Guideline for care of pregnant women who misuse substances

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Specialty:	Midwifery
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Contents

1 Introduction

1.1 All pregnant women who disclose current or previous substance misuse must be referred to the substance misuse team within Swansea bay UHB maternity services.

1.2 The substance misuse team work in conjunction with the maternity multidisciplinary team. The Community Drugs & Alcohol Team (CDAT) West Glamorgan Council on Alcohol & Drug Abuse Ltd. (WGCADA), BAROD Swansea, Review Agencies and PRAMS, will work alongside Health Visitors, Neonatal Nurses, Paediatricians, Obstetricians, General Practitioners and Social Services (Substance Misuse Delivery Plan, 2019-2022, Welsh Government 2019), and will promote best practice guidelines for professionals working with pregnant women who misuse substances or are prescribed medication which may have a detrimental effect on fetal wellbeing.

1.3 It is essential that all professionals are non-judgemental in their contact with the women as recommended within Maternity Health Care Wales - a 5 year Vision for the future (2019)

2 Aim of the guidance

2.1 To ensure that the advice given to women during pregnancy, from all professionals involved, is consistent, up to date and in line with National/All Wales guidelines, (Working Together to Reduce Harm – Revised Guidance for Substance Misuse 2017)

2.2 To ensure good communication between all professionals involved (Substance misuse treatment framework (SMTF) Welsh Government 2011)

2.3 To normalise antenatal, intra-partum and postnatal care as much as possible. Create women centred care involving the woman as early as possible, discuss their care using a planned co-operative, non-judgemental approach that encourages women to accept care for herself and her baby (Maternity Health Care in Wales 2019)

2.4 To ensure there is on going assessment to identify any concerns, which could lead to child protection issues (Social Services and Wellbeing Act 2014).

3. Client Group

- Women who misuse drugs and alcohol
- Women who misuse any other substance which is not being used for it's intended purpose
- Women who are undergoing a 'Detox' programme with CDAT.
- Women already prescribed Methadone or Subutex/Buprenorphine via CDAT or other prescribing agencies
- Women using medication which affects the fetus e.g. Tramadol, Gabapentin
- Women prescribed significant psychotropic medication necessary to maintain the woman's psychiatric wellbeing are cared for by a designated consultant and once born, their babies care will follow the PNAS guidance within 'Guidance for women who are prescribed psychotropic Medication in Pregnancy'

http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/Guidance%20for%20Newborn%20Assessment%20when%20Exposed%20to%20Pyschotropic%20Medication%20In-Utero%282018.3%29_Swansea%20Bay%20Neonatal%20Guideline%20May%202019.pdf

4 Substances Involved

- Alcohol: There is no known safe level of alcohol consumption during pregnancy. DOH, WAG and Health Board guidelines recommend abstinence (BMA Board of Science 2007)
- Amphetamines
- Benzodiazepines
- Cannabis
- Cocaine
- Crack Cocaine
- Hallucinogens
- Heroin
- Mephedrone (MCAT)
- Methadone
- New Pschyoactive Substances (**NPS**) formally referred to as 'legal highs'
- Opiate based analgesia **e.g**. **codeine dosage over 90mgs per day**
- Over the counter (OTC) preparations
- Solvents
- Subutex/Buprenorphine
- Tobacco **N.B. tobacco noted as a substance, not for routine referral**
- Any Prescription Only Medicine (POM) that are being misused **e.g. Tramadol, Gabapentin**
- Any POM that are necessary for the woman's own health
- Any substance that can affect the fetus in utero.
- **N.B**. **CBD Oil** products do **not** contain **THC** (Tetrahydrocannabinol), the psycho-active ingredient in cannabis, therefore, their use by the woman should not have a detrimental effect on the fetus.

5 Referrals

5.1 Initial referrals can be made by Midwives, Obstetricians, General Practitioners, Maternity Services, Drug Agencies, Health Visitors, Social Workers, Probation, Police, partner agencies, and women can self-refer.

5.2 Referrals must be made in electronic format by email which can be accessed via the Health Board 'Z' drive within the folder Z:\Maternity\Substance Misuse\substance misuse\mental health referral.

6. Antenatal Management

6.1 All women will be booked for pregnancy care by their named community midwifery team. If an issue with substance misuse is identified at any time during pregnancy, labour or the postnatal period, the woman must be referred to the Substance Misuse Specialist team.

6.2 The referral to the substance misuse team will be recorded on WPAS as an alert.

6.3 The referral to the substance misuse team will be triaged by the specialist team.

6.4 The referrer will receive an email from the substance misuse team to advise of the plan following triage (either appointment provided or referral declined). The referrer will be contacted to advise of the outcome of the triage.

6.5 The substance misuse team will manage all referrals to the appropriate support services. The community midwife will be informed via email of external agencies who are involved in the care of the woman.

6.6 The substance misuse specialist midwife will document all contacts with the woman on the antenatal notes section of WPAS.

6.7 Safegaurding notes and substance misuse notes will be available on the electronic sharing Z drive. The files will be stored using the NHS number as the reference.

6.8 The woman will be offered routine antenatal screening tests, plus Hepatitis 'C' screening. GammaGT estimation (GGT) (alcohol and long-term opiate misuse) and urine toxicology with appropriate counselling and referral to further specialist services as required.

6.9 The woman will be asked to sign a specific consent label in the All Wales Maternity Record with regard to consent to perform urine toxicology testing throughout the course of the pregnancy, in a bid to exclude any confusion over consent for this procedure (Substance Misuse Delivery Plan 2019)

6.10 If a woman requests a home birth, the midwife and substance misuse team will communicate to make an individualised plan of care. A homebirth may not be appropriate where safeguarding concerns exist or the home is not a suitable environment. However, if a woman chooses to birth at home, midwives have a duty to provide midwifery care if called in labour. Any immediate safeguarding concerns will be managed in line with social services and the police where necessary. The Consultant midwife can support the decision making on behalf of the community team who will provide intrapartum care.

6.11 The Neo-Natal Unit is to be informed of the pregnancy **between 28-32 weeks** gestation using a referral form.

6.12 The woman's individualised plan of care will be made between the named midwife and specialist substance misuse team to ensure effective communication and delivering *"wrap around"* care.

6.13 The Community midwifery team and substance misuse team will communicate every non-attendance for care to ensure suitable follow-up arrangements are made.

6.14 The woman must be informed of the care pathway if she fails to attend three consecutive appointments with the maternity health professionals. A discussion will take place with the safeguarding lead midwife and a referral to social services may be required.

6.15 Women will be offered fetal surveillance ultrasound scans in line with health Board policy (based on GAP/GROW) for Fetal Surveillance If necessary, a referral to the Anaesthetic Department will be sent at 28 weeks gestation for the woman to be reviewed by the anaesthetists prior to delivery. Due to COVID there is now an electronic referral system and patients are referred at the earliest opportunity to facilitate timely assessment by the anaesthetic team.

6.16 If necessary, an electronic referral to the Anaesthetic Department will be sent at 28 weeks gestation for the woman to be reviewed by the anaesthetists prior to delivery. This electronic referral form can be found on the Health Board 'Z' drive within the folder Z:\ Maternity\Substance Misuse.

6.17 The woman should be encouraged to attend Parenting Sessions and offered referral to Parenting programmes, such as, JIGSO, or one to one ante-natal education if considered helpful. (see Appendix 3)

6.18 A Cause for Concern file should be completed in all cases and entered into the Safeguarding Database on the Health Board 'Z' drive.

6.19 The current All Wales Safeguarding guidelines can be downloaded and accessed via a desktop or by using an 'App'. https://play.google.com/store/apps/details?id=com.socialcarewales.safeguarding&hl=en_US All Safeguarding referrals should be made following local guidelines in the locality where the woman resides.

6.20 Where women are referred to Social Services, plans may need to be made using a multi-disciplinary approach which could include discussion with the safeguarding midwife

6.21 A care plan will be completed by the Substance Misuse team if necessary in collaboration with the woman and obstetrician, The care plan can be accessed on the health Board 'Z' drive.

6.22 An intra-partum and immediate post-natal care plan will be completed by the Substance Misuse team if necessary in collaboration with the woman and obstetrician (NICE Guideline for Pregnancy and Complex Social Factors (2010). The care plan can be accessed on the Health Board 'Z' drive within the folder Z:\Maternity\Substance Misuse.

7. Intrapartum Management

7.1 It is recommended that birth takes place in an Obstetric Unit (OU). An individualised birth plan will be created for women who decline to birth in an OU. A comprehensive risk assessment and birth plan should be developed by 36 weeks. This should be completed by the MDT in conjunction with the woman. A recommendation for the safest place of birth should be made and documented. For some women a midwifery led birth setting may be appropriate this assessment will be made on intrapartum risk factors, the level of neonatal care and monitoring required and safeguarding plans. A referral to the consultant midwife should be considered where women are choosing to birth outside of the recommended care.

7.2 All women with difficult venous access should have a planned anaesthetic review at 30-34 weeks. This will be arranged by the specialist team.

7.3 Universal precautions in line with Infection prevention and control standards must be applied in line with health Board policy.

7.4 Methadone/Subutex/Buprenorphine must be continued during labour as detailed on care plan.

7.5 Adequate pain relief must be ensured. Additional opiates may not be very effective if the receptors are already saturated, Epidural should be considered at an early stage.
(http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/patient%20controled%20epidural%20analgesia.pdf))

7.6 There is little evidence to suggest that a fetus already sensitised to opiates, will be caused harm by opiates given for pain relief.

7.7 Opiate withdrawal in labour will be shown by fetal distress on electronic fetal monitoring e.g. fetal tachycardia/bradycardia, excessive movements or meconium stained liquor. Ensure woman has an adequate amount of opiate throughout labour to ensure that opiate withdrawal leading to fetal distress may be excluded.

7.8 For maternal withdrawal signs from opiates see Guidelines for the management of adult opiate dependant patients in the acute hospital setting (COIN ID 127)
http://howis.wales.nhs.uk/sites3/Documents/926/CID127%20Guidelines%20for%20the%20Management%20of%20Adult%20Opiate%20Dependent%20Patients%20in%20the%20Acute%20Hospital%20Setting%20-%20September%202020.pdf.

7.9 Substance misuse is not a contra-indication for use of PCA Pump, for pain relief/control following caesarean section. See
(http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/Remifentanil%20Patient%20Controlled%20Analgesia%20%28PGA%29%20For%20Labour_ABMU%20Maternity%20Guideline2017.pdf

7.10 The woman's substance misuse may be discovered when in labour, if opiate withdrawal is identified, the anaesthetist should be contacted for specialist medicine management advice.

7.11 The Neonatologist/Paediatrician must be informed when the woman is in established labour. The neonatologist/Paediatrician is not routinely required to attend the birth unless clinically indicated (Wales Neonatal Network Guideline on the Management of Neonatal Abstinence Syndrome 2017)

7.12 If resuscitation of the infant is required at birth, **DO NOT** give Naloxone, unless prescribed by the paediatrician present, as it could lead to acute withdrawal & perinatal morbidity and mortality. (Gibbs 1989)

8 Postpartum Management

8.1 Urine from both mother and baby should be collected within 24 hours following delivery if indicated on the care plan. **Mother's consent is required for this unless an emergency child protection order has been served**. In circumstances where consent is refused, consideration must be given in line with the 'consent policy' to over-ride parent's wishes in relation to the baby.

8.2 Inform relevant professionals of delivery, e.g. Paediatrician, Substance Misuse Specialist team, Social services if involved. Care of baby, as usual. Encourage 'skin to skin' contact & Breast Feeding.

8.3 Breast Feeding should be encouraged, even if continued drug use.

8.4 Early, regular feeding of infant will be required to prevent hypoglycaemia. http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/Term%20Bundle%20for%20Babies%20at%20Risk%20of%20Hypoglycaemia%20on%20the%20Postnatal%20Ward_Swansea%20Bay%20Neonatal%20Guideline%202020.pdf

8.5 Mother and baby to be transferred to the postnatal ward as usual. Baby to be transferred to the Neonatal unit only if there are medical indications to do so. Ward staff to observe baby for withdrawal symptoms. (see Appendix 1)

8.6 A guide to which babies will require Finnegan Scoring and if so, for how long, can be found in Appendix 2

8.7 Any substitute therapy that the woman has been prescribed, e.g. Methadone or Subutex/Buprenorphine, should be continued. If this is not given, the woman will experience withdrawal symptoms.

8.8 The mother should be made aware that other members of the multidisciplinary team will be informed of her birth. If midwives with specialist parenting skills, such as, JIGSO, are involved they should be ready to continue/begin help with parenting if the mother so wishes.

8.9 If 'Safeguarding' issues are highlighted, then staff must adhere to the All Wales Safeguarding Procedures and implement the plan as agreed. This should all be conducted with full consultation with the mother and partner if present.

8.10 Infant feeding should be that of the mother's choice. Breast feeding should be encouraged, and is only contraindicated if the woman is HIV positive with a high viral load, or it has been identified as so in her care plan.

8.11 Midwives on the ward will need to inform CDAT of the woman's discharge to enable them to recommence her opiate replacement prescription. (See Appendix 3)

8.12 To follow up from the SIP2 sent to the General Practitioner at the beginning of the pregnancy, a notification of the birth should be sent to inform the General Practitioner of the woman's discharge from hospital including any relevant information required for providing on-going care and treatment in the community

8.13 On transfer home, the midwives will visit mother and baby as often as required, to provide support, to monitor the transition to parenthood and the wellbeing of mother and infant, up to 28 days postnatal, when care will be transferred to the Health Visitor.

8.14 A face to face/virtual transfer of care to the Health Visitor must be performed, this will be supported by documented entries in the 'Red Health Book'

8.15 Support, advice and guidance can be accessed in the first instance from the Substance Misuse team.

8.16 Named Midwife for Safeguarding must be informed if appropriate.

9 Breast Feeding

9.1 Most drugs of misuse do not pass into breast-milk in sufficient quantities to have a major effect on the baby. The **Relative Infant Dose (RID)** is a method for estimating risk to the baby from exposure to medication taken by the mother in breast milk. The RID of the vast majority of drugs is < 1%. The (RID) of each medication is found on the LactMed website https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

9.2 Apart from all well documented benefits, breastfeeding will certainly support the mother in feeling that she is positively comforting her baby, should he/she be difficult to settle. (ISDD 1995)

9.3 It is important that the mother be given all the information she needs to make an informed choice and she should be fully supported in that choice by all professionals involved

9.4 Hepatitis C positive women can breastfeed their babies if their recorded viral load in pregnancy is considered low, or they are RNA negative. HIV positive women should be advised of the risk of vertical transmission through breastfeeding. Current evidence based advice (2020) is that women with a negligible or very low HIV viral load may breastfeed if they wish. Those with a moderate to high viral load should be advised to feed their baby using formula feed. https://www.bhiva.org/file/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rd-interim-update.pdf

9.5 Women and their partners who use drugs, take alcohol or smoke must be advised against bed-sharing as recommended in the Health Board Infant Sleep Policy which can be accessed on the Health Board 'Z' drive pow_fs1\ABM_W&CH_\ClinicalGovernance-Q&S\Policies&Procedures-Ratified\Maternity .

10 Monitoring and Treating Neonatal Drug Withdrawal

10.1 The aim of managing an infant who is at risk of neonatal drug withdrawal is to:

- Maintain normal temperature
- Reduce hyperactivity, excessive crying and motor instability
- Ensure adequate weight gain
- Promote adequate sleep patterns

10.2 Infants assessed for signs of drug withdrawal by a scoring system are less likely to be inappropriately treated and may have a shorter stay in hospital. However,

assessing signs of drug withdrawal involves an element of subjectivity. The assessment chart aims to reduce distress and control potentially dangerous signs.

10.3 **Withdrawal from**:

- Opiates may occur within 24 hours (Heroin)
- Opioids may occur 48-72 hours after birth (Methadone)
- Benzodiazepines combined with opiates/opioids may delay withdrawal up to 10 days
- Polydrug use may delay or skew withdrawal signs

10.4 Treatment should be considered (after all other causes have been excluded) if the baby has convulsions, profuse watery stools, profuse vomiting or requires tube feeding due to in co-ordinate suckling. If the baby has been persistently distressed since the last feed and has been inconsolable with standard comfort measures, treatment may also be considered.

10.5 Monitor infants at risk of neonatal withdrawal by using the standard assessment chart which aims for comfort **not sedation**. (see Appendix 1)

11 References

BMA Board of Science: Fetal Alcohol Spectrum Disorders. A Guide for Healthcare Professionals. June 2007

Guidelines for the Management of HIV Positive Pregnant Women ante-natal, intra-partum and post-natal care) in Swansea Bay Health Board 2020

Management of Hepatitis C SIGN 133 2013 P.12

Maternity Health Care Wales - a 5 year Vision for the future (2019-2024)

Maternity Matters: Choice, Access and Continuity of Care in a Safe Service DOH 2007).

NICE Guideline for Pregnancy and Complex Social Factors: a model for service provision for pregnant women with complex social factors 2010 www.nice.org.uk/guideance/cg110

Relative Infant Dose (RID). LactMed website
https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

Social Services and Wellbeing Act 2014

Substance Misuse Delivery Plan, 2019-2022 Welsh Government 2019

Substance misuse treatment framework (SMTF) Guidance for evidence based community prescribing in the treatment of substance misuse Welsh Government 2011 www.cymru.gov.uk

The Institute for the Study of Drug Dependence (ISDD) Eur Addict Res 1995 ; 1:152-153

Working Together to Reduce Harm – Revised Guidance for Substance Misuse Welsh Government 2017

Bibliography

Alcohol and Pregnancy: Information for Midwives: NOFAS-UK Reviewed by the Royal College of Midwives 2007

help@nofas-uk.org

Jordan S Pharmacology for Midwives: the evidence base for safe practice 2nd ED Palgrave Macmillan 2010

National Assembly for Wales Health and Social Care Committee Alcohol and substance misuse August 2015

National Institute for Health and Clinical Excellence (NICE) Drug Misuse- Methadone and Buprenorphine for the management of opioid dependence January 2007

NMC Midwives Rules and Standards (2018)

Scottish Intercollegiate Guidelines Network (2019) SIGN 156: Children and young people exposed prenatally to alcohol

SIGN 133-Management of Hepatitis C (2013)

Siney C (ED) 'The Pregnant Drug Addict' pp24-33. Books for Midwives Press: Haig & Hochland 1999

UK Confidential Enquiry into Maternal Deaths – still learning to save mothers' lives 14 March 2018

Welsh Government (2018) A Healthier Wales: Our plan for health and social care. Cardiff: Welsh Government

Welsh Government (2017) Your Birth, We Care: A survey exploring women's experiences of pregnancy and birth in Wales. Cardiff: Welsh Government

Welsh Government Tobacco Control delivery plan for Wales 2017-2020 (2017)

Appendices

Appendix 1 – Modified Finnegan Score

Patient Label

Modified Finnegan Score

Score infants 30 minutes to 1 hour after feeds
Infants at risk will score from each of the 3 sections in the scoring sheet
Designed for Term babies who are fed 4-hourly
Appropriate allowance needs to be given to preterm babies *

Date:

Record Time:

SYSTEM	SIGN	SCORE										
C.N.S.	Excessive cry Continuous cry	2 3										
	Sleeps <1hr after feed Sleeps <2hrs after feed Sleeps <3hrs after feed	3 2 1										
	Over active Moro reflex Very over active Moro reflex	2 3										
	Mild tremors disturbed * Mod/sever tremors disturbed * Mild tremors undisturbed * Mod/severe tremors undisturbed *	1 2 3 4										
	Increased muscle tone	2										
	Excoriation *	1										
	Myoclonic jerks	3										
	Generalised convulsions	5										
G.I.T.	Excessive Sucking	1										
	Poor Feeding *	2										
	Regurgitation * Projectile Vomiting	2 3										
	Loose Stools Watery Stools	2 3										
OTHER	Sweating	1										
	Fever 37.3 to 38.3C Fever 38.4C and above	1 2										
	Frequent yawning (>3-4 in ½ hr)	1										
	Mottling	1										
	Nasal Stuffiness	1										
	Sneezing (>3-4 in ½ hr)	2										
	Nasal flaring	1										
	Respiratory rate >60/min Respiratory rate >60/min & retraction	1 2										
	TOTAL SCORE											
Adapted from L.P. Finnegan (1986) Signature												

Explanation of Signs
- Tremors – infants should only get one score from the four options in this category
- Excoriation – score when presents, rescore only if it increases or appears in another area
- Poor feeding – score if slow to feed or baby takes inadequate amounts
- Regurgitation – score if it occurs more frequently than usual in a newborn

*see main guidelines

Alert Paediatrician if there are two scores >8 in last 24 hours or any score >12

Appendix 2 – Finnegan Scoring Advisory chart

FINNEGAN SCORING ADVISORY CHART

Useful Numbers:

Substance Misuse Specialist **Midwife: Ann Saunders** 07891485872 Substance Misuse Specialist **Nurse CDAT:** Swansea: **Nicola Cook** 01792 654630/07969442693 NPTH: Awaiting appointment (November 2020)

This table is for guidance only. In some circumstances, following advice from a Senior Neonatologist, some durations of observation may be shortened or lengthened depending on the substance, the dose and the circumstances. In all cases, decisions must be reached by reviewing mother's notes and any individual guidance already given should be taken into consideration.

Drug/Medication	Effects	Time Scoring Advised:	Breastfeeding Guidance Advice
Alcohol	Use in pregnancy associated with Fetal Alcohol Syndrome and withdrawal in newborn infants (irritability, unstable temperature, poor feeding, wakefulness)	If there has been regular and frequent alcohol intake **during late pregnancy,** examine for dysmorphic features and observe infant for **48** hours for signs of withdrawal.	Evidence of disturbed sleep pattern and impaired motor development. Breastfeeding **not** advisable within **8** hours of drinking alcohol[1]
Anti-Depressants/SSRIs/Tricyclics, SNRI's, Anti-psychotics, any other medications prescribed for Mental Health issues	**PLEASE REFER TO THE PNAS GUIDELINE:** http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/Guidance%20for%20Newborn%20Assessment%20when%20Exposed%20to%20Pyschotropic%20Medication%20In-Utero%282018.3%29_Swansea%20Bay%20Neonatal%20Guideline%20May%202019.pdf		
Amphetamines (non-prescribed): eg Phet, Powder, Speed, Whiz	Irritability, hyperstimulated, unstable temperature, overfeeding.	5 days	Not advisable
• **Benzodiazepines:** e.g. Valium (diazepam) **OVER 30mgs daily**	Hypotonia, hypothermia, lethargy, poor feeding	5 days	Not advisable
• **Benzodiazepines: UP TO 30mgs daily**	Possibly slow to feed	24 hours	If stable on current dose, breast feeding

			benefits may outweigh risks.
Beta blockers; e.g. Propranolol	Irritability, hypoglycaemia	See hypoglycaemia pathway	Yes
Cannabis	No proven physical effects	None	Yes
Cocaine **Including Crack Cocaine**	Effects highly variable - irritability, poor feeding, hyperalert state, excessive sleeping	5 days	Not advisable
Codeine	Small risk of NAS. Ultrafast metabolisers (up to 1 in 10 of population, up to 1 in 4 of African ethnic background) will convert codeine to morphine with subsequent risk of sedation and apnoea in the newborn infant	48 hours	Yes, but inform mothers of risks of excessive sleepiness/apnoea. Any symptoms should prompt urgent medical attention. Consider suspending breastfeeding until the cause of the baby's symptoms can be identified.
Heroin	Neonatal Abstinence Syndrome (NAS)	5 days	Not Advisable
MCAT (mephedrone) Meow Meow; Bonsai; Bubbles; Bounce	See Amphetamines	5 days	Not Advisable
Methadone	NAS	5 days	Yes
Morphine based analgesics: **MST, Orimorph**	NAS	2 to 5 days depending on dose and circumstances.	Yes
Subutex (Buprenorphine)	NAS	5 days	Yes
NPS (New Psychoactive Substances) **Formerly 'Legal Highs'** Genesis, Terminator, Clockwork Orange	See Amphetamines	5 days	Not Advisable
Tramadol	Rapid onset of NAS, within 24-48 hours	2 to 5 days depending on dose and circumstances	Yes
Pregablin **Gabapentin**	Case reports of withdrawal syndrome described	48 hours	Yes

[1] Risk of breast feeding should be weighed against its benefits. If in doubt, advice from a senior member of the neonatal team should be sought.

[2] When there is insufficient data to guide management a pragmatic approach may be taken in which the baby can be observed for between 2 and 5 days depending on dose and circumstances (eg parenting skills, social concerns). At discharge the midwife/clinician should advise the mother on potential risks and inform her what symptoms to look out for. This should then be documented in the notes.

Appendix 3 - Contact Details

Agency & Address	Contact Name & Number
Maternity services Substance Misuse Team	Ann Saunders, Specialist Midwife, (Substance Misuse) Tel: Mobile: 07891 485872 SBU.PregnancySubstanceMisuse@wales.nhs.uk Mr R Llewellyn
CDAT **Neath/Port Talbot:** Tonna Resource Centre, Tonna, SA11 3LX Tel: 01636 872872 **Swansea:** St James Crescent, Swansea, SA1 6DR Tel: 01792 530719	Nicola Cook Substance Misuse Specialist Nurse Email: Nicola.M.Cook@wales.nhs.uk Tel: Mobile; 07969442693
PSALT - YMCA, 1 the Kingsway, Swansea, SA1 5JQ	Tel: 01792 475595/8
WGCADA **Port Talbot:** 46 Talbot Road, Port Talbot, SA13 1HU **Neath – Substance Misuse Clients** **Harm Reduction:** 30 Victoria Gardens, Neath, SA11 3BH **Web site**: www.wgcada.org	Tel: 01639 890863 Tel: 01639 633630
BAROD **73/74 Mansel Street** **Swansea** / *Abertawe* **SA1 5TR** **website:** www.barod.cymru.	**Phone /** *Ffon :* 01792 472002
Flying Start **Neath Port Talbot Areas** **JIGSO Midwives** JIGSO Business Support 07929 848 972 SBU.jigsoreferrals@wales.nhs.uk	Maggie Davies Tel: 07970 514967 Maggie.Davies@wales.nhs.uk Tina Francis-Reed Tel: 07973 627789 Tina.Francis-Reed@wales.nhs.uk Sally Roberts 0785498181 Wendy Sunderland-Evans 07773 248663 Sally Roberts 07854 981 815 Julie Morgan 07977 267286 Andrea Grey 07870 805202 Rhian Hewitt 07870 805 235 Elizabeth Smith 07870 805 236 Emma Richards 07870 805 204

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Guideline for care of pregnant women who misuse substances
Name(s) of Author:	Ann Saunders & Sian Phillips
Chair of Group or Committee approving submission:	Antenatal Forum
Brief outline giving reasons for document being submitted for ratification	Previous document dated 2011 required well overdue revision
Details of persons included in consultation process:	Vicky Owens Consultant Midwife Katie Donovan Ante-Natal Screening Specialist Midwife Helen Griffiths Safeguarding Lead Midwife Rebecca Lewis Swansea Community Midwifery Co-Ordinator Lisa Rees Midwife (Hypoglycaemia pathway) Dawn Apsee Intra-Partum Lead Midwife Mr Rob Llewelyn Consultant Obstetrician Ms Louise-Emma Shaw Consultant Obstetrician Rachel Evans Breastfeeding Lead Midwife Wendy Sunderland-Evans JIGSO Lead Midwife Dr Geraint Morris Consultant Neonatologist Dr Ashok Ryani GP Susan Jose Deputy Head of Midwifery Helen Thompson-Jones BBV/Liver Clinical Nurse Specialist Dr Zelda Summers CDAT Nicola Cook Specialist Substance Misuse Nurse CDAT
Name of Pharmacist (mandatory if drugs involved):	
Issue / Version No:	
Please list any policies/guidelines this document will supercede:	Policy for pregnant women who misuse substances
Date approved by Group:	November 2020
Next Review / Guideline Expiry:	November 2023
Please indicate key words you wish to be linked to document	Pregnancy substance misuse, alcohol misuse, substance misuse, drug misuse, dependency
File Name: Used to locate where file is stores on hard drive	