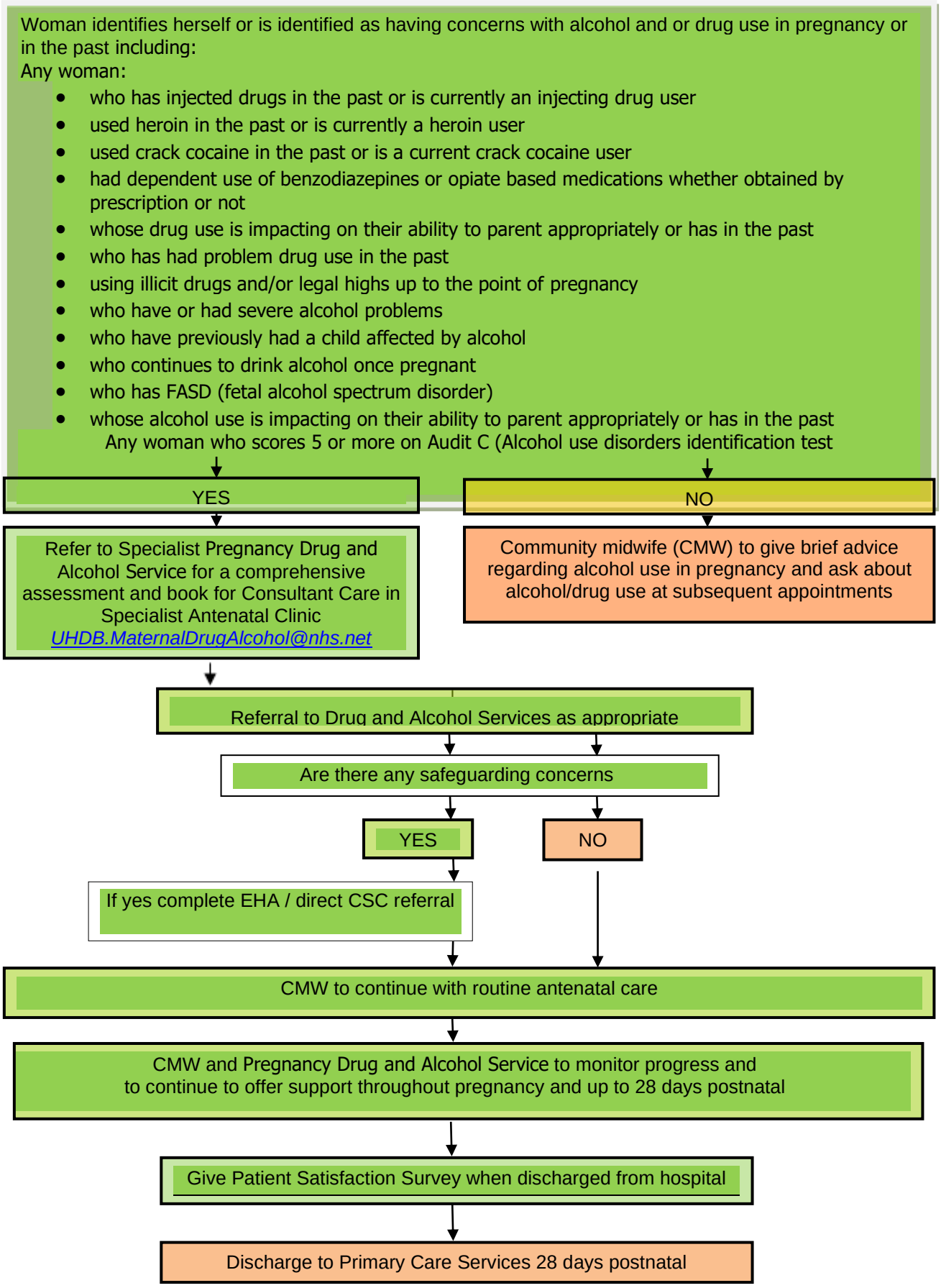
Pathway of care for women using drugs/alcohol in pregnancy - Full Clinical Guideline

Reference No.: UHDB/Obs/11:23/S6



WOMEN WHO USE DRUGS / ALCOHOL *(includes prescription medication)* in PREGNANCY
Full Clinical Guideline

Contents

1. Introduction

This guideline outlines the key procedures to be followed during the antenatal, intrapartum and postnatal care of women with a history of or current substance use.

2. Purpose and Outcomes

The purpose of this guideline is to rationalise and formalise the care available to these women and reduce the number of complications arising relating to substance muse.

3. Abbreviations

BBV - Blood Bourne Virus
CNS - Central Nervous System
CCL - Maternity System
CTG - Cardiotocograph
CYPD - Children and Young Persons Department (Social services)
DNA - Did Not Attend

EHA - Early Help Assessment
NICU - Neonatal Intensive Care Unit
VCM - Vulnerable Children's Meeting

4. Key Responsibilities/ and Duties

All pregnant women are asked at their booking appointment about drug and alcohol use. If drug / alcohol use (alcohol, illicit drugs, prescription medications likely to cause dependence and/or withdrawal, over the counter medications and legal highs) is disclosed then the woman should be referred to the Pregnancy Drug and Alcohol Service. We are also happy to accept email referrals stating the patient's name, hospital number or NHS number and drug of choice. The woman must be informed of the referral. For the referral pathway see **Flowchart (p1)**
The Pregnancy Drug and Alcohol Service will carry out a full assessment on all women who are referred appropriately.
All documentation pertaining to involvement of the Pregnancy Drug and Alcohol Service will be recorded on orange paper and placed in front of the current obstetric notes and behind any safeguarding notes.
Correspondence will be initiated with the relevant agencies including obstetricians and paediatricians.
This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient.

5. Background

The true extent of drug taking in women is largely unknown as reliable figures are difficult to obtain.
Research suggests that between 2.3% and 11% of the pregnant population, in different cities, are taking illicit drugs.
Recent data from America found that 1 in 13 women admit to drinking whilst pregnant and 1 in 4 of those women admitted to binge drinking. Other data suggests that drinking levels in pregnancy are much higher.
Alcohol and other drug use during pregnancy can have unfavourable effects – both specific and non-specific – on the outcome of the pregnancy.
Specific effects of drug/alcohol use can be found in **Appendix B.**
Non-specific effects can include growth deficiency both pre and postnatally, resulting in small infants and in some cases decreased head circumference, CNS disturbance affecting behaviour and intellect.
Illicit drug / alcohol use by parents / carers does not on its own automatically indicate that children are at risk of abuse or neglect. However, where illicit drug and or alcohol use is causing physical, psychological, social, interpersonal, financial and or legal problems, the implications for children and families must be properly assessed. Parental illicit drug and alcohol use can impact on children of any age and the impact may be cumulative

6. Confidentiality

Confidentiality is a fundamental right of all people using healthcare services. In regard to people who use drugs or alcohol confidentiality takes on a particular significance because of the social stigma attached to these conditions.

Women should be reassured that they will receive a confidential service however the information relevant to appropriate management of their pregnancy and treatment will be documented and shared on a need-to-know basis. Women referred to the Specialist Midwife in Drugs and Alcohol are asked to sign an information sharing agreement when an initial assessment is completed.

Women with drug and/or alcohol problems should not be automatically referred to CYPD. However, if agencies involved with the care have concerns about the following issues they are obliged to refer the case to CYPD for assessment:

- Childcare provision
- Non-compliance with Drug and Alcohol Services or antenatal care
- Concerns about complex social factors, chaotic drug use, no fixed abode.
- Unwanted pregnancy or other vulnerability such as learning disability or mental health issues
- If referral to VCM or CYPD is decided the women should be informed whenever possible.

CARE SHOULD BE TAKEN AT ALL TIMES TO ENSURE CONFIDENTIALITY IS MAINTAINED. MANY WOMEN HAVE FAMILY, FRIENDS AND EVEN PARTNERS WHO ARE NOT AWARE OF THEIR DRUG USE

7. Management of Care

7.1 Antenatal care (General Principles)

- Confirmation of pregnancy at first contact with health professional.
- Arrange booking appointment with the relevant Community Midwifery Team (self referral or professional referral)
- All pregnant women should be asked about personal history of drug and alcohol use (and that of their partner) at the booking appointment. Care should be taken to see women on their own to ask these questions as they may not be willing to disclose in front of partners or other family members.
- If a problem is identified the woman should be referred to the Pregnancy Drug and Alcohol Service. Patients disclosing drug/alcohol use for the first time and requesting help should be referred to appropriate drug/alcohol services. Most services require the patient to make contact themselves as an indicator of motivation to engage with Drug and Alcohol Treatment Services however referrals are accepted from Health Professionals.

Derby Drug and Alcohol Treatment Services	**Tel: 03007900265**
Ilkeston Drug Treatment Service	**Tel: 01159309442**
Ripley Drug Treatment Service	**Tel: 01773 /744594**
Derbyshire Alcohol Treatment Services	**Tel: 08453084010**
Burton Treatment Services - Staffordshire service)	**Tel: 01283 741053 (Humankind –**
Staffordshire rehabilitation centre (BAC O Conner rehabilitation centre)	**Tel: 01283 537280**

- Alcohol use is assessed using the Audit C screening tool (**Appendix D**). A total score of 5 or more will correctly identify those with increasing risk drinking practices and the need for referral to the Specialist Midwifery Service.
- Many women with drug related problems in Derby City/ Burton are already known to drug treatment services and will be prescribed the appropriate substitute medication. These women will have regular input from the Pregnancy Drug and Alcohol Service. If late booking (after 12 weeks), please ensure scan is undertaken as a matter of urgency.
- If women are not attending antenatal appointments refer to the 'Missed Appointments' guideline (A3) for DNA antenatal appointments and The Safeguarding DNA policy for children and neonates which includes DNA's of antenatal appointments in those with Safeguarding issues.

- Women should be encouraged to discontinue the use of recreational substances by discussing the possible impact on pregnancy (**Appendix B**). This can be done in conjunction with specialist advice.
- If a woman is admitted in the antenatal period, and not already in treatment refer to the Pregnancy Drug and Alcohol Service and the relevant Drug/Alcohol Treatment Services. It is not advised to start methadone prescribing without discussion with drug treatment services or the mental Health Liaison Team

Booking appointment (ideally by 10 weeks)

- Follow antenatal care pathway
- Complete referral to Pregnancy Drug and Alcohol Service (**Appendix A**)
- Give smoking cessation advice and support
- Alcohol brief interventions if required i.e. inform woman that no level of alcohol consumption is known to be safe in pregnancy.
- Refer to drug/alcohol services if required *UHDB.MaternalDrugAlcohol@nhs.net*
- Refer for Consultant Led Care with the Consultant with a specialist interest in Drugs and Alcohol in Pregnancy.
  If the woman does not attend follow the DNA guideline.

First appointment with Specialist Midwifery Service (usually 12-20 weeks depending on receipt of referral)

- Full assessment using the Pregnancy Drugs and Alcohol Service Initial Assessment Form
- Identify Safeguarding Issues and need for EHA or referral to CYPD. Birth plan should be in place by 32 weeks as there is a high risk of premature birth
  Identify who will take forward EHA or CYPD referral.
- Give relevant information leaflets: -
  "How much is too much when you are having a baby" - (Alcohol)
  "Methadone Maintenance Treatment and Pregnancy" - (Methadone)
  "Store Methadone and Medicines Safely" - (Methadone)
  "Neonatal Abstinence Syndrome" (Opiates, Opioids and Benzodiazepines)
- If there is a history of injecting drug use consider testing for hepatitis C (if positive follow BBV pathway)
- Assess venous access and refer to anaesthetist if poor
- If using cocaine, the anaesthetic team should be informed using the anaesthetic referral form but tick for information only
- Encourage engagement with drug and alcohol services if not already in place.
- Request that woman signs the Consent for sharing information (**Appendix E**)
- Lateral checks will be completed including checks on A & E attendances, if known to social care and/or drug treatment services
- Enter details on the Pregnancy Drug and Alcohol Service data base and safeguarding database (to be discussed in safeguarding supervision)
- Letter giving details of assessment and care plan to be sent to all involved agencies and copy placed in the obstetric notes.

20-week hospital appointment and all following appointments

- Anomaly scan (20-week appointment only)
- Discuss assessment and care needs with obstetrician i.e., Women who have problematic or heavy drug/alcohol use should have regular scans to assess fetal growth from 28 weeks gestation.
- Discuss and agree maternity care plan with the woman
- Discuss management of drug/alcohol use with Services and the Woman
- Monitor progress including drug/alcohol use

- The Pregnancy Drug and Alcohol Service will notify the paediatricians of expected babies where problems are anticipated following delivery by documenting in the paediatric notes. At Burton a neonatal alert form is used.
- If there is a possibility that the baby may need admitting to NICU, a visit can be arranged for the parents.
- Complete Drug/Alcohol Special Instructions form (**Appendix F)** and place in obstetric notes

Follow up appointments will be arranged depending on specific requirements for each woman. Women who are being cared for by the Drug and Alcohol Service should be seen by Specialist Midwife whenever they attend antenatal clinic at Royal Derby Hospital / Queens Burton Hospital.

7.2 Intra Partum Care

- If the woman has been using opiates and starts withdrawing in labour, the CTG could suggest fetal distress – consider the use of opiates as a cause before deciding it is an obstetric emergency. For this reason it is recommended that the birth takes place within the acute setting
- There is no general indication that these women will not be able to progress to a normal delivery.
- Anaesthetic considerations are covered in **Appendix B**
- **Narcan must not be given** to the infant of a mother who has been using opiates – as it can cause acute withdrawal possibly leading to the death of the infant. (Siney, 1995)

<u>Drug Dependent inpatient on Maintenance Treatment</u>

- Continue maintenance medication whilst in hospital, but first:
  - Confirm maintenance dose on admission
  - If no proof of dose, contact prescriber (GP or Drug Service) or pharmacist
  - Inform usual prescriber or pharmacist that the patient has been admitted
  - If possible, check when last dose was taken
- Inform anaesthetist of maintenance drug especially if buprenorphine
- Do not add benzodiazepines but continue if confirmed long-term prescription
- On discharge, inform prescriber in advance so regular prescription can be started.
- Methadone users still require analgesia as well as their maintenance medication.
- Treat their addiction and pain separately.
- Follow normal analgesia ladder, maximising use of non-opioids
- If they require opioids, give in the usual dosage and frequency; however, be prepared to increase the dose due to their increased tolerance of opioids. During this time continue their maintenance medication as prescribed.
- Avoid the use of cyclizine when treating methadone users as it has psychoactive effects and potentiates the effects of methadone (British National Formulary)

<u>Management of pain in women who are on buprenorphine</u>

- Continue usual dose of buprenorphine. It has a ‘ceiling effect’ so increasing the dose may not give any extra pain relief.
- Avoid other opioids, including intrathecal or epidural opioids
- Anaesthetist will try to maximise use of local anaesthesia, e.g., epidural 0.25% bupivacaine boluses, TAP (transversus abdominis plane) blocks
- Maximise use of non-opioid analgesia, e.g., regular paracetamol, and postnatally regular NSAID (non-steroidal anti-inflammatory drugs), consider nefopam

7.3 Postnatal Care

- Routine post natal care
- Please ensure any administration of prescribed substitution therapy is handled discreetly.
- Encourage the mother to remain in hospital with baby, if at risk of neonatal abstinence syndrome, for at least five days as withdrawal symptoms in the baby may take up to 5 days (or even longer) to become evident please refer to **NAS Prescription medication, drugs and alcohol use in pregnancy - Neonatal Care - Prescription medication - Neonatal Clinical Guideline**
- Discharge needs to be planned, taking into consideration any community prescription requirements e.g., if the woman is discharged late on a Saturday afternoon she may not be able to get her community prescription until Monday.
- Inform the Pregnancy Drug and Alcohol Service and/or Drug Treatment Services and Community Pharmacist of the woman's discharge from hospital and CYPD where appropriate.
  All relevant contact numbers are to be found on the Drug/Alcohol Special Instructions Form (Appendix F) in each woman's notes and they are different for all women.

7.4 Infant feeding

- Breast feeding is not contraindicated in those on substitute medication with no concomittent drug use
- Any alcohol and/or illicit drug use should be discouraged if the mother is breast feeding. COCAINE is specifically contraindicated. Cannabis should preferably be avoided as THC passes into the breast milk however there is no evidence of this causing harm to the baby.
- Babies of mothers with problematic drug/alcohol use may have feeding problems and poor weight gain

8. Neonatal Considerations

- Effects of maternal illicit drug use on the fetus and newborn infant – see **Appendix B**
- Mother and baby to be kept together if possible
- Maternal drug use is not an indication for admission to Neonatal intensive Care unit.
- Babies may be more unsettled and fractious and could develop full blown neonatal abstinence syndrome (for nonmedical and medical management of neonatal abstinence syndrome please refer to **NAS Prescription medication, drugs and alcohol use in pregnancy -Neonatal Care - Substance Misuse (NAS) - Paediatric Clinical Guidelines**

9. Contact details

- **Royal Derby Hospital - Pregnancy Drug and Alcohol Service –**
  Telephone: 01332 786749 / 789631.
  Mobile: 07799337678 / 07917650845 9am – 5pm or answer phone
  Email: uhdb.maternaldrugalcohol@nhs.net
- **Queens Hospital Burton – Pregnancy Drug and Alcohol Service**
- **07385 411 672**
- Email: uhdb.maternaldrugalcohol@nhs.net
- **Royal Derby Hospital Pharmacy** Tel: 01332 785362
  Ward Bleep – 3412
- **Queens Hospital Burton Pharmacy** Tel: 01283 511511
  Ext 5169

- **Derby City Drug and Alcohol Treatment Services** Tel: 0300 7900265 /Option 1
- **Ilkeston Drug Treatment Service** Tel: 0115 9309442
- **Ripley Drug Treatment Service** Tel: 01773 744594
- **Derbyshire Alcohol Treatment Services** Tel: 0845 3084010
- **Burton Treatment Services -** Tel: 01283 741053 (Humankind – Staffordshire service)
- **Staffordshire Treatment Services -** Tel: 01283 537280 (BAC O Conner rehabilitation centre)
- **Aquarius Family Drug and Alcohol Safeguarding Service –** Tel: 0300 7900265 Option 3.

10. Monitoring Compliance and Effectiveness

Monitoring requirement	All health records of women who have delivered with a history of substance misuse. Criteria as set by service specification.
Monitoring method	Retrospective casenote review
Report prepared by	Specialist Midwife in Drugs and Alcohol
Monitoring report sent to:	Maternity Development Committee
Frequency of report	Annually

11. References

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www.isciencetimes.com)

University Hospitals of Derby and Burton
NHS Foundation Trust

Appendix A

Referral to Pregnancy Drug and Alcohol Service

ANC Royal Derby Hospital Uttoxeter Road Derby DE22 3NE
Tel: 01332 786749 / 07799337678 / 07917650845

Mother's Details Hospital Number: | | | | | | | | |

Name: _____

Contact ID: | | | |

Address: _____

_____

Postcode: _____ Tel No: _____

Date of Birth: __/__/____ Ethnicity: _____

GP: _____

Address: _____

Tel No: _____

Consultant: _____

Primary Care Midwife: _____ Tel No: _____

Hospital booked for birth: _____ EDD: __/__/____

Referred by: _____ Date: __/__/____

Date of Initial Contact __/__/____

Current Substance Use:

	Route	Amount	Frequency
Substance 1			
Substance 2			
Substance 3			

Ever Injected: Yes/ No

Accessing drug treatment services Yes/No

Accessing Antenatal Care Yes/No/Occasionally

Number of children: __ Living with client: __ In Care: __Elsewhere: __

Tests for Blood Bourne viruses

HIV: Yes/No Pos/Neg

Hep B: Yes/No Pos/Neg

Hep C: Yes/No Pos/Neg/NA

Other Involved Agencies (please list name and contact number)

_____

_____

_____

_____

Comments:

Is Client aware of referral? ☐ Yes
☐ No

Printed name: _____ Signed: _____

Position: _____ Date: _____

Anaesthetic considerations

Type	Drug name	Anaesthetic considerations
Opioids	Methadone	**Early IV access to be secured when difficult access is identified – in this case an anaesthetic referral will have been made during the antenatal period.** Avoid the use of cyclizine when treating methadone users as it has psychoactive effects and potentiates the effects of methadone. Do not attempt to withdraw perioperatively; continue maintenance dose. Central line may be needed for IV access. Analgesia; maximise regular simple analgesics including the use of IV paracetamol and local blocks. Pethidine, Morphine PCA / nurse-controlled analgesia may be needed – suggest subcutaneous (not IV) route.
	Buprenorphine	Continue usual dose of buprenorphine. It has a 'ceiling effect' so increasing the dose may not give any extra pain relief. Avoid other opioids, including intrathecal or epidural opioids Anaesthetist will try to maximise use of local anaesthesia, e.g., epidural 0.25% bupivacaine boluses, TAP (transversus abdominis plane) blocks Maximise use of non-opioid analgesia, e.g., regular IV paracetamol, regular NSAID, consider nefopam Once an opioid analgesic has been given it is necessary to wait at least 2-8hrs before giving buprenorphine. If taken too soon it may cause acute opioid withdrawal. This is caused by the high affinity of the buprenorphine displacing other opioids from opioid receptors but having less opioid activity. This acute withdrawal typically occurs within 1-3hrs after having taken the buprenorphine. Severe respiratory depression can occur when benzodiazepines are given with buprenorphine, do not use unless the patient is already on a long-term dose.
	Codeine, Tramadol, Diamorphine, Pethidine,	Do not attempt to withdraw perioperatively; continue maintenance dose. Follow normal analgesia pathway, maximising use of non-opioids. Consider the use of IV paracetamol. If they require opioids, give in the usual dosage and frequency; however, be prepared to increase the dose due to their increased tolerance of opioids. During this time continue their maintenance medication as prescribed.

Benzodiazepines	Diazepam Temazepam Lorazepam	After acute intake, reduce dose of IV induction agents, reduced MAC of volatile agents, opioids may cause prolonged respiratory depression. Treatment with flumazenil may provoke seizures in chronic benzodiazepine abusers. Withdrawal may lead to increased requirement for IV induction agents and volatile agents.
Solvents	Glues Gases Aerosols	After acute intake, MAC reduced, but risk of arrhythmias so avoid light anaesthesia and catecholamines.
Stimulants	Cocaine (including crack cocaine), Amphetamines, Ecstasy	Chronic use can lead to a profound effect on a patient's cardiovascular stability during anaesthesia and surgery. After acute intake; delay anaesthesia if possible. Control BP and heart rate with esmolol, or labetalol + GTN. Treat chest pain with GTN, verapamil, + phentolamine. Control agitation and seizures with benzodiazepines. Avoid propranolol, adrenaline and atropine. If anaesthesia cannot be delayed. Regional anaesthesia: beware cocaine-induced thrombocytopenia, combative behaviour, altered pain perception (pain despite apparently adequate block – requiring opioid supplements), and BP changes: □BP from vasoconstriction or ephedrine, or ↓BP from arrhythmias, myocardial dysfunction, haemorrhage, or the regional block itself. Hypotension may also be ephedrine-resistant, so titrate a low dose of phenylephrine. GA: monitor arterial BP, CVP, and temperature. Expect increased MAC and CVS instability. Use generous analgesia. Avoid halothane, ephedrine and Doxapram. Treat hyperthermia with muscle relaxation, cool fluids, paracetamol, and dantrolene if necessary. ITU required.
Hallucinogens	LSD, Cannabis, Ketamine ('Special K')	Sedatives may be required. Sympathetic effects → exaggerated responses to catecholamines. Atropine → worse sympathetic effects, + hallucinations
	'Magic' mushrooms	Watch for seizures, psychosis, and renal failure. Sedatives may be required.

Effects of maternal drug abuse on the fetus and new-born infant

Drug	Possible Effect(s) on Fetus	Possible Effect(s) on Baby
Opioids	Preterm and low birth weight	Withdrawal (see paediatric guidelines) Heroin – contraindicated in breastfeeding mothers.
Benzodiazepines	Low birth weight Premature delivery	Hypotonia Delayed onset / presentation of withdrawal (see paediatric guidelines) –
Solvents	Theoretical risk of reducing oxygen supply to infant	
Stimulants	**Cocaine** – Utero placental insufficiency, acidosis, hypoxia therefore increasing the risk of premature labour, placental abruption, and stillbirth.	Cocaine- Contraindicated in breastfeeding mothers. Feeding difficulties, difficult to settle.
Alcohol	Physical birth defects Intra uterine growth restriction – in particular reduced head circumference Low birth weight Premature delivery Still birth	Varying signs /symptoms of Fetal Alcohol Spectrum Disorder (FASD) Fetal Alcohol Syndrome (FAS) Potential withdrawal
Hallucinogenic	**Cannabis** - Cannabis is usually smoked with tobacco which is known to cause an increased risk of reduction in birth weight, and increased risk of miscarriage, premature labour, intrauterine growth restriction and placental abruption.	**Cannabis** - THC is found in breast milk however there is no evidence to suggest this causes harm – this does not mean it is safe. There is some evidence that there is an increased risk of night-time specific sudden infant death in households where cannabis is smoked

		NICE (National Institute for Clinical Excellence) states there is no good evidence that cannabis has a direct effect on pregnancy or the developing baby however this does not mean it is safe and WHO (World Health Organisation) suggest there could be a level of developmental delay and behavioural problems in children exposed to tobacco and cannabis in utero

Appendix D

Audit-C Test

The Alcohol Use Disorders Identification Test (AUDIT-C) is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence).

AUDIT-C	
The Alcohol Use Disorders Identification Test is a publication of the World Health Organization, @ 1990	
Q1: How often did you have a drink containing alcohol in the past year?	
Answer	**Points**
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4
Q2: How many drinks did you have on a typical day when you were drinking in the past year?	
Answer	**Points**
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4
Q3: How often did you have six or more drinks on one occasion in the past year?	
Answer	**Points**
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4
The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.	

Appendix E

Consent to share personal information

Name of child/young person ……

The service/activity this consent form relates to the Pregnancy Drug and Alcohol Service.

I understand that information is held about me/my child. I have had the opportunity to discuss what this means for me and my child.

Signature of parent (or person with parental responsibility)

..... Date .....

A copy of this form must be given to any parent signing it, and a copy placed on the child or young person's records.

Appendix F

DRUG AND ALCOHOL SPECIAL INSTRUCTIONS

Mothers Details: Hospital Number: | | | | | | | | |

Name: _____ G.P. _____

Address: _____ Address: _____

_____ _____

Tel. No: _____ Tel: No: _____

Date of Birth: _____ NHS Number _____

Details of Mothers Drug Use:

ANY EXPECTED MANAGEMENT PROBLEMS

OBSTETRIC

PAEDIATRIC

ANAESTHETIC

PRESCRIPTION DETAILS

Drug	Dose & Date	Dose & Date	Dose & Date	Prescriber	Dispensing Chemist

PROFESSIONALS INVOLVED

Professional	**Name**	**Contact Number**
Primary Care Midwife		
Health Visitor		
Social Worker		
Substance Misuse Key Worker		
Specialist Midwife		
Community Pharmacist		
Other Professional		

Appendix G

Urine Toxicology

Introduction

This information explains urine testing for illicit drugs on a pregnant woman and the benefits, limitations and risk surrounding urine testing.
Urine testing is just one of a variety of ways of identifying a woman who is in need of treatment services. Urine toxicology should never be the only reason for providing these services to a woman.

The overall purpose is to increase awareness of the importance of urine testing for illicit drugs during pregnancy and outline the aims and uses of urine testing during pregnancy. The following guidance recommends that drug testing should be done only in cases where it is absolutely necessary as it can have extremely negative effects on the woman.

Use of Urine toxicology

Urine toxicology is recommended for pregnant women in order to provide optimal and comprehensive medical care and alcohol and drug treatment, however they are only an adjunct to good history taking.
The use of urine toxicology can reduce morbidity that may result from misdiagnosis and the subsequent use of inappropriate medications, such as betamimetic tocolytic drugs for premature labour.
A toxicology test that is positive for drugs and/or alcohol, whether it is a ‘true’ positive or a ‘false’ positive may have extremely negative effects on women such as loss of child custody.

To request this test on ICM type in drugs of abuse screen. Urine testing for drugs is usually only done once a week. If urgent result required please liaise with the laboratory.

Issues of Informed Consent

There is a need to ensure that there is informed consent for urine toxicology testing. Testing a woman for illegal drugs in the absence of medical indications may be discriminatory. The woman has the right to be informed of the potential ramifications and the benefits of urine toxicology testing.
It is important to be honest and clear in communicating with the woman with regards to drug testing. All women should be informed of the planned test, the nature and purpose of the test and how the results will help and guide management.
There may be times when consent cannot be obtained because of medical considerations.
Before testing neonates, informed consent should be obtained from the mother.
Successful treatment for alcohol and other drug use depends on a positive therapeutic relationship between the patient and care givers. Informed consent helps and is an integral part of a trusting and co-operative therapeutic relationship.

Signs and symptoms of drug/alcohol use in pregnant women

Drug/alcohol use can pose various complications in pregnant women for both them and their baby so it is important that clinicians are looking for clinical and historical clues that may indicate the possibility of drug/alcohol use. There are various signs and symptoms to be aware of that may indicate whether testing is needed in order to provide information for the health care of the pregnant woman and/or newborn. Symptoms can be found physically, behaviourally or medically in the woman.

The following are indications used by some organisations to screen a pregnant woman for drug use:

- History of alcohol and other drug use.
- Loss of custody of other children.
- No prenatal care.
- Altered mental state (e.g., incoherent, unconscious, lethargic, combative)
- Preterm delivery, preterm labour, premature rupture of membranes.
- Third trimester vaginal bleeding (e.g., placental abruption).
- Physical evidence of alcohol and other drug use (e.g., track marks).
- Signs and symptoms of intoxication or withdrawal.

A pregnant woman who is known to be using drugs, through self-report or positive toxicology results, should be treated for any acute medical condition and referred for alcohol and other drug treatment. In addition, a positive history of drug use or urine toxicology may suggest the need for a newborn toxicology screen which may be ordered and obtained after delivery. In a newborn, a positive toxicology for non-prescribed drugs suggests that a social work assessment should be done if it has not already been completed.

References

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Appendix H

INFORMATION FOR STAFF

Methadone

Key Points for Clinical Practice

Pharmacology of Methadone

Methadone is an opioid. It acts in a similar way to morphine but is less sedating and much longer lasting. 'Once daily' methadone should not be administered within 24hrs of the previous dose as this may result in overdose of the patient (potentially causing respiratory depression or even death). However, during pregnancy women may choose to split their full dose and take half of it twice daily. Due to physiological changes postnatally, women may need to decrease their methadone dose.

Common Side Effects of Methadone

- Nausea / vomiting
- Respiratory depression
- Constipation
- Sedation
- Biliary Spasm

See BNF for full list of side effects.

Signs of Opioid Withdrawal

- Sweating
- Yawning
- Feeling hot, cold, feverish
- Anorexia and abdominal cramps
- Nausea, vomiting and diarrhoea
- Tachycardia and hypertension
- Insomnia and restlessness
- Increased bowel sounds
- Gooseflesh
- Dilated pupils

Analgesia and Drug Users

- **Avoid the use of cyclizine when treating methadone users as it has psychoactive effects and potentiates the effects of methadone Methadone users still require analgesia as well as their maintenance medication**.
- Treat their addiction and pain separately.

- Follow normal analgesia pathway, maximising use of non-opioids. Consider the use of IV paracetamol.
- If they require opioids, give in the usual dosage and frequency; however, be prepared to increase the dose due to their increased tolerance of opioids. During this time continue their maintenance medication as prescribed.
- As a general principle, we try to avoid the use of IV PCA in this group of patients, but it is also important to ensure they do receive adequate analgesia. If morphine PCA *is* needed, the anaesthetist may wish to increase the bolus time from 'stat' to 1 minute, and may even consider giving PCA subcutaneously (a larger dose at 30 minute intervals – using a higher concentration to decrease the volume) to try to avoid giving the patient a 'hit' every time they press the button. Total doses given may need to be higher than usual.

Opioid Dependent inpatient on Maintenance Treatment

- Continue maintenance medication whilst in hospital, but first:
  - Confirm maintenance dose on admission
  - If no proof of dose, contact prescriber (GP or Bradshaw Clinic 01332 221700) or community pharmacist
  - Inform usual prescriber or pharmacist that the patient has been admitted
  - If possible, check when last dose was taken
- Inform anaesthetist of maintenance drug especially if buprenorphine
- Do not add benzodiazepines but continue if confirmed long-term prescription
- On discharge, inform prescriber in advance so regular prescription can be started.

Discharge from Hospital

- Inform treatment agency well before discharge
- Arrange for restarting of former prescriptions
- Inform of any changes in prescription
- Make sure patient understands follow-up arrangements

Remember:

- In order to administer methadone in a punctual manner, timely ordering of the controlled drug needs to be initiated.
- A baby has not needed to be treated for withdrawal for 4yrs on this unit. Use the term withdrawal carefully unless diagnosed by medical staff.
- Treat the drug using patient as you would any other patient, exercising particular care about confidentiality.

References

Royal College of General Practitioners (RCGP). *Guidance for the use of methadone for the treatment of opioid dependence in primary care*. (July 2005).

Department of Health*. Drug Misuse and Dependence-Guidelines on Clinical Management.* London (2007).

Hidden harm: responding to the needs of children of problem drug users. *A* report by the Advisory Council for the Misuse of Drugs*.* London: HMSO, 2003.

British National Formulary

INFORMATION FOR STAFF

Buprenorphine (Manufacturer's name: Subutex)

Key Points for Clinical Practice

Buprenorphine is an opioid drug, and a licensed alternative to methadone. It produces pain relief, and a depressant effect on the body, similar but not identical to morphine, heroin (diamorphine) and methadone. Compared with morphine, it takes longer to work, and lasts for a longer time.

Although Buprenorphine is an opioid, it also blocks the effect of other opioids such as heroin, methadone, morphine, pethidine, and codeine. Therefore, if the above-mentioned analgesics are given post buprenorphine administration they will not work well. This is particularly important when considering pain management for this clientele as alternative pain relief may be required.

The respiratory depressant effects of buprenorphine are only partially reversed by even large doses of naloxone, however, doxapram will help.

Once an opioid analgesic has been given it is necessary to wait at least 2-8hrs before giving buprenorphine. If taken too soon it may cause acute opioid withdrawal. This is caused by the high affinity of the buprenorphine displacing other opioids from opioid receptors but having less opioid activity. This acute withdrawal typically occurs within 1-3hrs after having taken the buprenorphine.

Severe respiratory depression can occur when benzodiazepines are given with buprenorphine, do not use unless the patient is already on a long-term dose.

How is it administered?

- Buprenorphine comes in tablet form. It is placed under the tongue and left to dissolve; this takes approximately 3-5minutes. Buprenorphine will not work if swallowed. It should be taken as a single dose at the same time each day to help stabilisation.
- It lasts longer than morphine, typically giving pain relief for 6-8 hours.

Advantages of buprenorphine:

- Less dangerous in overdose
- Useful in maintenance and detoxification (reported as easier to withdraw from)
- Clearer head whilst on medication, less 'clouding' effect

Disadvantages:

- Can precipitate acute opioid withdrawal if used incorrectly
- Less opioid like
- More expensive than methadone

Side effects:
Similar to side effects of morphine. Drowsiness, dizziness, headache, confusion, nausea and vomiting may be seen

Management of postoperative pain in women who are already on buprenorphine: (unless this is covered elsewhere?)

- Continue usual dose of buprenorphine. It has a 'ceiling effect' so increasing the dose may not give any extra pain relief.
- Avoid other opioids, including intrathecal or epidural opioids
- Anaesthetist will try to maximise use of local anaesthesia, e.g., epidural 0.25% bupivacaine boluses, TAP (transversus abdominis plane) blocks
- Maximise use of non-opioid analgesia, e.g., regular IV paracetamol, regular NSAID, consider nefopam

References

Royal College of General Practitioners. *Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care.* 2nd Ed 2004

UK Health Departments. *Drug Misuse and Dependence - Guidelines on Clinical Management.* London: The Stationary Office 1999

Gowing L, Ali R, White J. Buprenorphine for the management of opioid withdrawal, (Cochrane Review) In: *The Cochrane Library*, Issue 2, 2004, Oxford.

British National Formulary

Sasada M, Smith S. *Drugs in Anaesthesia and Intensive Care:*
Oxford University Press

Patient Information

Methadone Maintenance Treatment and Pregnancy

A pregnant woman who uses illegal opioid drugs may possibly harm two people: herself and her unborn child. While methadone itself does not prevent all potential problems it can greatly reduce the risk of complications in the mother or child.

What advantages does methadone offer?

Illegal drug use can cause complications during pregnancy, including increasing the risk of miscarriage or premature birth. Babies born to mothers using drugs are also at greater risk of sudden infant death syndrome (cot death).

Methadone is recommended for opioid using pregnant women to help reduce the use of illegal drugs.

Other advantages are: -

1. It replaces illicit opiates enabling you to concentrate on preparing for the birth.
2. It reduces the risk of contracting HIV, hepatitis and other infections.
3. It stabilises your level of opiate use preventing the peaks and troughs of intoxication and withdrawal for your unborn baby.
4. It facilitates a healthier lifestyle including your nutrition which is so important in pregnancy.
5. It reduces medical complications both before and during childbirth.

What is the best methadone dose?

There is no single best methadone dose for pregnant women. Your dose needs to be determined for your needs, to prevent withdrawal symptoms and help to control cravings. Because of changes in your body during pregnancy, you may need to *increase* your dose at some point. This can be the case no matter how high your dose was to begin with, and it does not harm the unborn child.

Does methadone affect labour pain?

When you are in hospital, you will be given your regular methadone dose.

Although methadone is a painkiller, your body becomes used to its pain-relieving qualities. This means that you will feel pain just like any woman who has never taken methadone.

How is baby affected?

At birth, your baby may have a slightly lower than average weight. This can usually be avoided if you receive regular antenatal care and do not smoke or drink alcohol.

Some methadone does cross from mother to baby in the womb, and the infant may experience some withdrawal symptoms during the first few days after birth.

Withdrawal usually develops gradually and occasionally requires medical treatment. There is no lasting harm to the child from mother's use of methadone.

What about after the birth?

Your methadone should be continued daily as usual.

You can breast-feed your baby whilst you are taking methadone. Although methadone does pass into the breast milk, research has shown that it is too small an amount to affect or harm the child.

What else can you do?

Taking good care of yourself is vital for the health of you and your baby:

- Inform your doctor as soon as you think you are pregnant.
- Attend all antenatal appointments.
- Eat healthy foods and watch your weight.
- Stop or at least cut down on tobacco smoking.
- Don't take any drugs, vitamins, nutritional supplements, or alcohol without discussion with a health professional.

For further advice please contact: - Specialist Midwife in Drugs and Alcohol: 07799337678

Appendix J

Patient Information

Store Methadone and Medicines Safely

Keep all medication locked away out of sight and out of the reach of children.

If your child swallows METHADONE, other medication, drugs, or alcohol they could be seriously harmed or die.

As little as a teaspoon of methadone could kill a young child

Over half of the cases of poisoning in children are caused by them swallowing medicines/drugs.

Young children are naturally curious and have no understanding of danger. Young children do not know the difference between a pill and a sweet, or between medicines and drinks.

The pharmacist will supply your medications in a bottle with a child resistant lid. Some medications are provided in packets offering no resistance to children.

Child resistant lids make it hard for children to open them, but they are NOT 100% **child proof. Because of this it is** essential **to keep medicines locked away where children cannot reach them.**

DO NOT **put tablets and/or medicines in bottles without child-resistant lids.**

DO NOT **keep methadone, tablets, drugs, or alcohol where children can get hold of them.**

If you buy illicit drugs REMEMBER:

- **You cannot be sure of the strength or purity**
- **They may not be in bottles with child-resistant lids.**
- **If a child does swallow them you may not know what they have taken.**
- **Make sure you store drugs** SAFELY.

EMERGENCY ACTION

If you think a child has swallowed your medication:

- **Phone for an ambulance to get the child to accident and emergency as quickly as possible.**
- **Take the medication container (and any remaining medications) with you so the doctor knows what the child has taken.**
- **Do not make the child sick – this may make things worse.**
- **If the child is unconscious lay them on their side to make breathing easier and prevent them from choking if they are sick.**

SAFETY CHECKLIST

- **Do** lock all medicines /drugs away from children or store them safely somewhere high and out of sight.
- **Do** talk to your children about the dangers of taking medicines not meant for them.
- **Do** take old and unwanted medicines back to the chemist to be safely disposed of.
- **Do** store and dispose of all sharps and injecting equipment safely.
- **DO NOT** keep methadone in the fridge.
- **DO NOT** store unused methadone/medications
- LOCK MEDICINES/DRUGS AWAY WHERE CHILDREN CANNOT SEE OR REACH THEM

Information for Parents

Neonatal Abstinence Syndrome

Will my baby have withdrawal?

If you were using opiates (heroin, methadone, codeine, DF's) or benzodiazepines (valium, benzo's temazepam) during your pregnancy, your baby may experience withdrawal symptoms (Neonatal Abstinence Syndrome).

Withdrawal symptoms are rarely seen in babies born to mothers who have used stimulants (crack/cocaine/amphetamines) or have used cannabis.

Withdrawal symptoms may be seen in babies of mothers who have been drinking heavily during pregnancy.

Symptoms usually start 24 hours after birth and may last up to two weeks. However, it has been known for withdrawal symptoms to start a few weeks after birth especially with methadone.

If baby has shown few symptoms 4 days after birth it is unusual for withdrawal to be serious.

For this reason, you will be advised to remain in hospital with your baby for about 4 days.

How will you know if your baby has signs of withdrawal?

- Baby is difficult to settle
- High pitched cry
- Tremor or twitching
- Difficulty in feeding
- Diarrhoea and vomiting

What you can do to help your baby

Help your baby to feel comfortable, safe and warm.
Keep the baby in a dimly lit quiet environment.
Skin to skin contact can help if your baby is difficult to settle. To do this remove baby's clothes leaving the nappy in place and cuddle baby next to your naked chest - underneath your nightie. Blankets can then be placed over baby if required.
The safest place for your baby to sleep is in a cot in your room for the first six months.

Occasionally a baby may require treatment in the neonatal unit if the withdrawal symptoms are severe.

Breastfeeding

If your drug use is stable then the benefits from breast feeding for you and baby outweigh the risk of hazards to baby. For more information on breast-feeding talk to your midwife or the Specialist Midwife in Drugs and Alcohol.

Confidentiality

The withdrawal score chart for baby will be kept with the baby's notes, which are only seen by medical and midwifery staff.

(Specialist Midwife in Drugs & Alcohol: 07799 337678)

Documentation Control

Reference Number: UHDB/OBS/11:23/S6	**Version:** **UHDB Version 2**		**Status: Final**	
	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	1	November 2002	Pregnant Drug Users Working Group	New
	2	December 2009	J. McCulloch Specialist Midwife	CNST review
	3	November 2012	J. McCulloch Specialist Midwife	3 yearly review
	4	October 2015	J. McCulloch Specialist Midwife	3 yearly review
	5	June 2020	J. McCulloch Specialist Midwife	Review/update
	6	July 2020	J. McCulloch Specialist Midwife	Safeguarding amendment following an incident
	Burton Trust prior to merged document:			
WC/OG/4	2	May 2017	Laura Pickford – Specialist Midwife for Vulnerable Women	Review and update
Version control for UHDB merged document:				
UHDB	1	June 2021	J. McCulloch Specialist Midwife	Previously agreed as UHDB. To become an active UHDB site once staffing issues resolved
	2	Sept 2023	J. McCulloch Specialist Midwife	Triannual review - change from use of FAST scoring system to Audit-C scoring system
Intended Recipients: All staff caring for women during pregnancy/labour & the puerperium				
Training and Dissemination: Cascaded through lead midwives/nurses/doctors; Published on KOHA; NHS e-mail circulation list; Article in BU newsletter.				
To be read in conjunction with: Neonatal Abstinence syndrome guideline **PAED/04:12/S7**				
Consultation with:	Obstetricians & Maternity Staff			
Business Unit sign off:	03/10/2023: Maternity Guidelines Group: Miss A Joshi – Chair 19/10/2023: Maternity Development Committee -- Miss S Dixit 06/11/2023: Maternity Governance Committee / CD - Mr R Deveraj			
DQGP sign off:	21/11/2023			
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Key Contact:	Joanna Harrison-Engwell			