GUIDELINES FOR THE CARE OF THE PREGNANT ALCOHOL/ILLICIT DRUG USER

This policy should be read in conjunction with
Worcestershire Mental Health Partnership NHS Trust Policy Data

Unique Identifier: CP0089

Ratified by: Governance Committee

Ratification Date: 22nd September 2008

Review Interval: Three Years

Version Update: 

Review Date: September 2011

Owner: Chief Operating Officer

Reviewer: SMS Consultant Psychiatrist et al

Responsible Forum: Clinical Effectiveness Group

Document Type: Clinical Policy

Superseded Policy: 

Search Criteria

If printed, copied or otherwise transferred from its originating electronic file, this document must be considered to be an uncontrolled copy.

When documents are updated, notification will be circulated throughout the organisation. Policy amendments may occur at any time and you should always consult the PDF file held on the Trust’s Intranet.
1. GUIDELINE FOR THE CARE OF THE PREGNANT ALCOHOL OR ILLICIT DRUG USER
   a. Alcohol or drug abuse in pregnancy is associated with significant maternal and
      foetal morbidity. This is often further complicated by associated legal, social and
      environmental problems that can interfere with both provision of care and
      patients ability to care for her child after delivery. Therefore multidisciplinary
      team (MDT) involvement is essential in management of this at risk and
      vulnerable group. The aim of multidisciplinary team working is to provide an
      environment that is non-judgemental and supportive to minimize the risk,
      achieve optimal pregnancy, birth and parenting outcomes for each women and
      her infant.
   b. This clinical guideline is intended to support a range of health care workers who
      care for pregnant women with illicit drug and alcohol use issues. The guidelines
      are based on the best currently available evidence and local consensus.

2. PATIENTS COVERED
   This guideline specifically covers pregnant patients with illicit drugs and or
   alcohol abuse problem.

3. COMPETENCIES REQUIRED
   a. Doctors must be FY2 with Full GMC registration and above in order to be able to
      prescribe methadone or buprenorphine (Subutex). Methadone or buprenorphine
      can be administered by registered nurses/ midwives caring for opiate dependant
      patients in acute setting. If in doubt contact a senior member of staff.
   b. This guidance does not override the individual responsibility of health
      professionals to make appropriate decision according to the circumstances of
      the individual patient in consultation with the patient and /or carer. Health care
      professionals must be prepared to justify any deviation from this guidance.

4. INTRODUCTION
   a. Alcohol/ drug abuse in pregnancy is associated with significant maternal and
      fetal morbidity. This is often further complicated by associated legal, social and
      environmental problems that can interfere with both provision of care and
      patients ability to care for her child after delivery. Therefore multidisciplinary
      team involvement is essential in management of this at risk and vulnerable
      group. The aim of multidisciplinary team working is to provide an environment
      that is non-judgemental and supportive to minimize the risk, achieve optimal
      pregnancy, birth and parenting outcomes for each women and her infant, which
      can be achieved by:
- An effective system which clearly identifies the main case worker and lead consultant.
- Individualised care plan made in consultation with the women
- Timely and accurate documentation and communication
- Seamless referral system

b. This clinical guideline is intended to support a range of health care workers who care for pregnant women with drug and alcohol use issues. The guidelines are based on the best currently available evidence and local consensus.

GUIDELINE

5. CONFIDENTIALITY

a. Women should be reassured that they will receive a confidential service. However the information relevant to the pregnancy and treatment will be discussed within the MDT. The woman’s permission will be sought before speaking to anyone else.

b. Women with drug misuse problem should not be automatically referred to the social services. However if the MDT members involved with the case, have concerns about the following issues they are obliged to refer the case on to social services for assessment, which does not necessarily lead to case conference:
   - Concerns about child care provision
   - Non-compliance with Substance Misuse Service (SMS), Community Drug Team (CDT) or antenatal care
   - Concerns about life style issues on top of chaotic drug misuse e.g. no fixed abode, nutritional issues,
   - Unwanted pregnancy or other vulnerability such as learning disability or mental health issues etc.

c. If referral to social services is decided the woman should be informed first whenever possible social workers may also be able to offer supportive and practical role around housing, benefits and other social difficulties

6. ANTENATAL CARE

a. All pregnant women should be asked about personal history of drug and alcohol misuse and of their partner at the booking visit. Patients disclosing substance misuse for the first time in pregnancy and requesting help should be referred to
Turning Point (TP) for full comprehensive assessment unless the woman is already known to the substance misuse service. (TP is the referring agency and works with all drugs, whereas CDT works with substitute prescribing). GP may refer the woman to the drug worker in the surgery for initial assessment and then refer to SMS.

b. Women with current history of alcohol abuse should be referred to Alcohol Liaison Service by a midwife or other health care professionals (See below for contact numbers). Women who independently wish to address their alcohol use can self refer to Worcester Community Alcohol Team or be referred by their GP. Women attending antenatal clinic at WRH can be triage assessed and referred to Community Alcohol Team by contacting the alcohol liaison nurse on bleep 565, provided the woman has given her consent.

c. If a woman discloses illicit drug use or alcohol abuse, ask what she is using, the quantity used how often, by which route, when she last used and about financing and how much her weekly spend is on substances.

d. A specific leaflet detailing support for the woman with drug or alcohol misuse in pregnancy and its effects on pregnancy and her baby is offered by the CDT, SMS and TP.

e. A woman who is identified as an illicit drug user should be asked for her consent and a urine specimen should be checked each visit, weekly till stable and then fortnightly (by CDT) in order to confirm or exclude the presence of illicit drugs and/or methadone.

f. CDT offers a priority appointment to these women where they receive comprehensive assessment to ascertain whether they are drug dependant and informing them about options for specialist care, counselling and treatment.

g. **Multidisciplinary team approach** is ideal to provide care for the alcohol or drug dependant pregnant woman. The community midwife (CMW) will be care coordinator on most occasions. **Multidisciplinary-maternity team** should include GP, midwife, obstetrician, neonatologist, Worcestershire Substance Misuse Service (SMS), Community Drug Team (CDT) and Turning Point team member. MDT may also involve alcohol liaison service, social services and other relevant authorities if needed. MDT members should liaise on regular basis.

h. Early referral should be made for consultant booking clinic so the patient can be seen by the consultant AT THE LATEST by 16 weeks. Late referral may delay consultant review due to non-availability of urgent appointment.
i. Clear plan of care should be formulated and documented in patient hand held green notes and also in hospital notes as chaotic users may not present with their green notes so it is readily available to other health workers particularly if a woman presents out of hours. The plan should be regularly reviewed with the woman.

j. Paediatric referral should be made at time of booking and may need to be repeated with any new relevant information later in pregnancy.

k. Community Midwife should work closely together with SMS and CDT to ensure relevant information is shared at the earliest opportunity.

l. Record of every appointment and DNA in the green hand held notes.

m. The CMW & CDT will be notified if the woman does not attend for antenatal visit.

n. Women should be seen regularly by their community midwife in order to build trust and rapport.

o. A letter from the professional supplying the methadone script should be issued and a copy filed in the woman’s notes. This information is necessary to prescribe methadone/bupenorphine for the woman as an inpatient.

p. Psychosocial assessment should be performed at the booking and antenatal visit and it should include
   - financial issues
   - Housing
   - Domestic violence
   - Sexual abuse / relationship issues
   - Legal issues
   - Past history of child protection issues
   - History of mental illness (see below)

q. **Infection Screening** In addition to routine antenatal screening, screening should be offered in the first and third trimester for Hepatitis C. Screening for sexually transmitted infection (STI) should be offered for the woman and her partner.

r. The woman and her partner should be offered a visit around Special Care Baby Unit and Transitional Care Unit.
s. The CMW should discuss with the woman the length of stay required postnatally (at least 3-5 days). This should be documented in the woman’s hand held notes.

t. **Ultrasound scan** A dating scan should be offered between 8 – 12 weeks, followed by a mid-trimester detailed anomaly scan.

u. **Monitoring fetal growth** There is increased risk of IUGR in women who use illicit drugs and abuse alcohol. If there are risk factors like smoking and low BMI serial growth scan and Doppler should be offered in addition to routine measurement of symphysis-fundal height.

v. **Co morbid mental health** problems are common in drug and alcohol misusers. All health care workers involved in pregnancy care must be able to recognise signs of serious mental health problems e.g. anxiety, depression, psychosis, suicidal or self harming ideation. Mental health questionnaire should be completed at booking and situation assessed regularly in antenatal period and if felt appropriate refer these women urgently to a psychiatrist. Ensure woman is safe while awaiting consultation. (PERINATAL MENTAL HEALTH GUIDELINE) WHAT OBS074

w. **Oral health:** There is some evidence that periodontal disease may increase the risk of preterm birth. Oral/nasal hygiene should be encouraged and dental infection should be treated aggressively in pregnancy.

x. **Child protection issues.** If MDT members involved with the case have concerns about childcare provision or any other child has been on child protection register social services should be involved to look at the particular circumstances. If a team member learns that a child is at risk or potentially at risk of significant harm as a result of neglect, or emotional, physical or sexual abuse – then there is clear obligation to act. Unless such discussion may add further risk to the child, the woman will be appraised of the team’s concern and given the opportunity to discuss the issues. All procedures should also be explained to the woman. **If there are any Safeguarding concerns, a pre-birth planning meeting will be arranged.**

y. **Late Bookers** Women who present for the first time in third trimester or in labour are at a high risk of complications as a result of inadequate antenatal care and should be seen by a senior obstetrician available. IMMEDIATE SUPPORT CAN ALSO BE ACCESSED FROM THE FAMILY SERVICES PROJECT AT TURNING POINT. CONTACT CDT/ALCOHOL LIAISON SERVICE ASAP.
z. **Anaesthetic** assessment should be considered antenatally to discuss venous access and optimum mode of analgesia for labour, birth and postpartum period.

aa. **Ongoing assessment and treatment planning** should be performed at each antenatal visit AND MANAGEMENT PLAN UPDATED IN GREEN NOTES. The following issues must be reviewed:

  - Compliance with care and counselling
  - Maternal and fetal wellbeing
  - Drug, alcohol, and tobacco use (Self and of partner)
  - Socioeconomic circumstances and psychosocial issues
  - Mental health
  - (If relevant) withdrawal symptoms and dose of drugs used

bb. **Out of hour emergency presentation** – It is not unusual for pregnant women who use drugs or alcohol to present to emergency services after hours, either intoxicated, or in withdrawal or for social reasons such as violence. There are risks to maternal and fetal health from all of the above and therefore after initial assessment, delivery suite/on-call obstetric registrar should be informed. (See guideline on Management of adult opiate dependant patients for initial assessment, consent, screening and prescription)

c. Obstetric/antenatal assessment of the patient should be made by obstetric staff either in A&E or if fit to be transferred in delivery suite.

dd. Fetal heart should be monitored by performing CTG.

e. If there is history of abdominal trauma a Kliehuer test should be performed and in Rhesus negative woman prophylactic Anti-D should be considered.

ff. Ultrasound scan for fetal assessment may be required if clinically indicated.

gg. If alcohol abuse is suspected bloods should be taken for LFT. BAC (Blood Alcohol Concentration) may be performed. Observe for alcohol withdrawal.

hh. The obstetric consultant in-charge of her care should be informed (message left with the secretary along with the notes for review)) of the admission so that women are not lost to follow up.
7. INDUCTION OF LABOUR (IOL)
   a. IOL is indicated only for obstetric or medical reasons. If IOL is planned, preferably arrange for this to occur early in the day in beginning of the week. This will ensure that infant is observed closely for signs of neonatal abstinence syndrome during the week, rather than on the weekend when experienced staff and neonatal specialist may not be readily available.

8. INTRAPARTUM CARE
   a. See WRH Policy L16 for Intrapartum Care
   b. A letter from the professional supplying the methadone script will be requested antenatally and filed in the woman’s notes. This information is necessary to prescribe methadone for the woman as an inpatient.
   c. Once the woman is an inpatient, the Professional supplying the prescription of methadone/buprenorphine will be notified, to ensure that the woman is only receiving methadone/ bupenorphine from one source. Methadone/ bupenorphine prescription must be cancelled in the community.
   d. Women who are unbooked and disclose current history of illicit drug or alcohol abuse:
   e. If there are any child protection concerns, the bleep holder of maternity unit, and the on-call social worker should be notified as soon as the woman is in labour. Midwife can obtain support from the on-call supervisor of midwives for any concerns in practice.
   f. Analgesia in Labour: Women on methadone maintenance program will require additional analgesia for pain relief and pain must be assessed as a separate issue. Methadone should be given at the usual time and dose. Any analgesia can be offered to women who are receiving a methadone script. Dose of analgesic should be titrated to response, bearing in mind the tolerance to opioid developed during methadone maintenance programme. Pethidine may be ineffective in women who are on opioid or cocaine dependant, due to changes in opioid receptors. Therefore regional anaesthetic may be more appropriate and should be discussed with the anaesthetist on-call.
   g. Alcohol Abuse and Labour/ Delivery: These patients may require high levels of opiate analgesics in labour. There may also be problems with anaesthetics because of induced liver enzymes and cross tolerance to benzodiazepines.
   h. Benzodiazepines are CNS depressants and are best avoided if the woman is prescribed methadone, due to risks of enhanced CNS depression.
i. **Management of Vomiting in Labour in Women on Methadone** is a serious concern. Vomiting of methadone dose may lead to withdrawal in both mother and fetus. Withdrawal symptoms can cause fetal distress and should be avoided. It is preferable that staff have observed the vomiting, if there is doubt she should be assessed within 4-6 hours after vomiting to determine if additional small dose is required.

j. Consider antiemetics - cyclizine / prochlorperazine/ metoclopramide are commonly used in pregnancy.

k. If methadone is vomited within 10 minutes of dosing – consider giving repeat dose

l. Within 10-60min of dosing consider giving half a repeat dose

m. > 60 min after dosing – consider half a repeat dose if withdrawal symptoms occur.

n. If vomiting persists other causes of vomiting should be excluded and anti-emetics prescribed.

o. **Venous access:** Assess venous access on admission. If known IV drug user or poor veins obtain venous access early in labour as poor venous access may cause problems in emergency.

p. **Fetal monitoring:** Continuous fetal monitoring is recommended in established labour. CTG interpretation may be difficult due to effect of opiates on fetus.

q. Avoid FSE & fetal blood sampling if HIV and/or Hep C positive or if infection status unknown.

r. Routine infection control procedures should be followed.

s. Water birth/birthing pool is not recommended as alcohol/opiate and other illicit drugs slow maternal response and reflexes. Continuous fetal heart monitoring is not possible in birthing pool.

t. Not suitable for early discharge.

u. Paediatrician presence at delivery depends upon any clinical/ obstetric indication.

v. Naloxone should not be given to neonates of women receiving methadone as it may induce sudden infant withdrawal.

w. Neonate should be transferred to TCU/MBU (Mother and baby unit) with the mother unless clinical/ medical reason for transfer to SCBU/ NICU.
POSTNATAL CARE

See WRH Policy PN3 for routine Postnatal Care

1. Mother and baby should be transferred to MBU/TCU. This will reduce the amount of methadone to be ordered on the Maternity Unit. The woman and her baby do not necessarily require side room/separate toilet facilities. This may be considered for confidentiality purposes.

2. Methadone is given as prescribed, and should be as near to time taken when at home. The methadone should be administered in the office to maintain confidentiality. A glass of fruit juice/milk should be given following administration to ensure ingestion of methadone.

3. The woman should be advised antenatally that she will be expected to remain in hospital, with her baby, for a minimum of 3-5 days. This will be extended by 48 hours, if the mother is using benzodiazepines and even longer if any other existing maternal or neonatal complication. This will ensure that any signs/symptoms of neonatal withdrawal can be monitored.

4. After 3-5 days, if the full-term baby has shown no major signs of withdrawal, then he/she will not now withdraw. If however, the baby becomes ill after this time, treat as an ill baby, not as withdrawing.

5. CDT should be informed after delivery ASAP.

6. Discharge planning: A timely and thorough written discharge plan, initiated in pregnancy must be reviewed with the woman and care providers before discharge. A Methadone prescription should be requested from CDT / woman’s GP and started the day following discharge.

7. The discharge plan must take into account assessments commenced in antenatal period:
   a. parenting ability
   b. psychosocial issues
   c. mental health
   d. child protection issue
   e. SUBSTANCE MISUSE TREATMENT PLAN

8. A discharge form will be completed by hospital midwives, to ensure that relevant professionals are informed and can give on-going support. Copies of the discharge plan should be kept in woman’s notes, POSTNATAL NOTES neonatal notes and given to the woman. It needs to include the appointment dates and contact details, which are given to the woman and forwarded to community providers.
9. A **contraception** advice should be offered on discharge.

**CARE OF INFANT**

10. The baby will be transferred to TCU/MBU with mother.

11. The baby to be admitted to SCBU/NICU if clinically necessary.

**BREAST FEEDING**

a. If the mother is stable on methadone, is not supplementing with street drugs and is HIV negative, breast feeding should be encouraged. The secretion of **methadone** in breast milk is variable but it may help to reduce withdrawal symptoms.

b. However if mother is still **injecting heroin** and or is using other street drugs (e.g. **cocaine**) or is **HIV positive** breast feeding is not advisable.

c. If the woman is **Hepatitis C positive**, it will depend upon her viral load at time of delivery and hence discuss with virology department. The virus does appear in breast milk but there is not enough evidence that breast feeding increases the transmission of hepatitis C. It is essential that the woman makes an informed decision. The woman should be advised to discard the breast milk if it may be contaminated with blood such as by cracked/bleeding nipples.

d. If **alcohol abuse** continues after delivery, breast feeding should be discouraged. Alcohol abuse can cause drowsiness in the baby and may aggravate existing nutritional problems.

e. Women who are breast feeding their infant are advised to consider not drinking at all; if a woman wishes to drink alcohol she should breast feed before drinking and then wait 3-4 hours before breast feeding again. Although there is not much evidence about the effect of alcohol on the infant even low levels may reduce the milk secretion and cause poor feeding with irritability and sleep disturbances in the infant. Women advised not to bed share with the baby if taking alcohol, leaflets to be given

f. Women **abusing other drugs** who wish to breast feed needs to be reviewed by a paediatrician to discuss the potential effects on the infant and to make an informed decision.

12. All infants of dependant drug users must have observations commenced from birth using Neonatal Drug Withdrawal Chart (Appendix C). Instructions for treatment – see Guidance for Management.

13. Support mother to help with baby’s minor symptoms e.g. use of pacifiers.

14. Discuss with lead Paediatric Consultant need for baby Hepatitis B immunisation programme. Any blood-borne virus test will need informed consent from mother.
15. All babies of pregnant dependent drug/alcohol users will be offered a six week outpatient appointment by Lead Consultant Paediatrician in Worcester.

16. NEONATAL DRUG WITHDRAWAL CHARTS WILL BE KEPT IN BABY’S NOTES (NOT AT END OF COT).

THE PROVISION OF METHADONE TO OPIATE DEPENDENT PREGNANT WOMEN

17. The following information gives guidance to midwives and prescribers on the correct method of dealing with a woman’s own supply of methadone on admission or discharge, or the provision of methadone to a woman admitted without a supply of this drug. Antenatally the woman will be advised not to bring in any drug.

18. This information addresses the legal category of methadone and that supply made to registered drug users is strictly controlled.

19. Admission:

20. Women admitted with own supply of methadone

21. Women admitted without a supply of methadone

22. Women not registered as drug users with Worcestershire Community Drug Team / G.P.

23. On Admission:

24. As soon as is possible, the professional supplying the methadone prescription should be notified that the woman is an inpatient, so that the woman obtains her daily pick-up from only one source.

WOMEN ADMITTED WITH OWN SUPPLY OF METHADONE

25. Request that drug be retained on ward in Controlled Drugs Cupboard. **N.B. This is the property of the woman.**

26. Estimate volume of supply (two Midwives) and enter in back of Controlled Drugs Register. This should be retained in drugs cupboard unused until discharge. After consultation with drug agency, the disposal of a woman’s own supply of methadone may be advised. This can be overseen by pharmacist, or seek advice from Supervisor of Midwives. New supply dispensed for discharge as unsure of what own drugs contain.

27. Use ward supply of methadone once the dose has been prescribed by doctor. Notification of methadone dose, from professional supplying script in the community, will be found in the woman’s notes.
WOMEN ADMITTED WITHOUT A SUPPLY OF METHADONE

28. Dose, once prescribed, should be given from ward stock.

29. Urine drug screen should preferably be performed to confirm.

30. Inform the pharmacy which has methadone prescription details.

31. **Women not registered with Worcestershire Community Drug Team or G.P.**

32. Ascertain: Method of Administration
   i. Drug being used
   ii. Quantity used daily
   iii. Time/s of administration.

33. During office hours contact WCDT for advice.

34. Outside office hours, clinical decision by doctors on-call and to seek advice as soon as possible from WCDT.

ON DISCHARGE

35. (Refer to guideline on Management of Adult Opiate Dependent Patients – section vi under prescription details)

36. Methadone to take home will need to be arranged prior to discharge.

37. If there are any problems in relation to arranging methadone as to take home, contact one of the services below.

38. **Important Note**

39. The supply of stocks direct to patients contravenes policy.

40. Women cannot be discharged with supplies of methadone from ward stock.

41. Methadone for take home will be prescribed by a doctor and dispensed from pharmacy.

MONITORING AND TREATING NEONATAL DRUG WITHDRAWAL (NEONATAL ABSTINENCE SYNDROME)

42. The aims of managing an infant who is at risk of Neonatal Abstinence Syndrome (NAS) are to maintain normal temperature, ensure adequate sleep pattern, reduce hyperactivity, excessive crying and motor instability and to ensure adequate weight gain. Infants assessed for signs of drug withdrawal by a scoring system are less likely to be inappropriately treated with drugs and may have a shorter hospital stay. However, assessing signs of drug withdrawal involves
an element of subjectivity. The assessment chart used aims to reduce distress and control potentially dangerous signs. Treatment should be considered after other causes have been excluded; if the infant has profuse watery stools or profuse vomiting or requires tube feeding due to inco-ordinate sucking, if the infant has been persistently distressed and has been inconsolable with standard comfort measures (cuddling, swaddling or using a pacifier) since the last feed, treatment may be considered. Withdrawal from short acting opiates may occur early (under 24 hours), withdrawal from longer acting agents may occur 3-4 days after birth and poly-drug use may be associated with a delay or a biphasic pattern of drug withdrawal.

43. There is little objective evidence to support the use of any individual drug for the treatment of NAS. A number of randomised trials have been performed attempting to assess the use of various drugs in the treatment of NAS. When an opiate was used, a morphine derivative seems to be the most effective at controlling signs. When there is poly-drug usage, Phenobarbital may be more effective.

44. Chloral Hydrate may be used on an as-required basis to ease the infant’s distress over the withdrawal period. With benzodiazepine use, later withdrawal may occur and there has been anecdotal success with the use of clonazepam to treat this.

FOR THE MANAGEMENT OF NEONATAL DRUG WITHDRAWAL:

45. Monitor infants at risk of NAS by using the standard assessment chart.

46. (Guidelines for management appear with the standard assessment chart)
   a. Minor signs do not require treatment, e.g. sneezing.
   b. Withdrawal from short acting opiates may occur less than 24 hours after birth (e.g. heroin)
   c. Withdrawal from longer acting agents may occur 3-4 days after birth (e.g. methadone)
   d. Polydrug use may delay or skew withdrawal signs.

47. **Aim of treatment:** Comfort not sedation
   Infant is reviewed daily by paediatric staff

48. **Treatment plan:** Level 4
   0.04 mgs/kg morphine sulphate
   oral preparation given 4 hourly
   Level 3
   0.03 mgs/kg morphine sulphate
oral preparation given 4 hourly
Level 2
0.02 mgs/kg morphine sulphate
oral preparation given 4 hourly
Level 1
mgs/kg morphine sulphate
oral preparation given 4 hourly

49. Level reduced every 24 hours, if the infant is feeding well and settling better between feeds.

50. If the feeding and settling does not improve or profuse watery stools and profuse vomiting continue – discuss with senior paediatrician.

51. Other medication may be required e.g. clonazepam for benzodiazepine use or cloral hydrate.

52. If pharmaceutical treatment not required – the mother will still require support to help her comfort her baby – cuddling and swaddling is helpful.

53. An infant pacifier (dummy) may be necessary.

ALCOHOL/DRUGS MISUSE AND THEIR EFFECTS IN PREGNANCY

ALCOHOL

54. (Link this to RCOG guideline “Alcohol consumption and outcome in pregnancy”)

55. No completely safe level of alcohol consumption has been determined for the fetus.

56. Women should be informed to limit use of alcohol to <1 standard drink (1 UK unit=12gms) per day and if possible not to drink at all in first three months of pregnancy

57. Alcohol is known to have teratogenic effects

58. Binge drinking (>5 standard drinks at one occasion) may be particularly harmful to the fetus.

59. Advice in DoH publication, Pregnancy and Alcohol (2006): No more than 1-2 units of alcohol once or twice a week

60. Advice in Safe, Sensible, Social HM govt.(2007) is: “Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk”
61. Most effects are dose dependant and most studies have not shown any substantial effect on child development with low alcohol intake, there are concerns about long term neuro-development of the offspring.

62. Pregnant women identified as consuming risky levels of alcohol should have priority access to Alcohol Liaison Services.

63. Miscarriage in first trimester is associated with any level of alcohol consumption early in first trimester.

64. Excessive use of alcohol is linked with Foetal Alcohol Spectrum disorder and major congenital cardiac defects

65. Alcohol withdrawal occurs after 48 hours and may be a problem postnatally. Appropriate sedation can be used together with vitamin -particularly thiamine supplementation. Women may appear agitated and have difficulty caring for the neonate.

66. Alcohol abuse reduces milk secretion and problem feeding in infant

67. There is a risk of intellectual impairment in children of mothers who abused alcohol in pregnancy

**OPIATES**

Opiates are not teratogenic

Sudden withdrawal may lead to fetal distress:

- There is risk of intra-uterine growth restriction and preterm delivery
- There is higher incidence of fetal distress in labour and admission to NICU
- Risk of deficit in cognitive development of the child and behavioural problems.
- Increased risk of Sudden Infant Death(SID)
- Opiate use in pregnancy leads to neonatal abstinence syndrome(NAS)

**COCAIN**

No substitute drug is available to help with stabilisation in pregnancy.

However, sudden cessation is not associated with adverse fetal effects.

If cocaine use is stopped at anytime during pregnancy it improves the outcome.

Use of cocaine in pregnancy is associated with risk of:

- Fetal abnormalities: GU anomalies, abdominal wall defects
- Placental abruption, PPROM, Meconium stained liquor, preterm delivery, IUGR & resuscitation at birth.
- Prolong postnatal stay
- Newborn shows signs of irritability, poor feeding and abnormal sleep patterns.

**CANNABIS**

- There is no evidence that cannabis itself is teratogenic.
- Cannabis is often mixed with tobacco and smoked which is harmful for the developing fetus

**BENZODIAZEPINES**

- Benzodiazepine use should be discouraged in pregnancy and patient should be stabilised on lowest levels tolerated.
- Stopping suddenly is safe for the baby but may cause maternal convulsions
- There is some non-conclusive evidence of cleft lip/palate in the fetus with long term use.
- Newborn can experience withdrawal symptoms.
- Can cause hypotonia and feeding problems in neonate if taken immediately before delivery.
- Excreted in milk in low levels and should not cause neonatal problems

**AMPHEMATINES**

- Teratogenecity is not well documented but it appears to be associated with cleft palate.
- It causes hypertension and there is increased risk of pre-eclampsia, IUGR and still birth
- There is no drug substitute and these women should be encouraged to stop its use in pregnancy.
- These addicts are problematic and most difficult to treat.

**BARBITURATES**

- No evidence of teratogenicity
- Fetal dependence is a problem
- Acute withdrawal in pregnancy can affect the fetus and is not recommended. Gradual withdrawal can be achieved.
SERVICES THAT CAN BE USED FOR INFORMATION AND ADVICE

Worcester Community Drug Team

(C Wurmli) 01905 681460

Kidderminster Community Drug Team 01562 823211

Redditch Community Drugs Team 01527 61010

All 3CDT bases operate 9-5 Mon- Thu & 9-4 Fri

TURNING POINT ( J CRAWSHAW) 01905 724754

Pharmacist at WRH- 01905763333

Pharmacist at Alexandra Hospital 01527512067

Miss Rabia Imtiaz- consultant Obstetrician 01905763333 ext 30486 (Sec)

Dr NS Kudlur Chandrappa – Consultant Substance Misuse Services - 01905681416

Worcestershire Community Alcohol Team -

Worcester 01905 27417

Kidderminster 01562 863386

Bromsgrove 01527 870707

Alcohol liaison Nurse – 01905763333 bleep 565

(for only WRH referrals but trust-wide advice )

Safeguarding (Child protection) – Lead Nurse Catharine Whitehouse

Worcestershire Mental Health Pharmacy Team 01905 354180
CDT (COMMUNITY DRUG TEAM) TRANSITIONAL CARE LIAISON FORM

Name: 
DOB: 
Address: 

GP: 
Community Midwife: 
EDD: 

Current prescribed medication: 
Pharmacy details: 

Social services involvement YES/NO
If yes please give social worker contact detail:
Name: 
Office Base: 

Any other relevant information (i.e. other professionals involved, significant others):

Named worker CDT: 
Contact Number: 
Date: 

Please inform named key worker or relevant CDT link worker of impending discharge.
CARE PATHWAY FOR PREGNANT DRUG USERS

1. Obstetrician - Worcester Royal Hospital & Kidderminster Treatment centre - Ms. Rabia Imtiaz
   Alexandra Hospital: Individual Consultant Obstetrician the woman is booked under.

2. All pregnant women are issued with green notes from the Midwife. Enter in notes if client attends or DNA’S, nothing more due to confidentiality issues. It is important to liaise with the Midwife and green pregnancy notes issued to individual service users by the midwifery service.

3. TCU - Transitional Care Unit.

4. It is important to liaise with the allocated midwife/s
MONITORING TOOL (OPTIONAL)

<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>%</th>
<th>Clinical Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All women referred for consultant care</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>All women seen by consultant by 16 weeks gestation</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

How will monitoring be carried out?

When will monitoring be carried out?

Who will monitor compliance with the guideline?
REFERENCES


# CONTRIBUTION LIST

## Key individuals involved in developing the document

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss Rabia Imtiaz</td>
<td>Consultant Obstetrician</td>
</tr>
<tr>
<td>Dr NS Kudlur Chandrappa</td>
<td>Consultant Psychiatrist, Substance Misuse Service</td>
</tr>
<tr>
<td>Mr J F Watts</td>
<td>Clinical Director – Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mrs Judi Barratt</td>
<td>Clinical Midwife Specialist</td>
</tr>
</tbody>
</table>

## Circulated to the following individuals for comments

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr J Elias-Jones</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mr J Labib</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Miss J Meggy</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mr P A Moran</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mr M D Pickrell</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mr B A Ruparelia</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mrs J Shahid</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mr J Uhiara</td>
<td>Consultant Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>Mrs Toni Martin</td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td>Mrs E Newell</td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td>Ms K Kokoska</td>
<td>Skills Drills Facilitator (Risk Management)</td>
</tr>
<tr>
<td>Mrs F Beadle/Ms S Scott</td>
<td>Medicines Information Pharmacist, Redditch</td>
</tr>
<tr>
<td>Mr Alan Pollard</td>
<td>Chief Pharmacist Worcestershire Mental Health Partnership</td>
</tr>
</tbody>
</table>

## Members of the Guidelines Group

- D Campion: Lavender Postnatal, WRH
- S Castle: Community Midwife Team Leader, Bromsgrove Team
- M Chong: Manager – Delivery Suite, WRH
- Y Cowling: Community Midwife, West Team
- C Crompton: Team Leader, Ward 15, Alexandra Hospital
- J Farmer: Antenatal Clinic, WRH
- D Hadley: Community Midwife, WFBC
- L Haywood: Community Midwife, Evesham Team
- J Hughes: Midwife Team Leader, WFBC
- J Jefferies: Team Leader Ward 15, Alexandra Hospital
- B Kavanagh: Community Midwife Team Leader, Redditch Team
- T Meredy: Antenatal Clinic, Alexandra Hospital
- C Syers: Lavender Antenatal, WRH
- P Taylor: Community Midwife, Droitwich Team
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>L Thomas</td>
<td>Ward Manager – Central Delivery Suite</td>
</tr>
<tr>
<td>A Tilley</td>
<td>Community Midwife Team Leader, Halos &amp; Saints Team</td>
</tr>
</tbody>
</table>
Glossary:

CDT  Community Drugs Team
MDT  Multidisciplinary team
SMS  Substance Misuse Service
TP   Turning Point
GP   General Practitioner
WRH  Worcestershire Royal Hospital
CMW  Community Midwifery Service
IOL  Induction of Labour
CNS  Central Nervous System
CTG  Cardiotocography
FSE  Fetal Scalp Electrode
TCU  Transitional Care Unit
NICU Neonatal Intensive Care Unit
SCBU Special Care Baby Unit
DNA  Did Not Attend the appointment with Clinician
STI  Sexually Transmitted Infections
IUGR Intrauterine Growth Retardation
BMI  Body Mass Index
A&E  Accident and Emergency
IOL  Induction of Labour