6.3 MANAGEMENT OF WOMEN WITH ALCOHOL AND OTHER DRUG (AOD) USE- POSTPARTUM

AIMS

• Provide current information to women and the support person/s about the effect of drugs and alcohol or opioid replacement therapy and breastfeeding.

• To assess the neonate and provide educational advice to the family about Neonatal Abstinence Syndrome (NAS).

• Offer written and verbal information about interventions that can provide comfort and settling measures assisting a neonate withdrawing from drugs or alcohol effect.

• Identify psychosocial problems and provide strategies to ensure the mother and the neonate are discharged home to a safe environment.

• Organise discharge follow-up appointments, and provide advice on how to access assistance for treatment programs, community support services, and harm reduction/prevention strategies.

• Provide the mother with written and verbal information about ‘safety planning’ prior to discharge.

• To ensure the mother is supplied with appropriate and adequate analgesia postpartum as required.

• Make a follow up appointment for the mother and baby for the WANDAS Post Natal Clinic

ADDITIONAL POSTNATAL CARE

In addition to routine postpartum care women with AOD use issues will require extra education and support from medical/midwifery personnel, allied health groups, and community support groups associated with drug and alcohol use.

See Clinical Guideline Section B6 Routine Postpartum Care.

Refer all WANDAS women or women with AOD use issues to the Specialist Child Health Nurse during their postpartum hospital stay.

OPIOID PHARMACOTHERAPY

Refer to Clinical Guidelines Section P 4.1 Management of Community Programme for Opioid Pharmacotherapy.

NB: Before writing any prescriptions for opiate substitution therapy the patients’ usual dispensing pharmacy should be contacted to check the time the last dose was dispensed, the current dose and inform them that the woman is an inpatient and will be having her treatment in hospital.

NEONATAL MANAGEMENT

NEONATAL ABSTINENCE SYNDROME

Commence a MR495 NAS scoring system chart within two hours of birth to provide a baseline set of observations. Once commenced it is continued for five days.

For instructions of how to use the NAS scoring system refer to:

Neonatology Clinical Guidelines Section 17 Neonatal Abstinence Syndrome.
HEPATITIS B VACCINATION

Encourage immunisation of the neonate prior to discharge.
See:
- Clinical Guidelines Section B10.4.3 Neonatal Hepatitis B Vaccination
- Clinical Guidelines Section B10.4.4 Neonatal Hepatitis B Immunoglobulin – given to the neonate if the mother is known to be hepatitis B surface antigen positive.

BREASTFEEDING AND ALCOHOL AND OTHER DRUG USE

1. Alcohol or other drugs and medications not listed below should be checked with:
   - The KEMH pharmacy.
   - On the Intranet via KEMH library electronic service and access sites such as:
     - LacMed database
     - Micromedex database

2. Encourage skin-to-skin contact for all mothers (also for women who choose not to breastfeed).


4. Advise women who are breastfeeding and plan recreational drug or alcohol use to:
   - ensure a responsible adult is available to supervise the baby during this period
   - breastfeed prior to alcohol and other drug use
   - consider expressing breast milk prior to alcohol and other drug use- ensuring availability of breast milk for the next feed
   - know when to express and discard breast milk, and how long before breastfeeding can be resumed.

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<tr>
<th>SUBSTANCE</th>
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<th>RECOMMENDATION / ADVICE</th>
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<tbody>
<tr>
<td>Alcohol (Ethanol)</td>
<td>Delays the let-down reflex and may reduce milk supply.¹</td>
<td>• Avoid breastfeeding if intoxicated.</td>
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<td>Ethanol can increase odour and change taste of milk.³</td>
<td>• Women ingesting moderate amounts of alcohol can generally return to breastfeeding as soon as they feel neurologically normal.³</td>
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<td>Can lead to maternal sedation, and lead to irritability, sedation, and weak sucking in infants.³</td>
<td>• Chronic or heavy users of alcohol should avoid breastfeeding.³</td>
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<td>Beer has been reported to stimulate prolactin levels and milk supply.²⁴</td>
<td>• Advise women who intend to ingest alcohol while breastfeeding to:</td>
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<td>Long term effect of daily alcohol use is unclear.⁴</td>
<td>- breastfeed prior to alcohol ingestion.¹</td>
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<td>- avoid breastfeeding for 3-4 hours after having the last drink of alcohol.²⁵</td>
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<td>- ensure a responsible adult is supervising the baby.</td>
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Date Issued: January 2008  
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Review Date: February 2017  
Written by/Authorised by: OGCCU  
Review Team: OGCCU/ WANDAS  
2008 All guidelines should be read in conjunction with the Disclaimer at the beginning of this section
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<td><strong>Amphetamines</strong></td>
<td>May interfere with milk production.(^5) May pose risk to the breastfed infant or breast milk, but benefits from breastfeeding may be acceptable despite risk to the infant.(^5) Relevant published information is unavailable regarding safety of breastfeeding with amphetamine use.(^5)</td>
<td>Avoid the use of amphetamines while breastfeeding. If a women decides to use amphetamines while breastfeeding advise her to: • ensure a responsible adult is available to supervise the baby • breastfeed prior to use • breast pump and discard milk for 24 hours.(^1, 6) If the woman has expressed and stored milk prior to using this can be given to the baby, otherwise artificial milk is required during this period. • prepare artificial feeds prior to substance use.</td>
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<tr>
<td><strong>Methamphetamines</strong></td>
<td>See section on Amphetamines.</td>
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| **Benzodiazepines** | **Temazepam** – low levels is found in breast milk, however has a relatively short half-life and would not be expected to cause adverse effects.\(^7\)  
**Diazepam** – repeated doses will accumulate in breast milk. The long half-life means timing breastfeeds has no or little benefit in reducing exposure. If given as a single sedative dose e.g. prior to surgery then breastfeeding may resume at the next due feed.\(^8\)  
**Oxazepam** – low levels are found in breast milk. It is not expected to cause adverse effects in breastfed infants with normal maternal doses.\(^9\)  
**Lorazepam** - low levels are found in breast milk. It is not expected to cause adverse effects in breastfed infants with normal maternal doses.\(^10\) | • The benefits of breastfeeding must be weighed against the risks.\(^11\)  
• Inform the woman benzodiazepines should not be stopped abruptly. Supervised gradual withdrawal is advised should she wish to stop use.\(^11\)  
• Advise women using short-acting benzodiazepines to avoid breastfeeding immediately after taking as it may cause drowsiness for the mother and infant.\(^11\)  
• **Temazepam** – advise taking the bedtime dose after the infants last feed for a older infant who is sleeping through the night.\(^7\)  
• **Diazepam** – avoid breastfeeding a neonate or preterm infant for 6-8 hours after a dose.\(^8\) |
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| **Buprenorphine** | Little published material exists on the effect of buprenorphine and breastfeeding.3  
Low weight gain and reduced breast milk production has been shown in one study.3  
Buprenorphine has a low oral bioavailability and infant exposure is only 1/5 to 1/10 of the total amount ingested by the mother.12  
Low serum and urine concentrations are found in breastfed infants.13 | • Women should be supported to breastfeed if there are no other contraindications, but advised there have been limited studies.12  
• Monitor the infant for drowsiness, adequate weight gain, and developmental milestones.13  
• Refer immediately for medical assessment if the infant shows any signs of increased sleepiness, difficulty in breastfeeding, breathing difficulties, or limpness.13  
• Advise slow weaning1 under medical supervision if a woman decides to cease use of buprenorphine. |
| **Cannabis** | Small to moderate amounts are secreted into breastmilk, with significant absorption and metabolism in babies.1  
Infants receive an 8-fold accumulation in breast milk compared to maternal plasma levels with chronic use, although significant side-effects are not shown.3  
Breastfeeding with cannabis use is not recommended by some authors, while others advocate potential risks should be weighed up against benefits noting that there is insufficient evidence to make an evidence based recommendation.6 | • Cannabis use for breastfeeding mothers should be avoided as it impairs their judgement and childcare abilities.6, 14  
• Can cause sedation in infants. If women chose to smoke cannabis advise them to smoking only after feeding, and to avoid smoking in the vicinity of the infant.1 |
| **Cocaine** | Cocaine is excreted in milk in high concentrations.1  
It is slowly metabolised and excreted over a prolonged period. The infant will test positive for cocaine metabolites for days after use.3 | • Cocaine use is contraindicated in breastfeeding mothers.6  
• If a woman has used cocaine she should express and discard the milk for a minimum of 24 hours.6  
Advise the mother to express and storing breast milk if no drug use prior to using cocaine, or arrange artificial feeds. Organise a responsible adult to care for the infant if the mother plans to use. |
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| **Heroin / other Opioids** | Heroin excreted in breast milk can cause addiction in the infant. Prolonged use of narcotics can produce neonatal abstinence syndrome in neonates when ceased. Infants of users often have low birth weight and require additional calories for growth. | • Unstable mothers or women continuing to use short acting opioids should not breastfeed.6  
• If a mother has used heroin observe the infant for sedation, tremors, restlessness, vomiting and poor feeding. Seek medical assistance immediately if symptoms occur.3  
• If a mother elects to use heroin while breastfeeding advise them to:  
  ➢ ensure a responsible adult is available to supervise the infant.6  
  ➢ breastfeed prior to use  
  ➢ express and discard milk for 24 hours. If a woman has expressed and stored milk prior to use this can be given to the infant.6  
  ➢ prepare artificial feeds prior to use.6 |
| **Inhalants** | Check effect of individual inhalants with KEMH pharmacy, or the above mentioned databases which can be accessed via KEHM library intranet site. Lactation risk is dependent of the components of the inhalant. | • Solvents generally have short half lives, but many pass readily into breastmilk.1  
• Avoid breastfeeding if the mother is intoxicated.1  
• If a mother intends to use solvents:  
  ➢ encourage her to arrange a responsible adult to be available to supervise the baby6  
  ➢ breastfeed prior to using6  
  ➢ arrange artificial feed replacement prior to use6 |
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| Methadone | Most studies indicate only small amounts of methadone pass into breast milk. The amount in milk is insufficient to prevent NAS. Research is unavailable about the long term effects on infants receiving small amounts of methadone from breastmilk. | • Women on methadone maintenance are suitable to breastfeed.  
• Advise women not to abruptly cease methadone treatment while breastfeeding as it can result in NAS.  
• Inform the mother to seek urgent medical advice if the infant shows signs of NAS. |
| Naltrexone | Limited data indicates naltrexone is minimally excreted in breastmilk. | • Breastfeeding considered safe.  
• Mothers should be informed studies however are limited.  
• If naltrexone is required by the mother, breastfeeding can continue. |

**UNBOOKED POSTNATAL WOMEN WITH ALCOHOL AND OTHER DRUG USE**

Women who have not been attending WANDAS shall remain under their allocated obstetric team. The WANDAS should be contacted to provide guidance and advice. An unbooked postnatal woman will not transfer to the WANDAS team.

**PLANNING DISCHARGE**

**TIMING OF DISCHARGE**

1. All women with a history of alcohol and other drug use or receiving opioid replacement therapy during pregnancy are expected to stay for 5 days or more postpartum to allow assessment of NAS.
2. Refer to the MR004 ‘Obstetric Special Instruction Sheet’ for individualised management plans.
3. Any deviation from the plan needs to be discussed with the WANDAS CMC, obstetrician and the paediatric consultant.
4. A woman with a history of alcohol and other drug use or receiving opioid replacement therapy not under the care of WANDAS should not be discharged without consultation with the WANDAS CMC and the WANDAS obstetric consultant. This ensures appropriate support services are notified, and medical issues are addressed.

**DISCHARGE AGAINST MEDICAL ADVICE**

If a mother or father wish to take their baby home and medical concerns exist for the safety of the neonate refer to the Neonatal Clinical Care Guidelines Section 19 Discharge against medical advice for management.

The WANDAS CMC and the hospital Nurse Manager should be informed as soon as possible.
CONTRACEPTION
1. Contraception is to be discussed prior to the woman transferring home. Advice provided will be based on consideration of the woman’s lifestyle and her ability to regulate medication.
2. Consider contraception that may be administered prior to transfer home if the woman has an unpredictable lifestyle e.g. Implanon which may be inserted prior to transfer home.
3. Book a KEMH Family Planning Outpatient appointment if requested.

ADDITIONAL PARENTING ADVICE

NEONATAL ABSTINENCE SYNDROME
1. Refer to the Neonatal Clinical Care Guidelines Section 17 Neonatal abstinence syndrome.
2. Provide the WANDAS ‘Neonatal Abstinence Syndrome’ booklet to all parents.
3. Advise the woman/parents about the signs of NAS. Inform parents to seek immediate medical consultation should signs develop.
4. Discuss supportive measures a woman can use to calm and settle her baby. Information for this is provided in the:
   - WANDAS ‘Neonatal Abstinence Syndrome’ booklet
   - WANDAS ‘Safety Plan in the Event of Alcohol or Drug Use’ pamphlet.

BREASTFEEDING AND INFANT FEEDING
1. Discuss feeding management strategies should the mother participate in drug or alcohol use.
2. Provide the mother with the WANDAS pamphlet ‘Safety Plan in the Event of Alcohol or Drug Use’.
3. Supply women with verbal and written information about expressing breast milk, hiring and purchasing of expressing equipment.
4. Offer a demonstration about preparation of artificial feeds even if the woman intends to breastfeed. This provides her with education should she need to temporarily replace breastfeeding due to drug or alcohol use, or for psychosocial reasons.
5. Provide written and verbal information about Hepatitis C and breastfeeding. See information about Hepatitis C, breastfeeding, and neonatal management in the Neonatology Clinical Care Guidelines, Section 8 Infection, septic screening and management.

PREVENTION OF SUDDEN INFANT DEATH SYNDROME
1. Emphasise preventative measures and safe sleeping practices – drug and alcohol use (especially opiates) increases the risk for SIDS.
2. See:
   - Clinical Guidelines Section B 10.2.5.1 Bed-Sharing/Co-sleeping
   - Clinical Guidelines Section B 10.2.5 Strategies to reduce Sudden Infant Death Syndrome (SIDS).
3. Provide parents with the written pamphlet ‘SIDS AND KIDS SAFE SLEEPING’.

COMMUNITY ORGANISATIONS
1. The social worker links the woman with community groups that assist women and families involved in drug or alcohol use, and those involved in opioid replacement therapy.
2. Parents should be informed of telephone services that may provide assistance e.g. Parent Drug Information Services and Alcohol and Drug Information Service.
3. The WANDAS team will arrange referral to the appropriate drug and alcohol services as required or requested for postnatal follow-up.
REFERENCES


