



Women, Pregnancy and Substance Misuse: Good Practice Guidelines

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Policy Reference: 020413	Date of Issue: May 2013
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Ratified by: NMAHP Policy, Procedures & Guidelines Ratification Group	Date Ratified: May 2013
PFF: Yes	Date PFF: Jan 2013

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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 (Hidden Harm-Next Steps 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 going on to have poorer outcomes.

Evidence suggests that women who misuse substances and their infants have better outcomes if they take up antenatal care early and if they use services consistently throughout pregnancy (Scottish Executive 2003). Pregnancy may motivate many women to access support for substance using issues but some may feel inhibited due to feelings of guilt or fear that their children may be removed from them (Hidden Harm-Next Steps 2006). Services therefore need to be accessible, welcoming and empowering for those women affected by substance use, just as they do for others.

The pathway detailed in this guidance represents best practice for maternity staff across Highland. Other agencies 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 appropriate information, support and referral to specialist services are provided to all women based on need (NHS QIS 2009). This equally applies to women who have problems with drug or alcohol misuse, who should have access to a full range of services within a multi-disciplinary assessment process. Good practice in maternity care can help to provide the necessary early links with families and ensure that resources are in place to enable everyone to work together to provide a coherent and responsive service.

“Women, their partners and their families should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times.”

(NICE 2008).

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Summary of Guidelines

- Pregnant women who misuse 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).
- Staff who are taking a booking history should always ask sensitively but routinely about all substance misuse. 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 alcohol/drug services.
- Information on any social problems that could impact on outcomes of the pregnancy, including substance misuse, 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 addiction 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 who have drug or alcohol problems, including obstetricians, GPs, midwives, Public Health Nurse/health visitors (PHN/HV), social work and addiction services, require on-going training to ensure they have the knowledge and skills required to identify problems, assess severity and refer women to other appropriate, specialist services.
- Women with problem drug and/or alcohol use have potentially high-risk pregnancies 'The Pathways for Maternity Care' (NHS QIS, 2006) enable the beginning of risk assessment . These 'Women. Pregnancy and Substance Use guidelines' offer further assistance to enable assessment.
- Women who have misused alcohol and/or drugs, within the 12 months prior to their pregnancy, will follow a Red Pathway 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 multi-agency network, which should include both addiction and social services.

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- The management of women who have substance misuse 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.
- Close follow-up and multi-agency 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 Health for All Children (Hall 4) programme and Highland Practice Model (GIRFEC) where women who misuse substances will be assessed as requiring additional/intensive support from services.
- Substance misuse 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.

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1. Background

We live in a drug using society. Heroin, tobacco, prescription medicines, alcohol, cannabis 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, a developing baby or an infant/child. The answer lies in ensuring that services are provided in ways that 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.

The Women, Pregnancy and Substance Use Guidelines for tobacco, alcohol and drugs have been revised in line with current legislation and national policy to support professionals within the maternity and drug services in Highland and 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 appropriate referral criteria and 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 through the Early Years Framework and the recently established Early Years Collaborative recognises the impact that our experiences both pre-birth and during the early years have on not only childhood but longer term into adulthood. 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) also 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.

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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.

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- It is normal to feel in two minds, or ambivalent, and a practitioner can help the 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.

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3. Smoking

Stopping smoking...

- is one of the most important things a woman can do to improve her health and increase her chances of having a healthy baby
- will have a significant impact on the health and wellbeing of her baby into childhood and beyond
- at any gestation will reduce the risks of developing complications during pregnancy
- will have a significant positive impact on the woman's health, quality of life and life expectancy

There are short and long term benefits to quitting smoking:

-  20 minutes: blood pressure and pulse return to normal
-  1 hour: the risks of complications during pregnancy reduce
-  24 hours: carbon monoxide levels will be eliminated from the body - baby will immediately receive more oxygen
-  2 days: nicotine eliminated from the body; sense of taste and smell improves; second-hand smoke is no longer affecting baby's growth
-  Long term: health risks decrease (for example: heart disease, cancer); increased energy; finances improve

Women need to be made aware of the risks to them and their baby of continuing to smoke but the emphasis should be on the positive benefits of giving up. Women are found to be receptive to an approach which recognises the benefits of quitting smoking to them as individuals, as well as the benefits to their unborn baby (Lowry et al 2004).

Quitting smoking reduces:

- The risk of developing pregnancy related complications such as placenta praevia and placental abruption
- The risk of pre-term delivery
- The incidence of intrauterine growth retardation and low birth-weight.

When a pregnant woman smokes, oxygen in her blood is replaced by carbon monoxide which limits the oxygen and nutrients reaching her baby, affecting the baby's growth and wellbeing.

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Smoking during pregnancy will:

- Increase the miscarriage rate (27% higher in smokers)
- Increase the stillbirth rate (33% higher in smokers)
- Damage a baby's airways before birth. Babies whose mothers smoke during pregnancy are born with smaller airways, making them more vulnerable to breathing problems such as asthma and chest infections.
- Increase the likelihood of a baby being born with an oral cleft lip and palate
- Expose the woman and her baby to the harmful properties of cigarettes (4000 chemicals, tar and 69 known human carcinogens).

Smoking during pregnancy can cause serious health problems and can increase the risk of infant mortality by an estimated 40% (NHS Health Scotland 2007). Risk increases with the amount smoked. Exposure to second-hand smoke also increases the risk of complications. Many women are aware of the potential adverse health effects of smoking during pregnancy but guilt about smoking may hinder open discussion between the woman and the health professional. Therefore, a non-judgemental approach is required.

The incidence

The reported level of pregnant women smoking in Scotland has decreased from 29% in 1995 to 18.1% in 2009. However, the level of 'not known' smokers has increased from 5% to 14.2% in the same time period. In Highland 21.8% of pregnant women are recorded as smokers however 'not known' numbers are only 3.6% suggesting that smoking numbers are being captured more accurately. In 2009 8.8% of pregnant women in Scotland were former smokers compared to 16.5% in Highland who reported they were former smokers. It is suggested that self-reported smoking during pregnancy in Scotland is underestimated by 17% (Shipton, Tappin et al 2009).

It is recognised that smoking prevalence generally increases with deprivation. In Scotland 30% of pregnant women in the most deprived areas report smoking compared with only 6.7% in the least deprived areas (2008 statistics www.isdscotland.org). There should be an awareness of the difficult circumstances and sociodemographic factors which may impact on a pregnant woman who smokes: service provision must be sensitive and culturally relevant.

Working with women

The health professional should enquire about the woman's knowledge of the effects of smoking in pregnancy and whether she would be interested in receiving help to stop. When appropriate, her partner and other family members should be involved in this discussion and referral offered for specialist support. The Smoking Cessation Pathway (see 3.1) can be used to structure conversations about smoking.

Written information should be offered which details the risks of smoking and the benefits of quitting (Fresh Start leaflet, Smoke-Free Homes, Aspire magazine) as described in the Highland Information Trail, (NHS Highland 2012).

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<http://intranet.nhsh.scot.nhs.uk/Org/CorpServ/PublicHealth/Documents/information%20trail%2021%20Augu%2012.pdf> and on the For Highlands Children website www.forhighlandschildren.org

Motivation is likely to change during pregnancy so every contact should be seen by the health professional as an opportunity to discuss smoking and offer specialist referral. Any misinformation can also be corrected.

It should be highlighted to women that support from specialist smoking cessation services can double the chances of successfully quitting. Health staff should be familiar with their local smoking cessation services and advisors. Referrals into the service may be by telephone, referral form or email and staff dependent on local service. Community pharmacies also offer a smoking cessation service which includes individual support and NRT products which can be obtained directly from the pharmacist.

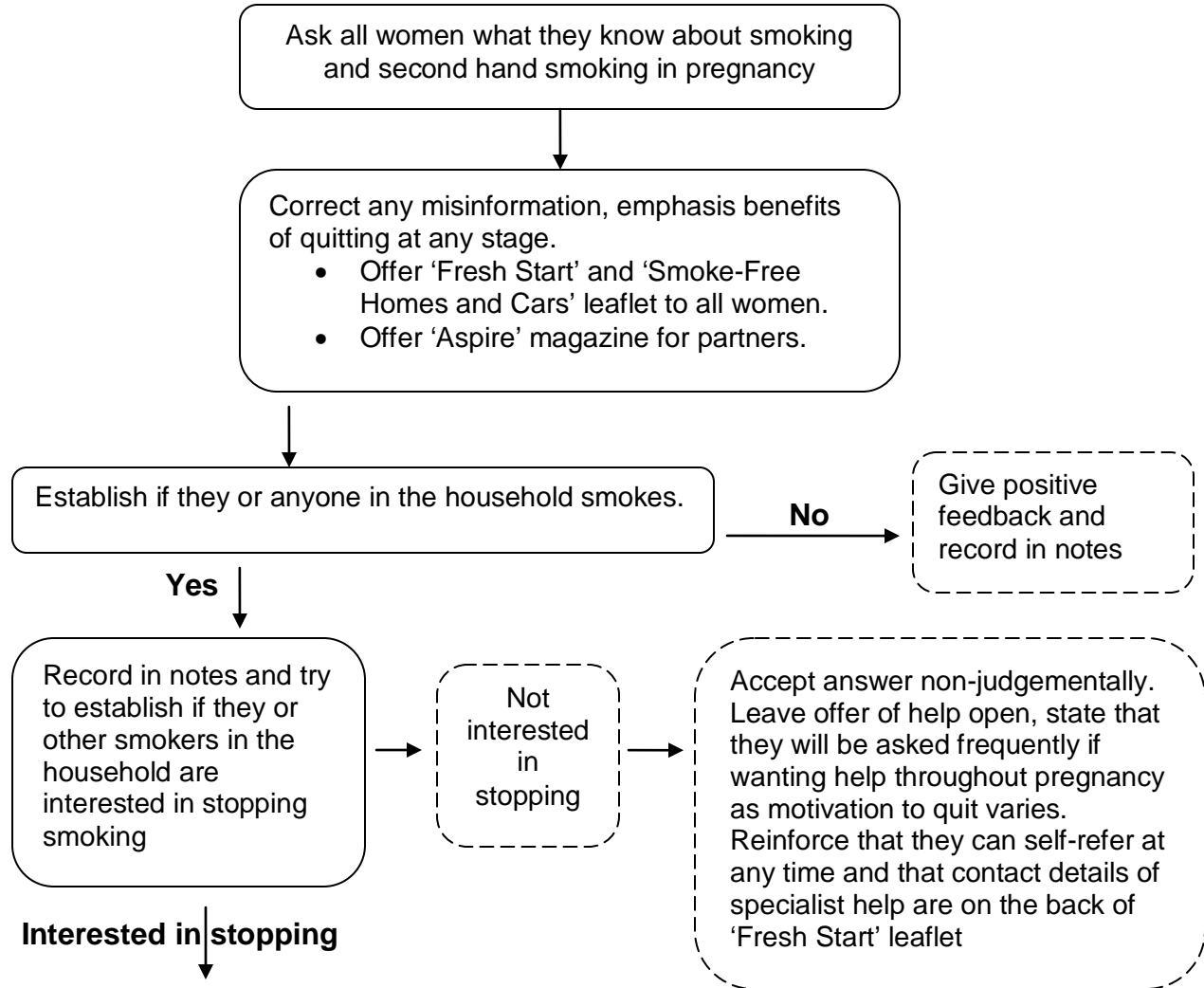
Pregnant women should be aware that it is important to quit smoking altogether. Cutting down does not eliminate the risks from second-hand smoke for both mother and child. Most people who cut down are still exposed to a high level of toxins as they retain the smoke in their lungs for longer. Moreover, the number of cigarettes they smoke gradually increases again. The children of parents who smoke are also highly likely to take up the habit themselves with all the potential health risks becoming generational problems within families (NICE 2010).

NICE Public Health Guidance 26 (2010) recommends using a carbon monoxide (CO) monitor to obtain a CO reading from all pregnant women booking for maternity care. They advocate referring anyone with a reading around 7 ppm² (parts per million in breath) for specialist smoking cessation support.

This practice has been adopted in NHS Highland and is now being undertaken at the scanning clinic appointment at Raigmore Hospital and Caithness General. However, practitioners may consider offering to take a CO reading from pregnant women at any stage in pregnancy ensuring they are familiar with the process and the monitor is correctly calibrated. **Due to the high levels of under-reporting of smoking, the issues of smoking and second-hand smoke should be discussed with all pregnant women and their families.**

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3.1 Smoking Cessation Pathway



Examples of motivational questions:
*What have you heard about smoking in pregnancy?
 Would you be interested in receiving help to stop?
 Have you ever considered stopping smoking?
 Have you ever tried to stop smoking before?
 What might help you stop smoking?
 Can you imagine how it would be for you if you stopped smoking?*

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3.2 The Smoke-Free Homes challenge

In 2010, NHS Highland and its partners developed a project targeted at parents to raise awareness of the impact of second-hand smoke on their children's health. A leaflet has been produced to help practitioners raise the issue of second-hand smoke, and an application form is available to order clients a FREE Smoke-Free Homes Starter Pack (see Highland Information Trail).

Second-hand smoke is the smoke breathed in from other people smoking. Children and infants are more vulnerable to second-hand smoke than adults as they have smaller airways, faster breathing rates and immature immune systems.

UK data suggests that approximately 50% of all children in the UK are exposed to second-hand smoke in the home. Babies and children exposed to a smoky atmosphere suffer increased levels of asthma and chest infections and are more likely to require hospital care. Keeping the home and family car smoke-free will reduce this risk. It also reduces the likelihood of children and young people choosing to become smokers.

3.3 Nicotine Replacement Therapy (NRT)

Ideally, a pregnant woman should stop smoking without NRT. However, if this is not possible, NRT may be recommended to assist a quit attempt if the risk to the baby of continued smoking by the mother is considered to outweigh any potential adverse effects of NRT (Highland Formulary 2009).

If NRT is required, it should be commenced as early in pregnancy as possible and discontinued after two to three months use. Oral forms of NRT provide nicotine intermittently and are preferable to patches, which release nicotine continuously. If a woman cannot tolerate oral forms of NRT (for example if nausea and vomiting are a problem) a 16-hour patch, which is removed at night, is preferable so that the developing baby's exposure to nicotine is minimised.

NRT can be used by women who are breastfeeding. The amount of nicotine the infant is exposed to from breast milk is relatively small and less hazardous than the second-hand smoke they would be exposed to if the mother continued to smoke. Intermittent NRT products (for example gums, sprays, lozenges) are preferable. Patches should be avoided (Highland Formulary 2009). The woman should aim to avoid feeding times, when taking NRT products, to minimise the amount of nicotine in her breast milk. Women who chew nicotine gum should refrain from breastfeeding for 2- 3 hours (Hale 2012).

Champix® (varenicline) and Zyban® (bupropion) are contraindicated and unlicensed for use during pregnancy and breastfeeding. However, they may be appropriate for partners and other family members who wish to stop smoking. Both are taken in tablet form and support a quit attempt by reducing cravings and withdrawal symptoms.

NB Zyban® (bupropion) is no longer available in the Highland Formulary (2009).

Electronic cigarettes are not recommended for use in any quit attempt for any client group at present. National updated guidance is due to be released later this year.

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4. Alcohol

No safe level of alcohol use has been established in pregnancy, NHS Highland therefore supports the view that:

Women who are pregnant should avoid drinking alcohol

This approach is largely consistent with the advice endorsed throughout the UK and is stated in *'Ready Steady Baby!'* By focussing efforts on promoting abstinence, NHS Highland advocates a more precautionary approach than the following advisory bodies:

Advisory Body	Recommendation
Chief Medical Officer's Report, 2007	Women who are pregnant should avoid alcohol entirely. If they do choose to drink, to minimise the risk to the baby, they should not drink more than 1 to 2 units of alcohol, once or twice a week and should not get drunk.
National Institute of Clinical Excellence (NICE) 2008	Women should avoid alcohol in the first three months of pregnancy, because of the increased risk of miscarriage.
Royal College of Obstetricians and Gynaecologists (RCOG) 2006	There is an increasing body of evidence suggesting harm to the developing fetus from alcohol consumption during pregnancy. While the safest approach may be to avoid any alcohol intake during pregnancy, it remains the case that there is no evidence of harm from low levels of alcohol consumption, defined as no more than one to two units of alcohol, once or twice a week.

Rationale

NHS Highland's discretionary decision to recommend abstinence as the safest approach, clarifies the advice offered to pregnant women. It also avoids perceived inconsistencies among promoting abstinence and then qualifying this advice with possible discussion related to limiting intake to 1 to 2 units once or twice per week. In order to avoid any confusion for pregnant women and take cognisance of the limited awareness of alcohol units generally across society, staff are directed to promote clear and consistent advice that; **the safest option is to abstain from alcohol throughout pregnancy as no safe limit has been established.**

Health Risks

Alcohol is a teratogenic compound (i.e. a substance that can interfere with the normal development of the fetus/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 with respect to the individual after birth. Very few studies have focused on the adverse effects on the growing baby. 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.

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Alcohol consumption during pregnancy can increase the risk of:

- Miscarriage
- Low birth weight
- Pre-term labour
- Fetal Alcohol Syndrome (FAS)
 - ~ Growth restriction
 - ~ Central nervous system dysfunction
 - ~ Facial abnormalities
- Fetal Alcohol Spectrum Disorders (FASD)
 - ~ Developmental / behavioural problems e.g. ADHD

4.1 Prevalence of alcohol consumption in pregnancy

NHS Highland's advice that abstinence is the safest option is also set within the context of current evidence which suggests that alcohol consumption during pregnancy is common. National surveys suggest that between 25% - 50% of women in Scotland continue to drink whilst pregnant (compared to 54% UK-wide). However, the levels of consumption appear to be low with only 5% of mothers in Scotland (compared to 8% UK-wide) reporting drinking more than two units per week on average.

Shown below is a breakdown of alcohol consumption during pregnancy in the Highland area. This data has been collected on the Scottish Morbidity Record 02 (SMR02) form by ISD Scotland from April 2003. It should be noted however that the early original data was not robust however collection has become stronger each year. Figures for 2011 are provisional. The total number of maternities in Highland in 2009 was 2446, 4.5% of these recorded alcohol use. In 2010 this decreased to 3.2% of all maternities recording alcohol. And in 2011 this was expected to stay relatively level at 3.4%.

Year	2009		2010		2011	
Area	All Maternities	Maternities Recording Alcohol	All Maternities	Maternities Recording Alcohol	All Maternities	Maternities Recording Alcohol
C,S&R	710	39	649	24	659	23
Inverness & Nairn	1044	33	964	19	1019	29
S,L&B	692	39	674	31	668	28

(C,S&R – Caithness, Sutherland & Ross Shire; S,L&B – Skye, Lochaber & Badenoch)

Women and alcohol

The female drinking culture has changed over the past two decades. Revised estimates from the Scottish Health Survey suggest 20% of women exceed the weekly benchmark of 14 units. Prevalence rises to 36% when considering the numbers of women that drink above the daily limits i.e. >3 units. In addition, 41% of 16 – 24 year olds are likely to binge drink which is concerning due to the role alcohol can play in sexual risk taking and the subsequent link with pregnancy. The update also found that women from professional and managerial groups with higher incomes were more likely to continue drinking during pregnancy. Women living in remote

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and rural areas are also more likely to consume alcohol in pregnancy. Societal increases in numbers of women drinking, the amounts being consumed and the frequency of drinking raise the question of whether it is naïve to expect that most women automatically abstain whilst pregnant or only consume small amounts of alcohol.

4.2 Fetal Alcohol Spectrum Disorders

Fetal Alcohol Spectrum Disorders (FASD) are a series of completely preventable mental and physical birth defects resulting from maternal alcohol consumption during pregnancy.

A definition of FASD is given by fasaware.co.uk as:

“The full range of permanent birth defects caused by prenatal exposure to alcohol. FASD is caused when alcohol in a pregnant woman's bloodstream circulates to the foetus by crossing the placenta.”(<http://www.fasaware.co.uk/>).

Each individual with FASD may have some or all of a spectrum of mental and physical challenges in varying degrees from mild to very severe. These mental and physical defects exist only as a result of antenatal exposure to alcohol.

The potential challenge an individual with FASD may face includes (FASD Trust):

Mental Challenges	Physical Challenges
<ul style="list-style-type: none">• Intellectual disability: lowered IQ• Memory disorders• Learning disorders• Attention disorders• Sensory disorders• Speech and language disorders• Mood disorders• Behavioural disorders• Autistic-like behaviours• Sleep disorders	<ul style="list-style-type: none">• Visual and eye defects• Hearing and ear defects• Mouth, teeth and facial defects• Weak immune system• Epilepsy• Liver damage• Kidney defects• Heart defects• Cerebral Palsy, muscular defects• Height and weight deficiencies• Hormonal disorders• Skeletal defects• Genital defects

FASD are difficult to diagnose. Approximately 10% of children affected by fetal alcohol syndrome (FAS) will have the characteristic facial features and can be diagnosed at birth. In the absence of these features, diagnosis is based on a set of clinical criteria and the determination of a history of antenatal alcohol exposure. 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 2007).

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Babies born with Foetal Alcohol Syndrome (FAS) can be quite easily identified due to their distinguishable facial features. They may have shortened eye openings, a low nasal bridge, an abnormal distance between nose and top lip (either too long or too short), and their ears may be set lower. They may be born with low birth weight and remain small compared to their peers. Development may also be delayed. Young children aged approximately 6-11 years may have difficulty paying attention for even short periods of time; they also experience developmental delays and may display impulsive behaviour. By the time these children 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.

The prevalence of FAS in the Highland Council area is 1-2 in 1000 births, this equates to about 2-5 occurrences per year. There is no cure for FAS, however it is completely preventable.

(<http://www.fasaware.co.uk/>)

(<http://www.drugscope.org.uk/>)

(<http://www.patient.co.uk/doctor/Fetal-Alcohol-Syndrome.htm>)

Proactive approach

Emerging evidence on the risks of alcohol to the developing baby, debate on the potential impact of small amounts of alcohol, prevalence of alcohol consumption during pregnancy and increases in female drinking patterns all emphasise 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 service for appropriate assessment and support.

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) are based on the recommendations in SIGN Guideline 74 which highlight the use of motivational interviewing approaches for the delivery. Current practice in antenatal settings already includes enquiries about alcohol consumption, and the Scottish Woman Held Maternity Record (SWHMR) includes questions on alcohol consumption and the following stages of delivering a brief intervention should be followed:

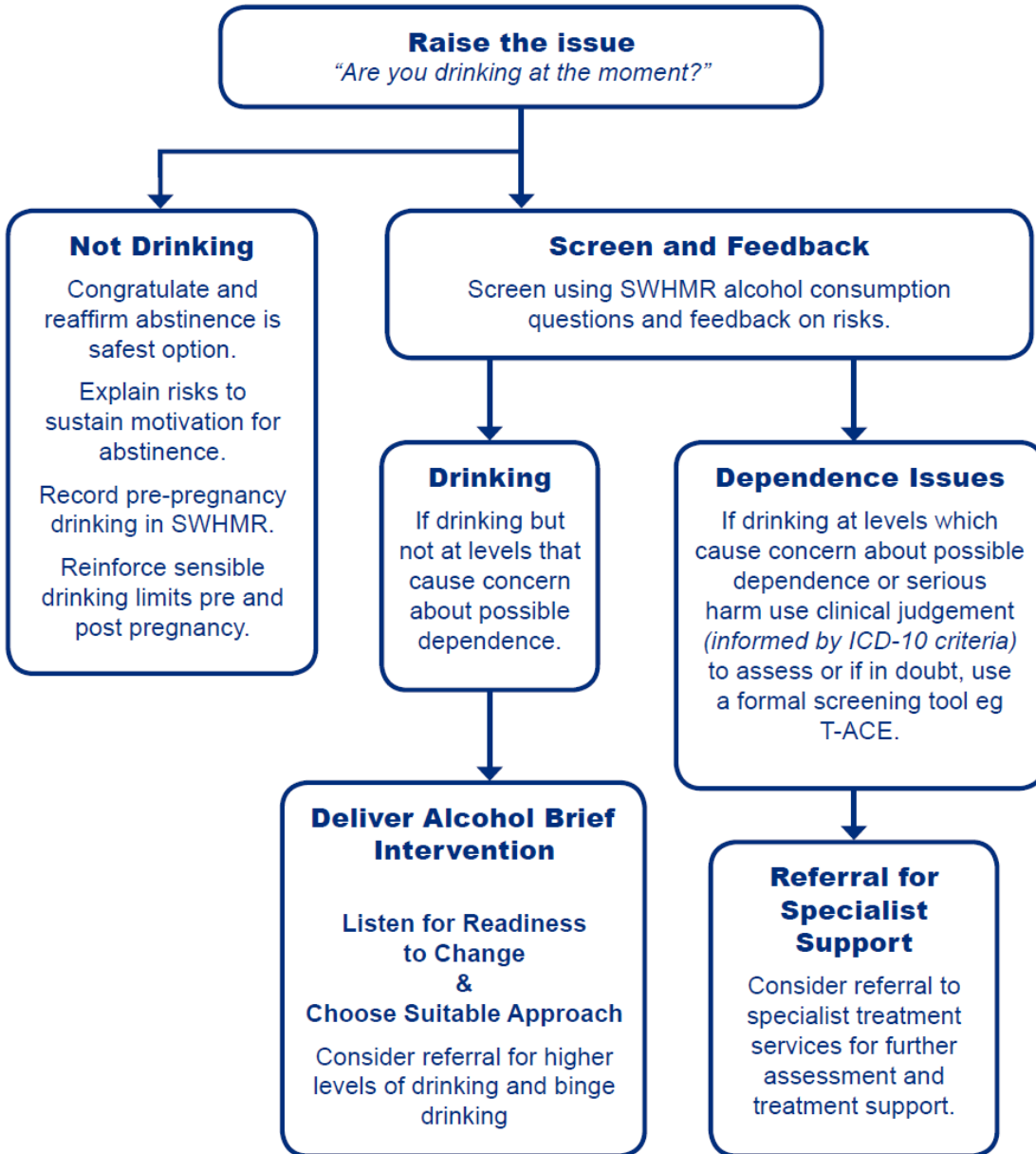
Stages of a Brief Intervention

Throughout the brief intervention remember to:

- Maintain rapport and empathy.
- Emphasise the woman's personal responsibility

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4.4 Alcohol Brief Intervention Care Pathway



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4.5 Alcohol dependency

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

ICD – 10 criteria for alcohol dependence can also 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 used to inform clinical judgement

T-ACE Alcohol Audit Tool	
T-ACE	
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	<input type="text"/>
Date of test	<input type="text"/>
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.	

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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 (SIGN 2003). Osprey House, Community Psychiatric Nurses for Addictions (CPNAs), Community Addiction Nurses and Dual Diagnosis Nurses (substance misuse and mental health) can offer further support and advice to women and other health 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, cited in Whittaker 2003).

Drinkline 0800 917 8282 can be helpful in supporting women address their drinking, and referral to specialist agencies for support must be considered. Further support agencies can be found in Appendix 1 and in *'Ready, Steady, Baby!'* (NHS Health Scotland, 2008).

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5. Drugs

There has been a huge 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.

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. These women often book late and their associated lifestyle may mean that there are more urgent demands on their time. Pregnant women with substance misuse problems should be managed by a team who will provide co-ordinated multi-disciplinary and multi-agency 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 intra-uterine growth restriction, pre-term delivery, increased rates of still birth, neo natal 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, multi-agency network is in place for all women who require specialist advice or support in pregnancy and their care should reflect this.

Good maternal history taking is essential to ensure delivery of high quality maternity care. This is a dynamic process which should 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 (NHS Quality Improvement Scotland 2004). 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 their 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. (See 'Useful Contacts', 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.

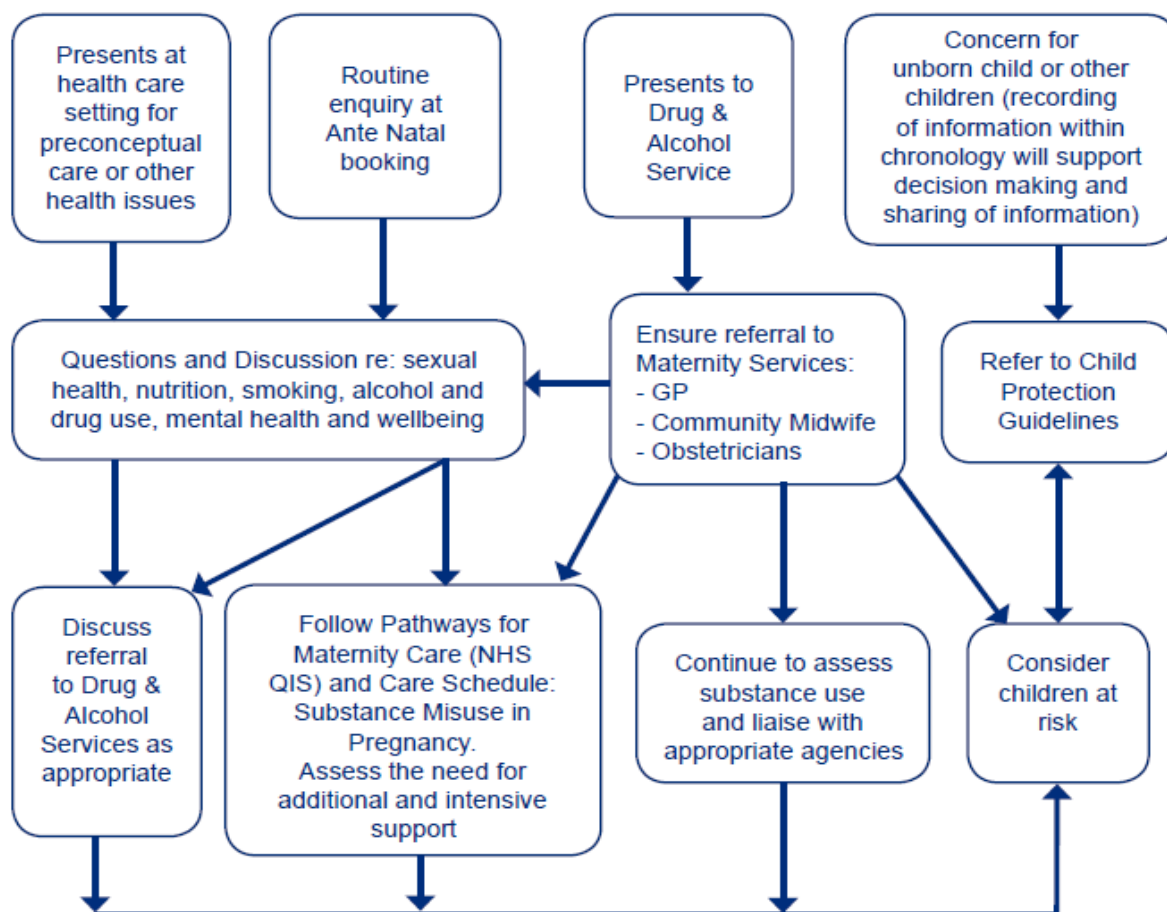
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- If a woman is new to substance misuse services have specialist services completed the SMR25a data collection form for ISD
- If there is a need for early liaison with all community services to maximise and clarify support. Assessment and completion of the 'Antenatal Plan' will ensure co-ordination of services and make sure that 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 women who misuse substances



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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 discussion which includes parents, should assess risk, set goals 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 Methadone use 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.

At present, methadone is recommended for opiate dependence and commencement involves daily assessment and titration of dose.

The rationale for commencing methadone:

- 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

Methadone maintenance programmes have contributed to rapid and substantial improvements in the time that users spend focusing on their family and home life (Keen & Alison (2001), cited in Hall & Elliman 2003).

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 methadone 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. Routine drug screening is an integral part of prescribing and can be an indicator of safe compliance with medication.

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6. The Challenges

In 2009, 18.1% of women in Scotland reported smoking at booking but the smoking status of 14.2% was unknown (ISD) making it 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.

In 2013 the Growing Up in Scotland Report, stated that 80% of Scottish mothers indicated that they had not consumed alcohol during their pregnancy which is a greater number than previous reports. The evidence regarding levels of safe drinking and the effect of alcohol on a fetus and growing baby are inconclusive and women should be advised to abstain from alcohol use throughout pregnancy.

The true extent of drug taking in pregnant women is unknown, as reliable figures are hard to obtain. In Scotland in 2007/08 drug misuse was recorded at a rate of 8.8 per 1000 maternities; 62% of these maternities involved opiate misuse (ISD, 2010). In the NHS Highland area in 2007/08 drug misuse was recorded at a rate of 8.1 per 1000 maternities (ISD, 2009).

The SMR02 (Scottish Morbidity record – Maternity Discharges) 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 are optional and consequently not regularly recorded. The Data Quality Assurance Review recommends that these questions be made mandatory to help capture a more accurate and robust picture of alcohol and drug use during pregnancy in Scotland (ISD, 2010).

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 will be responsible for completing 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 misusing substances, clear lines of communication, information sharing and multi-disciplinary 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 and supports the use of common language and practice models across all agencies when assessing risk and planning care for children.

For women who misuse 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.

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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 2008) 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.

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 (2011) 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.

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.”

(Interagency Guidelines to Protect Children and Young people in Highland, Highland Child Protection Committee, 2011: intro:1).

Maternity services provide support and care to all pregnant mothers as detailed in the Pathways for Maternity Care (NHS QIS 2009), assessing risk and need at every contact.

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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' (April 2013) should be completed by the named midwife. This allows for a more detailed assessment of risks and needs within the Highland Practice Model (Girfec). The plan should detail the strengths and pressures and the impact these are 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 Scottish Woman Held Maternity Record (SWHMR) and provide a detailed plan and review of care. A copy of the Antenatal Plan should be shared with the GP, obstetrician and PHN/HV inform the 'Child's Plan' following birth.

<http://www.forhighlandschildren.org/4-icspublication/>

http://www.forhighlandschildren.org/4-icspublication/index_72_750819843.pdf

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.

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).

http://www.forhighlandschildren.org/4icspublication/index_56_3923857013.pdf

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.

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All professionals should have knowledge and understanding of their local Child Protection Policy Guidelines and managers should ensure that their staff undertake regular Child Protection training relevant to their post at least every 3 years but more often if required. All midwives and PHNs must attend Programme 1 training and also Hidden Harm training which addresses working with substance misusing parents (Highland CP Action Plan 2012) Training calendars are available on the Intranet and also the For Highlands Children site.

<http://intranet.nhsh.scot.nhs.uk/Training/ChildProtection>

<http://forhighlandschildren.org/2-childprotection/publications.htm>

<http://www.forhighlandschildren.org/3-icstraining/>

6.3 Mental health

Perinatal Mental Health issues may be more common in women who use alcohol or drugs who may have used these 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 PHN/HV and G.P and they should be included in any planning of care for mother and baby..

The NHS Highland 'Perinatal Mental Health Good Practice Guidelines' (2008) presently being reviewed, provides 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

They are available of the NHS Highland intranet and For Highlands Children website

<http://www.forhighlandschildren.org/4-icspublication/>

6.4 Domestic abuse

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 domestic abuse 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.

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Multi-agency Guidance on Violence Against Women is available to all staff in Highland and training programmes are available on the NHS intranet site and For Highland Children website

The Highland 'Domestic Abuse: Pregnancy and the Early Years' protocol has recently been updated (2013) and is also available on the websites as above.
<http://www.forhighlandschildren.org/4-icspublication/>

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 most 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 as this allows monitoring of how services are being used and what can be done to improve engagement and the quality of service provided.

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. Global interpretation services can be booked on 01463 258839.

For full details on how to use any of the communication support services, please see the guidance available on the following intranet link:
<http://intranet.nhsh.scot.nhs.uk/Staff/EqualityAndDiversity/AccessibilityandCommunication/Pages/Default.aspx>

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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 misuse drugs and alcohol 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, gender based violence 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 (NHS QIS 2004) and the booking appointment provides an ideal opportunity to:

- identify specific needs or pressures a family may have
- initiate a relationship with the woman
- gain 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 (CPN), Drug and Alcohol Services, support worker, social worker, Councils on Alcohol, Alcoholics Anonymous, housing or others.

In Highland, the woman's named community midwife (Named Person) is often the first point of contact in pregnancy however, some women will make initial contact with their G.P. Although questions about smoking, alcohol and drug use are asked about at the booking appointment it

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is important that previous history of a woman's substance use is communicated between midwives, G.P.s and maternity services so that an accurate assessment of the likely impact on them and their 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. An 'Antenatal Plan: additional support for mother and unborn baby' must be completed where there is alcohol or drug misuse reported and this can be commenced from booking if information has been collected to suggest the mother has additional support needs in relation to her alcohol or drug use.

Staff should also consider a request for service from Children 1st who are presently commissioned to offer Family Solutions/ Family Group conferencing to all families affected by alcohol or drug use. Women should be informed of the service and given the leaflet issues by Children 1st to midwifery and PHN bases which contains more information. Women can contact the service directly on 01381 620757 or killen@children1st.org.uk

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 as the Named Person. If there are child protection concerns then social work must be informed and Child Protection Procedures followed.

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7.2 Care schedule: substance misuse in pregnancy

Pre-pregnancy	<p>Discuss general health and wellbeing, mental health and relationships, substance misuse (smoking, alcohol, and drugs). Give advice on healthy diet, folic acid supplementation. Ensure women have details of how to contact their local community midwife.</p> <p>If appropriate offer referral to specialist services (e.g. Smoking cessation, drug/alcohol services including Family Solutions see p.31).</p> <p>Offer blood borne virus testing.</p>
First point of contact	<p>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.</p>
8 -12 weeks 15 -16 weeks	<ul style="list-style-type: none"> • 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, offer referral for specialist support and offer Family Solutions 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 women and her baby • 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. • Consider the MW to PHN/HV handover protocol that states that women with additional support needs should have agreed joint plans in place which may include joint visiting. • Share information about alcohol or drug misuse with G.P., PHN/HV, CPA and obstetrician. • If alcohol or drug misuse 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 misuse with woman.
22 - 25 weeks	<ul style="list-style-type: none"> • On-going assessment of substance misuse and additional support needs • Update Antenatal Plan • Ensure engagement with specialist services as required. • Discuss Neonatal Abstinence Scoring System (NAS). • Discuss infant feeding • Consider initial discussion around contraception.

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28 weeks	<ul style="list-style-type: none"> • 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 include the PHN/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. • Give details of Family Solutions/Family Group Conferencing
31- 32 weeks	<ul style="list-style-type: none"> • Discuss birth plan • Reiterate Neonatal Abstinence Scoring System (NAS). Offer visit to SCBU. • Complete Infant Feeding Checklist. • Discuss contraception and give contraception leaflets
34 - 36 weeks 37 - 38 weeks 39 - 40 weeks	<ul style="list-style-type: none"> • Assessment of substance misuse and continued engagement with specialist services. • Update Plan • Close liaison with PHN/HV as per handover protocol. • PHN/HV to undertake antenatal contact which must include home visit where alcohol or drug misuse has been identified • Continue preparation for parenthood including discussion regarding Sudden Infant Death Syndrome. • On-going discussion regarding contraception.
Labour	<ul style="list-style-type: none"> • If there are issues of substance misuse deliver in Consultant Led Unit with paediatric facilities. • Inform Named Person 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	<ul style="list-style-type: none"> • Hepatitis B vaccine for baby as per protocol. • Neonatal Abstinence Syndrome (NAS) assessment and care ensuring mother is aware of the signs. • Offer support regarding infant feeding. Consider contact with Infant Feeding Advisor and referral to specialist breastfeeding clinic if required. • 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 • 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/PHN/HV and others involved in the plan.
Postnatal	<ul style="list-style-type: none"> • Continue to offer multidisciplinary support to woman and her baby. • Be aware of NAS and encourage mother to continue to be observant • Ensure MW to PHN/HV handover protocol is followed. • Close assessment and support by the PHN/HV and GP must continue • Follow up Hepatitis B immunisation for baby at 1 month old as per protocol. • Give details of Family Solutions/Family Group Conferencing.

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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 Guide to Screening Tests During Pregnancy (NHS Health Scotland 2012) 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
- Rubella status
- 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 that women, their partners, their babies and their 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 immunisation has been recommended for current injecting drug users for many years (Scottish Executive 2003) 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 including new born babies
- children of hepatitis C positive mothers

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/GreenBook/fs/en

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 (NAM 2005). 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

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Communicable Diseases in Pregnancy NHS Highland, 2012.) 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>

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 (STRADA, 2004). HCV is easily transmitted through injecting drug use and 61% 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 2006

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 2007)

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

- Highland Viral Hepatitis Service tel: 01463 706642
- A&B residents will be referred to the appropriate service within Greater Glasgow and Clyde.

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7.4 Role of wider maternity team

Following booking in the community and assessment of risk, women will either receive midwife-led care or will require further assessment, support and care from the wider Maternity Team. Women with a history of alcohol and/or drug misuse (within the last 12 months) will require additional support and obstetric led care' (NHS QIS 2009). An initial hospital visit will include an ultrasound scan to confirm the expected date of delivery (EDD). 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 misuse alcohol or drugs at this 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 also mean that her pregnancy will be high risk and professional collaboration is essential for safe and effective care.

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 the multidisciplinary and multiagency 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 'Useful contacts' 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. Some areas may provide specialist antenatal classes for women who are pregnant and misusing substances. 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 re substance misuse.
- On-going multi-agency collaboration and communication.
- Discussion of drug use and potential effects during pregnancy and on the newborn an explanation of Neonatal Abstinence Syndrome and the use of the Neonatal Abstinence Scoring System Assessment Form (Appendix 3).
- Preparation for parenthood, including discussion of pain relief during labour, breastfeeding, social support, partner's role.
- Sudden infant death syndrome.
- Explanation of, and visit to, Special Care Baby Unit (SCBU) services.

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Liaison with the family's PHN/HV is essential to ensure that agreed, support and joint working are developed and maintained through the transition from midwifery to health visiting care. The Procedure for the 'Communication and Handover of Health and Social Information between Midwife and Public Health Nurse/Health Visitor' highlights that this communication process should take place from booking (NHS Highland 2012). Any assessments should be shared with the PHN/HV who should also prioritise a home visit, 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 (Scottish Executive 2003)

There appears to be little correlation between the amount of maternal drug use and the severity of NAS, although there is a correlation between methadone dose and NAS. Women will be expected to remain in hospital with their baby for a minimum of 6-7 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 (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. 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 Neonatal Abstinence Scoring System 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 Midwives from SCBU will also follow-up babies admitted for treatment for withdrawals. Community midwives and GPs should also maintain 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

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Addiction Nurses are able to offer follow-up at home and provide a vital link between services. However, it should 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.

As the Named Person, the 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 at 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 take part in the pre-birth planning meeting and may have an active role as a partner to the plan (Antenatal or Childs). The PHN/HV should be invited to meetings regarding substance misusing parents. 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
- Clear discussions around when intervention is necessary?
- What are 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

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- 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?

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 methadone, 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 will be the Named Person for the woman and 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

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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, 2012. 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 methadone programme this should be continued during labour and standard analgesia should also be administered. A daily dose of methadone 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 contra-indication 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:

In the mother	In the baby
restlessness	bradycardia
tremors	tachycardia
sweating	increased foetal movements
abdominal pain	meconium stained liquor
cramps	
anxiety	
vomiting	

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 6-7 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 form should have been fully explained to the mother in the antenatal period and she should be involved in the scoring process. This form should be kept in the ward office for reasons of confidentiality.

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All babies of mothers who are injecting drugs 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' (2013).

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 6). 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 PHN/HV bases in NHS 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 and PHN/HVs 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. Social drinking by the mother is unlikely to pose a risk to breastfed babies however, alcohol passes freely into the breast milk and peak levels appear 30 – 90 minutes following intake. Binge drinking 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.

Staff can refer to NHS Highland 'Breastfeeding Policy 2011' and the 'Maternal and Child Nutrition Best Practice Guidance' 2012 for advice on infant feeding.
<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Maternal%20and%20Child%20Nutrition%20Best%20Practice%20Guidance.pdf>
or <http://www.forhighlandschildren.org/4-icspublication/>

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 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

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possible following delivery as recommended in the Highland Breastfeeding Policy (NHS Highland 2011). 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: (Jones 2013)

- 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.

Injecting drugs whilst breastfeeding should be discouraged because of the risks of BBV transmission. 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 (Scottish Executive 2003).

To open up discussion about infant feeding the booklets '*Ready, Steady, Baby*' and '*Off to a Good Start*' (NHS Health Scotland 2006) 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

7.14 Discharge planning meeting

A discharge planning meeting should be viewed as a supportive measure arranged with the aim of discussing arrangements in place for going home, making practical arrangements for

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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 appropriate for this client group. This 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 G.P. and Highland Sexual Health Services. Discussion should include:

- Individual's own health/contra-indications
- 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 G.P. and PHN/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 prescribed methadone, 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 G.P. or prescriber may not be available at weekends.

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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 Named Person and 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 PHN/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 (2012) 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 PHN/HV and G.P. 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.

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Appendix 1

Drugs and their effects on pregnancy and breastfeeding

OPIATES	For example: heroin, methadone, temgesic and diconal.	
Withdrawal	Risks in Pregnancy	Withdrawal Symptoms in New born
Sweating, stomach cramps, muscular pain, runny nose, diarrhoea	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.	Babies born to mothers who use opiates throughout pregnancy show withdrawal symptoms within three days of birth but it can be in excess of 7 days if the mother has been using methadone. Symptoms may include restlessness, shrill crying, sleeplessness, constant sucking, diarrhoea, yawning, sneezing and seizures (see Appendix 4 Neonatal Abstinence Score Sheet).
BENZO-DIAZEPINES	For example: diazepam, temazepam, nitrazepam	
Withdrawal	Risks in Pregnancy	Withdrawal Symptoms in New born
Panic attacks, distortion of perceptions, feelings of unreality, sweating, restlessness and tremors. Sudden withdrawal can lead to seizures.	Some studies suggest certain drugs can cause defects, such as cleft palate if used in the first trimester of pregnancy.	Babies born to mothers taking these drugs can initially be quite flat and sleep excessively. Withdrawal symptoms that may develop later include tremor, irritability, hyper activity, frantic sucking and seizures. Symptoms may be more severe than expected from the dosage the mother is taking as benzodiazepines build up in the baby's system over time.

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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.
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Withdrawal	Risks in Pregnancy	Withdrawal Symptoms in New born
Withdrawal is characterised by hunger, fatigue, periods of fitful sleep, increase in dreaming and depression- in some cases prolonged and severe.	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.	There is no conclusive evidence of withdrawal symptoms in the newborn but babies can experience shrill crying and irritability.

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 drugs appear and trends in drug use change. Drugs such as mephedrone and methedrone (not to be confused with methadone) are increasingly popular in the Highlands but, at this time, there is little evidence of the effects they have on pregnancy. Both of these are now illegal but variations appear on the market very quickly and can be easily and cheaply purchased from the internet. They tend to be very potent with users having little guidance /knowledge of how much to "safely" use. The 'highs' reported are often fast and intense with Users having to increase amounts taken very quickly to achieve the same effect. These "highs" can be combined with considerable anxiety and paranoia and often followed by psychotic symptoms, depression and tiredness. These are known as "legal highs" and are often injected.

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A new stimulant called N.R.G.1 is currently popular. Like the others it will probably be made illegal as soon as possible. The 'highs' reported are often fast and intense with Users having to increase amounts taken very quickly to achieve the same effect.

There have also been specific concerns raised nationally about the risks of taking drugs called "benzo-fury" and "anhiolation". Currently there is little research to evidence the effects of these drugs on pregnancy. Continued use can increase heart muscle mass and seriously affect the renal system. Anecdotally, those with mental health problems and those currently prescribed anti-psychotic medication, appear to be more adversely affected with psychosis both whilst under the influence of and when "coming down" from these drugs.

'Getting Our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse' 2003.

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Appendix 2 Useful contacts

Agency	Tel No
Action for Children, Inverness.	01463 717227
Alcoholics Anonymous	0845 7697555
Al-Anon/Al-Ateen Helpline 10am - 10pm	02074 030 888
Antenatal clinic, Raigmore Hospital, Inverness	01463 704278
APEX Scotland Progress2Work service, assisting recovering drug misusers back to employment	01463 717033
Benefits Agency	01463 663500
Beechwood House, Inverness	01463 711335
Childline	0800 1111
Child Protection, for info on local teams, Inverness Argyll & Bute	01463 701307 01546 604281
Children 1 st Family Solutions/Family Group Conferencing killen@children1st.org.uk	01381 620757
Citizens Advice Bureau, Inverness Argyll & Bute	01463 235345 01546 605550
Cocaine Anonymous	0800 6120225
Community Midwives, Inverness. Outwith Inverness, contact GP surgery for details of local midwife.	01463 704342
Community Psychiatric Nurses for Addictions, Inverness Argyll & Bute Addiction Team 01546 605602	01463 706973/ 706972
Community Addiction Nurses, Argyll & Bute	01546 605602
Criminal Justice Team, Inverness Dingwall Wick Argyll & Bute	01463 724022 01349 865600 01955 603161 01586 559050
Domestic Abuse National Helpline	0800 027 1234
Directory of Highland Drug and Alcohol Services, Highland Alcohol and Drug Partnership (HDAP) www.highland-adp.org.uk Information Line Argyll & Bute	01463 704603 0844 848 3778 01546 604948
Drugline Scotland	0800 776600
Dual diagnosis Service (Community), RNI, Inverness	01463 706958
Drug & Alcohol Services, Osprey House, Inverness. Contact for local details Argyll & Bute Community Addiction Teams	01463 716888 01546 605602

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Agency	Tel No
Drug Treatment & Testing Order DTTO.	01463 716324
Harm Reduction Nurse, Inverness	01463 716324
Harm Reduction Nurse, Argyll & Bute	01631 571294
Health Information & Resources, HIRS, Assynt House, Beechwood Park, Inverness	01463 704647
Highland counselling services, Inverness Ross, Sutherland, Wick Lochaber Skye & Lochalsh Encompass Counselling and support, Argyll & Bute	01463 220995 01862 894097 01397 702340 01478 612633 01631 566090
Homeless Shelter, Inverness Homeless Housing Officer, Argyll & Bute Homeless Nurse, Argyll & Bute	01463 718669 01546 604673 07920 548252
Kintyre Alcohol and Drugs Advisory Service (KADAS)	01586 553555
Narcotics Anonymous	0845 373366
Osprey House, Drug and Alcohol Services, Inverness	01463 716888
Police, Northern Constabulary, Inverness, for local details. Strathclyde Police (Argyll & Bute) Non-emergency number – crime or other concerns Emergency	01463 715555 0141 532 6200 101 999
Rape and Abuse Helpline, Dingwall (Lines open 7am-10pm)	080 8800 0123
Road to Recovery, Inverness Dingwall Muir of Ord Black Isle	01463 715809 01349 862183 01463 871223 01349 866067
Scottish Drug Misuse Database	0131 551 8221
SMART Recovery, Inverness	01463 729548
Smoking Cessation Service, Highland. Ring for details of locality numbers.	0845 757 3077
SNFAD (for parents and families of drug misusers)	0808 010 1011
Social Work Services, Highland Council, (Emergency out of hours 08457 697284) Social Work Services Argyll & Bute (Emergency out of hours 0800 811505)	01463 703456 01631 563068
STRADA – Scottish Training on Drugs & Alcohol, www.projectSTRADA.org	0141 330 2335
Substance Misuse Co-ordinator, NHS Highland, Inverness. Information for clients and professionals	01463 704969
Scottish Women's Aid (National)	0131 475 2372

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Agency	Tel No
Women's Aid, Inverness Ross-shire Lochaber office Caithness & Sutherland Argyll & Bute	01463 220719 01349 863568 01397 705734 08454 080 151 0870 241 3548
Websites	
www.carecommission.com www.turningpointscotland.com www.knowthescore.info www.sdf.org.uk www.drugmisuse.isdscotland.com www.clearingtheairscotland.com www.ashscotland.org.uk www.canstopsmoking.com www.streetwise-highland.org www.highland-adp.org.uk www.ab-adp.org.uk www.fasdtrust.co.uk www.alcohol-focus-scotland.org.uk www.alcoholconcern.org.uk www.downyourdrink.org.uk www.nhs24.com/alcohol www.infoscotland.com/alcohol	

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Appendix 3

Neonatal Abstinence Score Sheet

SYSTEM	SIGNS AND SYMPTOMS	SCORE	AM	PM	COMMENTS
CENTRAL NERVOUS SYSTEM DISTURBANCES	Excessive high pitched (or other) cry	2			Daily weight
	Continuous high pitched (or other) cry	3			
	Sleeps <1 hour after feeding	3			
	Sleeps <2 hours after feeding	2			
	Sleeps <3 hours after feeding	1			
	Hyperactive moro reflex	2			
	Markedly hyperactive moro reflex	3			
	Mild tremors disturbed	1			
	Moderate-severe tremors disturbed	2			
	Mild tremors undisturbed	3			
	Moderate-severe undisturbed tremors	4			
Increased muscle tone	2				
Excoriation (specific area)	1				
Myoclonic	3				
Generalized convulsions	5				
METABOLIC/A SOMOTOR/RESPIRATORY DISTURBANCES	Sweating	1			
	Fever < 101 (37.2-38.2°C)	1			
	Fever > 101 (38.4°C and higher)	2			
	Frequent yawning (>3-4 times/intervals)	1			
	Mottling	1			
	Nasal stuffiness	1			
	Sneezing (> 2-4 times/intervals)	1			
	Nasal flaring	2			
Respiratory rate > 60/min	1				
Respiratory rate > 60/min with retractions	2				
CASTRO-INTESTINAL DISTURBANCES	Excessive sucking	1			
	Poor feeding	2			
	Regurgitation	2			
	Projectile vomiting	3			
	Loose stools	2			
Watery stools	3				
TOTAL SCORE					
INITIALS OF SCORER					

Figure 8-2 Neonatal Abstinence Score Sheet. (From Finnegan LP: *Neonatal abstinence Syndrome* in Nelson N Editor: *Current therapy in neonatal perinatal medicine*, ed., Ontario, 1990 BC Decker)

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Appendix 4

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.

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Appendix 5

Contributors

Name	Job title	Agency
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Cath Cakebread	Addiction Team Manager	NHS Highland/ A&B Council
Jane Groves	Local Public Health Network Co-ordinator	NHS Highland
Margaret Kinsella	District Manager - South	Highland Council
Karen Mackay	Infant Feeding Advisor	NHS Highland
Claire McPhee	Smoking Cessation Midwife	NHS Highland
Lorna MacAskill	Family Nurse Partnership Nurse	NHS Highland
Lorraine McKee	Health Protection Nurse Specialist	NHS Highland
Kay Mackillop	Child Protection Advisor	NHS Highland
Denise May	Smoking Prevention Officer	NHS Highland
Jim Neville	Dual Diagnosis Nurse, Inverness (Community)	NHS Highland
Jocelyn Reid	Lead Midwife Sonographer	NHS Highland
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