Maternity Substance Misuse Guideline

Author/Owner	Public Health Specialist Midwife	
Version	1	
Status	Approved	
Publication date	27/09/2023	
Review date	27/09/2026	
Approval recommended by	Women's Business and Governance meeting	Date: 15/09/2023
Approved by	CBU 3 Overarching Governance Meeting	Date: 27/09/2023
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments	

Table of Contents

	Section headings			Page
1.0	Introduction			4
2.0	Objective			4
3.0	Scope			4
4.0	Main body of the document			5
	4.1	Discussing Alcohol Use During the Antenatal Period		5
	4.2	Identifying: Substance Misuse		6
		4.2.1	Identifying Alcohol Misuse	6
		4.2.2	Identifying current drug misuse	6
		4.2.3	Previous Drug use	7
		4.2.4	Partner/Co-parent Support	7
		4.2.5	Neonatal Alert	7
	4.3	Substance Misuse Referral		7
	4.6	Antenatal care		8
	4.7	Labour & Delivery		9
		4.7.1	Analgesia	9
	4.8	Postnatal Care Of Mother & Baby		10
		4.8.1	Care of the Mother	10
		4.8.2	Care of the Baby	11
	4.9	Breastfeeding		12
	4.10	Discharge from Hospital		12
	4.11	Care by Community Midwife		13
5.0	Associated documents and references			14
6.0	Training and resources			14
7.0	Monitoring and audit			15

8.0	Equality, diversity and inclusion		15
	8.1	Recording and monitoring of equality, diversity and inclusion	15
Appendix 1	Glossary of terms		17
Appendix 2	The Alcohol Use Disorders Identification Test (AUDIT C and AUDIT)		18
Appendix 3	Recovery Steps Barnsley Referral Form		19
Appendix 4	Modified Finnegan Neonatal Abstinence Scoring Tool		21
Appendix 5	Drug and Alcohol Quick Reference Guide		23
Appendix 6	Document history/version control		24
	Approval Form		25

1.0 Introduction

The guideline uses the term 'woman' or 'mother' and should be taken to include people who do not identify as a woman but who are pregnant.

This guideline covers issues that may arise from alcohol and drug misuse during pregnancy and the care that should be offered to women and birthing people. Heavy drinking during pregnancy could increase the risk of Fetal Alcohol Spectrum Disorder (FASD), and, even low and moderate level drinking can affect the unborn baby.

When a pregnant woman drinks alcohol, the alcohol in her bloodstream passes freely through the placenta into the fetus' blood. As the fetus does not have a fully developed liver, it cannot filter out the toxins from the alcohol as the mother can. Instead, the alcohol circulates in the fetus' blood system which can harm brain cells and damage the nervous system of the developing baby throughout the entire nine months of pregnancy. Therefore, women and birthing people must be advised **to avoid alcohol at all stages of pregnancy and while trying to conceive** (CMO DOH, 2016; NICE, 2022)**.**

Alcohol misuse is when the individual is drinking in a way that is harmful, excessive or when they are dependent upon it.
Drug misuse is when an individual uses the drug (whether prescribed or not) in a manner for which the drug was not directed causing a harmful effect to the individual and/or leading to dependency.
'Harmful' describes when the individual puts themselves or others in danger. This includes but is not limited to putting themselves at risk of illness, psychological problems or physical accidents, and causing harm to the unborn baby.
'Dependent' means the individual craving alcohol or drugs continues to use them even though it causes social, health or financial problems.

2.0 Objective

The purpose of this guideline is to provide staff with adequate guidance on necessary actions to take when a pregnant woman and/or their partner discloses misuse of drugs or alcohol.

3.0 Scope

This guideline applies to all midwifery, neonatal and children's staff including: Midwives/Nurses, maternity/nursing support workers, specialist staff and doctors working in all areas throughout the hospital and community setting. All professionals working alongside pregnant and postnatal women have a responsibility to ensure that they keep up to date with any changes to practice.

4.0 Main body of the document

4.1 Discussing Alcohol Use During the Antenatal Period

At the midwifery booking appointment all pregnant women will be asked about their use of alcohol using the AUDIT C tool (see appendix 2). Maternity staff are advised to use the brief questionnaire. If a full assessment is required the Midwife should refer to specialist services and the Safeguarding Team (NICE Quality Standard on FASD, 2022). See section 4.3 for how to refer to professionals.

A pregnant woman who is identified as misusing alcohol will be offered consultant led care.

Midwives and other healthcare professionals will give women clear and consistent advice on avoiding alcohol throughout pregnancy, and explain the associated risks including:

- Drinking alcohol during pregnancy increases the risk of harm to the baby.
- There is no known safe level of alcohol consumption during pregnancy (NICE Quality Standard on FASD, 2022).

Talking about and recording alcohol consumption during pregnancy allows personalised discussions about the risks of alcohol use as part of routine healthcare throughout pregnancy. It gives opportunities to offer tailored support and interventions which may include (but not exclusive to) one-to-one support, a structured recovery programme, detox from alcohol and/or drugs. See section 4.3 on how to make a referral to Barnsley Recovery Steps. Pregnant women who engage with specialist support may reduce risks and improve outcomes for the woman and the baby, preventing fetal alcohol spectrum disorder (FASD); and may reduce the risks of low birth weight, preterm birth and the baby being small for gestational age. (CMO DOH, 2016; NICE, 2022).

At every antenatal clinic the midwife or obstetrician must enquire about alcohol use in pregnancy and document ((NICE FASD QS204, 2022). Women must be given clear and consistent advice on avoiding alcohol throughout pregnancy, and explain the benefits of avoiding alcohol use in pregnancy, including preventing fetal alcohol spectrum disorder (FASD) and reducing the risks of low birth weight, preterm birth and the baby being small for gestational age (NICE FASD QS204, 2022). Pregnant women who continue to misuse alcohol and drugs must be informed by the midwife or doctor during the antenatal period that due to exposure to alcohol, illegal drugs and also some prescribed medication, a stay of up to 72 hours may be required to monitor the new born baby in the immediate postnatal period. The midwife or obstetrician must explain the involvement of safeguarding and social care. An early discharge will not be possible and this should be explained to the pregnant woman. However, if the mother insists on discharge, then the emergency duty social work team must be informed.

A plan for care must be made by the named midwife or obstetrician responsible for the woman's care; if the woman is known to Barnsley Recovery steps information regarding medicines should be checked with them. The plan includes the management of medications, prescribed and non-prescribed, over the counter and herbal medicines, see Medicines Reconciliation Procedure. This must be documented within the Electronic Patient

Record (EPR) as part of a medicines review at every appointment, see Antenatal Care Guidelines.

The NICE Quality Standards FASD (2022) states that the same principles must be applied for those using other substances.

4.2 Identifying: Substance misuse.

The term substance misuse will be used to refer to alcohol and/or drug misuse in the rest of this document.

All pregnant women should be asked about substance misuse in a sensitive and non-judgemental manner at every contact.

4.2.1 Identifying Alcohol Misuse

Use the Brief AUDIT-C tool (Alcohol Use Disorders Identification Test – Consumption) if any alcohol use is identified (see Appendix 2). An AUDIT-C score of five (5) or above requires a referral to the Alcohol Care Team (ACT) and the Barnsley Recovery Services for specialist care and support. Referrals must be sent to the Safeguarding Team and the Early Help Team (see section 4.3).

4.2.2 Identifying Current drug misuse

Sensitively discuss current substance misuse and document in the woman's records as per Trust guidelines at every contact:

- The type/name of drug used
- How obtained (prescribed, over the counter and/or illicit)
- Frequency and amount of use
- Route of administration
- Time last used
- Any physical concerns including signs of withdrawal

Discuss and document all risks associated with drug misuse. These should include Intra Uterine Death (IUD), Intra Uterine Growth Retardation (IUGR), pre-term birth, a deterioration in mental health, Sudden Unexpected Death in Infancy (SUDI), sedation. Substance misuse may cause harm to the unborn child and can stop individuals from proving safe care for their children.

Discuss and document all concerns associated with drug misuse. Include the legal implications of illicit drug use and at the personal risk of associating with drug dealers.

Offer referral to drug and alcohol services such as Barnsley Recovery Steps. See Section 4.3 for referral processes to Barnsley Recovery Steps.

An ongoing history of intravenous drug use (IVDU), partner IVDU, sharing of drug paraphernalia, razors, or toothbrushes are indicative of an increased risk for Blood Borne Viruses such as Hepatitis B, Hepatitis C and HIV. Recommend a self-referral to Spectrum Sexual Health clinic to the woman and their partner for sexual health screening.

Barnsley Spectrum Sexual Health Services telephone: 0800 055 6442; e-mail Barnsley@spectrum-cic.nhs.uk; opening hours Monday, Tuesday and Thursday 8:15am-7:30pm, Wednesday 3pm-8pm and Saturday 9am-1pm. Follow Trust Approved Safeguarding Policy for referral to the Safeguarding team.

4.2.3 Previous drug use, where woman or partner stopped within 1 month prior to conception

If there is a past history of dependency:

- Send a record of contact to social care and follow-up response.
- Offer referral to the Substance Misuse consultant clinic.
- Discuss and offer referral to Early Help Team for support.
- Encourage continued abstinence from drugs/alcohol.

4.2.4 Partner/Co-parent Support

Information regarding partner/co-parent of baby is required at booking and should include any substance misuse, any services they are engaged with and any treatment programme they are undertaking. If no treatment programme is identified, but it is felt to be required, encourage self-referral to drug & alcohol services.

4.2.5 Neonatal Alert

A neonatal alert form will be completed by the midwife or obstetrician antenatally or as soon as substance misuse is identified in the pregnancy. The professional making the referral will document this in the maternal notes and must ensure that any follow up is actioned and clearly documented. A neonatal alert form must be sent in the following circumstances:

- Continued use of illicit substances on top of or instead of prescribed substitute medication (Methadone or Buprenorphine).
- Any concern that identifies a need for a paediatric alert.

As above, referrals must be documented, followed-up by the referrer and action plans clearly communicated and documented in maternal EPR and hospital held files.

4.3 Substance Misuse Referral

All women with current substance misuse concerns will be referred to the following services:

- **Social care:** call Children's Social Care (**Multi-Agency Safeguarding Hub, MASH**) on 01226 772423 Monday-Thursday 8.30am-5pm and Friday 8.30am- 4.30pm.
- **The Safeguarding Team:** call the team on extensions 2092 or 5432 or email bhnft.safeguardingteam@nhs.net
- **The Alcohol Care Team (ACT):** Referrals can be made by any healthcare staff on phone extensions 5299, 3117 or 3118; leave an answerphone message if no-one able to answer during ACT working hours (8am-8pm, 7-days a week), or if referring out of hours. Alternatively, referral can be made via Careflow Connect. The ACT office is located in the minors area in the Emergency Department.

- **Barnsley Recovery Steps** who provide substance misuse services. See Appendix 3 for referral form which can be emailed to: brsreferrals@humankindcharity.org.uk; Telephone - 01226 779066 (9am-5pm Monday to Wednesday, and Friday; 9am-7pm Thursday)
- **Early Help** referral must be offered to all women with vulnerabilities. Office extension is 5827; Mobile: 07747564002 or 07557820711; Email address: earlyhelpnavigator@barnsley.gov.uk

Consider other vulnerabilities such as domestic abuse, mental health illness, homelessness, or trafficking and include these in referrals made to other agencies.

Named Midwife to arrange a Multidisciplinary team meeting to discuss management of complex care see Complex Care Meeting.

Document all discussions, referrals and care given in the patient's records and EPR.

Engagement with maternity and drug services will be encouraged. Use a variety of methods, for example text messages, to remind women of upcoming and missed Trust related appointments.

Refer to Appendix 5 for quick referral guidance

4.6 Antenatal Care

All pregnant women with identified current substance misuse will be offered routine antenatal care in line with Antenatal Care Guideline with the following additions as appropriate:

- Women who are dependent on alcohol should be advised to avoid sudden cessation of alcohol consumption as this may lead to withdrawal seizures. Pharmacological treatment and supervised withdrawal may be required. Refer to the ACT team (see section 4.3) for advice and a treatment plan, and/or call the on-call medical team if out of hours.
- Treatment options will be discussed by drug and alcohol services and their prescribing team. Maintenance, partial reduction, and drug/alcohol withdrawal will be offered with ongoing support and counselling. Harm reduction and stabilisation of drug/alcohol use is the priority.
- Offer 5mg Folic Acid a day for the duration of the pregnancy as alcohol use delays absorption of vitamins.
- Any identified increase in substance misuse/alcohol use during the pregnancy will be highlighted to the obstetric consultant, maternity safeguarding team and social care.
- All women currently misusing substances in pregnancy will be offered growth scans as per the recommendations of the obstetric consultant.
- Referral to the Anaesthetic clinic will be advised for woman with current or past intravenous drug use (IVDU); poor venous access; history of current heroin/crack cocaine use
- Discuss with all women which drugs should be avoided during pregnancy.
- A pre-birth safe discharge meeting should be completed and the plan attached to the maternal notes and on maternal EPR.
- The midwife responsible for the woman's care and the pregnant woman will complete a personalised coordinated care plan. The care plan must be coordinated with other services supporting the pregnant woman such as key contacts from safeguarding, social worker; health visitor; GP; Barnsley Recovery Steps and any other services.
- EPR and hospital notes must be updated at each contact. Documentation will specify the following:
    - Current alcohol use - type of alcoholic beverage, amount taken and frequency
    - Current drug use – name of drug, route of use, amount used, frequency
    - Current prescribed/ non-prescribed medication

4.7 Labour & Birth

All staff involved will be aware of the current status of the woman's substance misuse/treatment as documented in the patients' records and EPR.

The midwife caring for the woman must inform the following service on admission;

- Drug treatment services (Barnsley recovery Steps)
- The Maternity Safeguarding Team
- Adult and Child social care

If the woman is on an opiate substitute prescription (Methadone or Buprenorphine) the prescription must be placed on hold whist an inpatient, the dosage should be verified by the information in her hospital notes and EPR and confirmed by contacting the dispensing pharmacy or the original prescribing doctor/Barnsley Recovery Steps (01226 779066 9am-5pm Monday to Wednesday, and Friday; 9am-7pm Thursday).

Out of hours contact the Trust's ACT or the on-call medical team for advice and support - information regarding dosage and dispensing details should be found in the woman's hospital notes/maternity EPR also the patient may be able to clarify. This information should be verified at the first opportunity.

Opiate substitution treatment should be continued as normal when admitted in labour. Out of office hours contact the anaesthetist and obstetrician for a joint discussion on prescribed medication during labour and delivery.

Women who need urgent mental health support must be referred to the Mental Health Liaison Team. The team are based at BHNFT and offer a 24-hour service, 7 days a week; contact numbers are 01226 462113 or 07769162703.

4.7.1 Analgesia

Women with drug dependency concerns can be offered all analgesic options for labour and delivery, unless there are specific contraindications. Analgesia management may be more challenging if opiates are used. The default position should be to continue standard opioid administration. It is recommended that pre-existing doses of prescribed opiate substitute medication (Methadone or Buprenorphine) are not altered. To achieve pain relief, other forms of analgesia via an epidural are recommended, or additional opiates are prescribed as required. The aim is to achieve adequate analgesia with the lowest dose of additional opioids for the shortest period of time.

Liaison with the anaesthetic team is likely to be required to ensure effective analgesia.

Entonox® can be used unless contraindicated as a form of analgesia in labour.

Epidural administration of analgesia is recommended as the most effective form of pain relief for women with opiate dependency for two main reasons:

- Avoids the use of additional IV opioids particularly if this reminds the woman of any past IVDU.

- Can be useful for women who are taking high doses of opiates antenatally where it may be difficult to control pain with standard opioid analgesia.

The newborn infant exposed to opiates antenatally MUST NOT receive Naloxone as this could precipitate immediate acute and severe withdrawal symptoms including seizures resistant to anticonvulsants.

4.8 Postnatal Care of Mother & Baby

Most babies of substance misusing mothers are cared for on the Antenatal Postnatal ward (ANPN) with a daily Paediatric review until discharge. If admission to the neonatal unit (NNU) is required, the mother will be encouraged to stay with her baby unless she is discharged home.

4.8.1 Care of the Mother

All postnatal women with identified current substance misuse should be offered routine postnatal care in line with the Guideline for postnatal care .

Standard pain relief such as Paracetamol and non-steroidal anti-inflammatory medications should be offered.

Do not prescribe any additional methadone or buprenorphine other than the prescribed dose from drug treatment services.

Any change to the patient's regular opiate substitute prescription must be agreed with Barnsley recovery steps/original prescriber.

For women who are admitted and disclose current drug misuse but are not prescribed methadone or buprenorphine see Appendix 5 and follow the appropriate pathway.

Staff must ensure that prescribed analgesia is effective and request review by the obstetric team daily. Opioid analgesia initiated during this admission should be reduced/stopped as soon as is appropriate.

Maternal withdrawal signs and symptoms may include but are not limited to:

- Anorexia
- Abdominal Cramp
- Diarrhoea
- Dilated pupils
- Generalised Aches & Pains
- Gooseflesh (piloerection)
- Increased bowel sounds
- Insomnia & Restlessness
- Lachrymation & Rhinorrhoea (watering eyes and a runny nose)
- Nausea & Vomiting
- Rigors
- Sweating

- Tachycardia and hypertension
- Tremor
- Yawning

4.8.2. Care of the Baby

All babies born to women with identified current substance misuse will be offered routine newborn care as outline in the maternal Guideline for postnatal care .

In addition:

- The baby must be reviewed by the neonatal medical team at delivery and then daily as a minimum.
    - A management plan should be documented in the notes.
- It is important to ensure that results of antenatal serology testing, toxicology screening and social circumstances as well as the drugs and dosages to which the fetus was exposed during pregnancy are clearly documented in the baby's notes
- Neonatal observations should be undertaken 4-hourly.
    - All observations and actions taken must be documented on the Modified Finnegan Chart (see Appendix 4) and in the mother's notes as appropriate.

It is important to document in maternal and baby records any signs of baby's withdrawal as this may be required should the child show any developmental signs or symptoms in their later life to support a potential NAS/FASD diagnosis.

Symptoms of methadone or buprenorphine withdrawal may take several days to present. For this reason, a minimum of 72 hours monitoring of the infant is recommended. Symptoms may last up to 2 weeks with opiates and longer with other drugs such as Benzodiazepines.

The mother should be advised that the aim is to detect signs and symptoms of NAS/FASD, and minimise the potential for neonatal seizures.

If the baby displays symptoms of withdrawal and requires treatment, he/she may require admission to the Neonatal Unit for further management.

Safeguarding midwives and Social Care must be informed of admission and will visit whilst on the ward to support care and discharge planning as required see section 4.3 for contact details:

Neonatal withdrawal symptoms and signs may include but are not limited to:

- Dehydration
- Diarrhoea/ excoriation of nappy region
- Hiccups
- High pitched cry
- Hypertonicity (limb rigidity)
- Hyperthermia/Sweating
- Hypersalivation
- Jitteriness / Tremors / Seizures
- Limb rigidity
- Nasal stuffiness & sneezing
- Poor feeding
- Tachypnoea

- Vomiting
- Weight loss
- Yawning

The risks of SUDI are significantly higher for women and birthing partners who misuse substances. The midwife must advise parents about the additional risks with co-sleeping when one or both parents misuse substances.

The parents should be included in the assessment of the baby in order to encourage their involvement and knowledge of the care of the newborn. The midwife will observe and assess parenting skills, and will document this in the maternity records. The Guideline for postnatal care must be followed.

The parents may require additional support as the baby may well be fractious and unsettled due to the impact of withdrawal symptoms on the newborn.

If the mother is observed leaving the ward for long periods, the midwife will enquire as to the reason for the absence and will challenge the woman if the midwife suspects the use of illicit substances or alcohol. If suspected of using illicit substances follow Trust procedure for Illicit substances.

4.9 Breastfeeding

Breastfeeding should be encouraged. Although the risks and benefits will be considered before using any drug when breastfeeding, it should be noted that most drugs pass through the breast milk in very small quantities with a milk-to-plasma ratio <1%.

If the mother has continued to use illicit drugs in pregnancy then they are advised of the risk of harm from maternal substance misuse and to abstain should they wish to breastfeed.

If a mother wishes to breastfeed and has used an illicit substance recently or prior to delivery then it is recommended that the mother waits for 24 hours to elapse following substance misuse, before commencing or continuing breastfeeding.
Expressing and discarding breastmilk should be encouraged to support maternal milk supply.

The administration of Codeine Phosphate should be **avoided** if a mother wishes to breastfeed. Small amounts of codeine pass into breast milk and can cause breathing problems, poor feeding, lethargy, drowsiness and bradycardia in the baby see Breastfeeding Network information sheet on Codeine.

In the event of a baby being placed in the care of the local authority and the mother wishing to supply breastmilk, the infant feeding team can be contacted to give advice on breast milk/chest milk expression or storage (see the Joint Infant feeding policy).

4.10 Discharge From Hospital

Discharge planning should start during the antenatal period and prior to admission in labour.

If required, a pre-birth planning and discharge planning meeting is arranged by Social Care. This meeting should include the mother and any support networks she has; community midwife; ward midwife; neonatologist; nursing staff from NNU if admitted; social worker; health visitor; GP; Barnsley Recovery Steps and any other services involved.
The plan should be attached to the maternal notes and on maternal EPR.

In the absence of the pre-discharge planning meeting follow the Procedure for the maternity multidisciplinary team (MDT) care plan for women with additional health or support needs.

Safeguarding issues should have been identified during the pregnancy and any referrals to social care actioned.
A social worker should be identified, and either a Child In Need (CIN) plan or a Child Protection Plan (CPP) should be drawn up during the antenatal period and documented in the maternal hospital notes and the patient EPR.

The Alcohol and Drug Recovery Services must be informed of discharge in order that drug substitution prescription(s) can be reinstated.

The mother will have been made aware that hospital admission for up to 72 hours is required to monitor her baby; and that an early discharge is not possible if there has been any substance misuse in pregnancy. If the mother insists, the emergency duty social work team must be informed.

Any new safeguarding concerns during labour or postnatally must be acted on immediately. The Safeguarding team and social care must be informed without delay. Parents should be informed that this is happening.

The midwife will discuss safe sleep and infant crying prior to discharge with the parents, foster carers, adoptive parents or social care if baby in going into Looked After care.

Avoid weekend or Bank Holiday discharge. Where this is not possible the duty social worker, safeguarding team, on-call obstetric consultant and community midwife must be informed.

For weekday discharges:

Opiate substitute medications (methadone and buprenorphine) can be processed in pharmacy before 3pm. Give the patient a dose for that day whilst they are on the ward but do not supply any additional doses, advising the patient to collect the next dose from the chemist as usual.

For weekend or bank holiday discharges (if this cannot be avoided):

Give the patient their dose for the day on the ward and then either supply 1,2 or 3 days (depending on day of discharge) to cover them until their usual prescription can be collected.

4.11 Care By Community Midwife

Community Midwives will provide routine postnatal care for all women on their caseload, and discharge care of the mother and baby to the Health Visitor routinely.

For women who have written agreements or where there is a child protection plan in place, the case-holding community midwife will provide routine postnatal care up to 10 days.

They will continue to review weekly as required up to 28 days before discharging care of the mother and baby to the Health Visitor when appropriate.

5.0 Associated documents and references

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NICE (2021) Antenatal guideline https://www.nice.org.uk/guidance/ng201

NICE (2012) Quality standard for drug use disorders. NICE quality standard 23. London: National Institute for Health and Clinical Excellence

NICE (2022) Fetal alcohol spectrum disorder: Quality standard www.nice.org.uk/guidance/qs204

NICE (2010) Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. Clinical guidance 110 https://www.nice.org.uk/Guidance/CG110

NICE (2010) Alcohol-use disorders: diagnosis and management of physical complications. Clinical Guideline cg100 https://www.nice.org.uk/guidance/cg100

Office for Health Improvement and Disparities (2020) Alcohol use disorders identification test for consumption (AUDIT C) (publishing.service.gov.uk)

UK Chief Medical Officers' Low Risk Drinking Guidelines (Department of Health, 2016), www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking

6.0 Training and resources

Training will be delivered annually within Midwifery mandatory training as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis. Staff are supported to develop skills and knowledge within their remit of practice and job role. All midwifery staff

and maternity support workers will receive training to equip them with the skills to advice and support women who misuse substances in pregnancy.

7.0 Monitoring and audit

Any adverse incidents relating to the management of Alcohol and Substance Misuse Guideline will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for Alcohol and Substance Misuse will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

8.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This procedure should be implemented with due regard to this commitment.

To ensure that the implementation of this procedure does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

8.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Glossary of terms
List all terms/acronyms used within the document and provide a summary of what they mean.

ANPN – Antenatal Postnatal Ward
BBV – Blood Borne Virus
CIN - Child In Need
CPP - Child Protection Plan
EH – Early Help
EPR - Electronic patient Record(s)
FASD - Fetal Alcohol Spectrum Disorder
GP – General Practitioner
Hep B- Hepatitis B
Hep C – Hepatitis C
HIV – Human immunodeficiency Virus
IUGR – Intra Uterine Growth Retardation
IUD – Intra Uterine Death
IV – IntraVenous
IVDU – IntraVenous Drug Use
ICON – Infant crying is normal, Comfort methods can sometimes soothe, It's Ok to walk away if baby is in a safe sleep position, Never ever shake or hurt a baby.
MASH – Multi Agency Safeguarding HUB
MDT – Multi Disciplinary Team
NEWS – Newborn Early Warning Score
NNU – NeoNatal Unit
SUDI – Sudden Unexpected Death in Infancy

Appendix 2

The Alcohol Use Disorders Identification Test (The Brief AUDIT C)

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

AUDIT C score	

Scoring

- 0 - 4 indicates low risk
- A score of **5 or above indicates AUDIT C positive**

What to do next?

Discuss the fact that the AUDIT C score of 5 or more indicates drinking is at a level of high risk for both the woman and her baby's health. Refer to the Alcohol Care Team and Barnsley Recovery Steps for specialist substance misuse services; and the Safeguarding team and the Early Help team for support (See Section 4.3).

Appendix 3

Recovery Steps Barnsley Referral Form

Referrer Information		*Office Use:*
Date of Referral:		Date referral received: / /20
Referred By:		
Name / Organisation / Address:		
Tel:		
Email:		Date of Initial Screening: / /20

Client Information	
Clients Full Name	
Client D.O.B	

Address and Contacts Details	
Address (including postcode)	

Please provide details of preferred communication methods	
Mobile	
Text	
Landline	
Email	
Letter	
Voicemail	
Should someone else answer the phone are we able to say where we are calling from?	

GP Details Client to be advised that in order to access treatment they need to be registered with a local GP

Barnsley Recovery Steps Service store this information about you in order to support you if you access the service. By filling out this form, the client is agreeing for us to retain this information. You can choose at any time to have this information removed at your request to the service.

Presenting Need
Reason for initial referral to Barnsley Recovery Steps:
Any known Risks? (e.g. mental health, safeguarding, clinical vulnerabilities)
Any relevant additional information:

Appendix 4

Modified Finnegan Neonatal Abstinence Scoring Tool (FNAST)

Patient ID: Name Todays weight: DOB: Date:

		am	pm	Comments
Signs & Symptoms Time	Score			
Central Nervous System Disturbances				
Crying: Excessive High Pitched	2			
Crying: Cont. High Pitched	3			
Sleeps <1 Hr After Feeding	3			
Sleeps <2 Hr After Feeding	2			
Sleeps <3 Hr After Feeding	1			
Hyperactive Moro Reflex	2			
Markedly Hyperactive Moro Reflex	3			
Mild Tremors: Disturbed	1			
Mod-Severe Tremors: Disturbed	2			
Mild Tremors: Disturbed	3			
Mod-Severe Tremors: Undisturbed	4			
Increased Muscle Tone	2			
Excoriation (specific area)	1			
Myoclonic Jerk	3			
Generalized Convulsions	5			
Metabolic, Vasomotor and Respiratory Disturbance				
Sweating	1			
Fever <101 (37.2,38.3c)	1			
Fever >101 (38.4c)	2			
Frequent Yawning (>3)	1			
Mottling	1			
Nasal Stuffiness	1			
Sneezing(>3)	1			
Nasal Flaring	2			
Respiratory Rate(>60/Min)	1			
Respiratory Rate (>60/Min w Retractions	2			
Gastrointestinal Disturbances				
Excessive Sucking	1			
Poor Feeding	2			
Regurgitation	2			
Projectile Vomiting	3			
Loose Stools	2			
Watery Stools	3			
Score				
Total score				

Adapted from Finnegan, L.P. and Kaltenbaach. K. (1992)

Management of the Neonatal Abstinence Score

- Start scoring within 24 hours of birth and monitor every 3-4 hours.
- Initiate pharmacologic treatment for:
    - Two consecutive scores ≥12
    - Or three consecutive scores ≥8

  Discuss with Paediatric consultant and Neonatal Pharmacist/Pharmacy team for management.
- If neither of the above, continue to monitor scores every 3-4 hours. The duration of observations will be determined by the Paediatric Team for each individual case depending on substance(s) the baby has been exposed to.

Appendix 5

Barnsley Hospital NHS Foundation Trust

Drug and Alcohol Quick Reference Guide

For advice email the safeguarding team (bhnft.safeguardingteam@nhs.net)

No Concerns

No concerns with alcohol or Drugs, with negative assessment AUDIT C,

No further action

AUDIT C each trimester

Revisit if required at any point

Careflow documentation

Alcohol

Positive 3 question AUDIT C score 5+ or continued alcohol use of 14 units per week continued in pregnancy

Refer to Safeguarding Midwife for Full AUDIT on bhnft.safeguardingteam@nhs.net

Refer to the Alcohol Care Team if AUDIT score is 7and above on extension(s) 5299, 3117 or 3118: alternatively refer through Careflow Connect

In addition, refer to Alcohol and Drug Recovery Services – Barnsley Recovery Steps (779066) with consent.

Careflow Documentation

If in withdrawal refer to Alcohol and Drug Recovery Services – Barnsley Recovery Steps for advice and /or accident and emergency

Discuss risks

Disclosure of previous drug misuse

Refer to Safeguarding if used within 1 month prior to booking pregnancy

bhnft.safeguardingteam@nhs.net

Advice will be provided by email

Careflow documentation

Consider sexual health/BBV screening (Hep C)

Consider referral mental health

Consider EH/MASH

Revisit if required at any point

Disclosure of Current drug use

Refer to Safeguarding if high risk drug use, heroin, prescribed substitute medication, support from Human Kind, opiate dependency, crack cocaine, cocaine, Ketamine use

bhnft.safeguardingteam@nhs.net

Refer to Alcohol and Drug Recovery Services – Barnsley Recovery Steps Human Kind (779066) for structured support

Refer MASH

Consider sexual health/BBV screening (Hep C)

Consider referral to mental health services

Careflow documentation

MDT approach

Refer appropriate Obstetrician

Alcohol use and drug misuse in pregnancy should be discussed with every woman at each contact regardless of substance (mis)use status at booking.

Appendix 6

Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date