Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of Guideline	**Management of substance misuse in pregnancy**
Contact Name and Job Title (Author)	Daisy Team – Specialist Midwives
Division & Specialty	Surgery - Obstetrics
Guideline Number	**Obs 45**
Version Number	7
Date of Review	December 2024
Approving Committee(s)	Clinical Cabinet
Date of Approval	15th December 2021
Explicit definition of patient group to which it applies	Maternity patients
Abstract	
Statement of evidence base of the guideline Evidence Base (1-5)	
Consultation Process	O&G Guideline Group
Target Audience	Maternity staff
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.	

1a	Meta analysis of RCT
1b	At least 1 RCT
2a	At least 1 well designed controlled study without randomisation
2b	At least 1 other well designed quasi experimental study
3	Well –designed non-experimental descriptive studies (ie comparative / correlation and case studies)
4	Expert committee reports or opinions and / or clinical experiences of respected authorities
5	Recommended best practise based on the clinical experience of the guideline developer

Management of substance misuse in pregnancy
Written by R El Gawly, December 2001, reviewed December 2004. Extended until December 2008 pending a reorganisation of local services.
Rewritten by Caroline Grundy May 2009. Extended in May 2012 pending review of new guidance. Reviewed and no changes needed November 2012. Updated January 2015 by Sarah Howard and Caroline Grundy. Extended until June 2018 pending service updates. Updated by Caroline Grundy July 2018
Updated by Daisy Team Midwives December 2021 (v7)

Introduction

In June 2011 the Advisory Council on the Misuse of Drugs Inquiry (ACMD) produced the Hidden Harm Document which reported:

- there are between 250,000 and 350,000 children of problem drug users in the UK - about 1 child for every problem drug user
- parental problem drug use causes serious harm to children at every age from conception to adulthood
- reducing the harm to children from parental problem drug use should become a main objective of policy and practice
- effective treatment of the parent can have major benefits for the child
- by working together, services can take many practical steps to protect and improve the health and well-being of affected children
- the number of affected children is only likely decrease when the number of problem drug users decreases

Overview

It is hoped that as a result of early support and intervention, alongside positive attitudes pregnant women will feel more confident in identifying their substance use.
The purpose of this guideline is to ensure that appropriate and high standards of care are offered to all women who identify substance misuse in pregnancy.
In order to achieve this the maternity service must work in partnership with parents as well as other agencies.
A clear plan of care is required to meet both the individual needs of the mother and identify risks to the fetus and neonate. The service will need to be flexible, and it is important that the mother is involved in all aspects of care planning whenever this is possible. Ideally the mother will be offered maternity care from an enhanced model of maternity, with midwives who have specialised knowledge of substance misuse.

The objectives are to achieve stability – pharmacological, social, medical and psychological (Drug Misuse and Dependence – UK Guidelines on Clinical Management – Department of Health 2007).

Access to specialist midwifery services antenatally improves pregnancy outcome through interdisciplinary coordination, facilitative outreach and improved engagement with mainstream services (NICE 2021)

Aim

To encourage women to access maternity care and engage in treatment as early as possible and to inform women of the support offered by other services.

To provide a flexible service able to meet the individual needs of the woman and integrate care from other services.

To provide honest and accurate information to pregnant women regarding the risks and implications of substance use in pregnancy to allow them to make informed choices.

To provide holistic, non-judgemental care as this will promote optimal pregnancy outcome.

To provide a co-ordinated, multi-agency approach to care and jointly develop personalised plans of care across agencies.

To provide information and guidance to health professionals which results in the normalisation of pregnancy whilst recognising the often complex social and medical issues associated with substance misuse.

- To promote health, stability and minimise harm.
- To implement child protection guidelines when appropriate.

LOCAL AND NICE GUIDANCE FOR ANTENATAL / INTRAPARTUM AND POSTNATAL CARE IS IN PLACE FOR ALL PREGNANT WOMAN. PREGNANT SUBSTANCE USING WOMAN WILL REQUIRE ADDITIONAL SPECIALISED CARE (NICE 2021)

Antenatal care

	Action	Rationale
1.	Booking should preferably be undertaken by a midwife from the Daisy Team. If Daisy Team are unable to facilitate the booking the woman should be booked by the team midwife and referred to Daisy Team following booking. Consideration should be given to the timing of appointments as early mornings may be unrealistic. **All** women should be asked	To normalise pregnancy. To reduce clinic defaults. To provide specialist advice To encourage the woman to work

	sensitively about possible use of drugs and alcohol intake. Women should be reassured that they will not be discriminated against as a result of drug or alcohol use and that the overall aim is to provide non-judgemental care. This is essential as the engagement of women is dependant on a feeling of confidence in the services. It is important to clarify: Which drug / drugs are being used? What amount of drugs are being used, this may be disclosed in monetary terms or dosage. What is the method of drug use? This may be smoking, snorting, swallowing, injecting. It may be necessary to observe the injection site for signs of infection or damage. See information below regarding injecting and needle exchange for further information. Audit C (refer to AN risk assessment document) should be used to assess a woman's alcohol intake at booking. This should be repeated at 36 weeks. A unit calculator should be used to accurately assess the woman's alcohol intake. If ongoing alcohol use this should be discussed at each A/N contact Advice should be given regarding alcohol intake in pregnancy and the associated risks. Referral to "We Are With You" should be discussed if the woman requires support regarding her alcohol intake particularly for women who disclose they are alcohol	with the agencies involved in a positive and effective way. This client group can be vulnerable and hard to reach. Early intervention will maximise health benefits and reduce the risk to the fetus. To provide non judgemental care The safest approach is not to drink alcohol at all, to keep risks to the baby to a minimum. Drinking in pregnancy can lead to

	dependant. The Daisy Team Midwife will carry out a comprehensive assessment if accepted for care on their caseload. If appropriate and the woman is not already involved with a substance misuse agency she should be encouraged to attend as soon as possible. Self-referral is the preferred method and can be made by telephone (see contact details). If possible, this should be done at point of contact. Pregnant women will be seen as a priority. Seek further professional advice immediately if required.	long-term harm to the baby, with the more that is drunk the greater the risk. The risk of harm to the baby is likely to be low if only small amounts of alcohol consumed before knowing about pregnancy. Once pregnancy confirmed further alcohol should be avoided. Current Chief Medical Officer's Recommendations on Pregnancy and Alcohol (Popova et al 2017)
2.	On no account should a drug / alcohol **dependant** pregnant woman be told to stop using drugs or alcohol without first seeking advice from the Daisy Team, We Are With You Service or other appropriate professional. Woman should be encouraged to reduce their substance use if possible whilst avoiding withdrawal symptoms. If a woman is injecting substances, she should be strongly encouraged to use an alternative method if possible, ensuring that she is aware that she should not suffer from withdrawal symptoms. Explanations should be given regarding the risks of intravenous drug use and the need for sterile equipment. We Are With You offers a needle	Acute maternal withdrawal from some substances can cause serious complications including seizures. Too rapid a withdrawal may cause a miscarriage or premature labour. Harm reduction and health promotion are the initial priorities. Injecting drug use increases the risk of complications including transmission of blood borne virus, infections and DVT (if injects into groin).

	exchange service	
3.	Routine screening bloods should be offered, Hepatitis C antibody testing should also be offered if the woman is considered at risk and has not previously been tested. A woman should be considered at risk if they have: • Used intravenous drugs • A partner who is Hepatitis C positive or have concerns about the status of a sexual partner. (Although it is not common Hepatitis C can be transmitted by sexual contact). • Shared other drug paraphernalia such as spoons, straws etc. If Hepatitis C antibody or viral load has previously been identified, then Hepatitis C viral load testing should be offered to confirm the current status. If further counselling is required for additional screening this can be offered by the Daisy Team Midwife or at obstetric clinic. Baseline LFT should be offered to any woman with a history of hepatitis infection or excessive alcohol use. If a woman is identified as HIV or Hepatitis B e antigen positive the antenatal screening coordinator will be notified by the laboratory. If a Woman is identified as Hepatitis C positive then the specialist midwife or consultant obstetrician should be notified. An appointment will be arranged to discuss the results and referral will then be made to gastroenterology and	Overall Hepatitis C infection among injecting drug users has increased in recent years, with almost half now infected. The level of HIV infection in England and Wales among injecting drug users has increased since the start of the decade to one in 75. (H.P.A 2006). Refer to HIV and Hepatitis B guidelines and paediatric guidelines.

	paediatrician. If venous access is difficult the woman should be advised to attend the phlebotomy department and the completed blood request form provided to take with her. Substance use or positive blood results should never be discussed in the presence of a woman's partner, family member or friend without her consent. Do not assume that other people are aware.	 To maintain confidentiality.
4.	Routine antenatal care should be documented in the handheld notes and hospital notes as usual. All details related to substance misuse should be documented on Euroking. A copy of the SCRF should then be sent to the multi-agency panel for referral for Daisy Team support, (see **Maternity safeguarding SOP TW11-031 SOP 8** for further direction) Brief information may be included in the handheld notes with the woman's consent and 'Under the care of Daisy Team' should be documented at the top of the special features page (page 19) and the named midwife's name, mobile number and office telephone number should also be documented on the front of the notes. Consideration should be given to the following questions. Is the lifestyle appropriate for caring for the newborn / children? What help / services / intervention may the mother need	 To ensure that relevant information is communicated where appropriate whilst confidentiality maintained. This will highlight that they are being cared for by the Enhanced Team It should be noted that substance use in itself is not necessarily an indication for referral to social services.

	to provide good basic care? Is the environment into which the child will be discharged safe for a new-born baby, does it provide basic requirements for hygiene, stimulation or safety? Is there evidence of adequate support? If there is a partner, is he supportive? Are extended family members available to help? Is there any evidence of domestic abuse? Are there any mental health concerns? If indicated, a referral to the appropriate child protection service should be made. (Refer to Maternity safeguarding TW11-031 SOP 8 If domestic abuse is disclosed, consider referral to IDVA and refer to DA Guideline If Mental Health concerns, consider appropriate referrals – refer to Mental Health Guideline	Substance Misuse is associated with an increased risk of significant mental health issues. (NICE 2016)
5.	Advice should be given regarding diet and the importance of self-care and stability. Regular attendance for antenatal care should be encouraged.	Nutrition and self-care may be poor.
<u>Criteria for referral to Daisy Team</u> Disclosed Current Drug, or Dependant Alcohol Use. History of Drug or Dependant Alcohol Use. The Daisy Team can be contacted for advice regarding referrals.		
6.	Once substance use is identified consent should be obtained to refer to the Daisy Team. If consent is not given for referral to Daisy Team then the Team midwife should discuss the details with the Band 7's (Daisy	So that appropriate, multi-agency, evidence-based plan of care can be put in place.

	Team) or the named midwife for safeguarding for advice. It is essential that the yellow special circumstance referral form (SCRF) is completed and sent for consideration at the multi-agency panel for specialist midwife support. Whenever possible appointments including dating scan should be arranged at Thomas Linacre Centre on a Tuesday or Leigh Antenatal suite on a Friday as the named consultants are usually available at these clinics.	To maintain confidentiality. To identify possible child protection issues and implement appropriate intervention. To ensure they are offered the appropriate midwifery service To promote multiagency involvement and keep appointments to a minimum which reduce clinic defaults.
7.	A full initial assessment will be carried out by the Daisy Team midwife. A plan of care will be agreed between the woman, Daisy Team or team midwife, Obstetrician and substance misuse service. The Daisy Team (or if appropriate the named team midwife), will communicate appropriate information with the multidisciplinary team (including positive hepatitis and HIV results). Consent will also be obtained to liaise with wider members of the multidisciplinary team, e.g. We Are With You, probation, social care, and child protection services. If consent is not given the woman should be advised of the benefits of liaising, she should also be sensitively informed that any child protection concerns will be discussed even without consent if indicated. It should be emphasised that harm reduction and stabilisation are the priority.	To maintain effective communication and appropriate plans of care To maintain confidentiality. Share information appropriately to allow a multidisciplinary plan of care

	If appropriate the woman's partner should be encouraged to self-refer to the substance misuse service. Urine is not routinely screened for substances as this is usually done at the substance misuse service. Maternity care ideally will be provided by the Daisy Team however, if the woman declines specialist support, she will remain under the care of her team midwife, with support provided by the Daisy Team A fetal assessment scan will be arranged as normal. Serial scans should be arranged as necessary	To monitor the wellbeing of the fetus
8.	If it is appropriate an appointment will be arranged for the woman to attend the consultant clinic. Alternatively, the Daisy Team or team midwife will discuss the case with the appropriate consultant to agree the plan of care. If necessary, the consultant will refer the woman on to other specialities. Any specific instructions should be documented on the special features section and the management plan updated as appropriate in the maternal handheld notes and Euroking as appropriate.	
9.	Communication between the multidisciplinary team should be ongoing throughout the pregnancy and the plan of care reviewed and updated accordingly. A multi-disciplinary team (MDT) meeting should be considered to ensure a robust	

	plan of care is in place for delivery (see Maternity safeguarding**TW11-031 SOP 8)**	
10.	Safe Sleep should be discussed with parents during the antenatal period and ideally a home visit should be undertaken by the Daisy Team/Team Midwife or maternity support worker so sleeping arrangements can be seen and appropriate advice given. Smoking cessation should be discussed, and the woman referred to the Smoking Cessation Midwife if she is a smoker. CO monitoring should be undertaken at every A/N contact and the importance of maintaining a smoke free home discussed.	To ensure the risk of Sudden Infant Death Syndrome (SIDS) is reduced through appropriate education with parents. There is an increased risk of SIDS particularly with cocaine misuse, alcohol, and opiate misuse. Babies whose mothers smoke are four times more likely to die from SIDS than a woman who didn't smoke. (Fleming et al 2007)
11.	There should be communication with the consultant paediatrician via the Paediatric Letter by the named midwife (Appendix 1)	To ensure the paediatricians/neonatal unit are aware of the details of a baby who may need care at/following delivery or during the postnatal period. The consultant paediatrician can offer support and guidance to the named midwife

Admission and intra-partum care

	Action	Rationale
1.	A drug verification form should be commenced for all women who are prescribed substitute therapy (see Appendix 2). A new form should be commenced on every admission; it should be secured inside the front cover of the notes and filed in the relevant section on discharge. Patients prescribed benzodiazepines or substitutes should have their treatment maintained. The dose should be verified with the prescriber (i.e. substance misuse service or GP).	To prevent duplicate prescription /dispensing of medication. To ensure smooth transition of prescribing / dispensing on admission and discharge.
2.	The paediatrician should be notified when the woman is admitted in labour. If problems are anticipated the paediatrician should be present for delivery otherwise paediatric review can be carried out after delivery to exclude any problems	To allow for early assessment of newborn and early intervention if indicated. See **Neonatal abstinence SOP 28.**
3.	The obstetrician should be informed of the woman's admission but does not need to attend unless clinically indicated	The majority of labours and deliveries will be straightforward in drug and alcohol using women and their care will be similar to any other woman.
4.	If a woman attends unbooked in labour, she should be offered booking blood tests including hepatitis C if indicated. This should be treated as urgent to ensure that positive results are identified as early as possible.	Procedures which increase the risk of vertical transmission should be avoided and babies born to hepatitis B e antigen positive mothers can be given prophylaxis within 12 hours of birth

5.	If a woman using heroin is admitted and is not in treatment, then advice should be sought from the Doctor at the substance misuse service and a referral made with the woman's consent as soon as possible. If it is out of hours and withdrawal symptoms are present, then treatment may be commenced (See Guidelines for the Management of Illicit Drug Users in General Hospitals – CG13-023) Seek advice from the substance misuse service at the earliest opportunity. Managing amphetamine and cocaine dependency may be more difficult although withdrawal symptoms are less severe. Seek specialist advice from substance misuse service at the earliest opportunity. If there is use of illicit benzodiazepines again seek specialist advice from the substance misuse service. In extreme cases when the woman becomes 'agitated' diazepam can be prescribed at the discretion of the obstetrician until specialist advice obtained. DO NOT start benzodiazepine prescribing in an opiate dependant woman even if this is only intended during in patient admission.	To avoid maternal withdrawal from illicit substances.
6.	Pain relief should be given to women alongside the prescribed substitute. Any substitute medication should be given at the usual dose and time: this may be split up as it	Standard analgesia is indicated during labour as a daily dose of methadone will not provide pain relief. (Macrory 1997) To prevent withdrawal

	would at home. Medication should be given sensitively to maintain confidentiality; particular care should be taken if visitors are present.	 To maintain confidentiality
7.	The relevant agencies should be informed of the admission (including the named midwife or team). Unless otherwise indicated this can be done within normal working hours. If social care is involved, then the allocated social worker should be informed when the woman is admitted in labour and then updated when the woman delivers (see Maternity safeguarding SOPTW11-031 SOP 8).	To ensure appropriate management of care
8.	Fetal scalp electrode or fetal scalp sampling should be avoided when Hepatitis or HIV infection has been diagnosed or is suspected.	To reduce the risk of vertical transmission.
9.	Routine care in labour should be carried out. The woman should be asked about and observed for any withdrawal symptoms she may have and treated accordingly. Symptoms may include: • Restlessness • Tremors • Sweating • Abdominal Pain • Cramps • Vomiting • Diarrhoea Withdrawal symptoms in the fetus may include:	

	• Increased fetal movements • Passage of meconium • Tachycardia or bradycardia • Reduced baseline variability • Absence of accelerations	
10.	If a woman requires elective caesarean section, then the details should be discussed with the anaesthetist and the morning dose of methadone should be administered before going to theatre.	
11.	Naloxone should not be administered to the baby of women using prescribed or illicit opiates. If there are resuscitation difficulties the senior paediatrician should be called.	Naloxone is an opiate antagonist and may cause an abrupt withdrawal
12.	Breast feeding should be encouraged as long as there is stability and unless otherwise contraindicated. Advice can be obtained from medicine management. Information should be given which allows an informed choice to be made and the woman should be supported in her decision. Contraindications to breastfeeding include: • HIV positive women. • Chaotic or heavy use of any substance. This is particularly relevant with heavy use of stimulant drugs such as cocaine or crack cocaine (because of vasoconstriction	Drug misuse and dependence, UK guidelines on clinical management (2007).

	effects), cannabis, excessive alcohol intake, or use of large amounts of benzodiazepines (due to sedation effects), codeine and tramadol • Women prescribed more than 80ml methadone, (although this is not an absolute contra indication. The baby should be observed for sedation and advice given as appropriate). Any other concerns should be addressed on an individual basis and advice given accordingly. Medication should be taken following breastfeeding and if possible, in a single dose prior to the baby's longest sleep period.	Plasma concentrations are highest for up to 2 hours after dose and feeding is best avoided in this period.

Postnatal care

	Action	Rationale
1.	Ideally mother and baby should be transferred to the post-natal ward together unless otherwise medically indicated or there are child protection concerns which necessitate separation/ concerns re mother's presentation etc When required the baby should be admitted to the neonatal unit with full explanations given to the mother. (see Child Health Neonatal Abstinence Syndrome guideline CG14-048) and Neonatal Abstinence SOP 28)	
2.	Appropriate agencies should be informed of the delivery and any relevant issues / complications.	To ensure effective communication with the multidisciplinary team
3. .	Symptoms of neonatal abstinence are most common in the first 72 hours although they can be present after this time.	Withdrawal symptoms can vary and are not always predictable.

	Support should be offered and mothers should be encouraged to stay in hospital for **AT LEAST** 72 hours and until the baby is stable and feeding is established. The River Score should be completed and documented on the appropriate form. This should ideally be commenced within the first hour of birth – refer to Neonatal Abstinence (Maternity) TW19-048 SOP 28 Mothers should be supported in caring for their baby, if they are showing signs of withdrawal, light swaddling and cuddling often help although clear advice should also be provided about safe sleep. A quiet environment with minimal stimulation may also assist with the management of symptoms. Seek paediatric advice regarding discharge as per SOP 28.	Even if babies do not require treatment they may show some signs of withdrawal.
4.	Thromboprophylaxis should be offered to women who have a history of injecting into the groin.	To reduce the risk of postpartum thromboembolic events
5.	Babies of Hepatitis B, C or HIV positive mothers should be treated as per individual neonatal policies.	To reduce the incidence of vertical transmission.
6.	Contraception should be discussed and if appropriate provided prior to discharge.	To reduce any unplanned pregnancies.
7.	The verification form (Appendix 2) should be completed and filed on discharge.	To prevent duplicate prescription /dispensing of medication. To ensure smooth transition of prescribing / dispensing on discharge.
8.	If the baby is discharged home with the mother then the midwife and health visitor must be made fully aware of the discharge and	So that appropriate advice and support can be offered.

	the history.	
	It is essential to confirm discharge arrangements and discharge meeting requirements. A pre discharge meeting should take place for all cases on a child protection plan/ or at social worker discretion for child in need cases.	Withdrawal symptoms may only start several days following delivery particularly benzodiazepines and occasionally methadone.
	The team midwife should liaise closely with the Daisy team midwife, health visitor and any other relevant agencies as indicated.	
	The Daisy Team or team midwife will offer personalised post natal care dependant on the woman's need	
	Extra support may be required and visits should be arranged to meet the woman's individual needs.	
	Safe Sleep should be discussed again during the time mother is an inpatient and again at the first postnatal home visit. The Safe Sleep Assessment should be completed in the Child Health Record and documented in the post natal notes. This should be revisited during the postnatal period prior to discharge and documented in the hand held record.	To ensure the risk of Sudden Infant Death Syndrome (SIDS) is reduced through appropriate education with parents. There is an increased risk of SIDS particularly with cocaine misuse and opiate misuse and alcohol misuse.

References

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Process for audit

There are no specific audit criteria for this guideline but it will be audited as required dependant on clinical indications.

Contact Details

Title Name	Agency / Base	Contact telephone number
Daisy Team	Boston House Frog Lane Wigan	01942822772
Named Midwife safeguarding WWL Sharon Heap	Safeguarding Office, Christopher home WWL	01942 822821
Head of Safeguarding WWL	Safeguarding Offices Christopher home WWL	01942 778782
We Are With You (Substance misuse service)	Addiction Rehabilitation Centre Coops Business Centre Dorning St Wigan	01942 487578
Social Care	See Notes or alert for named social worker. Children's Social Care Duty team Social care Out of hours team Adult social care	 01942 828300 01942 828777 01942 828777

Appendix 1 – Paediatric Referral

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

STRICTLY PRIVATE AND CONFIDENTIAL

Address

Direct Line:
Mobile:
Email:

Date:

Dear Dr Zipitis/Neonatal Secretaries

Re: Unborn Baby of
Hospital No:
NHS No:
EDD:

History and Risk Factors

Maternal Medication

Professionals Involved

Safeguarding Plan

Yours Sincerely,

Cc: Via email:
Dr Zipitis (Consultant Paediatrician) Christos.S.Zipitis@wwl.nhs.uk
Paediatric Secretaries: Margaret.H.Lindley@wwl.nhs.uk and Anne.Gur@wwl.nhs.uk
Upload to Euroking

Appendix 2

CHECKLIST FOR VERIFICATION OF PRESCRIBED DRUG REPLACEMENT TREATMENT

(A new form should be used for each admission)

NAME . HOSPITAL NO .

DATE OF ADMISSION		
Verified prescription on Admission - verify with We Are With You – or pharmacy Date .	Medication . Dose .	Other information / dispensing instructions: Date Time . Signature
Prescribing agency informed of admission and dose verified with: (i.e. GP / We are with You)	Agency . Person informed . Contact no. .	Informed by . Date Time . Signature .
Dispenser informed of admission	Pharmacy . Person informed . Contact no. .	Informed by . Date Time . Signature .
DATE OF DISCHARGE		
Prescribing agency informed of discharge	Agency . Person informed . Contact no .	Informed by . Date Time . Signature .
Dispenser informed of discharge	Pharmacy . Person informed . Contact no. .	Informed by . Date Time . Signature .

Secure form inside front cover of notes and file on discharge