NORFOLK RECOVERY PARTNERSHIP (NRP)

PREGNANCY LIAISON PARTNERSHIP PROTOCOL FOR THE CARE OF DEPENDENT AND PROBLEMATIC SUBSTANCE USERS

Norfolk and Suffolk NHS Foundation Trust
This protocol was reviewed and agreed by agencies involved in the care of pregnant substance users and the subsequent care of the baby post delivery.

The agencies involved in the review and finalised document are:

Norfolk Recovery Partnership (NRP)
Children’s services- Safeguarding
Midwifery
Obstetrics
Health Visitors
Neonatologist
Paediatrics
# AIMS OF PROTOCOL

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- Primary care not in service/unwilling to engage with NRP
- Referral to NNUH
INTRODUCTION

This protocol has been developed to facilitate harm minimisation and health promotion principles in the shared antenatal and postnatal care for pregnant women who have substance use problems or dependence.

The principals of the protocol are in accordance with the policy developed by the Norfolk Safeguarding Children Board (NSCB) to which all agencies have agreed to adhere.

Drug taking and alcohol use may lead to changes in fertility and irregular or absent menstrual period, consequently, late presentation of pregnancy is not unusual. Lack of screening and detection of higher than recognised safe limits of alcohol use can also lead to significant developmental problems for the unborn baby, and subsequent health problems post birth.

Some service users will already be in treatment or known to services and not using substances illicitly/ problematically, but will need specific aspects of co-ordinated care to achieve best outcome.

Throughout her pregnancy the service user needs to be reassured that she will not be discriminated against because of her substance use, and empowered to engage in the treatment necessary for her and her unborn baby.

AIMS OF THE PROTOCOL

To encourage pregnant substance users and, where appropriate, their partners, to seek treatment for their drug/alcohol use.

To take a proactive approach to identifying potential problematic substance use, and provide the required advice and information.

To enable pregnant substance users already in treatment to access co-ordinated care in respect of their pregnancy.

For pregnant substance users to receive appropriate and non-judgemental antenatal care.

For pregnant substance users to receive consistent and reliable information regarding their pregnancy, substance misuse and breastfeeding in a sensitive and non-judgemental manner.

To ensure effective communication exists between all professionals.
Referral

Referrals are accepted at the Norfolk Recovery Partnership (NRP). These referrals should be made at the earliest possible opportunity.

Self-referrals are accepted and encouraged and can be made in person, by telephone, letter or fax. Referrals are accepted/available from all NRP bases as listed below:

- Weavers
- Unthank Road
- NNUH Liaison Team

Assessments will be arranged as a priority and usually the service user will be seen within one week.

Information provided in a referral may vary dependent upon the source.

If you are a professional making the referral please provide all relevant medical and obstetric history, prescribed medication, current drug or alcohol use, any risks and/or child protection issues and names of other professionals involved with the patient.

If a client self-refers this information will be established with them at assessment and shared with the identified care team.

Any information concerning the needs or level of support her partner can provide is also helpful.

ROLE OF SUBSTANCE MISUSE LIAISON TEAM WITHIN NRP

Pregnant women are seen urgently as a priority assessment, usually within one week.

At assessment, discussion regarding the continuation of the pregnancy will be handled in a sensitive way. If the woman is considering a termination, a referral can be made to Marie Stopes International either by the professional or by the woman herself.

A full Substance Misuse assessment will be completed and discussed within the multidisciplinary team meeting in the usual way leading to an agreed care plan with the client. Copies of the assessment and care plan will then be forwarded to the following care team:

- Community Midwife
- GP
- Dr. Anna Haestier, Consultant Obstetrician
- Dr Mark Dyke, Consultant Neonatologist
- Link NICU staff
- Senior Sister, Antenatal Clinic
- Safeguarding Team Children Advisor

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Any concerns regarding the pregnancy and/or maternal health should be directed to the midwife/antenatal clinic. It should be made clear that NRP does not take on the role of providing antenatal care as this is provided through maternity services.

Various treatment options are open to pregnant substance users depending on the stage of the pregnancy; past obstetric history and substance history. Substitute prescribing for opiate dependent women could be either Methadone or Buprenorphine. If substitute prescribing is to be the option, it is beneficial for both mother and fetus that prescribing ensues quickly.

Other treatment options may include benzodiazepine reduction alcohol detoxification and reduction support for other substances.

It should be established early on if the woman wishes to be drug and/ or alcohol free before the expected date of delivery and whether this is a realistic plan. Maintenance prescribing during pregnancy for opiate dependent women may be the preferred treatment choice in terms of risk reduction. Risk from sudden opiate withdrawal during pregnancy or labour carries significant risks including; miscarriage, premature labour and foetal compromise.

Provision of urine samples for drug screening are included in the ongoing treatment care plan. Screening for BBV's (HBV, HIV) are facilitated through the community midwife as routine bloods. Hepatitis C is not routinely screened as part of maternity bloods and will be facilitated by NRP. In order to minimise the need for invasive investigations, NRP can facilitate all BBV screening. If the woman has poor venous access NRP nurses can facilitate venepuncture with prior arrangements. If this option is to be used, all blood bottles and completed forms should be forwarded to NRP. NRP staff will then complete the procedure as per venepuncture guidelines.

Referral to Gastroenterology should be made in line with NRP ICP for HCV when a positive result in returned.

Hepatitis B vaccinations should be started/ completed whilst the pregnant woman is engaged with NRP.

Information regarding the mother’s BBV status will be disclosed; this will be discussed as part of pre-test discussion as this has implication for the baby. Information about any Hepatitis antigen positive (infection) results will be clearly communicated to ANC and Neonatal Team (in the form of a paediatric alert) to inform the birth and neonatal care plans.

Regular liaison between NRP staff and other professionals involved in the care of the mother and fetus is essential. As such, signed consent to contact other professionals should be obtained. Boundaries regarding information sharing will be discussed. Child protection issues, neonatal infection risk (BBV) and any other major risks to the service user or staff would be such exceptions to consent.

The service user should be encouraged to access antenatal care as soon as possible to establish the stage of gestation, as this will influence the care plan. If antenatal care has not already been booked, the NRP worker should contact the community midwife as a priority to expedite the booking system. In instances of late presentation or high risk
NRP staff can contact the Sister in Charge at the Antenatal Clinic to make a direct referral (as locally agreed). The service user can also have a visit to the Neonatal Intensive Care Unit (NICU) arranged through the NRP worker/NICU link staff.

The NRP worker needs to discuss with the service user and, if appropriate, her partner the following aspects of care:

1. The wellbeing of the baby will be everyone’s primary concern; and child protection concerns should be directed to Children Services in accordance with the Norfolk Safeguarding Children Policy.

2. The Mother/parents should be advised of the NRP policy statement on child care that has been negotiated with Children’s Services via the Norfolk Safeguarding Children Board (NSCB), which is that “…drug and alcohol use are not, in themselves, reasons for ‘taking children into care’ or for registering them as ‘at risk’”. Constructive, collaborative care with Children’s Services is encouraged.

3. There will be regular communication with all professionals concerned with the service user’s care including pre-delivery discussion. This will ensure that the care team are aware of events pertaining to the development and revision of any care plan.

4. The NRP worker will continue to follow up the service user postnatally for up to three months and care will then be transferred back to the designated worker if ongoing treatment with NRP is indicated.

5. Assessment of mental state is ongoing, throughout the duration of the pregnancy and postnataally. Formal psychiatric assessment for NRP client can be available from the NRP medical team. Where clinically indicated, or evidence of past mental illness history exists, liaison will be made with the relevant Community Mental Health Team. Care plans should emphasise the need to review mental state post-partum and at six weeks.

The NNUH Substance Misuse Liaison Team will be involved with all aspects of hospital care and subsequent discharge planning, to facilitate arrangement for ongoing prescriptions/ follow up appointments.

**Substance Misuse Care Plan**

A summary of the initial pregnancy assessment and subsequent care plan should be routinely sent by NRP staff to all members of Pregnancy Liaison Team, with a follow up report at 32 weeks gestation.

The care plan will be influenced by regular information exchange through the pregnancy liaison meetings (monthly intervals) and by service user involvement in care planning.
At 32 weeks gestation the care plan summary should include:

- Breastfeeding advice - substance specific
- BBV status
- Evaluation of care plan so far
- Current medication and review
- General discussion about progress
- Any concerns
- Revised care plan
- Contributing towards birth plan.

Any Child Protection concerns (at any stage) should be raised with Children’s Services. Referral is through agreed processes to the MASH (Multi Agency Safeguarding Hub).

Cranial Ultrasound for cocaine users will be arranged through an appointment with the Consultant Neonatologist. This will be requested by NRP and a visit to the NICU arranged through NICU link staff.

**ROLE OF MIDWIFE**

**Antenatal Care**

The first point of contact for the woman will either be GP, midwife or NRP. It is important to undertake a needs assessment and screening at the earliest opportunity. The maternity booking form must be sent to the hospital antenatal clinic at the first appointment with either the GP or midwife. If the woman presents late to NRP, and to avoid delays in screening, they can refer directly to the antenatal clinic.

History for drugs, alcohol use will be performed at the first appointment. This is recorded in the maternity handheld record. Shared care between midwife/ GP/ Obstetrician should be offered with an individual care plan.

A referral to NRP for assessment and establishment of collaborative care should be made. If the woman does not wish to be referred to NRP, the link midwife and community midwife must be informed of this.

Any safeguarding concerns should be managed in accordance with the pre-birth protocol of the NCSB. Women should be encouraged to discuss their birth plans with their midwife; this may include having a written birth plan to include pain relief in labour. Women on Buprenorphine, (partial agonist/antagonist), should be advised to avoid opiate analgesia. Parent education requirements should be explored and appropriate plans made for this.

If a woman defaults on scheduled appointments with the midwife/ANC the NRP Liaison Team will need to be informed, the usual midwifery DNA follow-up efforts will be implemented and the woman encouraged to re-engage with maternity services.
Routine antenatal screening tests are offered and all results will be recorded in the maternity handheld records.

As this screening covers HIV and HBV only, women or partners with a history of substance use should be actively encouraged to screen for HCV. Screening for this will be facilitated by NRP.

As previously mentioned - women can access this combined screening through NRP by prior arrangement with the NRP worker (see role of Substance Misuse Team section). Screen positive results for infectious diseases will require sharing between ANC/Consultant Obstetrician/community midwife/GP/NRP.

**Hospital Admission**

Midwives/Obstetricians should be familiar with the Trust processes for cancelling/re-instatement of Methadone, Buprenorphine and/or Benzodiazepine (refer to Trust guidelines) prescriptions and inform NRP that this has occurred.

Breastfeeding should be encouraged unless otherwise contraindicated.

Liaise with NRP regarding any outstanding Hepatitis B vaccinations.

Where possible, discharge should be on weekdays as NRP is not available to women at weekends. If the baby is on NICU/Transitional Care and Mum is resident on NICU, the NICU team should liaise with NRP regarding continuation of any substitute prescribing (01603 288874).

If a woman presents for admission, is opiate dependent and not known to NRP or not on substitute medications, requires alcohol detox, then the NRP Liaison Team can be contacted to arrange urgent assessment on 01603 288874 (see appendix 2 for guidance in the event of NRP or substance misuse expertise being unavailable).

**ROLE OF NEONATAL TEAM**

Antenatal visits to the NICU will be offered and recommended to pregnant substance users and partners as part of their overall care plan. This will be arranged through link NICU staff.

NICU nurses will discuss the rationale for the visit, possible treatment plan for the baby and signs and symptoms of neonatal withdrawal and possible length of stay.

Further discussion surrounding blood borne viruses (Hepatitis B, Hepatitis C, and HIV) should be undertaken on the visit to NICU and postnatally by the Neonatal Team.

Hepatitis B vaccination courses should be offered to all neonates and the first dose should be given within 72 hours of birth or as per schedule.

Any child protection concerns should be directed to Children’s Services as per Trust Guideline for Safeguarding Children.

The link NICU nurse or designated other should attend any pre-discharge planning meeting and inform NRP of discharge plans and dates.
ROLE OF GP/ PRIMARY CARE TEAM

The GP/Primary Care Team may be the first professionals to become aware that a substance user is pregnant. He/she should confirm the woman’s pregnancy and give consideration to advice regarding continuation of pregnancy or urgent referral to Marie Stopes International for counselling regarding termination, if this is the woman’s choice.

An urgent referral should be made to the hospital for antenatal booking. The blue booking form should be used for the referral to antenatal services whenever possible. If the woman is not engaged with NRP, an urgent referral should be made with her consent.

Whilst it is recognised that some GPs have experience in treating pregnant substance users, the involvement of NRP will enhance this intervention through its established group of other professionals with an interest in pregnant substance users. Contact NRP at any time, for advice.

Any child protection concerns should be made in the usual way through Children’s Services as per the pre-birth protocol.

If the woman is already prescribed an opiate substitute, then consultation with NRP is strongly encouraged before any decision is made to reduce or discontinue prescribing. If benzodiazepines and opiates are used, then reduction of the benzodiazepines should be achieved first.

Hepatitis B immunisation should be encouraged/ initiated.

The GP/Primary Care Team’s knowledge of the woman and the family can provide an important part of the assessment of needs and risk.

Role of the Health Visitor

The health visitor works within a locally based multi-disciplinary team that provides a healthy child programme. The aim of which is to promote the wellbeing of families by providing support and early intervention to all families with pre-school children. The role encompasses assessment of needs in relation to care giving relationships with a particular emphasis on early intervention to promote attachment and healthy relationships.

The ante-natal visit is priority as identified in the Multi-Agency Pre-Birth Protocol to enable a pre–birth assessment to be undertaken which can be done by the health visitors themselves or jointly with the midwife. Where there are concerns the assessment should begin around the 20th week of pregnancy and around the 36th week of pregnancy in all other cases.

The health visitor as part of the assessment will take into account family and social history as well as obstetric history and detail the family strengths as well as their concerns. The health visitor will explore substance misuse as part of their assessment as well as other areas such as domestic violence, mental health difficulties and the care of previous children and any other issues which may impact on the parent’s ability to parent the child whose needs are paramount.
The health visitor will liaise with other professionals with regard to the family and other professionals should liaise with the health visitor to ensure a seamless service for the child on discharge from hospital to the community setting.

Reduction of alcohol should be advised. If drinking under 10 units per week - this usually can be stopped without needing reduction. Advice should be sought on detoxification from NRP. Information is available from NRP and the Paediatric Liaison Nurse.

Attention should be given to mental health as the prevalence of mental illness is raised among substance users.

If the baby is admitted and requires treatment in the NICU, the Health Visitor should automatically be informed of this by NICU nursing staff and/or the Paediatric Liaison Nurse.
## APPENDIX 1

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<tbody>
<tr>
<td>Antenatal Clinic- NNUH</td>
<td>01603 282796</td>
</tr>
<tr>
<td>Link Neonatal Intensive Care Unit (NICU)</td>
<td>01603 286865</td>
</tr>
<tr>
<td>Link Health Visitor</td>
<td>01603 789527</td>
</tr>
<tr>
<td>Childrens Services</td>
<td></td>
</tr>
<tr>
<td>North &amp; East</td>
<td>01493 850317</td>
</tr>
<tr>
<td>West &amp; Breckland</td>
<td>01362 654600</td>
</tr>
<tr>
<td>City &amp; South</td>
<td>01603 224134</td>
</tr>
<tr>
<td>NRP Substance Misuse Liaison Team</td>
<td>01603 288874</td>
</tr>
<tr>
<td>NNUH</td>
<td>Bleep 0439</td>
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<tr>
<td>Norfolk Recovery Partnership</td>
<td>0300 7900 227</td>
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<tr>
<td>24 Hour Helpline</td>
<td></td>
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<tr>
<td>Frank- National Drugs Helpline</td>
<td>0800776600</td>
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APPENDIX 2

Guidelines on assessment and initial management for drug dependency problems in pregnant women.

Assessment/treatment of opiate dependent patients not engaged in substitution treatment.

This is intended for the guidance of staff in the obstetric service or general practice that need to manage a patient who presents without an existing treatment plan.

Where urgent treatment for their substance misuse is required and contact with NRP for further assessment is either impractical/ out of hours or is being declined by the patient, the hospital team should be contacted.

Management of these clients should not be done in isolation and services are able to work with fellow professionals on a consultative basis. Professionals should discuss with clients who decline services or referral the concerns this would raise in relation to safeguarding.

NNUH staff should follow the guidance provided in: Guideline for management of opiate dependence in adults; ref. CA2075 Version 2.

This is available on the Trust intranet under the clinical guidelines icon then access via the ‘Medicine’ group of guidelines. There is a section regarding pregnancy.