.

- Inform named midwife for safeguarding of all cases referred to social services.

3.3 Role of the Nominated Consultant Obstetrician

- A consultant obstetrician will be responsible for pregnant women with substance misuse (Mr Vathanan at Wexham / any at Frimley).

- The nominated consultant will participate in the assessment and the development of the obstetric care plan throughout the pregnancy, liaising with drug and alcohol support if necessary.
- Please consider prescribed opiate/sedative medication when assessing drug misuse/abuse. It may be that the original condition which led to prescribed medication could be now be managed by other means, and/or the patient may have refused alternative treatment or medication that are less additive or mind altering. Hampshire Safeguarding Children Partnership (2021)
- Best practice dictates the first assessment by the consultant should occur by sixteen weeks of pregnancy and then care based upon individual needs. It has been established that vulnerable women are far less likely to seek antenatal care early in pregnancy or to stay in regular contact with maternity services (MBRRACE-UK Saving Lives, Improving Mothers' Care, 2022) therefore it is important that the service has a

system in place to monitor these women. [Frimley health booking and antenatal care guideline, November 2023]

- Growth scans as required, as per consultant recommendation.
- The information needed by the obstetric team is as follows:
    - Drug history, past and current
    - Nature and frequency of any medication currently prescribed
    - GP/ pharmacy substitute prescribing
    - Urine toxicology assessment
    - The amount of alcohol and tobacco consumption
    - Psychiatric, psychological and social history
    - General health and medical history
    - Treatment plan which identifies whether stabilising drug use in the pregnancy or offering detox is appropriate before delivery.
    - Names and contact numbers of all agencies involved.
    - Any other concerns

And in addition, a birth plan to be discussed involving the women, midwives, health visitors and consultants regarding:

- Management of the drug dependency
- Pain relief during labour
- Infant feeding
- Parentcraft classes
- Management of known Hepatitis B/C or HIV infection
- The name of the health visitor and GP
- Neonatal care – obstetrician to liaise with the paediatricians regarding plan.
- Discharge planning
- In an emergency and where a woman is assessed as needing substitute medication, i.e., Methadone/Subutex and unable to get a prescription, it is the duty of the obstetric team to undertake this responsibility.
- Following birth, the obstetric team should provide information to the Neonatal Unit if the baby is admitted detailing:
    - What drugs and alcohol are being used or were used by the client
    - Time and date of last use
- Length of time of usage of substances by client
- Substitute prescriptions being used where applicable.
- Name and contact number of Lead Professional

4. Intrapartum Care

- Women who misuse drugs: with consent, a urine specimen for toxicology to be obtained from woman **on admission to hospital** (whether antenatally or intrapartum), before any prescribed medications are administered.
- It is recommended that the birth takes place within a hospital. The midwife needs to discuss and agree the place of birth with the mother. Taking into consideration that baby might need withdrawal observations and medical intervention.
- There is no current evidence for electronic fetal monitoring, however if there is evidence of IUGR on scan or other co-morbidities then electronic fetal monitoring is recommended by using CTG. If there are no other issues, then intermittent auscultation should be used.
- The woman's normal substitute therapy should be prescribed and provided without delay, irrespective of any pain relief she may have had. Drug use should not be considered as adequate. Drug charts to be reviewed by pharmacists for any substance misusers with, or without replacement medication.
- Pain control should be prescribed according to the doses defined by the protocols for the procedure being performed, making full use of anaesthetic techniques. If the woman is receiving medication, e.g., methadone for her addiction, pain control should not be omitted. The dose of pain-relieving agent may be at the top end of dose range.
- There is no indication that these women will not be able to give birth normally.
- Check antenatal plans on admission regarding admission to NNU.
- If baby is for admission to NNU, please do not delay transfer of baby to NNU if clinically unwell and inform NNU of substances which mother has misused, and drugs given in labour.

N.B.
If the woman has been using opiates and starts withdrawing in labour, the CTG could resemble fetal distress – **consider the use of opiates before deciding it is an obstetric emergency.**

NALOXONE (in the neonate) should only be used under the supervision of a paediatrician as it can cause acute abrupt withdrawal symptoms and induce refractory seizures in the neonate (TV&W Neonatal Network, 2023).

5. Postnatal Care for mother

- Please ensure any administration of prescribed substitution therapy is handled and stored appropriately, as per usual controlled drug process.
- Any positive urine toxicology in pregnancy for illicit drugs or known substance misuse, encourage the mother to stay in for a minimum of 72 hours. Withdrawal symptoms in the baby may take up to four days to become evident (Thames Valley and Wessex National Network Guideline 2023). This will also allow time for assessment of parenting skills and discharge planning, if required. Consideration should be given for these babies to be cared for on TCU.
- Pre-transfer planning – with special emphasis on drug prescription, i.e., if she is going home on a Saturday, Sunday or public holiday, staff must ensure they liaise with

substance misuse services on admission and discharge to stop/restart any prescriptions in community.

- Liaise with substance misuse services if the woman is engaged in treatment.

  or if they wish to commence treatment.

5.1 Infant feeding

- Skin-to-skin is not contra-indicated, mothers should be discouraged from holding and/or co-sleeping with their baby when receiving medication which causes drowsiness or alters their state of awareness.

- Breastfeeding is the mothers choice. If continuing to use substances discuss risks and signs of withdrawal should mother stop or reduced breast feeding. Care should be taken to observe mother and baby closely. Although unexpected collapse in the newborn is rare, observations should be made of the mother and her baby, with prompt removal of the baby if the health of either gives rise to concern.

- Babies of substance misusing mothers may be more susceptible to poor feeding which can lead to hypoglycaemia. [National Institute on Drug Abuse [2020b]. The opportunity for antenatal colostrum harvesting should be offered to support initiation and continuation of breastfeeding.

5.2 Neonatal care

- Mother and baby to be kept together unless there is a medical or social reason for separation.
- In most instances this will be on transitional care but admission to the NNU may be required.
- A urine specimen for toxicology is to be obtained from the baby at delivery.
  Urine bag should be applied to collect the first urine sample for toxicology – please make sure this has been explained to the mother and consent obtained.
- Babies of these mothers may be more unsettled and will need extra observation in case of withdrawal symptoms. Please refer to the (TV&W Neonatal Network, 2023).

- Baby withdrawal observation flowsheet to be used, alongside NEWS chart on EPIC. Ensure the mother is aware these observations are being undertaken.
- If open to social services, parenting observations to be completed using the parenting observations tool on the Safeguarding tab. Ensure the mother is aware these observations are being undertaken.
- Ensure paediatric follow up appointment given. NIPE to be completed by Paediatrician.

Care to be taken when writing in the records due to relatives' potential access to mobile devices. Document as Safeguarding notes.

6. Key Contacts

WPH – Crystal team – fhft.crystalteam@nhs.net – referrals to be sent via email (complete and send a copy of the safeguarding referral form)

Maternity safeguarding midwives – Referrals on EPIC will go to their in basket: Urgent referrals to also be sent by email.

WPH – fph-tr.MaternitySafeguardingHWPH@nhs.net
FPH – fph-tr.maternitysafeguarding@nhs.net

Trust medicines information pharmacist: Through Switch- 9-5 'on call'
Pharmacy email fhft.medicines.information@nhs.net.

7. Drug & Alcohol Services

New Hope (Berks): 01344 312360

Turning Point (Slough): 01753 692548

Resilience (Windsor & Maidenhead):01628 795939

SMART (Windsor & Maidenhead): 01628 683260

SMART (Wokingham): 0118 9772022

One Recovery (Bucks): 0300 772 9672

Inclusion (Hants): 0300 124 0103

Catch 22: 0800 599 9591 (Hants) – 11-25 year olds only.

I-access (Surrey): 0300 555 5932

Surrey drug and alcohol: 0808 802 5000 (Surrey)

For more specific area support please go to www.nhs.uk

8. Implementation Plan

This guideline will be implemented as follows:

- Guidelines are approved by the Obstetric Clinical Governance Group (OCGG), the minutes of which are available on the maternity shared drive
- After approval the guideline will be placed on the intranet informing all staff of the guideline.
- Staff will be made aware of the updating of the guideline via email.

9. Monitoring

An annual audit of health records of babies will be completed and reported to the Obstetric Clinical Governance Committee including the following:

- A urine bag was applied to collect the 1st urine sample to assess toxicity.
- Those fractious babies are observed for a period of 3-5 days.
- A withdrawal/observation chart be instigated for all babies at risk of withdrawal.
- A paediatric referral has been made.

Any deficiencies arising from the audit will be action planned to ensure compliance. The obstetric clinical governance committee will continue to monitor the action plan until completed.

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Appendix 1 – Adopted from the TVW guidance 2023

Infants exposed to certain drugs during pregnancy may become physically dependent on them and, after birth, suffer withdrawal symptoms, termed the neonatal abstinence syndrome (NAS).

Drugs which may cause withdrawal are:

Opiates – e.g., codeine, diamorphine (heroin), methadone, fentanyl, buprenorphine, tramadol Benzodiazepines – e.g., diazepam, temazepam, clonazepam

Barbiturates – e.g., phenobarbital Amphetamines

SSRI's – e.g., Sertraline, Citalopram,

Fluoxetine, Venlafaxine Antipsychotic

medications e.g., Quetiapine

Drugs which may cause other health concerns in the infant:

Cannabis – growth restriction, long term neuro-behavioural problems

Cocaine – vasoconstrictive effects on developing brain which may lead to neurological abnormalities Alcohol – fetal alcohol syndrome

Drug use during pregnancy can also be associated with:

Premature labour, placental abruption, stillbirth, neonatal death (especially with cocaine abuse) Birth defects: cleft lip / palate (heroin/opiates)

Underdeveloped limbs (cocaine)

Intrauterine growth restriction (IUGR)

Meconium staining of liquor

Delayed onset of respirations / respiratory depression

Longer term problems include sudden infant death syndrome, neurodevelopmental delay, behaviour and social problems.

However, unless there are other indications it is not necessary for a paediatrician to be called routinely to attend these deliveries.

CLASS A DRUGS:

- cocaine.
- crack cocaine.
- ecstasy (MDMA)
- heroin.
- LSD.
- magic mushrooms.
- methadone.
- methamphetamine (crystal meth)

Clinical Features of Neonatal Abstinence

Table 1: Clinical Features of the Neonatal Abstinence Syndrome		
Neurologic Excitability	Gastrointestinal Dysfunction	Autonomic signs
Tremors Irritability Increased wakefulness / loss of sleep wake cycle High-pitched crying Increased muscle tone Hyperactive deep tendon reflexes Exaggerated Moro reflex Seizures Frequent yawning and sneezing	Poor or excessive feeding Uncoordinated and constant sucking Vomiting Diarrhoea Dehydration Poor weight gain	Increased sweating Nasal stuffiness Fever Mottling Temperature instability **Other** PPHN – associated with SSRI's Tachycardia Increased blood pressure Apnoea / respiratory depression

Differential Diagnosis

Sepsis, Birth asphyxia, Hypocalcaemia, Hypoglycaemia, CNS bleeds, hyperthyroidism, hyperviscosity, milk intolerance – these must be considered when evaluating a baby for possible withdrawal.

Onset of symptoms

This will vary depending on type of drug taken, amount of drug taken, how recently drugs were taken, use of multiple drugs simultaneously and maternal physiology.

Table 2: Time of onset of symptoms			
Name of drug	**Onset of symptoms**	**Comments**	**Recommended observation period***
Heroin	24 - 48 hours	Duration may be 8-10 days	5-7 days
Cocaine	24 - 48 hours	May be 48 – 72 hours	3-5 days
Amphetamines	24 hours	Duration 7- 10 days	3-5 days
Methadone	48 - 72 hours	Duration up to 30 days	5-7 days
Buprenorphine	36 – 60 hours	Duration up to 28 days	5-7 days

Barbiturates	4-7 days	Can be 1-14 days	5-7 days
Benzodiazepines		Can be >10 days	5-7 days
SSRI's & TCA's	1-3 days	Duration 2 – 6 days	24 hrs in hospital, daily community midwifery review x 48 Hours **
Prescription opioid medications	36 – 72 hours	Duration 10 – 30 days	3 – 5 days

*Recommendations are subject to Local Unit and LMNS Guidelines and individual clinical decision making

Table 3: Length of time urine will remain positive	
Drug	**Length of time urine will be positive after last dose**
Benzodiazepines	Up to 30 days
Marijuana	1 – 10 days – depending on amount
Cocaine	72-96 hrs - longer with heavy use
Heroin, morphine, codeine	24-48 hrs
Methadone	2 – 3 days
Amphetamines	1 – 2 days
Barbiturates: short acting Long acting	<2 days 1 – 7 days

Risk factors for increasing severity and/or intensity of NAS symptoms:

Definite:

i. Term
ii. Good birth weight
iii. Polydrug use / abuse
iv. Combination with benzodiazepines
v. Delayed drug metabolism

Probable:

vi. Male gender
vii. Maternal smoking
viii. Maternal methadone use
ix. Combination with SSRI's/SNRI's

Specific drugs

Opioids

If more than 1 week between last ingestion and birth, incidence of NAS is relatively low. Incidence and severity of NAS is increased in methadone compared with buprenorphine or heroin. Withdrawal from opioids can be severe and prolonged with subacute signs persisting for up to six months. In the acute phase, seizures have occurred in 2 – 11% of cases of NAS. Seizures are also associated with barbiturates, alcohol and sedative hypnotic withdrawal. There have been a few cases described in the literature of NAS in babies born to mothers who were prescribed codeine in late pregnancy for pain relief. Mothers prescribed codeine in late pregnancy should be warned of this possibility.

Cocaine: (Elke H. Roland et al. Paediatric Neurosciences 2989; 15:88-94)
Cocaine use is increasing in pregnant women. There is no clearly defined abstinence syndrome. Clinical features are similar to narcotic withdrawal. Withdrawal score is higher with both cocaine and heroin. There is an increased risk of hypoxic-ischaemic cerebral injury. Cerebral infarctions and intracranial haemorrhage including subarachnoid bleeds have been reported. Blood pressure measurement must be done prior to discharge. A cranial ultrasound scan should be offered but may not detect abnormalities. Cocaine is teratogenic, therefore examine carefully for congenital anomalies (gastroschisis, genitourinary, gut atresias, limb reduction defects). Abnormal visual fixation and ocular abnormalities (uncertain clinical significance) can also be found. If there are clinical concerns – obtain an ophthalmology opinion.

Selective Serotonin Reuptake Inhibitors (SSRIs) & Tricyclic Antidepressants (TCAs)

SSRIs and TCAs are the most commonly used antidepressants in pregnancy and are generally considered to be safe (non-teratogenic) except for a possible relationship between paroxetine and cardiac defects. However, there is a slightly increased risk of developing PPHN in babies of mothers on SSRIs. Whilst babies on SSRIs and SNRIs are also at increased risk of developing toxicity or withdrawal symptoms if exposed in the third trimester, these are generally mild and very seldom require intervention. Symptoms are mainly CNS, gastro-intestinal, respiratory and autonomic. TCAs can produce withdrawal symptoms including irritability, agitation and seizures but there is no association with developmental delay.

1. Do pre- and post ductal saturations within 24 hours of birth to exclude PPHN prior to discharge home.
2. Consider observing babies in hospital for 12 - 24 hours. Babies should be observed at regular intervals (ideally daily by a suitably trained health professional) for the first 72 hours for signs of withdrawal. If no community midwifery support available, consider observing in hospital for 72 hours.
3. It is not contra-indicated to breastfeed.
4. If baby develops symptoms, readmit if already discharged home and, additionally, need to monitor for hypoglycemia.

Full version control record

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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.
This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

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1.0	April 2021	C Thompson / N Sharman	Final	First cross site version
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Related Documents

Document Type	Document Name
Guideline	Booking and Antenatal Care, including the Management of Non-Attendance to Antenatal Appointments (see section 6)
Form	Safeguarding Assessment Form – on Epic EPR
Guideline	Antenatal Screening
Guideline	Detection and Follow Up of Fetal Abnormality
Guideline	Neonatal Abstinence Syndrome (TVW Network)
Guideline	Management of a Concealed Pregnancy