Women, Pregnancy and Substance Use: Good Practice Guidelines

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Foreword

The foundations for health and wellbeing are established in the earliest moments of life and pregnancy offers an opportunity for services in Highland to provide effective intervention to ensure the best possible care is provided to promote the wellbeing of women and their infants pre-birth, throughout pregnancy and into parenthood. However, a significant number of children will have their health and wellbeing affected by their parents’ use of substances (Scottish Executive 2006). Moreover there is growing evidence that there is a relatively narrow window of opportunity for intervention in a child’s early years: lack of adequate nurture is likely to have a long-term damaging effect, with children more likely to have poorer health and wellbeing outcomes.

Women who use substances and their infants have better outcomes if they take up antenatal care early and if they use services consistently throughout pregnancy. Pregnancy may motivate many women to access support for substance using issues but some may feel inhibited due to feelings of guilt, anxious about the attitudes of healthcare staff or fear that their children may be removed from them. Services therefore need to be accessible, welcoming and empowering for those women affected by substance use, just as they do for others.

The detail in this guidance represents best practice for maternity staff across Highland however, other services involved with pregnant women who use substances have a critical role to play in supporting women and will find this guidance useful.

Health inequalities and social exclusion have an impact on health and wellbeing and it is essential that evidence based information and support provided through integrated working that is based on individual need, is provided to all women (NHS QIS 2009). This equally applies to women who have problems with drug or alcohol use, who require access to a full range of services within a multidisciplinary assessment process.

Good practice in maternity care can help to ensure the early links with families enables everyone to work together to provide a coherent and responsive service.

“Women should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman in relation to her care and that of her baby should be sought and respected at all times.” Pregnancy and complex social factors (Nice 2010)
Summary of Guidelines

- Pregnant women who use substances should be managed according to best practice as stated in Getting Our Priorities Right: Updated good practice guidance for all agencies working with children, young people and families affected by problematic alcohol and/or drug use (Scottish Government April 2013) along with Highlands Drugs and Alcohol Partnership/Child Protection Committee’s A practitioners guide to getting our priorities right (HADP/HCPC June 2015).

- Staff who are taking a booking history should always ask sensitively but routinely about all substance use. The Scottish Woman Held Maternity Record (SWHMR) contains specific questioning relating to the use of tobacco, alcohol and prescribed or illicit drugs.

- When appropriate, staff should deliver a ‘brief intervention’ regarding smoking or alcohol use. If required, women can be referred for specialist smoking cessation support or additional support from specialist drug and alcohol recovery services.

- Information on any social issues that could impact on outcomes of the pregnancy, including substance use, should be documented in the SWHMR and summary sheet. The Highland Practice Model (GIRFEC) should be used to enable robust assessment and planning of care for women and their babies.

- There are challenges for service providers to engage with women whilst balancing the needs of their children. Obstetricians, midwives and drug and alcohol recovery services need to be aware of the laws and issues that relate to child protection. If they have any concerns they must refer to the Highland Child Protection Guidelines or contact their designated Child Protection Advisor (CPA) for advice.

- All staff supporting pregnant women that have drug or alcohol problems, including obstetricians, GPs, midwives, health visitors (HV), social work staff and drug and alcohol recovery services, require on-going training to ensure they have the knowledge and skills required to identify problems, assess severity and the impact on children.

- Women who have problem drug or alcohol use within the 12 months prior to their pregnancy will follow a Red Pathway - Pathways for Maternity Care (NHS QIS, 2009) and will require review by an obstetrician and individual care planning by the wider Maternity Team.

- Pregnant women who have significant drug and/or alcohol use may also have other social problems and their care should reflect this. They should not be managed in isolation but by maternity services that are part of a wider multiagency network, which should include both specialist drug and alcohol and social work staff.

- The management of women who have problem substance use and mental health co-morbidity requires close supervision by specialist services during pregnancy.

- Women who are opioid users should be prescribed appropriate substitution therapy during pregnancy. Drug Misuse and Dependence UK guidelines on clinical management (Department of Health July 2017)
• Close follow up and multiagency support in the postnatal period is essential for women and their babies, as relapse can be a problem at this time. This is captured within the Universal Pathway for Health Visiting in Scotland (Scottish Government 2015) and Highland Practice Model (GIRFEC) where women who misuse substances will be assessed as requiring additional/intensive support from services.

• Problem substance use may be associated with past or current experiences of violence or abuse and with psychiatric or psychological problems. All staff must remain aware of this and support families appropriately with a trauma informed approach. Transforming Psychological Trauma: A knowledge and Skills Framework for the Scottish Workforce. (NES 2017)
1. Background

We live in a drug using society. Heroin, tobacco, prescription medicines, alcohol, cannabis, new psychoactive substances and caffeine are all drugs. Almost all of us use drugs every day or every week, and in the majority of cases the substances we use are legal and the way in which we use them does not cause problems for ourselves or others.

However, for some in society, substance use creates significant problems in functioning and in their ability to manage their day-to-day life, employment, parental and family responsibilities. The challenge for services and professionals is to be sensitive to the needs of women whilst being vigilant to the possibility that a woman may be using substances in a way that may cause harm to herself, her developing baby or a child in her care. Ensuring that services do not undermine a woman’s confidence to handle her situation or make her reluctant to disclose or come forward for help in the first place can help improve outcomes for her and her children.

These guidelines were first produced in 2009 and have been revised bi-annually since then in line with current legislation and national policy to support professionals within the maternity and drug and alcohol recovery services in Highland to assist them in providing optimal care to this client group. They should be used alongside other documentation, policies and good practice guidelines already in place which support pregnant women. They are designed to clarify information about:

- The implications of substance use in pregnancy
- Support available to women and their families
- The most appropriate pathways

The interests of a child and its mother are inextricably linked and maternity services and those who are helping the parent with their substance use must work closely together. The Scottish Government national Early Years Collaborative was developed to ensure the recommendations of the Early Years Framework (Scottish Government 2008) and GIRFEC are enacted and recognise the impact that our experiences both pre-birth and during the early years have on not only childhood but longer term into adulthood. It has been combined into the Children and Young Peoples Collaborative (CYPIC) and aligns closely with the Maternity and Children Quality Improvement Collaborative (MQUIC) to ensure quality improvement drives best practice.

Providing an early intervention, preventative and multiagency approach where additional needs are identified will provide the best chance of success in addressing health inequalities. The Highland Practice Model (GIRFEC) offers practitioners across all agencies in Highland the foundations to enable robust assessment and planning of care within a health and social context.

The planning for Fairness process has been applied to these guidelines to ensure that they address equality and diversity considerations.

Thanks to all who have contributed to the revision of the Guidelines, their names appear in Appendix 5.
2. Helping people to change: principles of health behaviour change

Encouraging people to take responsibility for their own health and providing them with skills to allow them to make positive changes to their lifestyle are key to a health improvement approach. This approach is very useful when working with people who are attempting to address their smoking, alcohol or drug use.

Changing behaviour is not easy. Even when we make choices, making change takes commitment, confidence and often support. It takes time to make changes and we tend to resist being told what to do. We may know many of the reasons for change already, but may need information relevant to our own lives at times which suit us.

**Motivational interviewing recognises:**

- Making change is a process which tends to take place over time, and a health professional may play only a small, although significant, part in that process. Most people will make these changes by themselves however, some need assistance.

- It’s a normal human reaction to want to solve others’ problems and practitioners often slip into the advice-giving and directive mode known as the ‘Righting Reflex’. However, the result is usually resistance as control has been taken away from the person.

**The role of the practitioner in negotiating change with women and families is to:**

- Act as a guide, helping them to find their own motivation and confidence to change
- Help resolve the ambivalence they may have about changing
- Support them to identify solutions and create a realistic plan

The key principles of motivational interviewing should underpin all good practice in supporting people to make changes. This makes the whole experience less frustrating for both client and practitioner and can lead to more sustained long-term outcomes of change.

**Key principles of motivational interviewing:**

- Collaboration: the engagement and involvement of women as partners and decision-makers is key
- Express empathy and establish rapport
- Evoke or elicit the case for change from the woman rather than provide it, although the practitioner can offer information which may guide this. Ask permission to give information or feedback.
- Respect the autonomy of women, don’t take control. A woman may not be ready to change, and moving forward and taking action too quickly may only cause resistance. Practitioners must constantly assess readiness to change.
- It is normal to feel in two minds, or ambivalent, and a practitioner can help a woman to explore and hopefully resolve this ambivalence by asking them how important they think the change is, and how confident they feel to take it forward. These two elements indicate motivation and thus readiness. Eliciting and listening for change talk is the practitioner's task.
Only when a woman is ready to change does the practitioner move on to support change planning, ensuring that they identify specific goals and the steps to take.

Support self-efficacy. This is a woman’s confidence and belief in her ability to do something-to be competent. This is a key indicator of change, and it should be nurtured and supported. The practitioner’s role is to support a sense of hope.

If faced with resistance, do something differently and in particular show that you are listening by reflecting back what seems to lie behind the woman’s expression of resistance. Emphasising personal responsibility is also a useful tactic. Most of all, recognise that resistance is in some ways a message to the practitioner that they are doing something wrong.

Remember inequalities, and the need to address life circumstances. Working with women is only one way of encouraging change.

Training

A suite of Health Behaviour Change and MI training is provided by NHS Highland health improvement team, their prospectus, training calendar and booking forms can be accessed here [http://bit.ly/2DqHELe](http://bit.ly/2DqHELe)
3. Smoking

Smoking in pregnancy remains a major preventable cause of maternal and fetal mortality and morbidity. Assisting women to stop smoking before and during pregnancy must remain a priority for maternity services. Midwives have a responsibility to ensure that they have the training and expertise to raise the issue of smoking with all pregnant women and the knowledge of how to refer on to specialist services.

3.1 Harm caused by smoking

There is robust and constantly emerging evidence to support the harm that continued smoking in pregnancy brings to the mother and her developing baby resulting in considerable childhood morbidity in later years and subsequent generations (Surgeon General's Report 2014) these include:

<table>
<thead>
<tr>
<th>Effects on Women</th>
<th>Effects on babies</th>
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<tbody>
<tr>
<td>• Placenta Praevia</td>
<td>• Stillbirth</td>
</tr>
<tr>
<td>• Placental abruption</td>
<td>• Sudden Infant Death Syndrome</td>
</tr>
<tr>
<td>• Premature rupture of membranes</td>
<td>• Premature Delivery</td>
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<tr>
<td>• Ectopic pregnancy</td>
<td>• Intrauterine growth retardation</td>
</tr>
<tr>
<td>• Infertility</td>
<td>• Sudden Unexplained Infant death</td>
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Smoking in pregnancy is also strongly implicated in causing:

- Club foot
- Gastrochisis
- Heart defects
- Attention Deficit Hyperactivity Disorder (ADHD)
- Miscarriage

(Hackshaw, Rodeck, Boniface, 2011)

Accurate recording of smoking status in pregnancy forms an important part of the risk assessment. Smoking 11 or more cigarettes per day equates to a major risk factor thus requiring serial growth scans and assessment of fetal wellbeing with Umbilical Artery Doppler from 26-28 weeks until delivery. Smoking 10 or less cigarettes per day is allocated a minor risk factor. If a woman has 3 or more minor risk factors they will require UTERINE artery Doppler studies at 20-24 weeks (NHS Highlands 2015) The accuracy of CUB(combined ultrasound and biochemical) screening also depends upon truthful recording of smoking status required to calculate risk.
3.2 Prevalence and reporting

Interpreting smoking data can be difficult as evidence suggests that self-reported smoking can be underestimated by up to 25% by pregnant women (Shipton D, Tappin D et al 2009). The number of women who are recorded as current smokers at the time of their booking appointment has steadily deceased year on year, alongside levels of 'unknown' recording. The disparity in smoking rates found in pregnant women living in the least deprived and the most deprived areas of the Highlands continues with 8% of pregnant women recorded as current smokers at their booking appointment in the least deprived quintile compared to 37% in the most deprived quintile (ScotPHO 2017).

Nationally, 33% of young women under the age of 20 years are current smokers at booking compared to 9% of those over the age of 35 years (ISD 2017). This highlights the need to particularly target efforts at young mothers living in areas of higher deprivation.

Current Smokers at booking, Highland compared to Scotland

<table>
<thead>
<tr>
<th>Year</th>
<th>Highland</th>
<th>Scotland</th>
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<tbody>
<tr>
<td>2005/06-2007/08</td>
<td>25.5</td>
<td>23.3</td>
</tr>
<tr>
<td>2007/08-2009/10</td>
<td>23.4</td>
<td>21.5</td>
</tr>
<tr>
<td>2009/10-2011/12</td>
<td>20.7</td>
<td>20.5</td>
</tr>
<tr>
<td>2011/12-2013/14</td>
<td>19.5</td>
<td>19.3</td>
</tr>
<tr>
<td>2013/14-2015/16</td>
<td>18.6</td>
<td>17.3</td>
</tr>
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</table>

Source(s): ISD Scotland, SMR02, ScotPHO Tobacco Control Profile

3.3 Carbon Monoxide Monitoring

Nice Public Health Guidance 26 (2010) recommends measuring expired Carbon Monoxide (CO) levels in all pregnant women. This should improve underreporting, increase referrals into smoking cessation services and ultimately reduce smoking prevalence in pregnant women.

CO is a poisonous gas and one of the 4000 chemicals which are absorbed into the blood stream via inhalation of tobacco smoke, it crosses the placenta, is absorbed by the fetus and harms both placental function and the developing baby.

All pregnant women presenting at 1st booking in NHS Highland should be offered CO testing by their community midwife regardless of smoking status. Any woman with a CO >= 4ppm, a current smoker, recent quitter or has a household member who smokes should be encouraged to accept referral to smoking cessation services as outlined in the referral pathway – Smoking Cessation Maternity Referral Pathway

NB.
*Recent quitter is someone who has quit after confirmation of pregnancy or in the last 2 weeks

A small number of women will have a CO ≥4ppm and not smoke or be exposed to second hand smoke. It is important to reassure these women that this will not harm their baby; the level is set at 4ppm for referral and screening purposes. They can still be referred to the Smoking Cessation Midwife for further information and advice. If their CO is 10ppm or above then advise contacting the Health and Safety Executive gas safety line on 0800 300 363 for advice on checking heating systems.
NHS Highland Smoking Cessation
Maternity Referral Pathway

At first contact/booking
- Use CO breath test.
- Assess knowledge around smoking and pregnancy.
- Establish is she smokes/has ever smoked.
- Ask if anyone in the household smokes.

If

The woman answers yes to one of the following
- CO ≥ 4ppm
- Current smoker
- Recent quitter *
- A household member smokes

Yes

- Explain the CO test result.
- Give CO-smoking and your baby leaflet.
- Refer to the smoking cessation service.
- Complete the Smoke free Homes and Cars leaflet.

No

Give positive feedback and record smoking stats and CO level in SWHMR.

- Accept answer
- Record smoking status, CO level and summary of discussion in SMHWR.
- At every contact discuss smoking, offer CO test and offer referral.

Referral accepted

No

- Give positive feedback and record.
- At every antenatal contact review progress and do a CO breath test.

Yes

CO test declined
3.4 Raising the issue of smoking in pregnancy

Discussing smoking in pregnancy can be a sensitive issue as many women are reluctant to discuss their smoking status due to guilt and low confidence of ability to quit. Midwives have in the past been worried that it may damage their relationship. It is vital that the issue is raised so that a frank discussion can take place ensuring that the risk of continued smoking is fully understood by women allowing them to make an informed choice based on robust evidence and that they are aware of the support available to them.

One of the best ways to raise the issue and assess her knowledge of harm caused is to ask what she knows or has heard about smoking in pregnancy. Asking permission to give advice has also been shown to be well received. Any partners and family members present should also be included in discussions and referral to smoking cessation services offered to them if appropriate. The use of open questions can aid and initiate discussion particularly if it is backed up by reflective listening skills. Some examples of motivational questions are:

- What have you heard about smoking in pregnancy?
- Can you tell me why you’ve wanted to cut down?
- Can you imagine how it would be for you if you stopped smoking?
- What are your thoughts around getting some help with your smoking?
- What made you want to try stopping before?
- It sounds like you have a fair bit of knowledge around smoking in pregnancy; would it be ok to tell you what I know, fill in the gaps?

NHS Highland have produced a useful conversation tool to support a brief evidence informed conversation with pregnant women who have a high CO result link Appendix 1

3.5 Smoking cessation

Stopping smoking in pregnancy particularly before the end of the first trimester can significantly reduce the harm caused to mother and baby (McCowan, et al 2009) and lower health care costs associated with poor obstetric outcomes. All Midwives have a responsibility to raise the issue of smoking in pregnancy and ensure that women and their partners are fully aware of the risks associated with smoking in pregnancy allowing them to make an informed choice. Referral to specialist smoking cessation services can double the chances of successfully quitting.

NHS Highland has a Specialist Smoking Cessation Midwife and Generic Smoking Cessation Advisors covering all geographical areas. Contact details of the advisors can be found at this link https://smokefreehighland.co.uk/contact/ as well as information and advice for both women and professionals. Referrals can be phoned, emailed or posted and should be made as early as possible in pregnancy as outlined in the Smoking Cessation Maternity referral pathway (page 11).

Contact: Smoking Cessation Midwife, Maternity Annexe, Maternity Unit, Raigmore Hospital, Inverness. Tel: 01463 706370. Mobile: 07824417514.
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Motivation to quit can vary throughout pregnancy therefore women who continue to smoke should be offered CO testing at each antenatal appointment and the offer of referral reiterated. Women and their families who decline referral to specialist services should also be informed of alternative methods of support to include, community pharmacy scheme, written information, national telephone helpline and self-help forums on websites.

Quit attempts from pregnant smokers, 3 year annual aggregate

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<tr>
<td>Highland</td>
<td>21.5%</td>
<td>32.9%</td>
<td>41.7%</td>
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<tr>
<td>Scotland</td>
<td>20.6%</td>
<td>29.3%</td>
<td>29.6%</td>
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Source(s): ISD Scotland Smoking Cessation database, ScotPHO Tobacco Control Profile

3.6 Smoke free homes and smoke free cars

Women who are unable or unwilling to quit should be praised in their efforts to ameliorate the effects of smoking whilst highlighting the only way to remove risk altogether is not to smoke. They should be supported in their effort to cut down by referral to smoking cessation services in the hope that it will lead to a full quit.

Pregnant women and their families should be supported and encouraged to reduce the harm caused by exposure to second hand smoke by smoking outside and making their homes and cars smoke free. Further information to support this is available to order via HIRS which contains practical advice to support families in their efforts to achieve a smoke free environment. See Highland Information Trail [http://www.forhighlandschildren.org/4icspublication/index_161_652594013.pdf](http://www.forhighlandschildren.org/4icspublication/index_161_652594013.pdf)

3.7 Training

The smoking Cessation Midwife offers free training in Raising the Issue of Smoking in Pregnancy and CO testing. Teams and individuals can request training by contacting her direct, contact details available through this link [https://smokefreehighland.co.uk/contact/](https://smokefreehighland.co.uk/contact/)

More in depth training in taking a person-centred approach to communication by using motivational interviewing techniques to support people to change their behaviour is available free to staff in NHS Highland. If you would like a bespoke course for your staff group or in a different locality, please get in touch to discuss the details. Training calendar can be accessed here [http://bit.ly/2DqHEle](http://bit.ly/2DqHEle) enquiries to high-uhb.healthimprovementtraining@nhs.net For courses in Argyll & Bute contact 01586 552224.

3.8 Nicotine replacement therapy (NRT) and pharmacotherapies

- The use of nicotine replacement therapy to assist a quit attempt in pregnancy is preferable to continued smoking but should only be used if smoking cessation without NRT fails and after a risk assessment.
- It should be used at as low a dose as possible for as short a time as possible bearing in mind that pregnant women metabolise nicotine faster than the general population.

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• Intermittent methods such as gum, lozenge, spray and inhalator are preferred to patches but liquorice flavours should be avoided.
• Patches can be used if women are unable to tolerate oral methods due to nausea but should be removed before sleeping at night.
• Women should be reminded not to smoke concurrently whilst using NRT (BNF 2018).
• Varenicline (Champix) and Bupropion (Zyban) are medications which reduce cravings associated with stopping smoking they are both contraindicated in pregnancy and should be avoided. They may be suitable for partners and other family members.

3.9 Electronic cigarettes

Current evidence on e-cigarettes as a quitting aid is limited, however there is some emerging evidence that they may be of some help. Little research has been conducted into the safety of e-cigarette use in pregnancy but they are likely to be significantly less harmful to a pregnant woman and her baby than cigarettes. Electronic cigarettes do not contain Carbon Monoxide or many of the other harmful chemicals found in tobacco.

• Licensed NRT products are the recommended option for pregnant women who can’t quit without pharmacotherapy support.
• If a pregnant woman chooses to use an e-cigarette to stay smoke free she should not be discouraged from doing so.
• Although not completely risk free, electronic cigarettes carry a fraction of the risk of smoking for users with no known risk to bystanders. McNeil, A et al 2015
• A guide for midwives and other healthcare professionals specifically on the Use of electronic cigarettes in pregnancy is available here http://smokefreeaction.org.uk/wp-content/uploads/2017/06/eCigSIP.pdf

4. Alcohol

No safe level of alcohol use has been established in pregnancy. In 2016, the Chief Medical Officers’ for the UK recommended that pregnant women or those planning to become pregnant avoid drinking any alcohol to keep the risks to a minimum. Long-term health risks for the baby are greater the more alcohol you drink.

Evidence

The CMO’s decision took account of the most up-to-date international and UK specific research. It found that low-to–moderate alcohol consumption during pregnancy (fewer than 2 UK units, no more than twice a week) was linked with an increased link of having a baby small for gestational age. (Department of Health 2016)

Advice

Staff should promote clear and consistent advice that the safest option is to abstain from alcohol throughout pregnancy as no safe limit has been established. Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk. Women who find out they are pregnant after having drunk in early pregnancy should be advised to avoid further drinking. However it is essential to communicate that they should not worry unnecessarily as the risks of their baby being affected are likely to be low.
Health Risks

Alcohol is a teratogenic compound - a substance that can interfere with the normal development of the baby that readily crosses the placenta. In the absence of a developed blood filtration system, the baby is unprotected from alcohol circulating in the blood system. The effects of alcohol consumption during pregnancy have been extensively studied and it is widely accepted that consumption of alcohol by women during pregnancy may result in adverse effects on the child’s health and wellbeing after birth.

Alcohol consumption during pregnancy can increase the risk of:

- Miscarriage
- Low birth weight
- Pre-term labour
- Fetal Alcohol Syndrome (FAS)
- Fetal Alcohol Spectrum Disorders (FASD)

4.1 Prevalence of alcohol consumption in pregnancy

Estimating the prevalence of alcohol consumption during pregnancy is known to be problematic because women may underestimate or under-report their alcohol intake for a number of reasons. The latest evidence from the Scottish Maternal and Infant Nutrition Survey found that in 2017 more than half of women (54%) in Scotland did not stop drinking alcohol before becoming pregnant, although a quarter (25%) said they had “cut down” the amount they consumed. The majority of women (88%) said they had not consumed any alcohol since they realised they were pregnant. However, more than one in ten women (11%) continued to drink alcohol after they realised they were pregnant; 2% with a frequency of 2 to 4 times a month and 9% monthly or less.


Women and alcohol

The female drinking culture has changed over the past two decades. The latest estimates from the Scottish Health Survey suggest 17% of women exceed the weekly guideline of 14 units and drink at hazardous/harmful levels. Furthermore, 32% of women consume over 3 units on their heaviest drinking days. In addition, 26% of 16 – 24 year olds are likely to binge drink and consume more than 6 units on their heaviest drinking day, which is concerning due to the role alcohol can play in sexual risk taking and the subsequent link with pregnancy.

The survey also found that women from professional and managerial groups with higher incomes were more likely to drink alcohol above recommended weekly limits than those with lower incomes (22% and 11% respectively).

4.2 Fetal Alcohol Spectrum Disorders and Fetal Alcohol Syndrome
A reliable and accurate maternal history is the best screening tool for identifying risk of FASD. SIGN 156 2019 recommends that “all pregnant and post-partum women should be screened for alcohol use with validated measurement tools by service providers who have received appropriate training in their use”.

Fetal alcohol spectrum disorder (FASD) is the name given to a group of permanent conditions that a person can have when exposed to alcohol prenatally. These conditions include physical and intellectual disabilities, as well as problems with behaviour and learning. Often, a person has a mix of these problems. FASD is the leading known preventable cause of intellectual disability and birth defects.

Fetal Alcohol Syndrome (FAS) is a condition that affects the development of a baby’s brain in utero due to maternal alcohol consumption. It consists of specific facial features, a low birth weight and significant neurodevelopmental problems and affects about 1-2 in every 1000 babies. It is 100 % preventable – no alcohol consumption, no FAS.

There are no accurate records of the incidence of FASD in the UK, but work undertaken by NHS Health Scotland suggests an incidence of a minimum of 1 in every 100 live births.

With approximately 2,200 live births annually in Highland, this equates to potentially 22 cases of FASD and 2 to 4 cases of FAS each year, and at least 375 people in Highland under the age of 18 who have been adversely affected by prenatal alcohol. These are based on the most conservative estimates from international evidence and likely to be an under representation of the number of babies affected each year.

<table>
<thead>
<tr>
<th></th>
<th>FASD</th>
<th>FAS</th>
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<tbody>
<tr>
<td>Incidence rate (live births)</td>
<td>1%</td>
<td>0.01-0.02%</td>
</tr>
<tr>
<td>New Cases per year</td>
<td>22</td>
<td>2 - 4</td>
</tr>
<tr>
<td>Total aged under 18 years with condition</td>
<td>375</td>
<td>38 - 75</td>
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Source(s): HADP, ISD Scotland

Babies born with FAS can be quite easily identified due to their distinguishable facial features including: small and narrow eyes, a small head, a low nasal bridge, a smooth area between the nose and the lips and a thin upper lip, and their ears may be set lower. They may be born with low birth weight and remain small compared to their peers. Each child with FAS may have some or all of a spectrum of mental and physical birth defects in varying degrees from mild to very severe, with all the challenges they may bring.

Much of the damage to a baby from alcohol occurs early in pregnancy so women who are considering pregnancy must be advised to abstain before contemplating pregnancy. Continued exposure compounds the problems. The clinical features are:
Mental Challenges | Physical Challenges
---|---
• Intellectual disability: lowered IQ | • Visual and eye defects
• Poor memory | • Hearing and ear defects
• Learning ability | • Mouth, teeth and facial defects
• Attention disorders | • Weak immune system
• Sensory impairment | • Epilepsy
• Speech and language problems | • Liver damage
• Mood disorders | • Kidney defects
• Behavioural problems | • Heart defects
• Autistic-like behaviours | • Cerebral Palsy, muscular defects
• Sleep disorders | • Height and weight deficiencies

It is more difficult to diagnose FASD than it is FAS because children with FASD may not have any facial deformities. It might not be until they start interacting with others or going to school that the following symptoms become apparent:

- Learning difficulties
- Problems with language
- Lack of appropriate social boundaries (such as over friendliness with strangers)
- Poor short term memory
- Inability to follow instructions
- Failure to learn from the consequences of their actions
- Self-absorption
- Mixing reality and fiction
- Difficulty with group social interaction
- Poor problem solving and planning
- Hyperactivity and poor attention
- Poor coordination

Often FASD is undiagnosed or misdiagnosed, for example as autism or attention deficit hyperactivity disorder (ADHD). Early diagnosis is vital to ensure appropriate treatment and support systems are in place at the earliest opportunity (BMA 2016).

By the time children with FASD reach their teenage years they may be more susceptible to peer pressure and therefore participate in more risk taking behaviours. They can also be more easily sexually exploited than their peers, experience difficulty getting and keeping employment, and may have problems with alcohol and/or drugs.

A leaflet for women explaining the risks in pregnancy has been developed by NHS Highland Alcohol and Drugs Partnership (HADP) and should be given to women contemplating pregnancy - *Alcohol and pregnancy don't mix* available in the HIRS library as detailed in the
Women, Pregnancy and Substance Use: Good Practice Guidelines (v.5)

Highland Information Trail (2018) Also, the leaflet *Help you keep your baby safe and healthy* should be given to women who are drinking at booking.

**Resources**

The following resources are useful for all staff to enhance knowledge:
The Scottish Government FASD Awareness Toolkit

**Proactive approach**

Emerging evidence on the risks of alcohol to the developing baby, debate on the unknown impact of small amounts of alcohol, prevalence of alcohol consumption during pregnancy and female drinking patterns all support the need to take a proactive approach to promoting abstinence.

An alcohol brief intervention should therefore be delivered to all women consuming alcohol during pregnancy and those who report pre-pregnancy levels over 14 units a week unless in the practitioner’s clinical judgement there are signs of dependency. Where dependency may be an issue the woman should be referred on to a more specialist drug and alcohol recovery service for appropriate assessment and support.

Wherever possible, consideration should be given to delivering an ABI to women who report pre-pregnancy consumption levels of over 14 units a week or 6 units on any one occasion at least once a week.

**4.3 Alcohol Brief Interventions (ABIs)**

An alcohol brief intervention provides a structured approach to discussing alcohol use and enhancing the woman’s motivation to make changes. The key stages of an alcohol brief intervention (ABI) use motivational interviewing approaches. Current practice in antenatal settings already includes enquiries about alcohol consumption with the Scottish Woman Held Maternity Record (SWHMR) including questions and recommending an ABI.

Less than 1% of all ABIs in the NHS Highland area were delivered in an antenatal setting in both 2015/16 and 2016/17. Work is ongoing to increase the confidence and skills of midwives to deliver ABIs and embed them into routine practice.

<table>
<thead>
<tr>
<th>Percentage of alcohol brief interventions delivered in antenatal settings</th>
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<tr>
<td>NHS Highland</td>
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<tr>
<td>Scotland</td>
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Source: ISD Scotland,

**Training**

Training in ABIs is available on line and face to face via NHS Highland Health Improvement the training calendar and booking forms can be accessed here [http://bit.ly/2DqHEle](http://bit.ly/2DqHEle) or contact elspeth.lee@nhs.net

**Throughout the brief intervention remember to:**

- Maintain rapport and empathy
- Emphasise the woman’s personal responsibility
4.4 Alcohol Brief Intervention Care Pathway

- **Raise the issue**
  “Are you drinking at the moment?”

- **Screen and Feedback**
  Screen using SWHMR alcohol consumption questions and feedback on risks.

- **Not Drinking**
  Congratulate and reaffirm abstinence is safest option.
  Explain risks to sustain motivation for abstinence.
  Record pre-pregnancy drinking in SWHMR.
  Reinforce sensible drinking limits pre and post pregnancy.

- **Drinking**
  If drinking but not at levels that cause concern about possible dependence.

- **Dependence Issues**
  If drinking at levels which cause concern about possible dependence or serious harm use clinical judgement (informed by ICD-10 criteria) to assess or if in doubt, use a formal screening tool eg T-ACE.

- **Deliver Alcohol Brief Intervention**
  Listen for Readiness to Change & Choose Suitable Approach
  Consider referral for higher levels of drinking and binge drinking

- **Referral for Specialist Support**
  Consider referral to specialist treatment services for further assessment and treatment support.
4.5 Alcohol dependency

If a woman is drinking, at levels which cause concern about possible dependence or serious harm then clinical judgement must be used to inform decision making or a formal screening tool can be used e.g. T-ACE.

ICD – 10 criteria for alcohol dependence can be used to inform clinical judgement. Dependence is diagnosed if three or more of the following have been present together during the previous year:

- Strong desire/ compulsion to drink
- Difficulty controlling drinking onset, termination, level of use
- Physiological withdrawal state
- Evidence of tolerance; increased doses required
- Progressive neglect of alternative pleasures or interests
- Persisting with use despite awareness of overtly harmful consequences

Alternatively the T-ACE screening tool can be applied

<table>
<thead>
<tr>
<th>T-ACE Alcohol Audit Tool</th>
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| T (tolerance) How many drinks does it take to make you feel high?  
  Answer: ‘3 drinks or more’ scores 2 points |
| A (annoyance) Have people annoyed you by criticising your drinking?  
  Answer: ‘Yes’ scores 1 point |
| C (cut down) Have you ever felt you ought to cut down your drinking?  
  Answer: ‘Yes’ scores 1 point |
| E (eye-opener) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?  
  Answer: ‘Yes’ scores 1 point |

Total Score

Date of test

Lowest score possible = 0
Highest score possible = 5
A total score of two points or more will correctly identify most women whose drinking is hazardous, harmful or dependent.

If the T-ACE Alcohol Audit Tool highlights a hazardous score then more detailed advice, information and support should be offered. Specialist referral is recommended for women with...
harmful alcohol dependence. Osprey House, Community Psychiatric Nurses for Addictions
Staff from the drug and Alcohol Recovery Service who are qualified nurses can offer further
support and advice to women their families and other workers.

An Antenatal Plan: additional support for mother and unborn baby should be completed and
risk assessment must include the impact of the alcohol consumption on the baby. Their care
should be managed by an obstetrician and provided by the wider maternity care team.

If required, it should be remembered that detoxification for alcohol dependent women should
normally be in an inpatient setting to ensure close monitoring of mother and baby (Plant 2001,

Women who choose to breastfeed, they should be informed that alcohol can, like most other
things you eat or drink find its way into breast milk. There is some evidence that regularly
drinking more than two units of alcohol a day while breastfeeding may affect the baby’s
development but an occasional drink is unlikely to harm breast fed baby.

It is recommended that breast feeding mothers have no more than one or two units of alcohol
once or twice a week.

5. Drugs

There has been a large increase in problem drug use both nationally and internationally since
the 1980s and this increase has been disproportionately high among women of childbearing age. In the triennial report into maternal deaths in the United Kingdom around 11% women
who died had problems with substance misuse (CEMACH 2007). Not all of the women died as
a direct result of their drug misuse: substance misusing women were found to have comparatively complex and chaotic lives which greatly increased their vulnerability.

The rate of pregnancies recording drug use in the Highland ADP area has increased between
2005/06 – 2007/08 (7.2 per 1000 maternities) and 2013/14 – 2015/16 (9.8 per 1000
maternities). Nationally the rate has steadily increased since 2005/06 (ISD Scotland 2017).

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<tbody>
<tr>
<td>Highland</td>
<td>7.2</td>
<td>8.9</td>
<td>8.9</td>
<td>9.2</td>
<td>9.8</td>
</tr>
<tr>
<td>Scotland</td>
<td>9.5</td>
<td>11.9</td>
<td>18.9</td>
<td>17.3</td>
<td>13.3</td>
</tr>
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Source(s): ISD Scotland, SMR02

Some pregnant women who misuse substances may be frightened of presenting to services for
fear of being judged regarding their drug use, yet supporting them in maintaining contact with
services is vital. Pregnant women with substance misuse problems should be managed by a
team who will provide co-ordinated multidisciplinary and multiagency care. Services should
fast-track women into drug treatment services to ensure early intervention and decision making.
A non-judgemental, empathic approach will enable them to feel supported in discussing their
concerns regarding how their use of substances may impact on their own health and the health
of their baby.

Problem drug use is often associated with socio-economic deprivation and maternal health
problems including poor nutrition, smoking, alcohol misuse, mental health problems;
complications from chronic infection, domestic abuse and homelessness. The effects of drugs on the baby include intrauterine growth restriction, pre-term delivery, increased rates of still birth, neonatal death and sudden infant death (see Appendix 1 – Drugs and their effects on pregnancy). These outcomes are multifactorial and are also affected by socio-economic deprivation. It is therefore essential that a co-ordinated, integrated network of support is in place for all women who require specialist advice or support in pregnancy.

Good maternal history taking is essential to ensure delivery of high quality maternity care. This is a dynamic process which will commence from the woman’s first contact with maternity services and continue throughout pregnancy. It should encompass not only physical health but also social circumstances and psychological wellbeing. It is important to ask at booking about drug use, frequency and method of administration and whether more than one sedative drug and medication are used in combination. It is also important to establish if a woman’s partner is using drugs or alcohol.

This assessment will better identify:

- If using intravenously, then a multi-agency approach should enable exploration of present injecting techniques, discuss safe practice and provide information on needle exchange. Osprey House, Inverness and Local CPNAs and Locality Teams will assist with this process and women will be encouraged to stop injecting and switch to a safer method. (Appendix 2).
- If they have previously had help and what this involved.
- If they are presently receiving support, are they prescribed any medication and who is prescribing?
- If their partner uses drugs; is he/she presently supported with his/her drug use and is engaged in treatment services.
- If a woman is new to substance misuse services, specialist services complete the SMR25a data collection form for ISD
- Assessment and completion of the ‘Antenatal Plan’ will ensure co-ordination of services and appropriate support is in place for the woman early in pregnancy.
- If the drug (or alcohol) use is likely to impact on the baby or any other children in the family

Women should be encouraged to accept referral to specialist services which can provide a more in-depth assessment of substance use. They can also provide drug screening to confirm present use and offer on-going counselling and support with reducing or stabilising use through substitute prescribing programmes. Osprey House, Inverness can provide this expert advice and guidance for professionals and can be contacted on 01463 716888. Alternatively, staff can contact addiction nurses, along with other agencies who can offer advice and support with regard to substance misuse.
5. 1 Referral pathway when working with pregnant women who use substances

The Care Schedule: Substance Misuse in Pregnancy describes a woman’s journey through pregnancy and should provide practitioners with more detailed information when planning care for this client group. Pre-birth planning discussions which include parents, should assess risk, determine outcomes and plan support networks thereby reducing the need for emergency child protection procedures at birth (see Section 7.2 in ‘The Woman’s Journey’).

5.2 Substitute prescribing in pregnancy

Substitute prescribing can occur at any stage during pregnancy and the risks to mother and fetus are lower than continuing illicit drug use. It promotes engagement with services and assessment of health and social needs. (Department of Health July 2017)

Within Highland the medication of choice during pregnancy is Buprenorphine (Subutex) as evidence suggests that it is associated with better neonatal outcomes. Buprenorphine has been evidenced as having less neonatal withdrawal symptoms (Jones et al 2011). Methadone has been linked with visual disorders in infants, particularly lifelong nystagmus, squints needing glasses and lack of binocular vision. (see Appendix 1). Where a client is already prescribed Methadone they may remain on this should this be their choice following discussion regarding potential risks.
Commencement involves daily assessment and titration to reach optimum dose.

The rationale for commencing substitute prescribing:
- Prevents mother and fetus experiencing withdrawal symptoms during pregnancy if taken as prescribed
- Reduces the risks from injecting behaviour
- Reduces the risks from taking unknown substances
- Helps the mother withdraw from other drug users
- Reduces involvement in crimes related to drug use
- Provides stability and engagement with services
- Usually improves nutritional intake
- Time previously spent seeking drugs can be used to focus on own needs and prepare for the baby’s arrival

Substitute prescribing programmes have contributed to rapid and substantial improvements in the time that service users spend focusing on their family and home life.

The clinical team should highlight to women the advantages of substitute prescribing during pregnancy but should recognise that some women may choose to refuse treatment. In this situation, robust assessment of the woman’s circumstances will determine the level of risk to the unborn child and any other children she may have.

Support and advice is offered as an integral part of substitute prescribing to provide time to explore past/present drug use and how to implement changes, deal with on-going problems without resorting to using, and provide time to reinforce progress or discuss concerns. Random drug screening is an integral part of prescribing and can be an indicator of safe compliance with medication.

6. The Challenges

Collation of data around pregnancy and smoking, alcohol and drug use is improving however relies on women self-reporting in many cases. In 2013, 18.4% of women in Scotland reported smoking at booking but it is difficult to gain an accurate picture of smoking rates amongst pregnant women. Shipton, Tappin et al, (2009) concludes that reliance on self-reported smoking will lead to a significant number of pregnant smokers going undetected and missing out on the opportunity of specialist support.

The SMR02 (Scottish Morbidity record maternity hospital discharge summary) enables information regarding smoking, alcohol consumption and drug misuse during pregnancy to be recorded. Questions in the SMR02 concerning weekly alcohol consumption and drug misuse became mandatory in April 2011 to help capture a more accurate and robust picture of alcohol and drug use during pregnancy in Scotland (ISD, 2010). However, NHS Highland midwifery audit of records in 2013 suggests 100 % compliance with completing this section and should be commended.

The completion of the form Scottish Drug Misuse database SMR25 Assessment Report for every new problem drug user, can provide more realistic statistics for Highland. Specialist drug
misuse services complete the SMR25a form for a new client and the SMR25b for on-going service users.

6.1 Multiagency working and information sharing

Where a woman is known to be using substances, clear lines of communication, information sharing and multidisciplinary working must be in place during all stages of pregnancy and following birth. This will facilitate a comprehensive assessment of needs and risks and ensure a consistent approach to care. The Highland Practice Model (GIRFEC) approach will ensure that all children get the help they need when they need it.

For pregnant women who use substances it is important that they engage with services at the earliest stages in pregnancy as possible to ensure they are offered the full range of services. Their initial contacts and experiences will determine their future uptake of services and if women feel that their autonomy or their future as a parent is being threatened in any way, they are unlikely or less likely to disclose information or ask for help in the first place.

This requires skilful interviewing by staff. An open, honest and non-judgemental approach is essential to establish a relationship. An explanation of professional responsibilities regarding children/child protection is also essential to provide clarity at the beginning of any relationship.

The sharing of information, within and across services, underpins good practice and should occur where substance misuse involving alcohol or drugs is present. It is important to discuss multidisciplinary and multiagency working and the sharing of information proportionately and on a need-to-know basis at the earliest opportunity with women. Evidence has shown that women normally readily give their consent if it is explained that information sharing enables agencies to provide the best possible on-going care and support for them and their babies.

The ‘Data Sharing across the Highland Data Sharing Partnership Procedures for Practitioners’ (NHS Highland 2013) provides guidance for all practitioners to support a co-ordinated and seamless approach to information sharing. It provides staff with the principles governing the sharing of information, which is essential to multi-agency working and describes responsibilities and requirements for this. When a practitioner is making a decision about whether or not to share data, the welfare of the child must be the main consideration. Resources around the Children and Young People (Information Sharing) (Scotland) Bill - June 2017 further support staff with information sharing is provided Scottish Governments GIRFEC web pages https://www2.gov.scot/Topics/People/Young-People/gettingitright/information-sharing

The Data Sharing Partnership recommends asking two questions:

- Is data sharing in the best interests of the child (unborn baby)?
- Will the risk to the child (unborn baby) be increased by not sharing information?

Should consent for sharing information be refused it is essential to seek advice from line management and designated child protection advisors regarding subsequent management of the situation. The welfare of the unborn baby and any other children in the family is paramount. The Interagency Guidelines to Protect and Young People in Highland (2017 Interim update) offer further information for staff and should be accessible when working in clinical areas.
When sharing information it is vital that all discussions and actions are well documented, including what and why information has been shared, and with whom. Advice should always be sought if there is uncertainty from Managers and CPAs.

6.2 Keeping children safe

Assessment of risk and need is fundamental in planning care and it is important that all healthcare workers consider that children (born or unborn) may be in need of protection. Many agencies within health may have contact with pregnant women and their children and this does not just include maternity and early years services. Workers in adult services including substance misuse, smoking cessation, mental health and others may be the first point of contact with pregnant women. Where there are any risks to the unborn child or any other children in the household these risks must be acted on appropriately.

“It is everyone’s job to promote the safety and wellbeing of children. Every agency, manager and practitioner that works with children and their families, including services that work primarily with adults, takes responsibility for their contribution to the safety and wellbeing of children, and responding to any request for help.”

(Interim Interagency Guidelines to Protect Children and Young people in Highland, Highland Child Protection Committee, 2017: intro:1).

Maternity services provide support and care to all pregnant mothers assessing risk and need at every contact as detailed in the Pathways for Maternity Care (NHS QIS 2009). When there are additional support needs such as a woman having alcohol or drug issues then, the ‘Antenatal Plan: additional support for mother and unborn baby’ should be completed by the named midwife (April 2013). The plan should detail the impact any substance use is likely to have on the outcomes for the mother and her baby. Appropriate early support and intervention must be in place as soon as possible in pregnancy and certainly well before the baby’s birth to ensure the best outcomes.

The ‘Antenatal Plan’ assessment will supplement the information recorded in the SWHMR and provide a detailed plan and review of care. A copy of the Antenatal Plan should be shared with the GP, Obstetrician and Health Visitor, and inform the ‘Child’s Plan’ following birth.

Alcohol or drug use is not a sufficient reason to assume inadequate parenting, however for some families this will certainly be the case. Parental alcohol or drug use can have a damaging effect on the health and development of children which can begin before birth and it is vital healthcare workers remain proactive and vigilant to the children’s needs and intervene early with support in an effort to reduce the impact.

Children can experience both emotional and physical disturbances and they may exhibit symptoms of failure to thrive and anxiety. Health professionals should recognise the importance of secure attachment for an infant’s brain development. Any interruption to this can affect their psychological, social and emotional growth. This includes their life-long sense of security and ability to maintain relationships (Highland Infant Mental Health pre-birth – 3 years Best Practice Guidelines 2012).

Risk is dynamic and may change at any stage from conception onwards and therefore all professionals involved with the family need to ensure that risk is continuously evaluated. As
well as risk to the unborn baby, awareness and safety of other children in the household must be the primary concern and assessment of risk must include:

- Seeing the child/children is paramount
- Assessing their developmental stage and understanding the family context in which they live
- Awareness and understanding of those who care for the child/children about the effects of substance misuse
- Awareness and understanding of the needs of families from diverse ethnic and cultural backgrounds.

Assessing risk to children should be elevated when there has been previous history of alcohol or drug use or if there are additional stresses in the family such as domestic abuse, a chaotic lifestyle, homelessness or mental health issues (NHS Health Scotland 2009). It is also important to consider the additional needs of children affected by disability or with communication difficulties.

All professionals should have knowledge and understanding of their local Child Protection Policy Guidelines and managers should ensure that their staff undertakes regular Child Protection training relevant to their post. Midwives and Health Visitors have specific responsibilities for child protection as part of their role and should consult the Child Protection Training guide for managers and staff 2018 And book the relevant training via http://hcpc.scot/training/

Practitioner guidance is available to support the assessment process for children affected by alcohol and drug use A Practitioners Guide to Getting Our Priorities Right (GOPR) – supporting children affected by parental substance misuse (HADP/CPC 2015) http://www.forhighlandschildren.org/

6.3 Mental health

Perinatal Mental Health issues may be more common in women who use alcohol or drugs who may have used substances to deal with a history of anxiety, depression, sexual or physical abuse. This can impact on their long-term psychological, social and physical health and wellbeing and the effects of this on the mother can be devastating. Furthermore it can also have long term implications for a child’s emotional, physical and social development.

At booking all pregnant women are asked a series of questions about their own mental health and that of their immediate family within the SWHMR. On-going assessment of their mental health is made throughout pregnancy. If a woman requires additional support this may be in the form of early intervention or may require a referral to mental health services.

Any past history of severe or enduring mental health issues will indicate that a woman’s care must be managed by an obstetrician and mental health services. Any risks to the mother or baby must be discussed with the HV and GP who should be included in any planning of care for mother and baby.

Management of perinatal mood disorders Sign 127 (Health Care Improvement Scotland (2012) provide practitioners with more detailed information that can guide staff to ensure that the care of pregnant and newly delivered women is assessed and managed effectively.
6.4 Violence Against Women (VAW)

Far from being a time of peace and safety for a woman, over a third of women experiencing domestic abuse from their male partner have reported that the abuse began during pregnancy.

A woman who is misusing alcohol or drugs may also be experiencing violence and for a woman who already has a low self-esteem, the power and control that is demonstrated in domestic abuse will further add to her feelings of worthlessness and despair. Routine questioning about abuse which may be physical, sexual or emotional (including financial) must be included at booking or at another opportune time during the antenatal period. Women must always be given the opportunity to be seen on their own at least once during pregnancy to enable discussion or disclosure. Open ended questioning and reflective listening should be employed.

The Highland Violence Against Women Partnership has developed resources to support staff in their work. This includes guides on Responding to VAW; specific protocols for sexual violence, Female Genital Mutilation (FGM) and Forced Marriage; documentation to support MARAC risk identification and referral; information on support services; and Learn Pro e-learning (NHS staff) and face to face multi-agency training programme.

For the most up to date resources, please visit the Highland Violence Against Women Partnership website, [www.hvawp.scot.nhs.uk](http://www.hvawp.scot.nhs.uk) some resources are also available through HIRS (search under subject 1GBV gender based violence).

The Highland *Domestic Abuse: Pregnancy and the Early Years* protocol will be useful for staff.

6.5 Cultural issues

It is very important to consider specific needs in relation to language and cultural norms and this is particularly important when working with women from Black and Minority Ethnic Communities (BME). Although most evidence indicates that many of the health issues experienced by women from BME Communities are similar to those of women in the wider community it is often the case that their experience of health services is not always as comparable.

It is important not to make any uninformed judgements about a woman’s needs and it is always appropriate to ask each woman about their ethnicity and any cultural needs they might have. It is best practice to record the ethnicity of all women using services in the SWHMR. Many women using maternity and early year’s services will need appropriate communication support. It is essential that professional interpreters are used where needed. It is generally unacceptable to use family or friends. Many of the written resources used in maternity and early years are available in alternative languages and formats and should be available on the NHS Highland website. Where the needed resources are not available in the correct language, the guidance on obtaining translated information should be followed. If a woman does not have English as her preferred language then an interpreter should always be booked or the telephone interpretation service used.

Face to face interpretation is available for spoken languages through Global Languages and telephone interpretation is available through Language Line. British Sign Language interpretation is also available for service users who are Deaf or hard of hearing as well as other communication support such as lip reading or note taking.

NHS staff can access guidance here
7. The Woman's Journey

When a woman becomes pregnant she may experience a range of emotions from happiness and excitement to shock and anxiety. Women who use drugs and alcohol problematically are no different. There may be initial ambivalence towards the pregnancy and they will need time, information and support to enable them to make the right choices. Should they opt to continue with the pregnancy it can be a catalyst to motivate them to change their alcohol or drug use and lifestyle and accept help. People who are dependent on alcohol or drugs may have been using for several years and may have tried to stop several times. This is normal and change is a process that can take time. However, pregnancy can provide the motivation to reduce their use, if not to give up.

If women have a long-term problem it may be wrong to assume that pregnancy is the right time to stop. However, they can be offered help and information and most importantly, can still be supported to ensure that their behaviour is less risky. It is unrealistic to expect all women to detoxify during pregnancy and important to respect and support them in their choices.

To engage women more easily it is important that inappropriate service design does not compromise good practice. The lifestyle of someone using alcohol or drugs may be chaotic due to the demands of having to maintain their alcohol or drug use and additional associated problems such as financial difficulties, relationship problems, domestic abuse and homelessness. Social Work Services and the criminal justice system might also already be involved.

Families affected by substance misuse will require a multiagency, holistic approach and services must keep the safety and priority of children their priority. By reducing the need for multiple appointments that women may find hard to keep, and considering the option of afternoon sessions, women are more likely to engage with services. Good communication between practitioners across services is essential to provide safe and effective care.

7.1. Antenatal care and booking appointment

To ensure high quality maternity care, good history taking is vital and the booking appointment provides an ideal opportunity to:

- identify specific needs or pressures a family may have
- initiate a relationship with the woman
- gather information to inform the assessment process.

Those providing antenatal care should ask sensitively but routinely about all substance use, prescribed and non-prescribed, legal and illegal as detailed in the SWHMR. There may be other professionals and agencies already involved in supporting women and their families, and therefore it is important to ask about other service input such as Community Psychiatric Nurse
In Highland, the woman’s named community midwife is often the first point of contact in pregnancy however some women will make initial contact with their GP. Questions about smoking, alcohol and drug use are asked about at the booking appointment and it is important that any previous history of a woman’s substance use is communicated between midwives, GPs and maternity services so that an accurate assessment of the likely impact on her and her baby/other children can be made. Adult services who may already be working with women must encourage engagement with maternity services as early as possible and understand the need to share information to ensure safety of mother and baby.

Some women may be known to substance misuse services but others, especially non-dependent users, may be disclosing their use for the first time. They should be given appropriate information on harm reduction which may lead to a change in their drug use (Whittaker 2003).

The booking appointment begins the process of risk assessment but risk is dynamic and may change over time therefore continued vigilance is required throughout pregnancy, labour and the postnatal period. Risk assessment should take into account factors that may affect the woman’s ability to care for her baby.

It is important that a clear pathway of care is in place for all professionals involved with women who misuse drugs or alcohol. The Care Schedule provides practitioners with a minimum number of expected contacts that pregnant women will receive however; individual assessment may highlight the need for many more contacts.

If the woman’s named midwife is on a period of leave or absence then her caseload must be allocated to another named member of the team who will hold responsibility. If there are child protection concerns then social work must be informed and Child Protection Procedures followed.
### 7.2 Care schedule: substance misuse in pregnancy

| Pre-pregnancy                                                                 | Discuss general health and wellbeing, mental health and relationships, substance misuse (smoking, alcohol, and drugs). Give advice on healthy diet, dispense folic acid supplementation. Ensure women have details of how to contact their local community midwife. If appropriate offer referral to specialist services (e.g. Smoking cessation, drug/alcohol services). Offer blood borne virus testing. |
| First point of contact                                                      | Spend time gaining trust, aim for continuity of carer and promote attendance and engagement with maternity services. Undertake initial risk assessment of medical, obstetric and social needs that will determine woman’s pathway of care. Information must be given on screening and public health issues and maternal emotional health and wellbeing explored. Explore partner’s current drug and alcohol use. |
| 8 - 12 weeks                                                               | • Commence maternal history taking using SWHMR.  
  • Undertake enquiry about smoking, alcohol and drug use and use a Health Behaviour Change approach to discuss the risks of smoking, alcohol, drug misuse (prescribed/over the counter or illicit).  
  • If woman or her partner has recent history or current issues with substance misuse determine involvement with specialist drug and alcohol services. If required Children 1st 01463 220057 kinship care trauma recovery service.  
  • Undertake risk assessment of mother’s needs to support herself and her unborn baby, ensuring this is detailed in her records.  
  • Named midwife to commence Antenatal Plan: additional support for mother and unborn baby to determine strengths and pressures and the impact on the woman and her baby and chronology if appropriate.  
  • Consider the risks to the unborn baby and any other children in the family and discuss with the local Child Protection Advisor (CPA).  
  • If there are concerns at any stage in pregnancy they must be discussed with Social Work (SW).  
  • Discuss the need for information sharing with the woman and seek formal agreement for multiagency working and liaison.  
  • Have early discussion with HV and promote joint visit at 32-34 weeks.  
  • Share information about alcohol or drug use between GP, HV, CPA and obstetrician. Consider partners drug use.  
  • If alcohol or drug use is disclosed then care must be managed by the obstetrician working closely with drug and alcohol services.  
  • If drug issues offer blood borne virus testing.  
  • Discuss and agree care plan with woman.  
  • Discuss and agree on-going management of substance use with woman. |
| 15 - 16 weeks                                                              | • On-going assessment of substance misuse and additional support needs  
  • Update Antenatal Plan  
  • Ensure engagement with specialist services as required.  
  • Discuss Neonatal Abstinence Scoring (NAS) & Infant feeding and if on substitute prescribing there will be a 5 day minimum stay in hospital for observation, give SCBU Parental Information Leaflet on NAS (Neonatal guidelines NHSH intranet) |
| 22 - 25 weeks                                                              |                                                                 |

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### Women, Pregnancy and Substance Use: Good Practice Guidelines (v.5)

#### 28 weeks
- Promote long acting methods (LAC) provide leaflet as per Highland Info trail.
- On-going assessment of substance misuse and engagement with specialist services.
- Pre-birth planning meeting to re-assess social circumstances/risk - update Antenatal Plan/Child’s Plan/Child Protection Child’s Plan as required. This will include all partners to the Plan and should also include the HV who will provide on-going care and assessment.
- Named Midwife to undertake additional appointments as required which must include home assessment (consider lone working policy).
- Preparation for parenthood, labour and delivery & A/N conversation tool.

#### 31 - 32 weeks
- Discuss birth plan.
- Reiterate Neonatal Abstinence Scoring System (NAS) Offer visit to SCBU and requirement for 5 day P/N stay if on substitute prescribing.
- Encourage practical plan for contraception and organise LAC if appropriate

#### 34 - 36 weeks
- Assessment of substance misuse and continued engagement with specialist services.
- HV to undertake antenatal contact which must include home visit where alcohol or drug misuse has been identified
- Update Plan
- Close liaison with HV as per handover protocol.
- Continue preparation for parenthood including discussion regarding Sudden Infant Death Syndrome.
- On-going discussion regarding contraception.

#### 37 - 38 weeks

#### 39 - 40 weeks

#### Labour
- If there are issues of substance misuse deliver in Consultant Led Unit with paediatric facilities.
- Substitute prescribing should be continued and additional analgesia as required
- Inform Named Midwife and Lead Professional on admission and delivery.
- Do not give Naloxone to baby as it will induce an abrupt opiate withdrawal crisis and use supportive measures or ventilation.

#### Delivery
- Hepatitis B vaccine for baby if mother or household member Hep B positive.
- Neonatal Abstinence Syndrome (NAS) assessment and care ensuring mother is aware of the signs and need for 5 day P/N observation in hospital. See Full guidance available from SCBU
- Offer support regarding infant feeding including Infant Feeding Support Worker and peers.
- Accurate documentation and record keeping are essential.
- Monitor substance misuse. Organise discharge prescription and follow up from specialist services (relapse prevention support).
- Administer contraception prior to discharge if possible (LAC).
- Discharge arrangements from hospital should be completed as per Child’s Plan including Core Group meeting prior to discharge. Copies of discharge arrangements to CMW/GP/HV and others involved in the plan.
7.3 Booking bloods

It is important to obtain booking bloods at an early contact with women but professionals should be sensitive to the fact that having blood taken may cause distress to women who are trying to discontinue their intravenous drug use.

*Your're Pregnant! Scans and Tests* (NHS Health Scotland 2017) should be given to all women on confirmation of pregnancy. A pre-test discussion should take place and the woman should be asked to sign a consent form before testing. Current booking bloods include testing for:

- Blood group and Rhesus Factor
- Full blood count
- Syphilis
- Hepatitis B Virus (HBV)
- Human Immunodeficiency Virus (HIV).

7.3.1 Blood borne viruses (BBV)

BBV may be a particular concern when working with this client group and it is important that appropriate screening and practice protocols are followed to ensure those women, their partners, babies and care givers are protected against BBV.

HBV and HIV can be transmitted by heterosexual intercourse. Women who are not injecting may have a partner who is and are therefore at risk of infection. HBV is easily transmitted by both sexual contact or sharing injecting equipment.

Hepatitis B vaccine has been introduced to the UK routine immunisation schedule; all children born after 31/07/17 will be offered Hep B Vaccine.

Hepatitis B immunisation has been recommended for current injecting drug users for many years but because drug users are at particular risk of acquiring HBV, vaccination is also recommended for the following:

- those who inject intermittently
- those who are likely to ‘progress’ to injecting e.g. those who are currently smoking heroin/and or crack cocaine and heavily dependent amphetamine users
- non-injecting users who are living with current injectors
- sexual partners of injecting users
- children of injectors Those born after 31/07/17 will be vaccinated as part of the routine childhood immunisation schedule
• children of hepatitis C positive mothers those born after 31/07/17 will be vaccinated as part of the routine childhood immunisation schedule

• children whose mother is HBV positive (for management of babies of HepB positive mother see also separate guidance on the NHS intranet)

• Babies going home to a household where there is a member (other than the mother) who is Hep B positive should be vaccinated at birth prior to going home

HIV can be passed from mother to baby either during pregnancy, labour and delivery or through breastfeeding. In most cases, HIV is thought to be transmitted during the last few weeks of pregnancy or during delivery however the risks can be reduced by appropriate treatment (NAM 2011). There is now routine antenatal testing for HIV across Scotland. Clinical management of HIV positive women should be provided in accordance with national and local protocols and staff in ward areas should have access to Screening for Communicable Diseases in Pregnancy NHS Highland, 2017. The Highland policy is available on the intranet.

Hepatitis C (HCV) is not easily transmitted through sexual intercourse. The incidence is around 6%, although sexual practices that involve blood-to-blood contact would increase risk. HCV is easily transmitted through injecting drug use and 57% of IV drug users are infected with HCV. Testing for HCV should be considered for anyone with one of the following criteria:

• history of injecting drug use
• child with an HCV antibody positive mother
• HIV positive
• otherwise unexplained persistently elevated alanine aminotransferase
• recipients of blood clotting factor concentrates prior to 1987
• recipients of blood and blood components before September 1991 and organ/tissue transplants in the UK before 1992

• had a sexual partner/household contact who is HCV infected
• had a tattoo or body piercing in circumstances where infection control procedure is suboptimal
• received medical/dental treatment in a country where HCV is common and infection control may be poor
• a healthcare worker following percutaneous or mucous membrane exposure to blood suspected to be/or infected with HCV

SIGN 2013

Although screening for HCV does not yet form part of national screening for pregnancy, NHS Highland recommends screening women who meet any of the above criteria (NHS Highland 2015).

Anyone found to be BBV positive should be referred to the appropriate specialist service:

**HIV**

- Highland Sexual Health. Tel: 01463 704202
- A&B CHP Sexual Health. Tel: 01546 605672

**HBV and HCV**

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7.4 Role of the wider maternity team

Women with a history of alcohol and/or drug use within the last 12 months will require additional support and obstetric led care (NHS QIS 2009). Women will be given details about the pattern of antenatal care that best suits their needs and offered further screening and surveillance appropriate to their stage of pregnancy.

An obstetrician should see all women who use alcohol or drugs at their initial hospital visit and on-going follow up and assessment should be discussed with a clear plan of care in place. The related medical and social problems that may be associated with a woman’s substance misuse may mean that her pregnancy will be high risk.

Although most pregnant women in Highland receive the majority of their antenatal care within the community, this client group may also require additional support from specialist services as previously discussed. Information leaflets and contact numbers should be given to women who are identified as requiring extra support and are detailed in Appendix 2.

7.5 Continuing antenatal care

Routine antenatal care should be provided in the woman’s locality when possible and should include regular liaison with specialist services. Care should be individualised and informed by an integrated assessment of risks and needs and should include:

- Provision of information and education about general health including nutrition and dental care.
- Home visits to allow for adequate discussion and to ensure the home circumstances are assessed.
- Information about local support agencies, benefits and allowances.
- Time to discuss any concerns and reinforce progress on substance misuse.
- On-going multiagency collaboration and communication.
- Discussion of drug use and potential effects during pregnancy and on the newborn. An explanation of NAS and the use of the NAS System Assessment Form and need for increased PN length of stay for assessment of baby (min 5 days) (Appendix 3).
- Preparation for parenthood, including discussion of pain relief during labour, breastfeeding, social support, partner’s role.
- Sudden infant death syndrome.
- Visit to, Special Care Baby Unit (SCBU) services.

Liaison with the family’s HV is essential to ensure that the agreed support is maintained through the transition from midwifery to health visiting care. The Communication and Handover of Health and Social Information between Midwife and Health Visitor highlights that this communication process should take place from booking (NHS Highland 2018).
Any assessments should be shared with the HV who should prioritise a home visit for families with substance misuse issues, which could be a joint visit with the midwife. The importance of building relationships and establishing trust with professionals who will be supporting the family in the postnatal period cannot be overstated. The need for child protection measures should be regularly reviewed throughout the antenatal period to ensure that supportive measures are in place prior to the birth of the child.

7.6 Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs including opioids, benzodiazepines, alcohol and barbiturates. It is characterised by central nervous system irritability, gastrointestinal problems and autonomic hyperactivity and symptoms normally present within the first 24-72 hours after birth, but may occur up to 7-10 days later.

There appears to be little correlation between the amount of maternal drug use and the severity of NAS but certain drugs do intensify the signs. Women will be expected to remain in hospital with their baby for a minimum of 5 days after birth as withdrawal symptoms are often not evident before this time. Practitioners should be aware of the signs and symptoms of NAS in the newborn, as not all maternal drug use may have been reported and use the scoring sheet (Appendix 3).

It is very important that signs and symptoms of NAS are discussed with a woman well before her baby is due as these babies are often born premature. Caring for a Baby with Drug Withdrawals (see Appendix 4) can be used to support this discussion. A NAS leaflet has been developed for women whose baby develops NAS which can be downloaded via NHS providers at [http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/HospitalPaediatrics/Documents/Neonatal%20Unit/Maternal%20disorders%20affecting%20newborn/Neonatal%20abstinence/Paternal%20information%20Neonatal%20abstinence%20Syndrome.doc](http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/HospitalPaediatrics/Documents/Neonatal%20Unit/Maternal%20disorders%20affecting%20newborn/Neonatal%20abstinence/Paternal%20information%20Neonatal%20abstinence%20Syndrome.doc)

Further information about the more severe range of signs and symptoms that have been reported in babies born to opiate and benzodiazepine dependent women are included in Appendix 1.

It is important to assess all infants with the use of the NAS score sheet and ensure paediatric involvement if required. The assessment should be carried out twice a day after feeding which will reduce the bias that may occur if the baby were hungry. All babies who present with NAS will be referred to Social Work Services for assessment, support and follow-up. Neonatal Liaison staff from SCBU will also follow-up babies admitted for treatment for withdrawals.

Community midwives, HVs and GPs should remain vigilant for NAS following discharge and mothers should be made fully aware of the signs which they should report to a health professional.

7.7 Missed appointments

All those involved in providing support in the antenatal period should ensure that any missed appointments are communicated between services and documented in the chronology section of the woman’s records. Steps should be taken to address reasons for non-attendance and to determine whether it is appropriate to provide support to promote attendance at appointments. Community Midwives, Community Psychiatric Nurses for Addictions (CPNA) and Community Addiction Nurses are able to offer follow-up at home and provide a vital link between services. It should however be explained from the outset that if appointments are not kept, professionals involved will become concerned about the family as compliance is seen as part of the support being offered.

The named midwife must seek advice from designated Child Protection Advisors (CPA) and discuss concerns with Social Work Services. Missed appointments may be an indicator of increased risk and consideration.

7.8 Ultrasound scans

As well as being offered an ultrasound scan to determine gestation, all women in Highland are now given the option of a structural fetal anomaly scan at 18+0 - 20+6 weeks gestation. Substance misuse can be associated with structural fetal abnormality, particularly with alcohol consumption, benzodiazepine use in the first trimester and cocaine or amphetamine use. Further ultrasound monitoring in pregnancy may be required when an anomaly is detected, fetal growth restriction is suspected or other factors have contributed to concern for fetal wellbeing.

While some women will be reassured by frequent scanning and may request it, for others it may reinforce a fear that their drug use is adversely affecting their baby’s wellbeing, increasing anxiety and feelings of guilt.

7.9 Pre-birth planning meeting

A pre-birth planning meeting must take place no later than 28 weeks gestation or as soon as possible after this following any concerns of substance misuse. This review provides the opportunity to reassess social circumstances and risk. All partners to the plan should be invited and the Lead Professional role should be clear. All practitioners who are involved in supporting the family should also take part in the pre-birth planning meeting and may have an active role as a partner to the plan (Antenatal or Childs).

The HV should be invited to meetings regarding substance misusing parents and women and families should be involved and supported to take an active role in the meeting and agencies should act as a team and work together seamlessly. The assessment should include:

- Accommodation and home environment
- Provision of basic necessities, financial situation
- Physical health risks
- Family’s social network and support systems
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- Clear discussions around when intervention is necessary
- The parents’ perceptions of the situation
- History of any other children in the family that the parents may have contact with (or not)
- Attendance at appointments for antenatal care, social care, specialist drug services
- The pattern of parental drug/alcohol use and procurement
- Discussion of partner/fathers needs and any assessments required

The discussions and decisions that occur at the pre-birth planning meeting will inform the woman's individual care plan and must be documented in her medical notes in the unit where she will deliver. The Lead Professional should update the Antenatal/Child’s plan. Child protection procedures must be followed when required.

7.10 Admission

Admission to hospital can be an anxious time for mothers, particularly if they have encountered difficulties and increased their drug use prior to admission. They may be frightened of experiencing withdrawal symptoms if unable to maintain their normal supply. It is important to clarify their present medication and to ascertain whether they have been using anything else on top of their prescription. If this is the case; what has been used, how often and how has it been used must be documented.

The prescriber and others involved should be phoned to advise them of admission and to receive up-to-date information on progress, present medication, dispensing arrangements and results of recent drug screening tests. The dispensing community pharmacist should be contacted to clarify whether medication has already been given for that day and the present prescription cancelled. This should prevent medication being collected by anyone else while the woman is in hospital.

Women may be admitted several times throughout pregnancy and it is important that information is kept up-to-date, including the normal dispensing times to avoid withdrawal symptoms.

Confidentiality within the ward

Some women may not want family or friends to be aware that they have been using drugs or are receiving substitute therapy, and any clinical discussions, records or dispensing should be in private.

7.11 Labour and pain relief

Most labours and births will be straightforward but babies may be born prematurely, of low birth weight or suffer withdrawal symptoms. When there are substance misuse concerns, women should give birth in a consultant led maternity unit to facilitate paediatric care. The midwives on the labour suite will provide intrapartum care and the obstetric and paediatric teams should be informed of admission, progress in labour and delivery.
The community midwife should also be informed of admission and delivery as she is the woman’s main care co-ordinator. If a Lead Professional has been appointed other than the midwife they must also be informed.

For a woman with HIV the decision about mode of delivery will be made in conjunction with her, her obstetrician and HIV specialist doctor. An elective caesarean section may be recommended as the best way to prevent HIV transmission to the baby. This will depend on clinical parameters such as viral load and the use or otherwise of anti-retroviral agents. Care for babies born to women with BBV should follow the NHS Highland Protocol, Screening for Communicable Diseases in Pregnancy NHS Highland, 2017. The Highland policy is available on the intranet http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Policy%20for%20Screening%20for%20Communicable%20Diseases%20in%20Pregnancy.pdf

If a woman is on a substitute prescribing programme this should be continued during labour and standard analgesia should also be administered. Their daily dose will not provide adequate pain relief due to saturation of opioid receptors. Women should be reassured that they will be given adequate pain relief during labour and the options available should have been discussed antenatally. It should be remembered that some opiate users might require larger amounts of pain relief if tolerance has developed and a low threshold for epidural anaesthesia should be considered. Drug misuse is not a contraindication to the use of a patient controlled analgesia (PCA) pump following caesarean section (Whittaker 2003).

Routine care during labour should apply, with careful observation of mother and baby for signs of withdrawal or increased placental insufficiency. These may present as:

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Naloxone (an opiate antagonist) must NOT be given to reverse opioid induced respiratory depression in the newborn, as it will induce an abrupt opiate withdrawal crisis. Supportive measures or ventilation should be used.

7.12 Postnatal care

All mothers and babies should be transferred to the postnatal ward unless there is a medical reason for admission to SCBU and separation should be avoided whenever possible. Following delivery all known drug dependent women should be encouraged to stay in hospital for a minimum of 5 days so that any signs and symptoms of NAS can be detected. Withdrawal
symptoms from methadone are often not seen until then or later. The use of the NAS score sheet should have been fully explained to the mother in the antenatal period and she should be involved in the scoring process.

All babies of mothers who are Hep B positive require a course of Hepatitis B vaccine to be started as soon as possible after birth. Women can be offered Hepatitis B and Hepatitis A vaccination if appropriate. A leaflet is now available from NHS Scotland to give to women whose babies are at risk Hepatitis B immunisation: How to protect your baby (2017) and is available from the Health Information Resources Library (HIRS).

The multiagency team should be informed that the woman has given birth and details of her and her baby’s health. If a mother insists on early discharge she should discuss this with the paediatrician as she may be taking her baby home against medical advice. In this situation advice should be sought from the local CPA. If the mother discharges herself without her baby, the baby will be transferred to SCBU.

Some babies may not require treatment but may be restless and difficult to settle. This is a time when mothers can be supported and taught skills to comfort their babies (see Appendix 4) and the NAS leaflet.

Any parent can find it difficult to meet the demands of a new baby and it is not specific to women who use drugs or alcohol. Every opportunity should be taken to help mothers learn to recognise their baby’s needs and how these can be met. The play@home guidance (see Highland Information Trail) and introducing baby massage may assist mothers to feel they are positively supporting and interacting with their babies. All HV bases in Highland have a copy of ‘The Social Baby’ DVD which provides practical examples of parent and baby communication.

Withdrawal symptoms from methadone and benzodiazepines may not be evident until several days or weeks following birth. Parents and community staff including GPs, HVs and Community Early Years Workers caring for the family need to remain vigilant for signs of withdrawal in the baby.

7.13 Infant feeding

The benefits of breastfeeding should be discussed with all women antenatally and breastfeeding should be encouraged. There is some evidence that drinking more than 2 units of alcohol a day whilst breast feeding may affect babies development. An occasional drink is unlikely to harm a breast fed baby. Breast feeding mums should have no more than 1 or 2 units of alcohol once or twice a week. Alcohol passes freely into the breast milk and peak levels appear 30 – 90 minutes following intake. Binge drinking (more than 6 units of alcohol in 1 session) should be avoided (Jones 2013).

If drug use is stable and the woman is on prescribed methadone, she should be informed that the advantages of breastfeeding her baby outweigh the disadvantages. Apart from well documented evidence of the benefits of breastfeeding, it may also help to reduce withdrawal symptoms experienced by the baby, as small quantities of drugs may be passed via the breast milk. If a mother is on methadone and breastfeeding then weaning should be gradual to reduce withdrawal symptoms in the neonate.

Breastfeeding can bring comfort to the mother at a time when she may experience significant guilt regarding her drug use and potential withdrawal symptoms for the baby. Skin to skin
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Contact will help regulate the baby’s temperature, heart rate and breathing, and will also reassure and comfort both mother and baby. Breastfeeding should be commenced as soon as possible following delivery as recommended in the Highland Infant Feeding Policy for Midwives (NHS Highland 2014).

The exceptions to promotion of breastfeeding are:

- If a woman is HIV positive, due to the high risk of transmission.
- If she is using large quantities of stimulant drugs such as cocaine, ‘crack’ or amphetamines, because of vasoconstriction effects.
- If drinking heavily or taking large amounts of non-prescribed benzodiazepines, because of sedative effects.

The advice regarding drugs and breastfeeding includes:

- Amphetamines – should be avoided recreationally when breastfeeding as there is a lack of clinical data surrounding the effects
  Cocaine – is slowly metabolised and excreted over a long period and infants do not possess the enzyme necessary to metabolise cocaine and are at increased risk of its effects. Women who use cocaine should be advised to pump and discard their breast milk for 24 – 48 hours.
- Ecstasy – avoid during breastfeeding. If the mother does use she should pump and discard her milk for a minimum of 24 – 48 hours.
- Marijuana – regular use should be strongly discouraged
- Diamorphine – avoid during breastfeeding. Encourage enrolment on a methadone programme.
- Methadone – generally compatible with breastfeeding but monitor baby for sedation, breathing difficulties, level of arousal. When breastfeeding stops there is a possibility that the infant may experience withdrawal. Babies exposed to methadone in-utero will be more tolerant to the drug than babies whose mothers started postnatally.
  (Jones 2013)
- Buprenorphine – generally safe to take while breastfeeding. 1 study has reported slow weight gain in neonates and reduction of milk supply in women. (Hale 2012)

The injecting of drugs whilst breastfeeding should be discouraged because of the risks of BBV transmission to the baby. Women who are HBV positive can breastfeed once the baby has been given his/her first dose of Hepatitis B vaccine and immunoglobulin (HBIG) if required. These should be administered as soon as possible after birth and no longer than 24 hours later. Blood Transfusion Service (BTS) Highland recommends HBIG is given where applicable within 4 hours and all staff should refer to the Highland Policy for further clarity (Screening for Communicable Diseases in Pregnancy for NHS Highland). There is no evidence that the HCV is transmitted by breastfeeding and this should be conveyed to the mother.

To open up discussion about infant feeding the booklets ‘Ready, Steady, Baby’ and ‘Off to a Good Start’ (NHS Health Scotland 2018) available from HIRS will have been given out to all women during pregnancy, as per Highland’s Information Trail. Women should be able to make an informed choice on how to feed their baby and those who decide to artificially feed should be supported in this. Further advice about bottle or mixed feeding is detailed within the NHS
Highland publications, *postnatal breastfeeding booklet* and *postnatal formula Booklet* both detailed in the *Highland Information Trail* and available from HIRS.

### 7.14 Discharge planning meeting

A discharge planning meeting should be viewed as a supportive measure with the aim of discussing arrangements in place for going home, making practical arrangements for appointments and establishing where the mother and baby will be staying. The meeting should clarify for the mother and all professionals involved if there are any on-going concerns and any further help that maybe required. Where appropriate, meetings should also involve partners and an assessment of their needs as well as those of the mother, baby and any other children taken into account.

Planned support that continues into the postnatal period is crucial as this can be a stressful time for parents. For mothers who have managed to reduce their drug and alcohol use during pregnancy the risk of relapse to former levels of use is high. Relapse prevention work, careful drug management and intensive psychosocial support may be required for some time. Arrangements should be recorded in the medical notes, the Child’s Plan should be updated and a copy of appointments and contact numbers given to the mother.

### 7.15 Contraception

Many women who use drugs and alcohol do not see contraception as a priority as they often underestimate their fertility. However, it is a priority for service providers to ensure they are offered a form of contraception which best meets their needs. It is essential that discussion takes place about reproductive health and contraception throughout pregnancy to allow informed decision making prior to postnatal discharge. Women can then be enabled to make choices regarding their future sexual health before they leave hospital following delivery as once discharged they frequently do not access services.

Provision of contraception should ideally occur prior to discharge and long acting reversible methods such as progesterone implants and intrauterine devices are an appropriate choice for this client group. These should be encouraged wherever possible.

When providing information it is important to give contact details that are relevant to the area where the woman lives and ensure that she understands the important role of her GP and Highland Sexual Health Services. Discussion should include:

- Individual’s own health/contraindications
- Availability – how to access services
- Compliance
- Risk of sexually transmitted infections (STIs)
- Importance of contraceptive cover

To ensure robust follow-up and compliance, those involved in on-going care such as the GP and HV should be advised of discussions or choices made around contraception in order that it can be raised with the women to encourage uptake.

### 7.16 Prior to discharge
For those women who are on a substitute prescribing programme their keyworker/prescriber should be contacted and medical staff should advise whoever will be taking over the prescribing within the community. Medical staff will need to inform the prescriber of any changes to medication and when to take over prescribing. Liaison should be done on a weekday as the woman’s own GP or prescriber may not be available at weekends.

If the prescriber cannot be contacted, a maximum of a 3-day prescription could be provided when appropriate, with a community pharmacist identified, contacted and advised about arrangements. Prescriptions are issued under supervised consumption that is taken in sight of the pharmacist on the pharmacy premises or dispensed daily to be consumed elsewhere.

### 7.17 Continuing postnatal care

All staff should understand that the care of a pregnant woman who misuses alcohol or drugs and the safe delivery of her baby is just the beginning of her journey. Postnatal care should enable a woman and her family to make an effective transition into parenthood, and interagency communication and collaboration are essential in ensuring thorough child care risk assessment. This must include the baby or child being seen and examined regularly and also the home environment being assessed as safe.

Continuing support following discharge will be delivered primarily by the community midwife who will be the main provider of care and advice in the early postnatal period along with other agencies involved with the family. The postnatal visits may continue for an extended period following birth in order to meet the woman’s needs. This will be in addition to the care provided by the HV who will undertake her primary post-birth visit between day 11 and day 15.

Practitioners should follow the *Communication and Handover of Health and Social Information between Midwife and Public Health Nurse/Health Visitor Procedure* (2018) to ensure that continuity of care is safe, consistent, timely and effective. For this client group, on-going support in the postnatal period is essential with services working together to ensure that women are supported appropriately.

Children of parents who misuse drugs and alcohol will need additional and frequent assessment and support. They must not follow a core pathway. The HV and GP will provide continuing support to the family to ensure that the correct level of care is provided. The importance of attending baby clinics for immunisation and developmental monitoring must be emphasised to parents and any missed appointments must be followed up promptly. Any risks or concerns must be acted on and babies and children must be seen and assessed and the Named Person and/or Lead Professional if allocated must be informed.

Children whose parents have alcohol or drug issues should have their health and wellbeing assessed very frequently throughout their lives to ensure they are supported to meet their milestones and are kept safe. Any concerns should be addressed through a collaborative approach with practitioners working together to ensure the best interests of the child are paramount and the best outcomes are assured.

### 8. References
Women, Pregnancy and Substance Use: Good Practice Guidelines (v.5)

www.argyll-bute.gov.uk/abcpc last accessed July 2010


Department of Health (2017) Drug misuse and dependence: UK guidelines on clinical management


https://www.sign.ac.uk/assets/sign127_update.pdf

Highlands Alcohol and Drugs Partnership/Highland Child Protection Committee (2015) A practitioners Guide to getting our priorities right


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<th>Version: 5</th>
<th>Date of Issue: April 2019</th>
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<td>Page: 45</td>
<td>Date of Review: April 2021</td>
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</tbody>
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Highland Practice Model http://www.forhighlandschildren.org/5-practiceguidance/


Children and Young People (Information Sharing) (Scotland) Bill https://www2.gov.scot/Topics/People/Young-People/gettingitright/information-sharing


Surgeon General’s Report 2014, 50 Years of progress Chapter 9 Reproductive Outcomes pages 461-498

Appendix 1 Conversation tool: Brief conversation when raised CO in pregnancy

Talking to women about smoking in pregnancy
This scripted conversation supports a brief, evidence-informed conversation with pregnant women who blow a high CO reading.

1. **Explain**
   - Explain what carbon monoxide (CO) is and why you are testing her CO reading.
   - "Carbon monoxide is a poisonous gas that's very harmful to your baby. It is present in exhaust fumes, faulty gas appliances, and cigarette smoke. It passes via your bloodstream to your baby and deprives your baby of oxygen and nutrients. It also slows the baby's growth and development. Fortunately, CO levels return to normal very quickly once someone stops smoking."

2. **Find out**
   - If the CO reading is 40 mmHg or higher, find out if she or anyone in her family/home smokes.
   - "A reading above 40mm can be harmful to your baby. Do you or does anyone else in your family/home smoke?"

3. **Investigate**
   - If she says that she has stopped smoking or does not smoke but the CO reading is still above 40mm, there are other possible reasons for this high reading.
   - "If you or someone else in your family/home smokes, it's vital to find out why."

4. **Inform**
   - If she smokes, give her a copy of the booklet 1-Quit: Stopping smoking when you're pregnant and open it at pages 4/5. Tell her about how smoking harms her baby. Evidence indicates this is much more powerful than just handing over the unopened booklet. Make sure you give her a booklet to take home. 1-Quit should only be given to women who smoke during pregnancy.
   - "Carbon monoxide passes through your bloodstream to your baby and deprives your baby of oxygen and nutrients. It also slows the baby's growth and development. It increases your risk of miscarriage and stillbirth. It is important that you stop smoking, not just cut down."

5. **Discuss**
   - If she does not feel able to stop smoking or is reluctant to receive help, suggest she talks with the smoking cessation adviser. Research shows that support from partners, family and friends is important in determining whether a pregnant woman will be successful in her attempt to stop smoking.
   - "Pages 2/9 show how smoking harms your body. Pages 20/21 show the impact of second-hand smoke."

6. **Suggest**
   - If she has given up smoking in the last 3 months, give her the booklet 1-Quit: Stopping smoking when you're pregnant. Ask if she would like any extra support to stay stopped.
   - "Why don't you talk this through with the adviser when she calls you? She can also offer support to your partner or any other member of your family who would like to quit too."

7. **Inform**
   - If she has given up smoking in the last 3 months, give her the booklet 1-Quit: Stopping smoking when you're pregnant. Ask if she would like any extra support to stay stopped.
   - "Here's a copy of the 1-Quit booklet to take home. You may want any additional support to stay smoke-free."

8. **Encourage**
   - Finish the conversation with a positive, encouraging message.
   - "I'll look forward to hearing how you get on..."

With thanks to the National Centre for Smoking Cessation and Training (NCSTCT) for their permission to incorporate some wording from their 2016 resource 'Smoking Cessation: A briefing for midwifery staff.'
## Appendix 2

### Drugs and their effects on pregnancy and breastfeeding

<table>
<thead>
<tr>
<th>OPIATES</th>
<th>For example: heroin, methadone, temgesic and diconal.</th>
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</thead>
<tbody>
<tr>
<td><strong>Withdrawal</strong></td>
<td><strong>Risks in Pregnancy</strong></td>
</tr>
<tr>
<td>Sweating, stomach cramps, muscular pain, runny nose, diarrhoea</td>
<td>There is growing evidence that opiate use in pregnancy is associated with visual disorders in the infant: rates of strabismus and nystagmus in infants born to opiate using mothers are significantly greater than in matched controls. The effect is not just limited to those using illicit opiates but may also be seen in those on prescriptions. There is no evidence that opiates cause birth defects, but withdrawal leads to spasm of the placental blood vessels and reduction in placental blood flow resulting in low birth weight. Other factors such as poor diet and smoking can also contribute to this reduction in birth weight. If opiates are withdrawn suddenly, there is an increased risk of miscarriage, fetal distress or premature labour.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENZO-DIAZEPINES</th>
<th>For example: diazepam, temazepam, nitrazepam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Withdrawal</strong></td>
<td><strong>Risks in Pregnancy</strong></td>
</tr>
<tr>
<td>Panic attacks, distortion of perceptions, feelings of</td>
<td>Some studies suggest certain drugs can cause defects, such as cleft palate if used in</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Risks in Pregnancy</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Withdrawal is characterised by hunger, fatigue, periods of fitful sleep, increase in dreaming and depression— in some cases prolonged and severe.</td>
<td>There may be a link between amphetamine use and congenital abnormality but studies are limited and contradictory. Due to the vasoconstriction effects of cocaine there is an increased risk of miscarriage, placental abruption, fetal hypoxia and intrauterine death. There is some evidence of a correlation between ecstasy use in pregnancy and heart defects and limb deformities. Premature labour and low birth weight are risks associated with stimulant use.</td>
</tr>
</tbody>
</table>

**STIMULANTS**
For example: amphetamine, ecstasy, cocaine and crack. Dependence on stimulants is thought to be more psychological than physical, although recent evidence suggests possible long-term changes to the nervous system. Due to the adverse effects when ‘coming down’ from stimulant use, users often resort to taking sedative drugs (e.g., benzodiazepines or sleeping tablets) and/or alcohol to manage symptoms.

**CANNABIS**
Cannabis is frequently used together with tobacco (see section 3). The risks associated with tobacco are increased as people who smoke cannabis tend to inhale more deeply and for longer resulting in increased exposure to carbon monoxide and toxins.

NEW DRUGS

New psychoactive substances (NPS) are drugs which were designed to replicate the effects of illegal substances like cannabis, cocaine and ecstasy whilst remaining legal – hence their previous name ‘legal highs’. They fall into four main categories:

Synthetic cannabinoids - these drugs mimic cannabis and are traded under such names as Clockwork Orange, Black Mamba, Spice and Exodus Damnation. They bear no relation to the cannabis plant except that the chemicals which are blended into the base plant matter act on the brain in a similar way to cannabis.

Stimulant-type drugs - these drugs mimic substances such as amphetamine, cocaine and ecstasy

Hallucinogenic drugs - these drugs mimic substances like LSD

The packaging may describe a list of ingredients but it’s impossible to be sure what’s inside and the contents of one branded package could change from week to week.

Effects

The effects of NPS vary significantly from drug to drug and, compared to more traditional drugs, we have relatively little information on them. However, there is a growing body of evidence to demonstrate the potential short and long-term harms associated with their use. There have been hospitalisations and deaths linked to NPS.

The Scottish Drugs Forum carried out a survey of drug services in 2013 which summarised some of the key reported harms during intoxication and comedown:

- Overdose and temporary psychotic states and unpredictable behaviours; Attendance at A&E and some hospital admissions; Sudden increase in body temperature, heart rate, coma and risk to internal organs (PMA); Hallucination and vomiting; Confusion leading to aggression and violence; Intense comedown that can cause users to feel suicidal. Use was also associated with longer term health issues: Increase in mental health issues including psychosis, paranoia, anxiety, ‘psychiatric complications; Depression; Physical and psychological dependency happening quite rapidly after a relatively short intense period of use (weeks)

## Appendix 3
### Useful contacts

<table>
<thead>
<tr>
<th>Agency</th>
<th>Tel No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action for Children, Inverness.</td>
<td>01463 717227</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>0845 7697555</td>
</tr>
<tr>
<td>Al-Anon/Al-Ateen Helpline 10am - 10pm</td>
<td>02074 030 888</td>
</tr>
<tr>
<td>Antenatal clinic, Raigmore Hospital, Inverness</td>
<td>01463 704278</td>
</tr>
<tr>
<td>APEX Scotland Progress2Work service, assisting recovering drug misusers back to employment</td>
<td>01463 717033</td>
</tr>
<tr>
<td>Benefits Agency</td>
<td>01463 663500</td>
</tr>
<tr>
<td>Beechwood House, Inverness</td>
<td>01463 711335</td>
</tr>
<tr>
<td>Childline</td>
<td>0800 1111</td>
</tr>
<tr>
<td>Child Protection, for info on local teams, Inverness</td>
<td>01463 701307</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>01546 604281</td>
</tr>
<tr>
<td>Children 1st</td>
<td>01381 620757</td>
</tr>
<tr>
<td>Citizens Advice Bureau: Inverness</td>
<td>01463 237664</td>
</tr>
<tr>
<td>Nairn</td>
<td>01667 456677</td>
</tr>
<tr>
<td>Ross &amp; Cromarty</td>
<td>01349 883333</td>
</tr>
<tr>
<td>East Sutherland (Golspie)</td>
<td>01408 633000</td>
</tr>
<tr>
<td>Nth West Sutherland (Kinlochbervie)</td>
<td>01971 521730</td>
</tr>
<tr>
<td>Caithness ( Thurso)</td>
<td>01847 894243</td>
</tr>
<tr>
<td>Lochaber</td>
<td>01397 705311</td>
</tr>
<tr>
<td>Skye &amp; Lochalsh</td>
<td>01478 612032</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>01546 605550</td>
</tr>
<tr>
<td>Cocaine Anonymous</td>
<td>0800 6120225</td>
</tr>
<tr>
<td>Community Midwives: Inverness.</td>
<td>01463 704342</td>
</tr>
<tr>
<td>Out with Inverness, contact GP surgery for details of local midwife.</td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Nurses for Addiction:; Inverness</td>
<td>01463 706973/</td>
</tr>
<tr>
<td>Argyll &amp; Bute Addiction Team 01546 605602</td>
<td>706972</td>
</tr>
<tr>
<td>Community Addiction Nurses: Argyll &amp; Bute</td>
<td>01546 605602</td>
</tr>
<tr>
<td>Criminal Justice Team: Inverness</td>
<td>01463 724022</td>
</tr>
<tr>
<td>Dingwall</td>
<td>01349 865600</td>
</tr>
<tr>
<td>Wick</td>
<td>01955 603161</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>01586 559050</td>
</tr>
<tr>
<td>Domestic Abuse National Helpline</td>
<td>0800 027 1234</td>
</tr>
<tr>
<td></td>
<td>01463 704603</td>
</tr>
<tr>
<td>Service Description</td>
<td>Contact Details</td>
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<tr>
<td>Information Line</td>
<td>0844 848 3778, 01546 604948</td>
</tr>
<tr>
<td>Drugline Scotland</td>
<td>0800 776600</td>
</tr>
<tr>
<td>Dual diagnosis Service (Community), RNI, Inverness</td>
<td>01463 706958</td>
</tr>
<tr>
<td>Drug &amp; Alcohol Services, Osprey House, Inverness. Contact for local details</td>
<td>01463 716888, 01546 605602</td>
</tr>
<tr>
<td>Drug Treatment &amp; Testing Order DTTO.</td>
<td>01463 716324</td>
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<tr>
<td>Harm Reduction Nurse, Inverness</td>
<td>01463 716324</td>
</tr>
<tr>
<td>Harm Reduction Nurse, Argyll &amp; Bute</td>
<td>01631 571294</td>
</tr>
<tr>
<td>Health Information &amp; Resources, HIRS, Assynt House, Beechwood Park, Inverness</td>
<td>01463 704647</td>
</tr>
<tr>
<td>Highland counselling services: Inverness</td>
<td>01463 220995, 01862 894097, 01397 702340, 01478 612633, 01631 566090</td>
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<tr>
<td>Ross, Sutherland, Wick</td>
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<td>Lochaber</td>
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</tr>
<tr>
<td>Skye &amp; Lochalsh</td>
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</tr>
<tr>
<td>Encompass Counselling and support, Argyll &amp; Bute</td>
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</tr>
<tr>
<td>Homeless Shelter, Inverness</td>
<td>01463 718669</td>
</tr>
<tr>
<td>Homeless Housing Officer, Argyll &amp; Bute</td>
<td>01546 604673</td>
</tr>
<tr>
<td>Homeless Nurse, Argyll &amp; Bute</td>
<td>07920 548252</td>
</tr>
<tr>
<td>Kintyre Alcohol and Drugs Advisory Service (KADAS)</td>
<td>01586 553555</td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
<td>0845 373366</td>
</tr>
<tr>
<td>Osprey House, Drug and Alcohol Services, Inverness</td>
<td>01463 716888</td>
</tr>
<tr>
<td>Police Scotland</td>
<td>101, 999</td>
</tr>
<tr>
<td>Non-emergency number – crime or other concerns</td>
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<tr>
<td>Emergency</td>
<td></td>
</tr>
<tr>
<td>Rape and Abuse Helpline, Dingwall (Lines open 7am-10pm)</td>
<td>080 8800 0123</td>
</tr>
<tr>
<td>Road to Recovery: Inverness</td>
<td>01463 715809, 01349 862183, 01463 871223, 01349 866067</td>
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<tr>
<td>Dingwall</td>
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<td>Muir of Ord</td>
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<tr>
<td>Black Isle</td>
<td></td>
</tr>
<tr>
<td>Scottish Drug Misuse Database</td>
<td>0131 551 8221</td>
</tr>
<tr>
<td>SMART Recovery, Inverness</td>
<td>01463 729548</td>
</tr>
<tr>
<td>Smoking Cessation Service, Highland. Ring for details of locality numbers.</td>
<td>0845 757 3077</td>
</tr>
<tr>
<td>SNFAD (for parents and families of drug misusers)</td>
<td>0808 010 1011</td>
</tr>
<tr>
<td>Social Work Services, Highland Council, (Emergency out of hours 08457 697284)</td>
<td>01463 703456</td>
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### Women, Pregnancy and Substance Use: Good Practice Guidelines (v.5)

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<td>Social Work Services Argyll &amp; Bute (Emergency out of hours 0800 811505)</td>
<td>01631 563068</td>
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<tr>
<td>Substance Misuse Co-ordinator, NHS Highland, Inverness. Information for clients and professionals</td>
<td>01463 704969</td>
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<tr>
<td>Scottish Women’s Aid (National)</td>
<td>0131 475 2372</td>
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<tr>
<td>Smoking Cessation Midwife</td>
<td>01463 706370 07824417514</td>
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<tr>
<td>Women’s Aid: Inverness</td>
<td>01463 220719 01349 863568 01397 705734 08454 080 151 0870 241 3548</td>
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<td>Argyll &amp; Bute</td>
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<td>Youth Action Team: Inverness: Nairn, Badenoch &amp; Strathspey</td>
<td>01463 256603 01955 605792</td>
</tr>
<tr>
<td>North, West and Mid-Highland</td>
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### Websites

- [www.careinspectorate.com](http://www.careinspectorate.com)
- [www.turningpointscotland.com](http://www.turningpointscotland.com)
- [www.knowthescore.info](http://www.knowthescore.info)
- [www.ukna.org](http://www.ukna.org)
- [www.sdf.org.uk](http://www.sdf.org.uk)
- [www.ashscotland.org.uk](http://www.ashscotland.org.uk)
- [www.canstopsmoking.com](http://www.canstopsmoking.com)
- [www.highland-adp.org.uk](http://www.highland-adp.org.uk)
- [www.fasdnetwork.org](http://www.fasdnetwork.org)
- [www.nofas-uk.org](http://www.nofas-uk.org)
- [www.alcohol-focus-scotland.org.uk](http://www.alcohol-focus-scotland.org.uk)
- [www.alcoholconcern.org.uk](http://www.alcoholconcern.org.uk)
- [www.downyourdrink.org.uk](http://www.downyourdrink.org.uk)
- [www.h-sat.co.uk](http://www.h-sat.co.uk)
- [www.smokefreehighland.co.uk](http://www.smokefreehighland.co.uk)

### Appendix 4

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<td><strong>Page:</strong> 55</td>
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<td><strong>Date of Review:</strong> April 2021</td>
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## Neonatal Abstinence Score Sheet

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<tr>
<th>System</th>
<th>Signs and Symptoms</th>
<th>Score</th>
<th>AM</th>
<th>PM</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral System Disturbances</td>
<td>Excessive high-pitched (or other) cry &lt; 5 mins</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuous high-pitched (or other) cry &gt; 5 mins</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Sleeps &lt; 1 hour after feeding</td>
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<tr>
<td></td>
<td>Sleeps &lt; 2 hours after feeding</td>
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<td></td>
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<td></td>
<td>Sleeps &lt; 3 hours after feeding</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hyperactive Moro reflex</td>
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<tr>
<td></td>
<td>Markedly hyperactive Moro reflex</td>
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<td></td>
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<tr>
<td></td>
<td>Mild tremors when disturbed</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Moderate-severe tremors when disturbed</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild tremors when undisturbed</td>
<td>3</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Moderate-severe tremors when undisturbed</td>
<td>4</td>
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<tr>
<td></td>
<td>Increased muscle tone</td>
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<tr>
<td></td>
<td>Excoriation (chin, knees, elbow, toes, nose)</td>
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<tr>
<td></td>
<td>Myoclonic jerks (twitching/jerking of limbs)</td>
<td>3</td>
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<tr>
<td></td>
<td>Generalised convulsions</td>
<td>5</td>
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<tr>
<td>Metabolic/Vasomotor/Respiratory Disturbances</td>
<td>Sweating</td>
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<tr>
<td></td>
<td>Hyperthermia 37.2-38.3°C</td>
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<td></td>
<td>Hyperthermia &gt; 38.4°C</td>
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<tr>
<td></td>
<td>Frequent yawning (&gt; 3-4 times/ scoring interval)</td>
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<tr>
<td></td>
<td>Mottling</td>
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<td></td>
<td>Nasal stuffiness</td>
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<tr>
<td></td>
<td>Sneezing (&gt; 3-4 times/scoring interval)</td>
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<tr>
<td></td>
<td>Nasal flaring</td>
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<td></td>
<td>Respiratory rate &gt; 60/min with retractions</td>
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<tr>
<td></td>
<td>Respiratory rate &gt; 60/min</td>
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<tr>
<td>Gastrointestinal Disturbances</td>
<td>Excessive sucking</td>
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<tr>
<td></td>
<td>Poor feeding (infrequent/uncoordinated suck)</td>
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<tr>
<td></td>
<td>Regurgitation (≥ 2 times during/post feeding)</td>
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<td></td>
<td>Projectile vomiting</td>
<td>3</td>
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<tr>
<td></td>
<td>Loose stools (curds/seedy appearance)</td>
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<tr>
<td></td>
<td>Watery stools (water ring on nappy around stool)</td>
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</table>

**Total Score**

**Date/Time**

**Initials of Scorer**

Appendix 5
Caring for a baby with drug withdrawals

Information for parents/carers

Babies who show symptoms of drug withdrawal may require some special care and attention from their parents. There are a number of things that you can do to help your baby which will reduce the effects of withdrawal.

Some ideas that might be helpful:

- Make sure your baby is kept in quiet and calm surroundings with no bright lights or loud sounds that might upset your baby.
- Rock your baby gently and move them gently.
- Hold your baby as much as is possible and maintain 'skin to skin' contact.
- Swaddling - can be comforting for baby when trying to soothe, but baby shouldn't be put to sleep swaddled. (In line with cot death recommendations).
- Try a gentle massage with soft background music.
- Consider using a soother to help them settle, unless you are breastfeeding.
- Change their clothing to prevent sweating.
- Use a barrier cream around the baby's bottom to prevent skin damage and also keep a close eye on the skin around their mouth especially if they are vomiting.
- Do not smoke or allow anyone else to smoke in the same room as your baby.
- Avoid overheating baby.
- Feed baby on demand, frequent small feeds will suit your baby better than giving larger feeds less frequently.
- Keep a record of all the feeds your baby takes so that your midwife/health visitor can check whether your baby is feeding well enough and putting on weight.
- If your baby has any abnormal movements/convulsions, dial 999 and ask for an ambulance to take your baby to hospital.
## Appendix 6

### Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
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<td>Roderick Maclean</td>
<td>Speciality Doctor in Addiction Psychiatry</td>
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<td>Lorna MacAskill</td>
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<td>NHS Highland</td>
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<tr>
<td>Lynda Davidson</td>
<td>Health Protection Nurse Specialist</td>
<td>NHS Highland</td>
</tr>
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<td>Sarah Mackenzie</td>
<td>Research &amp; Intelligence Officer, Highland Alcohol and Drug Partnership</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>Margy MacDonald</td>
<td>Smoking Cessation Midwife</td>
<td>NHS Highland</td>
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<tr>
<td>Alan Richards</td>
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<td>Debbie Stewart</td>
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<td>Consultant Paediatrician</td>
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<td>Carolyn Hunterrow</td>
<td>Research and Intelligence Specialist, Highland Alcohol and Drugs Partnership</td>
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<tr>
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</tr>
<tr>
<td>Suzy Calder</td>
<td>Head of Service, Drug and Alcohol Recovery/Prison Service</td>
<td>NHS Highland</td>
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