NHS
University Hospitals Sussex
NHS Foundation Trust

Substance Use in Pregnancy

Maternity Protocol: MP015

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Guideline Reviewer:	Jo Sinclair
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Contents

1 Antenatal Care

1.1 Initial Assessment:

1.1.1 Ask all women and people in a non-judgemental way about their substance use when taking the booking history. This should be as early in pregnancy as possible. This should include use of substances and/or alcohol and whether prescribed or non-prescribed. Emphasis should be on shared care, collaboration, support, guidance and encouragement, rather than forced reduction or abstinence.

1.1.2 During the booking appointment, specific and consistent messages regarding advice and harm reduction should be applied with regard to the prevention of infection, which should be consistent with the key messages (see appendix) Women and people should be asked about their alcohol use at each antenatal contact, and a brief intervention framework used when alcohol use is identified. Evidence suggests that a brief motivational intervention reduces the number of drinks and the number of heavy drinking days during the postpartum period. (see appendix)

1.1.3 When a woman or person is no longer using drugs or alcohol but there has been exposure during pregnancy, the booking midwife should contact the Specialist Midwives or other member of the One Stop Team for advice. It is important that women and people are provided with consistent advice about any substance use (see appendix on list of substances, their effects and treatment options). It is equally important that the information given should not be loaded with exaggeration of the perceived risks of the drugs

1.1.4 Any woman or person who discloses non prescribed substance or alcohol use during any time in pregnancy or postnatally should be referred to the One Stop Clinic and the local Drug and Alcohol Service (see appendix)

1.1.5 Health professionals should be aware of an individual's mental capacity when considering information sharing and gaining valid informed consent (please refer to Mental Capacity Act 2005)

1.1.6 Inclusive and non-judgemental language should be used. The table below shows some suggested alternatives.

Previous term	Suggested term
Addiction	Dependence

Illicit use	Non-prescribed use
Substance misuse	Substance use
Neonatal withdrawal	Neonatal dependence
Street drugs	Non-prescribed drugs

1.2 Drug and Alcohol Service

1.2.1 ***In work hours***: The referrer (midwife or any other appropriate professional) should contact the duty nurse at the local Drug and Alcohol Service (see appendix)

1.2.2 ***Out of hours***: The referrer should contact the duty nurse at the local Drug and Alcohol Service when the service is next open (see appendix). The referrer should offer basic information and advice about harm reduction such as needle exchange, safe sexual intercourse, not to abruptly stop certain drugs (see appendix).Where a woman does not wish to discontinue intravenous use, it is important to discuss safer injecting technique.

1.3 Substance Use Midwives/One Stop Clinic

1.3.1 The referrer (midwife or any other appropriate professional) should contact the Substance Use Midwives by phone or email (see appendix) as soon as possible following disclosure

1.3.2 If the Substance Use Midwives are not available the referrer should contact another member of the One Stop Team (see appendix)

1.3.3 The Substance Use Midwives or member of the One Stop Team will arrange an appointment for the woman or person to attend the next One Stop Clinic, where assessment and review will take place.

1.3.4 At the One Stop Clinic the woman or person and their substance/alcohol use will be reviewed by the Substance Use Midwife and/or member of the One Stop Team and, if appropriate, a referral to a consultant obstetrician will be made.

1.3.5 If non-prescribed substance use is identified, the woman or person will be offered care in the One Stop Clinic. This will include twice-monthly antenatal appointments, home visits as indicated, support attending other pregnancy-related appointments, additional ultrasounds scans at 30/40 and 34/40 and referral to support services as required. *(April 2022: Please note it is our aim to achieve this however due to*

scanning capacity within our units this is currently not achievable, to be review with USS department within 6 months) Targeted postnatal care will also be offered.

1.3.6 Where there is non-prescribed use >37 weeks an induction of labour (IOL) should be considered. The decision for IOL will be made on a case-by-case basis. Social and lifestyle issues and challenges will be assessed alongside maternal and neonatal clinical factors.

1.3.7 The booking midwife should offer and arrange the routine scans as soon as possible by the usual referral processes.

1.3.8 Where there may be child protection issues, the appropriate documentation should be completed by the identifying health professional and referral made (please see Maternity Protocol MP012: Safeguarding Children and Child Protection)

1.3.9 The Substance Use Midwives will discuss the option of Long Acting Reversible Contraception (LARC) if appropriate, and ensure any plan is documented.

1.4 The One Stop Clinic

Women and people who use substances should be encouraged and facilitated to attend the One Stop clinic

1.4.1 Main objectives:
Provide support, information, guidance and encouragement. Early intervention may help to support the family before problems escalate, and may reduce the risks of substance use.

1.4.2 Target Group:

- Pregnant women and people with substance use issues who live within Brighton and Hove, the Ouse Valley and Mid Sussex.

1.4.3 How it Works:

- Referrals may be made via professionals when substance use is disclosed or known, or by self-referral.
- The Royal Sussex County Hospital (RSCH) One Stop Clinic takes place on the 2nd and 4th Thursday of the month between 14:00 - 16:30. There are appointment times, though the clinic also has a “drop in” component.
- At Princess Royal Hospital (PRH) the clinic is on the 1st Thursday of the month between 14:00 - 16:30.

- There is a pre clinic meeting at both sites between professionals prior to the One Stop Clinic, where information is shared confidentially.
- Women and people who are substance dependent are supported to attend the clinic on a regular basis. However, women and people who engage in brief, unsustained alcohol or substance use may attend a one-off appointment if appropriate. Re-referral may subsequently be made if necessary.
- All routine blood tests, including hepatitis C screening, and Liver Function Tests where appropriate, will be taken with the woman or person's consent following counselling at One Stop Clinic (please see Maternity Protocol MP006: Antenatal Screening: Hepatitis B). When the woman or person is 30-32/40 pregnant a neonatal and maternal/parental care plan is completed by the team and discussed with the mother or birthing parent. Copies of the plan will be added to the electronic maternity system, as will any specialist letters. If the neonate needs to be monitored for neonatal withdrawal, e.g. maternal or parental opioid use, the expected length of stay will have been discussed with the mother or parent during the pregnancy as part of the birth plan.
- If indicated, the One Stop midwives and other members of the team will provide home visits as required.

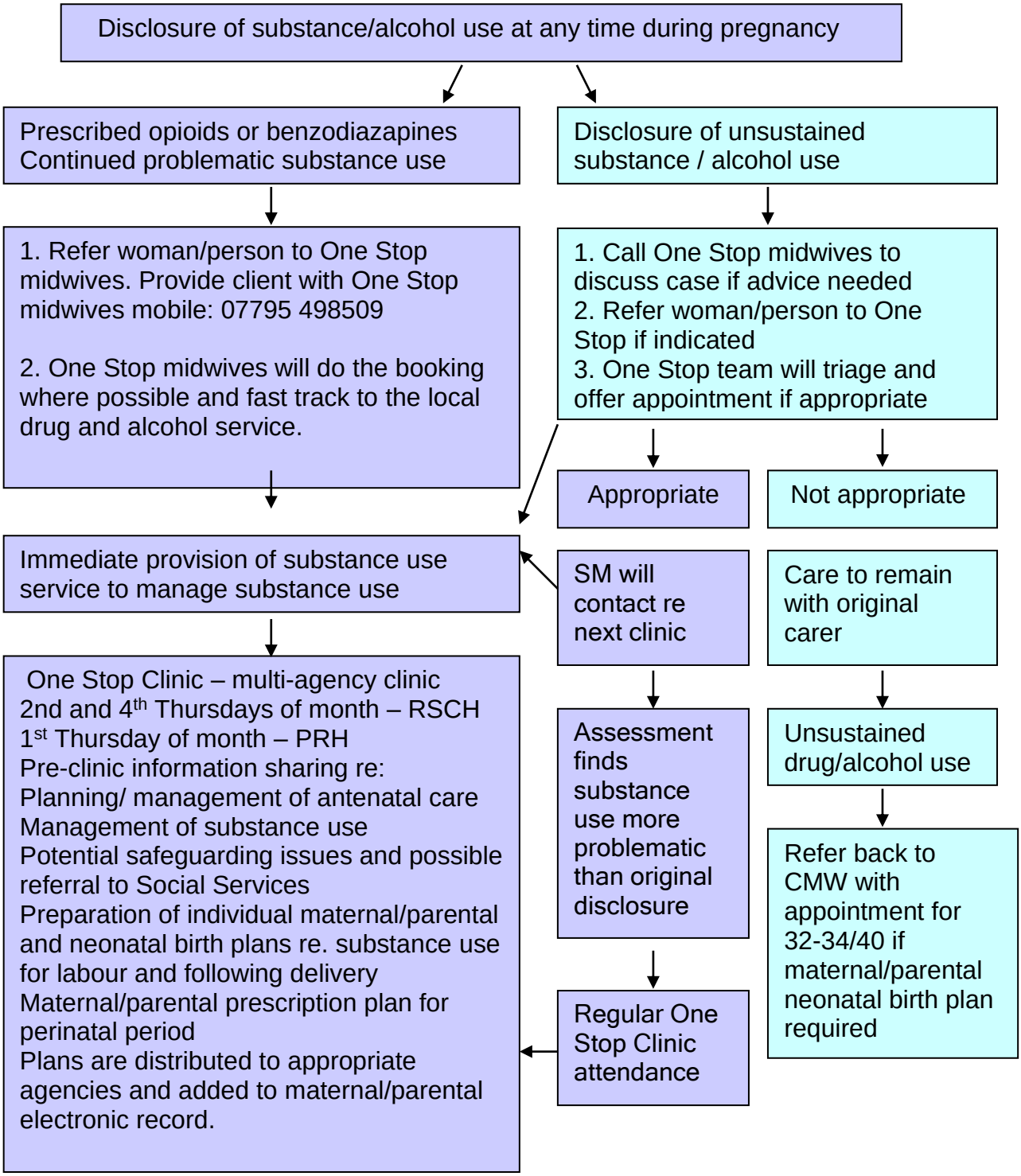
1.5 Documentation

1.5.1 Many women and people choose not to share the details of their substance use with their families.

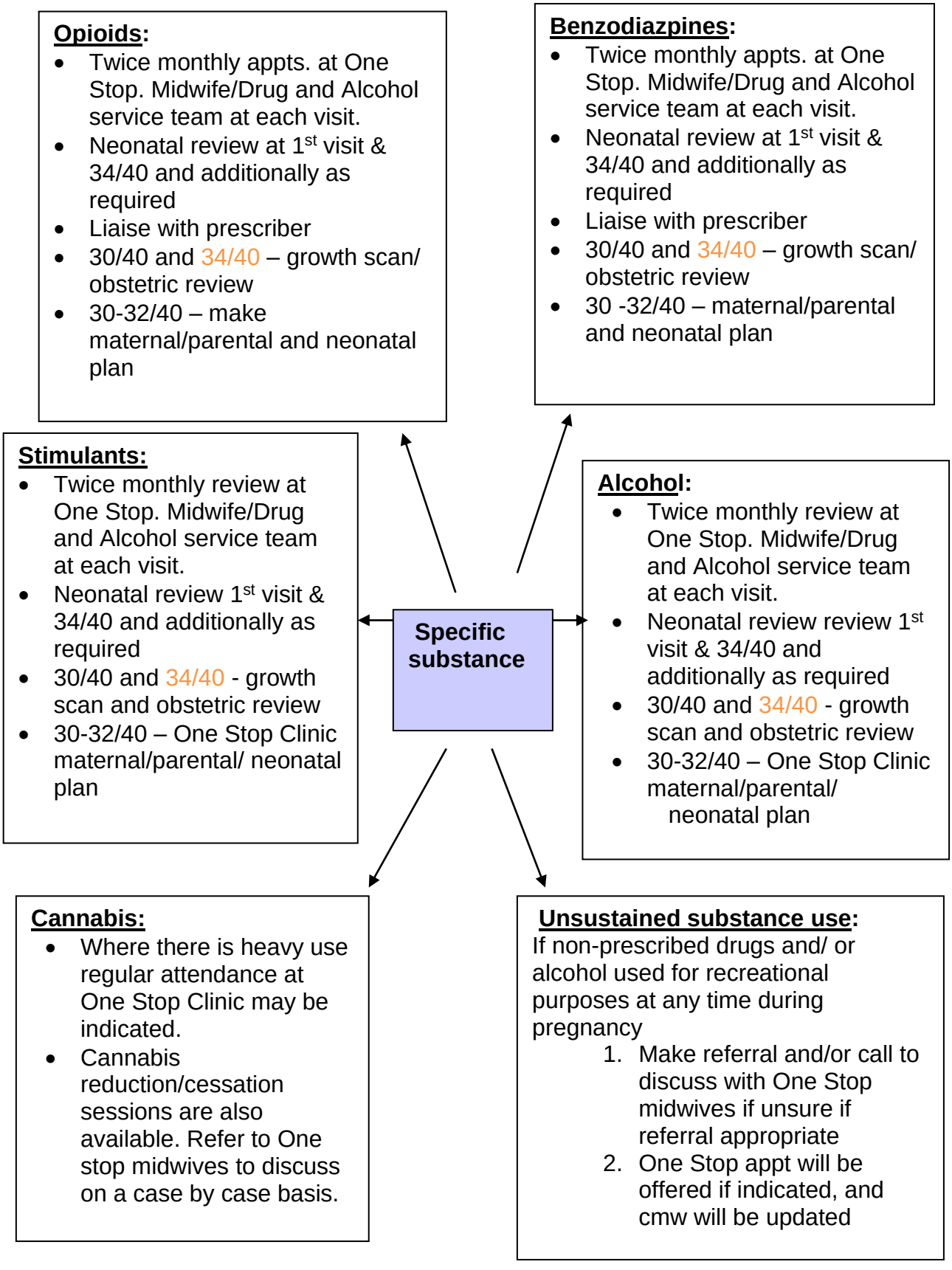
1.5.2 All issues around substance use should be documented in the electronic maternity record, but not in the woman or person's hand held electronic copy if they decline for it to be included there.

1.5.3 One Stop booking information sheets and maternal/parental and neonatal birth plans will be added to the 'Scanned Documents' section in the electronic maternity record.

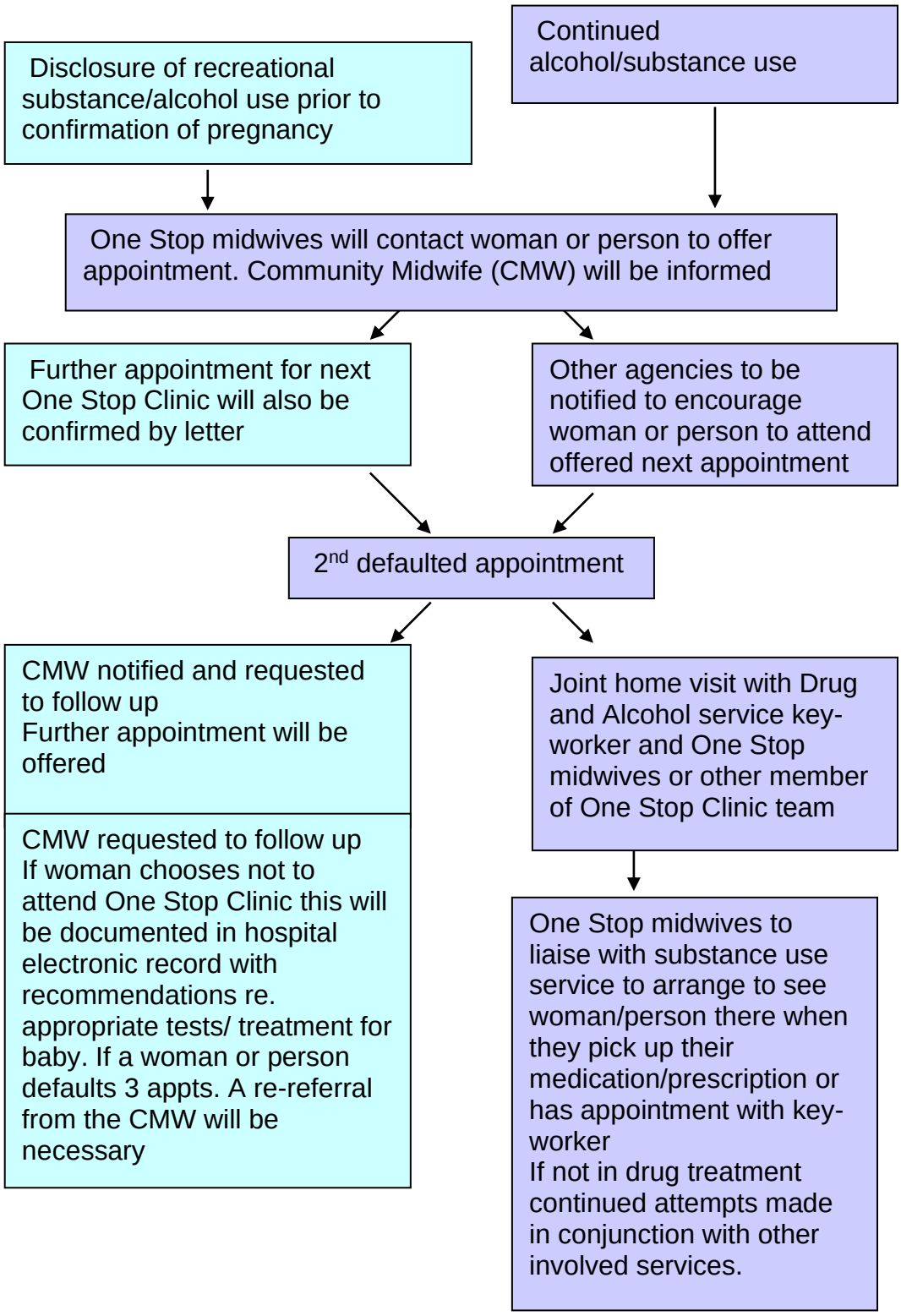
1.6 Care Pathway – One Stop Clinic



1.7 **One Stop Clinic Process regarding Specific Substances** *(April 2022: Please note it is our aim to achieve additional 34/40 USS, however due to scanning capacity within our units this is currently not achievable: to be review with USS department within 6 months)*



1.8 **Management of missed appointments**



2 Intra-Partum care

If substance use is stabilised, most pregnant women and people with substance-related issues will go on to have a normal pregnancy, labour and delivery of a term baby of normal birth-weight (Whittaker 2003, WHO 2017)

All women and people should receive the same options of pain relief as other women. Please see appendix for consideration where buprenorphine is prescribed.

2.1 A combined maternal/parental and neonatal One Stop Clinic birth plan will be in the *Scanned Documents* section of the electronic record. This plan contains important information and should be followed carefully.

2.2 If urine toxicology is requested in the birth plan this should be taken from mother/parent and/or neonate within 24 hours of birth.

2.2.1 The midwife providing intrapartum care should ask the woman/person to provide a urine specimen following birth (ideally the first void but should be within 24 hours of birth)

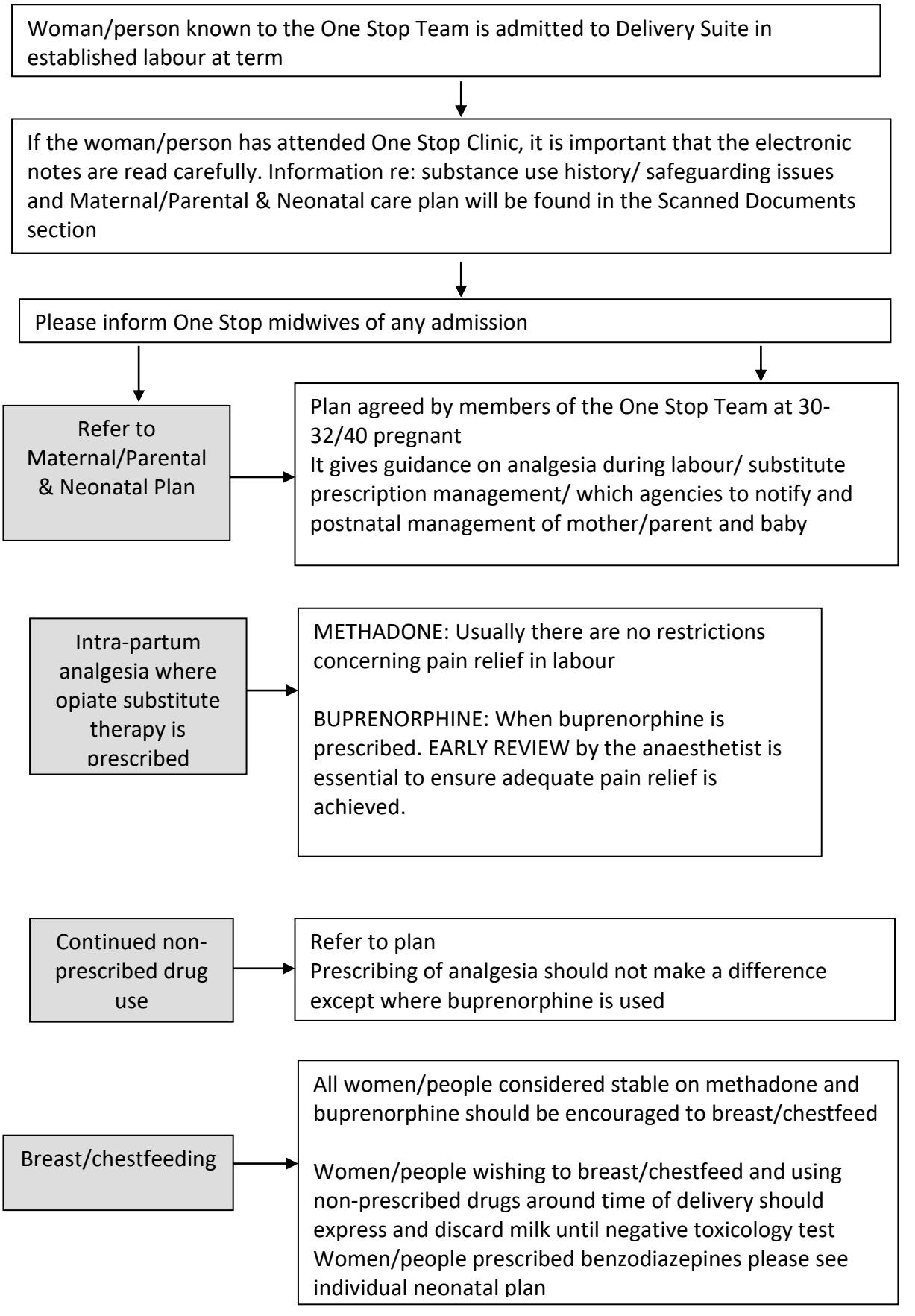
2.2.2 The midwife providing postnatal care should, with maternal/parental permission, place a urine collection bag on the baby and collect a urine specimen (ideally the first, but within the first 24hours)

2.2.3 The woman or person may refuse consent for urinalysis. If they refuse consent for the neonate's urine to be tested, the neonatologist must be informed.

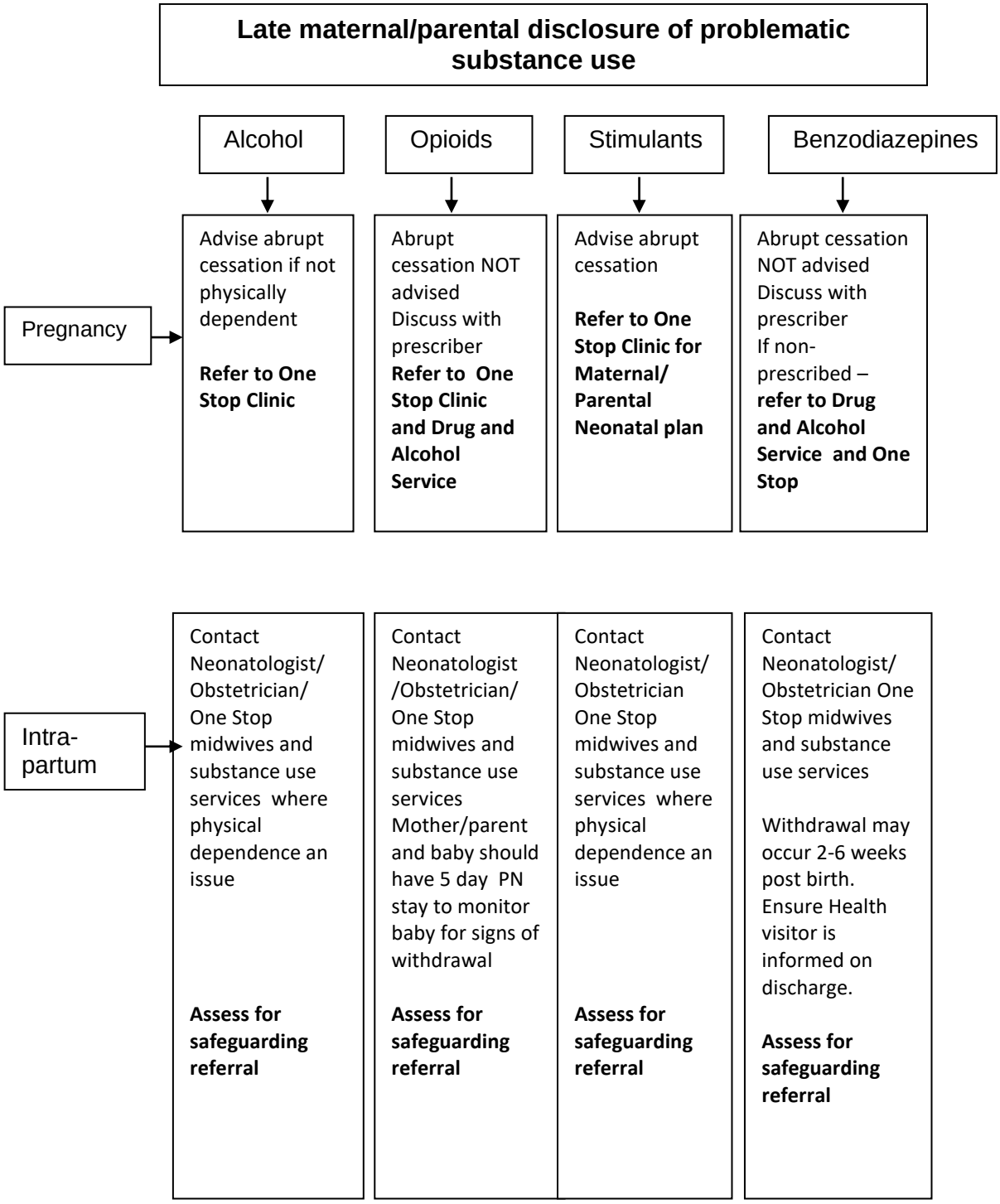
2.3 Avoid separating mother/parent and baby wherever possible. Unless stated otherwise in the child protection records, the parents may care for their baby as per routine prodecure and be transferred to the postnatal ward together.

2.4 Health professionals should consult and follow the care plan regarding breast/chestfeeding. Breast/chestfeeding should be encouraged unless there are clear contra-indications, which will be documented in the One Stop plan.

2.5 **Intra-partum care pathway for substance use:**



2.6 Disclosing drug use for the 1st time on admission to hospital:



2.7 Disclosing drug use for the 1st time on admission to hospital (antenatal & postnatal):

2.7.1 Admitting health professional should inform neonatologist, obstetrician and the Substance Use Midwives as soon as possible.

2.7.2 Following birth, send urine of either mother or birthing parent and neonate to lab for toxicology, so that decisions can be made about breast/chestfeeding. Consent for toxicology must be obtained. If consent is refused for neonate's urine toxicology, discuss with neonatologist.

2.7.3 Until lab results are obtained, encourage woman or person to express and discard human milk if they want to breast/chestfeed.

2.7.4 Keep mother or birthing parent and neonate together unless there are significant and objective concerns regarding the mother or birthing parent's ability to provide safe and adequate care.

2.7.5 Health professional providing care to contact Drug and Alcohol Service (see appendix)

- Give details to the Drug and Alcohol Service about the woman's reported substance use so that they are able to advise the about methadone starting dose. The normal starting dose is 30mgs daily, which is titrated accordingly.

2.7.6 Health professional providing care to contact Manager on call if appropriate.

2.7.7 Inform safeguarding midwife of admission if indicated.

3 Post-natal Care

3.1 Although parental problem alcohol and substance use affects families, research evidence does not support the assumption that parental substance use will automatically lead to child neglect or abuse. (Scottish Executive 2003) However, these families may need considerable help, reassurance and support during the postnatal period, as the stress of being a new parent may cause them to be more vulnerable to lapse/relapse.

Children of parents who use non-prescribed drugs and alcohol are more likely to be at an increased risk of adverse life experiences and poor outcomes. Recent evidence suggests that psychosocial interventions that not only target the primary symptoms, but also consider the person's situation from a societal and familial perspective (such as motivational interviewing and parent skills training) may be effective in reducing parental substance use at both short-term (6-month) and long-term (12-month) follow-up (McGovern et al, 2021. Cochrane Review)

3.2 Midwife providing postnatal care to ensure that obstetricians and neonatologists are aware of mother or birthing parent and baby.

3.2.1 Midwife providing postnatal care to liaise with specialist midwives and safeguarding midwife regarding substance use and any potential child protection issues.

3.2.2 If the woman or person is known to the One Stop Clinic team, midwife providing postnatal care should refer to the neonatal and maternal and parental care plan in the notes.

3.2.3 Midwife providing postnatal care should check with plan to ascertain whether baby needs to be monitored for neonatal abstinence syndrome.

- Where there has been maternal/parental use until the time of birth, babies may require observation for signs of neonatal abstinence syndrome.
- See Appendix for Neonatal Abstinence Scoring System chart

3.1.5 Any child protection concerns should be documented (please see Maternity Protocol MP012: Safeguarding Children and Child Protection).

3.1.6 Breast/chestfeeding advice is usually given on an individual basis. The huge benefits of breast/chestfeeding should not be ignored, but must be balanced against any particular risks. Therefore, refer to individual care plan.

3.1.7 If the woman or person continues to use alcohol or non-prescribed substances refer to birth plan and discuss with member of One Stop Clinic team.

3.1.8 Women and people who are considered stable and on Opioid Substitution Therapy should be encouraged to breast/chestfeed. Because methadone decreases slowly in the neonate's blood, the onset of any withdrawal symptoms will be slower (usually not until 24 – 48 hours after the birth) and more predictable.

3.1.9 The midwife providing care should contact the outreach contraception service ASAP, so that the outreach nurse can attend and discuss options with the woman or person before discharge.

3.1.10 Women and people who have used non-prescribed substances around the time of delivery should be encouraged to express and discard breast/chest milk until the laboratory reports are considered safe for them to breast/chestfeed

3.3 Prior to discharge the midwife providing care should:

3.3.1 Check with the neonatologist that the baby has had a cranial ultrasound scan where there has been maternal/parental stimulant use, i.e. cocaine, or alcohol use at any time during the pregnancy.

3.3.2 The midwife providing postnatal care should check that the Hepatitis B immunoglobulin for the baby was discussed with the mother or birthing parent during pregnancy. Where there is consent for the neonate to receive immunoglobulin – discuss with neonatologist who will arrange the vaccination and follow up (please see Maternity Protocol MP006: Antenatal Screening: Hepatitis B)

3.3.3 Contact the neonatal secretaries prior to discharge from hospital to arrange future appointments for babies to attend the One Stop Clinic for follow up and to complete vaccination programme.

3.3.4 Contact Drug and Alcohol Service this depends upon where the woman or person lives (see appendix)

3.3.5 If the woman or person is prescribed Opiate Substitution Therapy (methadone or buprenorphine) ensure that the community prescription is recommenced on discharge. This is arranged by contacting the Drug and Alcohol Service (see appendix) and asking them to re-start the community prescription. They will then contact the community pharmacy. This must be completed prior to discharge, so that the prescription is ready for collection on the day following discharge. The Drug and Alcohol Service will then make a follow up appointment with the client.

3.3.1 Aim for a timely discharge so that the woman or person is able to receive the next dose as prescribed. If this is not possible (for example, if out of hours / unable to contact the Drug and Alcohol Service and/or Pharmacy or they are unable to re-start the prescription in time) consider other options before discharge without OST in place. Suggested options to consider:

- Remain as in-patient until after next dose

- Remain as in-patient overnight to receive morning dose prior to discharge
- Bring forward dose by up to 4 hours if this means that the woman or person can receive their dose as prescribed

If these options are not possible, then a single dose can be prescribed on a TTO for the client to be discharged with. This should be prescribed with the volume written in words and figures, you must sign next to the CD drug as well as the TTO signature line once printed out (see example below). The request should go to pharmacy as per usual TTO procedure. A narrative should also be included to explain the one-off dose, for example: This person is prescribed methadone and the community prescription is unable to be recommenced until xx-xx-xx. Therefore this one-off dose as a TTO is being requested so that they can be discharged.

Medication	Dose/Frequency/ Duration/NFD	Drug Status	Comments	Indication	Dispensing Status
Methadone 1 mg in 1 mL Oral Liquid	20mg ONCE daily	A Admitted on – to CONTINUE	One off supply Drug and Alcohol Service to continue	20ml TWENTY mL **SIGN AND DATE**	To dispense

3.3.7 Ensure that any child protection plans are followed.

3.3.8 Ensure the correct details of discharge address and telephone number are obtained prior to discharge as this may be a different address to the home address, particularly where there is a Local Authority plan.

3.3.9 Give up to date details to Community Midwifery Team and Heath Visiting Service. Ensure that targeted postnatal care is requested if indicated.

3.3.10 If the woman or person is moving out of area, ensure that information is shared with the new community midwifery team.

(Please be aware of individual opening times of drug treatment services. Plans should be made well in advance where possible so that the person receives effective and timely drug treatment.)

4 Training

Please refer to the Training Needs Analysis document for details on staff training in relation to this protocol.

5 Monitoring Compliance

Please refer to the Monitoring and Auditing document for details on monitoring compliance for this protocol.

6 References

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Contributors

Dr. Neil Aiton, Dr. Giles Allen, David Annandale, Rob Bradley, Donna Evans RMN, Penny Gillis RM, Dr. Rebecca Mallick, Dr. Mark Paul, Andy Smith, Nichola Tuck RM.

Appendix A - Contact Details

One Stop Clinic Specialist Midwives mobile: 07795 498509
uhsussex.onestopmidwives@nhs.net

Drug and Alcohol Services
Brighton CGL (Change, Grow, Live) Drug and Alcohol Service 01273 731900
Brighton.info@cgl.org.uk Richmond House, Richmond Road, Brighton BN2 3RL

West Sussex CGL 0300 3038677 westsussex.firststep@cgl.org

East Sussex CGL 0300 3038160 eastsussex.firststep@cgl.org.uk

Appendix B – One Stop Clinic

The team consists of:
Consultant Neonatologist
Consultant Obstetrician
CGL Drug and Alcohol service link worker
Specialist Midwives
Link Social Worker
Link Worker from Brighton Oasis Project

The team also have links with other agencies working in the drug use and criminal justice fields, and work closely with the Specialist Perinatal Mental Health Service. The One Stop midwives attend additional appointments with One Stop clients in other services and disciplines wherever possible.

One Stop Clinic aims to

offer a service that is:

- *Accessible*
- *Client –friendly*
- *Non-judgemental*

ensure a multi-disciplinary approach for pregnant women and people who use substances and offer**:**

- *Assessment*
- *Advice*
- *Support*
- *Triage*
- *Routine care according to needs*

and in doing so aim to improve:

- *Engagement*

- *Harm reduction*
- *Stabilisation*
- *On-going support*
- *Improvements in drug use*

Our primary goal is to engage women and people into maternity or perinatal services as early as possible and encourage regular antenatal clinic attendance, with an overall aim of improving outcomes for women and people and their babies

Appendix C - Overview and background information

The One Stop Clinic focus remains on stability over abstinence, and aims to promote non-judgemental care and open access.

The key aim of this protocol is to engage women and people in maternity and perinatal services, in order to enable and encourage them to obtain the best possible outcomes for themselves and their babies.

Pregnancy may provide an opportunity for a woman or person, her partner and other people living in the household, to change patterns of alcohol and other substance use. Health workers providing care for women and people with substance use disorders during pregnancy need to understand the possible complexity of the woman or person's social, mental and physical issues and to provide the right advice and support throughout pregnancy and the postpartum period. (WHO, 2014)

Problematic substance use during pregnancy is an important public health issue which may affect outcomes for the woman or person and fetus. Pre-term labour, miscarriage, placental abruption and small for gestational age are obstetric complications which have been associated with women and people who are substance dependent. (WHO,2014)

Some of the substances used in conjunction with life style can affect the menstrual cycle. Although women and people with substance use disorders can experience secondary amenorrhoea, this does not mean that they no longer ovulate. As a result, some women and people may not realise that they are pregnant and will be late in accessing maternity care. Another reason for late involvement with services may be an associated lifestyle, which can make multiple demands on time. However, anxiety about judgemental attitudes from health professionals and fear of Social Services intervention have been highlighted as significant reasons why women and people do not engage with services (NICE, 2010).

Non-disclosure remains a key problem. Anecdotally, substance use is the highest undisclosed condition in maternity care. Fear of stigmatisation can be reduced by a maternity service that is accessible, welcoming and where the carers are non-judgemental, sympathetic and honest.

Historically this client group has had to attend a significantly increased number of appointments with a multitude of different professionals. Chaotic lifestyles can make engagement more challenging. Difficulties in attending appointments meant increased likelihood of "failure" and a negative view of engagement and hence stigmatisation. The One Stop Clinic works from the principle that any engagement is better than no engagement. It recognises that recovery is a process, not an event, and that lapse and relapse are a normal part of that process.

Appendix D – Breast/chestfeeding

Human milk provides optimal nutrition for the newborn. Enhanced maternal/parental-infant attachment through breast/chestfeeding may be especially important for women and people who may be feeling guilty about their substance use and may lack confidence in parenting skills. Evidence of decreased stress response and increased vagal tone, indicating better autonomic regulation, in lactating compared to non-lactating women and people is salient for substance dependent women and people. Stress can be a factor in the development of psychiatric symptoms, and has been linked to relapse to substance use (WHO, 2014). The significant and specific benefits of human milk and breast/chestfeeding where there is substance dependence necessitates a discussion regarding its risks and benefits. Maternal/parental functioning, infant functioning and toxicities associated with substances used must be considered (Jansson, 2014).

Prescribed methadone and buprenorphine are not contra-indications to breast/chestfeeding.

Appendix E - Alcohol Use in Pregnancy

Since 2016 the official UK recommendation has been that the safest approach is not to drink alcohol at all when planning a pregnancy, or pregnant (Department of Health, 2016) There is no safe level of alcohol use in pregnancy.

The UK is one of four countries in Europe with the highest known rates of prenatal alcohol exposure, all of which have rates of over 40% pregnancies exposed to alcohol. Recent UK research has confirmed previous estimates that one child per class of 25 to 30 children in the UK is alcohol affected. The condition is not rare, just rarely diagnosed. It is likely to be much more common than for example, autism, where much progress has been made in developing diagnostic pathways in recent years. (McCarthy R, Mukherjee RAS, Fleming KL et al, 2021)

Alcohol is a teratogen that readily crosses the placenta. In the absence of a developed blood filtration system, the fetus is totally unprotected from alcohol circulating in the blood system. Prenatal alcohol exposure can affect the fetus in a number of ways. The most devastating effects are the intellectual disabilities associated with the adverse impact of alcohol on fetal brain development and the central nervous system. Damage is irreparable and completely preventable. (BMA, 2007) Accurate alcohol history taking, early referral and the provision of a brief intervention service is recommended. (WHO, 2014) It is imperative that maternal/parental alcohol history is comprehensively documented in the maternal/parental and infant notes, so that it is available to inform any possible paediatric assessment in the future and improve outcomes for children who are alcohol affected.

Alcohol Brief Interventions

Where alcohol use is identified a brief intervention (BI) can be used alongside motivational interviewing (MI) to communicate effectively about alcohol. Although more research is needed regarding their efficacy in pregnancy, there is substantial evidence that BIs are effective in reducing harmful drinking. Even in light of the low-quality evidence that does exist, the 2014 World Health Organisation (WHO) guidelines on BIs strongly recommended that all pregnant women and people who are using alcohol should be offered a brief intervention.

An alcohol brief intervention (ABI) is a short, personalised interaction, which takes place on one or more occasions. It is designed to give specific information on the consequences of alcohol consumption, and in doing so encourage behaviour change.

An ABI should be seen as part of an on-going conversation, and MI should be an intrinsic part of the interaction. In practice this means using open-ended questions, actively listening to responses and trying to encourage a conversation about behaviour change.

What are the key Principles of Motivational Interviewing?
Express empathy: do not try to resolve a problem or sympathise about it. Empathy is best seen as **connection** between people, where one person takes the perspective of the other and recognises the vulnerability of their position. ***Understand discrepancy/ambivalence***: acknowledge the conflicting feelings that the client may have about their alcohol use. Accept that the issue may not be clear-cut for the client – that they may have simultaneous and contradictory feelings. ***Roll with resistance and avoid arguing:*** accept that the client needs to present their own reasons for change. ***Support hope and self-determination****:* ask clients what their reasons are for change – don't tell them why you think they should change.

A starting point could be questions such as:

> *'I have a concern about your alcohol use. I don't know if you are concerned about it too, but would it be ok if I tell you what I think, or is there anything else that you would like to ask about, or tell me, first?'*
>
> *'Can I tell you what I know about that?'*
>
> *'There is something I need to tell you here, is that ok?'*

As clients may already feel uncomfortable talking about their alcohol use, asking permission is useful in that it is inclusive and non-threatening. It includes the person in setting the agenda for the ABI, and in a subtle but very important way it places them in control of the conversation. The ABI will obviously need to include clear and

concise information about alcohol use in pregnancy, but this may be more accessible and assimilated when it is given in a spirit of collaboration and respect.

When alcohol use is disclosed an appropriate response to different levels of use is important. Firstly, where there is alcohol dependence - that is, where withdrawal symptoms are described when use is reduced or stopped - an in-patient programme in a specialist unit is indicated. Abrupt cessation of alcohol use where there is physical dependence may lead to miscarriage or pre-term labour, and it is important that reduction and cessation of use are managed appropriately. Secondly, where moderate/heavy alcohol use is described, or where low use is continuing, practitioners may feel that referral to a specialist service is required. This could be in the form of a specialist substance-use clinic within maternity services, or if this is not available, a local drug and alcohol service. Finally, it may be that a specialist service is not indicated, or not available, or the person declines referral to it.

Appendix F - Guidance on harm reduction to reduce rates of new hepatitis infection for people who inject drugs

Key Messages:

- Provide clean needles and syringes
- Offer safer oral therapy (such as methadone or buprenorphine)

These 2 services reduced the predicted risk of becoming infected with hepatitis C by 71%. (NIHR, 2017)

- Give safer sex advice: use condoms and lubrication and get tested for STIs
- Advise re: HIV, Hepatitis B and Hepatitis C testing
- Get Hepatitis A and B vaccinations
- Do not start injecting
- If currently injecting then if possible change to smoking
- If unable to stop injecting then aim to reduce harm by avoiding reusing or sharing all injecting equipment
- Use safer injecting practices (this includes **all** injecting paraphernalia)
- Use needle exchange system
- Avoid sharing toothbrushes, razors, nail clippers
- Use sterile tattoo and piercing equipment
- Only use personal snorting straws and crack pipes
- Avoid initiating others (or as a minimum provide them with harm reduction advice)
- Reduce alcohol consumption
- Get emotional support (National Harm Reduction Coalition, 2017)

Appendix G - Treatment of opioid dependency in pregnancy

Opioid Substitution Therapy (OST) can remove the risks and harms of non-prescribed opioid use. It also has the potential to allow pregnant women and people to focus on

other aspects of their lives. OST creates a stable in-utero environment for the fetus. There is normal fetal growth and development, and pregnancies progress to normal length. Breast/chest feeding is not contra-indicated, regardless of dose. Any neonatal dependence is treatable. Pregnant women and people who are dependent on opioids should be encouraged to use OST rather than attempt detoxification. Pregnant women and people who are already taking methadone or buprenorphine for OST should remain on that therapy. (NICE, 2022)

The two types of OST used in pregnancy are **methadone** (brand name: physeptone) and **buprenorphine** (brand name: subutex)

Methadone and buprenorphine are not the panacea for opioid dependency, but they do provide many benefits for maternal and parental wellbeing, the pregnancy and the fetus. Prescription medication, engagement with maternity and perinatal services and reduction of non-prescribed drugs can lead to successful outcomes during and after pregnancy.

Although OST includes a risk of neonatal opioid dependence, opioids are essentially non-toxic at stable levels. Cessation of opioids on the other hand carries a higher risk of relapse to unstable patterns of short-acting opioid use (for example, heroin). (WHO, 2014) Neither methadone nor buprenorphine have adverse effects on the pregnancy or neonatal outcomes – the incidence of neonatal abstinence syndrome (NAS) with buprenorphine is similar to methadone and there is some evidence that buprenorphine use results in less severe NAS (NICE, 2022)

Reducing OST is generally not recommended in pregnancy or the immediate postnatal period. Relapse is more likely following medication-assisted withdrawal than while undertaking opioid maintenance treatment (NICE, 2022)

Follow up studies have shown that long-term outcome in women and people who enter an OST programme during pregnancy are better in terms of pregnancy, childbirth and infant development, irrespective of continuing substance use (WHO, 2014). Where appropriate, it is also important to engage the woman or person's partner to participate in enabling and encouraging success in stabilising substance use.

Occasionally, when a woman or person is on OST they may continue to use non-prescribed drugs. This may be a problem when the woman or person is admitted in labour. Therefore, it is important that an honest, trusting and non-judgemental relationship is established between the woman or person and their midwife. This will hopefully encourage them to disclose any substance use over and above the prescribed medication. Although it is impossible to know the strength and dosage of non-prescribed drugs, honest disclosure will enable any treatment to be titrated accordingly.

Methadone

Methadone has been the OST of choice in pregnancy since the 1970s. The evidence shows that it supports normal fetal growth, birthweight and term pregnancies.

Methadone is a full agonist at the opioid receptor. There is no 'ceiling' effect, and as the dose increases so do the analgesic effects, and therefore so does the potential for adverse effects.

When in labour, women and people should be given their daily dose of methadone as usual. Non-pharmacological methods of pain relief (for example, water, TENS, mobilisation and relaxation) should be encouraged as they would be in normal labour care. Analgesia should also be offered as it would be in normal labour care. Additional doses of opioids can be carefully administered.

It is often necessary to increase the dosage of methadone in the third trimester to maintain response due to changes in drug distribution, metabolism and clearance. In the third trimester it may also be more effective to split the dose rather than increase it. It may occasionally be necessary to increase the dose or split it, from once-daily consumption to twice daily-consumption, or both (NICE, 2022)

Breast/chestfeeding should be supported and encouraged when women and people are stable on prescribed methadone, and wish to breast/chest feed.
Morning sickness may lead to the vomiting of methadone soon after it is swallowed and may lead to maternal and fetal withdrawal. If a methadone dose is vomited:

- Within 10 minutes of dosing – consider giving a repeat dose.
- Within 10-30 minutes of dosing – consider giving half a repeat dose.
- More than 30 minutes after dosing – consider giving half a repeat dose only if withdrawal occurs.
- Consider if the entire dose is likely to have been vomited.
- If there is doubt – assess (or refer to an experienced clinician 4-6 hours after vomitinmg when the effects of methadone should be at their peak, to determine whether an additional small dose is required. (NICE, 2022)

Buprenorphine

Buprenorphine acts as a partial agonist at the opioid receptor and has a prolonged duration of action due to its high affinity for the receptor. The pharmacological effects are very similar to methadone, however it has a lower potential for overdose. Some women and people prefer buprenorphine because they feel more "clear headed" than with methadone. The dosing of buprenorphine in pregnancy is similar to that in non-pregnant women and people. As with methadone it is often necessary to adjust the dose towards the end of pregnancy; on average the increase is 2mg.

Recent research has found that buprenorphine is a safe and effective alternative to methadone, and suggests that infants born to women and people who received

buprenorphine had milder symptoms of neonatal opioid withdrawal than those born to women and people who received methadone.

There is increasing evidence that due to the drug's poor bioavailability when taken orally, it is unlikely that there is significant systemic absorption from human milk. Therefore, breast/chestfeeding should be supported and encouraged where women and people are stable on prescribed buprenorphine, and wish to breast/chest feed (NICE, 2022)

When in labour, women and people should be given their daily dose of buprenorphine as usual. Non-pharmacological methods of pain relief (for example, water, TENS, mobilisation and relaxation) should be encouraged as they would be in normal labour care. Analgesia should also be offered as it would be in normal labour care.

As buprenorphine is a partial agonist women and people may have reduced analgesic benefit from additional opioids, because partial agonists displace pure agonists (i.e. other opioids) on the receptor. This is a dose-related effect and becomes significant at levels above 8mg. Additional doses of opioids can be carefully administered. Women and people may require careful supplementation following caesarean section/instrumental delivery. Early anesthetist review is recommended.

Missed doses

If a woman or person misses several doses of OST, it is important to contact the dispenser. Careful liaison should also take place with the prescriber - liaison with the Drug and Alcohol Service is important in this situation. It is important to remember that untreated withdrawal gives a risk of precipitating early labour. Efforts should be made to ensure the prescribed OST remains available in order to protect maternal/parental and fetal stability and clinical wellbeing.

Appendices H to J: Substances

These appendices provide a brief overview of a limited range of substances.

For a more comprehensive resource please consult the UK Teratology Information Service (UKTIS) website TOXBASE.

UKTIS also provides accessible leaflets for non-professionals on their Best Use of Medicine is Pregnancy (BUMPS) website. The BUMPS information is easy to

download and print, and therefore can be a useful source of information for pregnant women and people, and families.

www.toxbase.org
Log in: H2459
Password: CAY664

BUMPS
www.medicinesinpregnancy.org

Appendix H: Stimulants

Substance /street name	Duration of Action	Effects on the User	Effect on Pregnancy/Neonate	Effects on Lactation	Treatment Options
Tobacco Cigarettes *See Maternity Smoking Cessation protocol for comprehensive information.*	Nicotine can reach the brain in 7 seconds of inhalation of cigarette smoke. Duration of action is approx. 15 – 120 minutes	Claims to alleviate anxiety and stress and promotes relaxation and enhances mood. Increase pulse rate and tremor, reduces appetite	Smoking increases the risk of low birth weight, heart defects, stillbirth, preterm birth, miscarriage and Sudden Infant Death	Nicotine is excreted into human milk, the amount equating to the amount inhaled through passive smoking. High levels of nicotine in the blood can cause vomiting, diarrhoea, irritability and neonatal tachycardia. There is some evidence that cigarette smoking reduces milk volume. Smoking in the presence of the infant increases the risk of Sudden Infant Death	Offer CO testing at booking and 36/40. Risks should be discussed as early in the pregnancy as possible. Discuss and refer to Smoking Cessation Service if appropriate.
Caffeine Coffee Tea Coca cola Chocolate	2 – 12 hours	Restlessness, stomach upset, alertness, physical endurance and decreased fatigue. Extent of effec - variable in different individuals. Can be harmful if existing cardiac problems.	No significant effect unless taken in chronic doses, which is not generally attainable in normal consumption	Minimal amounts of caffeine enter human milk, which is unlikely to cause a problem unless it is taken in high and/or frequent amounts	No specific treatments available. Caffeine free products may be used as a replacement
Amphetamine Speed Whiz Uppers ***Class B***	4 – 8 hours	Powerful stimulant. General excitement, alertness, impulsiveness, restlessness, aggression. ↑self confidence. ↑BP, headaches. ↓appetite.	Vaso-constrictor→ increased risk of pre-term birth, placental abruption and intra-uterine growth retardation (IUGR). No conclusive link to congenital malformation.	Concentrates in human milk, may cause irritability and disturbed sleep in the exposed neonate. Long term effects are unknown	Advise immediate cessation Refer to One Stop Clinic
Pseudoephedrine Sudafed	4 – 6 hours - 60mgs 10 – 12 hours - 120 mgs	↑BP Insomnia	Decreases placental blood flow and may lead to fetal hypoxia	Excreted into human milk in small amounts. May cause irritability and disturbed sleep for exposed infants	Advise immediate cessation Refer to One Stop Clinic

Substance/ street name	Duration of Action	Effects on the User	Effect on Pregnancy/Neonate	Effects on Lactation	Treatment Options
Cocaine Crack Cocaine ***Class A***	Smoking crack: 30 -120 minutes. Snorting cocaine: 15-30 minutes. IV cocaine: immediate and peaks after a few minutes	↑ self confidence, alertness, excitement and euphoria and decreased fatigue. Vaso- constrictor. Cardiac toxicity = serious adverse effect. Perforation of nasal septum and rhinorrhoea is associated with regular snorting	Has powerful vaso-constrictive properties which may cause ↓ placental blood flow, fetal hypoxia → perinatal mortality .Has been associated with spontaneous abortion, placental abruption, premature labour, (IUGR) and Sudden Infant Death.	Cocaine is excreted into human milk and can result in cocaine intoxication of the infant: viomiting, diarrhoea, irritability, tachycardia and seizures. Long term effect is unknown. Current research looking at cognitive behaviour in exposed infants	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
MDMA Ecstasy, Adam, XTC, M, E ***Class A***	7 -8 hours	Less hallucinogenic and stimulatory effects than amphetamines. Emotional effects are more pronounced.	Vaso-constrictor→ increased risk of pre-term birth, placental abruption and IUGR No conclusive link to congenital malformation. Exposure correlated with poorer motor skills in infants up to age 2 years	May cause irritability in exposed infant.	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
Methamphetamine Ice , Crystal ***Class A***	> 10 – 12 hours	Impaired judgement, pronounced stimulatory	Has vaso-constrictive properties which may cause ↓ placental blood flow, fetal hypoxia → perinatal mortality.	May cause irritability in exposed infant. Long term effects are unknown	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
Khat ***Class C***	3 - 4 hours	Talkative/ Irritability/anger Appetite suppressant Psychological dependence	Unknown. Chemically similar to amphetamines. Vaso-constrictive so may carry similar risks as cocaine. No supporting data.	Unknown	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service

New Psychoactive Substances "Legal Highs" e.g. spice, bath salts, Mdat.	Various	Similar to ecstasy/amphetamines dependent on ingredients	Unknown. Presumed as per amphetamines. No supporting data.	Unknown	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
Mephedrone methedrone meow meow M-CAT ***Class B***	6 – 8 hours	Alert and/or paranoid, confident, affectionate and/or anxious, dizzy.	Unknown. Presumed as per amphetamines. No supporting data.	Unknown	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service

Appendix I: **Depressants**

Substance / street name	Duration of Action	Effects on User	Effect on Pregnancy/Neonate	Effects on Lactation	Treatment Options
Alcohol	Dependant on consumption. One unit clears the system in about one hour.	Loss of inhibition, slurred speech, general relaxation. May present with either sense of wellbeing or depressed	No safe level of alcohol use in pregnancy. Risk of Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorder.	Freely excreted into human milk. Heavy consumption may affect milk supplies. Women and people should be advised not to breast/chestfeed for 2 hours after having an alcoholic drink Evidenced link between drinking alcohol and Sudden Infant Death	Advise re. risks of alcohol in pregnancy in a non-confrontational way. Encourage open and positive communication. Advise immediate cessation if not alcohol dependent. If alcohol dependent will require in-patient treatment. Refer to One Stop Clinic Refer to Drug and Alcohol Service

Benzodiazepines Diazepam Oxaxepam Temazepam ***Class C***	Dependant on dose and medication type, Approx 1 to 3days.	Lack of muscle tone, relief of anxiety and tension. Sedative	May cause respiratory depression, hypotonia, poor feeding/ weight gain, neonatal dependence	Excreted in small amounts into human milk, Has the potential to accumulate in the infant. May cause sedation and poor feeding when used in high or prolonged doses. Infant may show signs of dependence which may not occur until 4-6 weeks after birth	Do NOT advise immediate cessation Refer to One Stop Clinic Planned reduction if indicated Refer to Drug and Alcohol Service
Cannabis Marijuana Grass, Weed, Dope, Pot, Blow, Hemp ***Class B***	Depending upon the method of consumption, complete elimination can take weeks / months depending on use	↑ relaxation and food cravings, loss of concentration and time orientation. Red eyes, tachycardia. Can be hallucinogenic	Similar to nicotine. ↑incidence of IUGR and ↓ birth weight Some evidence suggests cannabis exposure and its correlated factors are associated with greater risk for psychopathology during middle childhood (Paul, 2021)	Tetrahydrocannabinol (THC) may accumulate in the fatty tissue of the neonate. Important to avoid smoking in the presence of the infant to reduce the risks of Sudden Infant Death.	Refer to One Stop Clinic for cannabis reduction/cessation sessions WITH CONSENT
Opioids Heroin Opium Morphine ***Class A***	IV = 4 – 6 hours If smoked effects may be prolonged	Relief of pain (physical and psychological) and anxiety, lack of awareness, drowsiness, pinpoint pupils. Respiratory depression.	Blood born viruses Injecting abscesses May cause IUGR May cause neonatal dependence Acute withdrawal associated with spontaneous abortion, preterm labour and perinatal mortality and increased incidence of Sudden Infant Death	Heroin passes into human milk in sufficient quantities and has the potential to cause adverse effects in infants. Breast/chest feeding is contraindicated when there is non-prescribed opioid use.	Do NOT advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service Remember: OST = best outcomes for mothers and parents and babies
Opioids Codeine Co-dydramol, dihydrocodeine ***Class B***	4 – 6 hours	Warmth, wellbeing, sleepiness. Nausea, constipation, itching. Respiratory depression.	May cause neonatal dependence	Codeine phosphate should not be used if breast/chestfeeding. Excreted in varying amounts into breastmilk dependent on different rates of maternal metabolism.	Do NOT advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service OST may be indicated in some cases

Appendix J: Hallucinogens

Substance / street name	Duration of Action	Effects on User	Effect on Pregnancy/Neonate	Effects on Lactation	Treatment Options
Volatile Substances Petrol, Gas, Glue, Aerosols, Cans, Butane Gas	30 minutes, depending upon substance used	Euphoria. Chronic use associated with concentration, insomnia, and nightmares. Peripheral and central neurological damage, renal failure and acidosis have been reported	Volatile substances cross the placental barrier and may cause pre-term labour, and birth	Should not cause a problem unless the mother/parent is substance affected	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
LSD Trips Acid ***Class A***	10 – 12 hours +	Flushing, tachycardia, dry mouth, tremors, followed by euphoria, time distortion, visual and auditory hallucinations and depersonalisation. Psychosis =chronic problem	Limited research	Limited research, though LSD, even in low doses is extremely powerful, rapidly distributed through the body after consumption. Breastfeeding should be avoided	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
PCP **Phencyclidine**	6 hours though effects may take several days to wear off	Thought distortion, exaggerated sensation, hallucination affecting visual and sensory function and ↑ pain tolerance	Associated with birth defects. Long term behavioural and neurological effects have been observed in infants exposed to maternal/parental PCP misuse	Stored in fatty tissue and can accumulate and concentrate in breast milk Therefore, breastfeeding should be avoided	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service
Ketamine Special K K ***Class C***	30 – 120 minutes	Vaso-dilator Analgesic and psychedelic properties, hallucinations, agitation, dizziness, clonic movements, hypertension and tachycardia.	No research in pregnancy	In view of possible vaso-dilation breastfeeding should be avoided if used around time of birth	Advise immediate cessation Refer to One Stop Clinic Refer to Drug and Alcohol Service

Appendix K: Approximate detection times of some common drugs of use in urine

DRUGS	DURATION OF DETECTION IN URINE
Alcohol	Up to 1 day
Amphetamines (including MDMA, MDA)	2 days
Acetyl morphine (recent heroin)	24 hours
Barbiturates	1-3 days
Benzodiazepines	1-3 days
Cannabis	7~28days
Cocaine	1-3 days
Codeine	1-3 days
Cyclizine	<2 days
Dihydrocodeine	1-3 days
Methadone	1-3 days

Try to ensure that the specimen belongs to the person. A fresh and warm specimen of urine should always be used.

Note:

- Detection times are only very approximate and are dependant upon the dose, frequency, route of administration and urine excretion/ dilution.
- Results can be interpreted in the light of clinical findings, as false negatives and false positives can occur. False positives can be caused by the use of quinolones or loperamide (imodium). Note that many over-the-counter medicines contain opioids (e.g. codeine). Negative results can occur despite the presence of buprenorphine or tramadol, as these drugs do not test as opioid positive on urine tests.

Appendix L: Neonatal Abstinence Scoring System

Adapted from L.P.Finnegan (1986)

Infants displaying signs of withdrawal will score from signs in each of the 3 sections of the scoring chart.

System		Score																		
C.N.S.	Excessive cry Continuous cry	2 3																		
	Sleeps <1 hour after feed Sleeps <2 hours after feed Sleeps <3 hours after feed	3 2 1																		
	Mild tremors disturbed Mod/ severe tremors disturbed Mild tremors undisturbed Mod/ severe tremors undisturbed	1 2 3 4																		
G.I.T.	Poor feeding	2																		
	Regurgitation Projectile vomiting	2 3																		
	Loose stools Watery stools	2 3																		
OTHER	Sweating	1																		
	Fever (37.3.to 38.3C)	1																		
	Fever (38.4 and above)	2																		
	Frequent yawning (>3-4 in ½ hour)	1																		
	Mottling	1																		
	Nasal stuffiness	1																		
	Sneezing (>3-4 in ½ hour)	2																		
	Nasal flaring	1																		
	Respiratory rate >60 per minute Respiratory rate >60 per minute & recession	1 2																		