Women, Pregnancy and Substance Use: Good Practice Guidelines

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Date	Author	Change
April 2024	Hazel Inglis & Cat Clark	Expert peer group reviewed, National policies and guidance updated with references.
November 2024	Hazel Inglis & Cat Clark	Updated section 2.4 Alcohol Dependency- to include advice: Suddenly stopping alcohol consumption, if dependent can be dangerous. Abrupt cessation can trigger severe withdrawal symptoms, which may be harmful to both the mother and the fetus. Women need specialist support to safely manage withdrawal to reduce alcohol intake gradually under professional supervision

TABLE OF CONTENTS

Scope of Guidance

The foundations for health and wellbeing are established in the earliest moments of life. 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 children pre-birth, throughout pregnancy and into parenthood. Pregnancy and pre-conception stages are the earliest – and most critical stages – at which services can put in place effective interventions that will prevent long-term harm to children and families (Scot Gov 2013)

A qualitative study by Stone (2015) looked at the fear, stigma and barriers to care faced by pregnant women with problem substance use. Their findings suggest that some women may feel inhibited to accessing care owing to feelings of guilt, anxious about the attitudes of healthcare staff and fear of their children being removed. Services therefore need to be accessible, welcoming, and empowering for those women affected by substance use. Problem substance use may be associated with adverse childhood experiences. Staff should adopt a trauma-informed approach when supporting women and families

This guidance signifies best practice for maternity staff across Highland. It will likewise be helpful for other services who have a critical role in supporting women with problem substance use in pregnancy.

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

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

"Women should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman in relation to her care and that of her baby should be sought and always respected."
Pregnancy and complex social factors (NICE 2010)

Helping people to change: Principles of health behaviour change.

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

Changing behaviour is not easy. Even when we make choices, making change takes commitment, confidence and often support. It takes time to make changes and we tend to resist being told what

to do. We may know many of the reasons for change already, but may need information relevant to our own lives at times which suit us.

Motivational interviewing recognises:

- Making change is a process which tends to take place over time, and a health professional may play only a small, although significant, part in that process. Most people will make these changes by themselves however, some need assistance.
- It's a normal human reaction to want to solve others' problems and practitioners often slip into the advice-giving and directive mode known as the 'Righting Reflex'. However, the result is usually resistance as control has been taken away from the person.

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

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

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

Key principles of motivational interviewing:

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

- Only when a woman is ready to change does the practitioner move on to support change planning, ensuring that they identify specific goals and the steps to take.
- Support self-efficacy. This is a woman's confidence and belief in her ability to do something-to be competent. This is a key indicator of change, and it should be nurtured and supported. The practitioner's role is to support a sense of hope.
- If faced with resistance, do something differently and in particular show that you are listening by reflecting back what seems to lie behind the woman's expression of resistance. Emphasising personal responsibility is also a useful tactic. Most of all, recognise that resistance is in some ways a message to the practitioner that they are doing something wrong.
- Remember inequalities, and the need to address life circumstances. Working with women is only one way of encouraging change.

Summary of Guidelines

- Pregnant women who use substances should be supported according to best practice as stated in Getting Our Priorities Right: Updated good practice guidance (Scot Gov 2013) along with Highland Alcohol and Drugs Partnership and Highland Child Protection Committee: A practitioner's guide to getting our priorities right (HADP & HCPC 2015)

- Midwives who are taking a booking history should sensitively ask about substance use. Badgernet (Electronic Maternity Record) contains specific questioning relating to smoking, alcohol consumption, prescribed and non-prescribed medication.

- Problem substance use may be associated with adverse childhood experiences. Staff should adopt a trauma-informed approach when supporting women and families Transforming Psychological Trauma: A knowledge and Skills Framework for the Scottish Workforce. (NES 2017)

- Staff should deliver a 'brief intervention' regarding smoking or alcohol use **SEE APPENDIX 1 & 3**

- Women can be referred for specialist support for smoking cessation

- Midwives can self-refer for Advice & Support session with Specialist Midwives Nhsh.drugsandalcoholspecialistmidwives@nhs.scot

- Information on any social issues that could impact on outcomes of the pregnancy, including substance use, should be documented in Badgernet. Women should be supported by a wider multiagency network, which should include maternity services, specialist drug and alcohol services and social work staff. 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 (Obstetricians, midwives and drug and alcohol recovery services) to engage with women whilst balancing the needs of their children. If there are concerns, they must refer to the Highland Inter-Agency Child Protection Guidelines and contact the Child Protection Advisor (CPA) for advice and guidance

- All staff supporting pregnant women that have drug or alcohol problems, require on-going training to ensure they have the knowledge and skills required to identify problems, assess severity and the impact on children
    - Fetal alcohol spectrum disorders (FASD) | Turas | Learn (nhs.scot)
    - Drugs and alcohol : alcohol brief interventions (ABI) | Turas | Learn (nhs.scot)
    - Regular Drug & Alcohol awareness sessions
    - Online Training for Vulnerable Pregnancy (Nancy Healy) - Highland Child Protection Committee (hcpc.scot)

- Women who have had problem substance or alcohol use within the 12 months prior to their pregnancy should follow a Red Pathway - Pathways for Maternity Care (NHS QIS 2009) and require individual care planning by an obstetrician and maternity team.

- Women who use opioids should be prescribed opioid substitution treatment during pregnancy. Drug misuse and dependence: UK guidelines on clinical management (DoH 2017)

- It is essential that multiagency support in the postnatal period is in place for women and their babies. This is captured within the Universal Health Visiting Pathway in Scotland (Scot Gov 2015) and Highland Practice Model (GIRFEC) where women who use substances will be assessed as requiring additional/intensive support from services.

1. Smoking

Smoking in pregnancy remains the leading preventable cause of maternal and fetal mortality and morbidity. Supporting women to stop smoking before and during pregnancy must remain a priority for maternity services. (NICE 2021).

1.1 Harm caused by smoking

There is robust and constantly emerging evidence to support the harm that continued smoking in pregnancy brings to both the mother and her developing baby, as demonstrated in the table below:

Effects on Women	Effects on babies
• Placenta Praevia • Placental abruption • Premature rupture of membranes • Ectopic pregnancy • Infertility • Miscarriage • Premature delivery	• Stillbirth • Intrauterine growth retardation (IUGR) • Sudden Unexplained Death in Infants (SUDI) • Birth defects: Cleft lip/palate and heart defects • Increased risk of Asthma, chest infection and pneumonia

(SBLCBv2 2019)

The increased risk of IUGR necessitates referral for serial growth scans from 30 weeks gestation as per the Perinatal Institute GROW criteria. (NHS Highland 2022).
Children born to mothers who smoked in pregnancy also have increased likelihood of:

- Behaviour problems/ADHD
- Psychiatric morbidity
- Developing some childhood cancers
- Developing an adverse cardiovascular risk profile in later life (high cholesterol, obesity)
- Developing adult-onset respiratory disease
- Becoming a smoker
- Performing poorly at schools

(Diamanti et al. 2019)

While the harms of continue smoking in pregnancy have been highlighted here, when speaking with pregnant women who smoke, it's more effective to reframe this knowledge and discuss the benefits of stopping.

Stopping smoking at any stage in pregnancy will immediately reduce the baby's exposure to carbon monoxide and the toxins in tobacco

1.2 Carbon Monoxide (CO) Monitoring

- Carbon monoxide is a poisonous gas and is one of the 7000 chemicals which are absorbed into the blood stream via inhalation of tobacco smoke.
- CO crosses the placenta, is absorbed by the fetus and harms both placental function and the developing baby.
- Carbon monoxide binds to the maternal haemoglobin (carboxyhaemoglobin) and reduces the amount of circulating oxygen available.
- CO binds even more readily to fetal haemoglobin and CO levels for baby are about double that of Mum's levels.
- Routine CO breath readings for pregnant women provide a physical measure of smoking and exposure to other people's smoking. Decreasing levels of CO following stopping smoking can be motivational for women
- As CO levels drop quickly, consideration should be given to when the woman last smoked and the number of cigarettes smoked on the day of the test

Carbon monoxide is excreted quickly by the body and levels drop by half within 5-6 hours. Within 24 hours CO levels will return to that of a non-smoker.

All pregnant women presenting at their initial face to face booking appointment in NHS Highland should be offered CO testing by their community midwife regardless of smoking status. An 'opt out' referral to specialist smoking cessation services should be provided for all women who:

- Have a CO reading ≥ 4ppm
- Report they are smoking
- Say they have stopped or have recently quit
- Have a household member who smokes

(See Maternity Referral Pathway **Appendix 2**)

It should be stressed to women that it is normal practice to refer all pregnant women who smoke or have recently quit to smoking cessation services

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

1.3 Second-hand smoke

Exposure to second-hand smoke also carries significant risk to the health of both mum and baby

Completely smoke free environments are recommended for all women during pregnancy. Working with families or significant others to reduce second hand smoke exposure is important. All pregnant women should be asked whether their partner smokes or whether there are any other people who smoke in the home. (NCSCT 2019).

Pregnant women and their families should be encouraged to reduce the harm caused by exposure to second-hand smoke by smoking outside and making their homes and cars smoke free. NHS Highland's Smoke free homes and cars can support women to implement families to make these changes.
Scotland has a goal of creating a tobacco free generation by 2034 (Scottish Government 2018). To support this agenda the Scottish Government has introduced the following legislation:

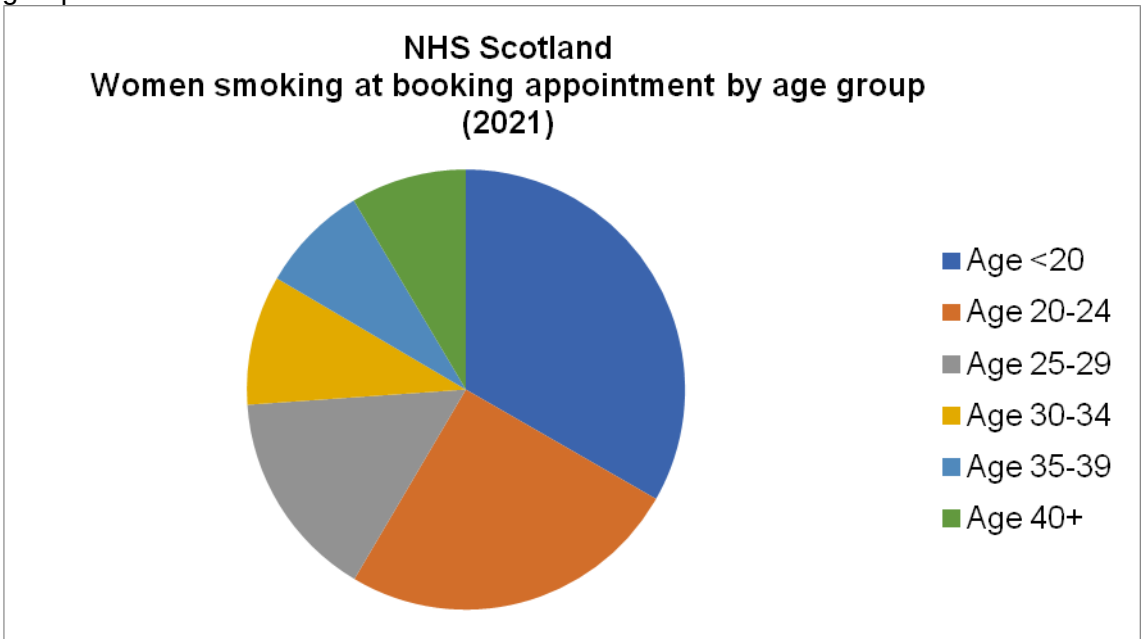
- It is illegal to smoke in a vehicle carrying anyone under 18.
- it is illegal to smoke within 15 metres of a hospital building. NRT is available within NHS Highland inpatient settings to support patients with abstinence from tobacco during hospital stays. (Scottish Government 2016).

1.4 Prevalence and reporting

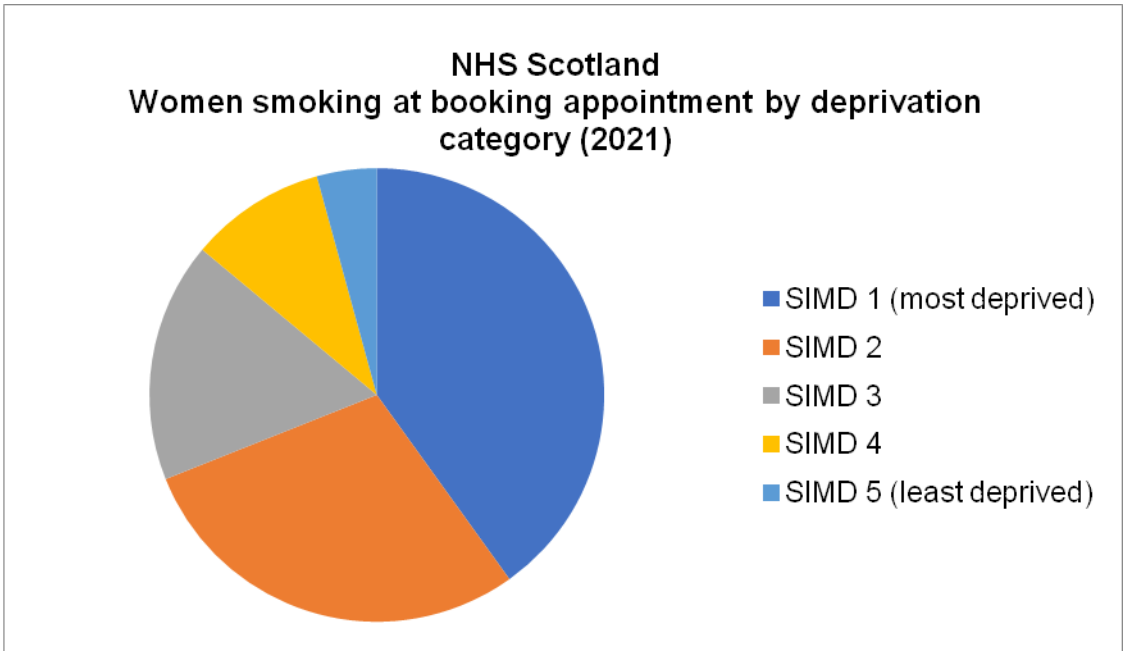
Interpreting smoking data can be difficult as evidence suggests that self-reported smoking can be underestimated by up to 25% by pregnant women (Shipton D, Tappin D et al 2009). Accurate recording of smoking status aids risk assessment and optimises care planning for pregnant women.

Carrying out CO readings at booking for all pregnant women can support open and honest discussions regarding smoking status.

The number of women who are recorded as current smokers at the time of their booking appointment has steadily decreased year on year. In 2020-2021, the number of pregnant women reporting as current smokers at booking appointment in Scotland was 13.1%. This is an improvement from 30.7% in 1997-1998 (PHS 2021). However, discrepancies between population groups remain as illustrated in the charts below.



Source: Public Health Scotland 2021



Source: Public Health Scotland 2021

Younger women, living in areas of deprivation are more likely to smoke in pregnancy

1.5 Raising the issue of smoking in pregnancy

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

The midwife can explain that it is her role to support the woman to have a safe pregnancy and a healthy baby – discussions regarding smoking in pregnancy are fundamental to this.

The NCSCT Very Brief Advice on smoking in pregnancy module provides examples of how to conduct conversations regarding smoking in pregnancy. In addition, NHS Scotland have produced a useful conversation tool to support a brief evidence informed conversation with pregnant women who have a high CO result (**See Appendix 3**).

1.6 Smoking cessation

There is no safe level of smoking in pregnancy. Women should be encouraged to quit smoking rather than to 'cut down'.

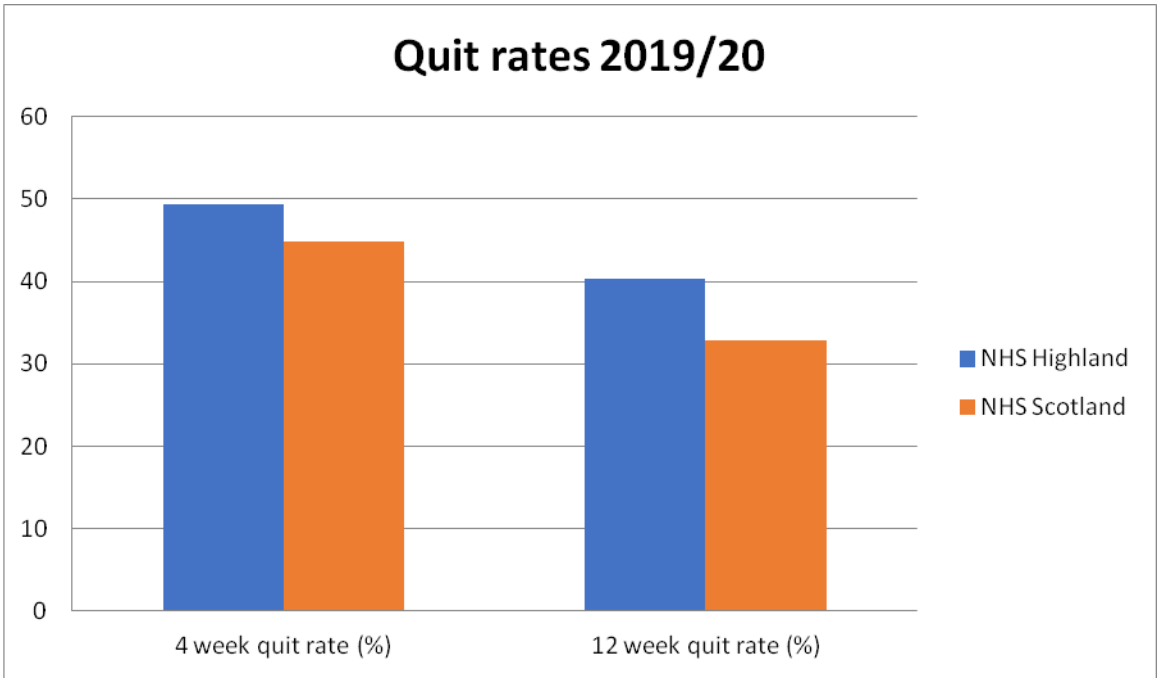
Stopping smoking at any stage in pregnancy is beneficial to the baby's development but quitting before 15 weeks of pregnancy reduces the risk of spontaneous premature birth and of having a low birth weight baby to the same as someone who doesn't smoke. (NCSCT 2019)

The only way to eliminate carbon monoxide and toxin exposure is to quit smoking completely.

Nicotine is highly addictive. When someone smokes, their brain and body become accustomed to regular doses of nicotine. If the number of cigarettes smoked is reduced then the smoker's brain and body continues to demand the same level of nicotine. As a result, the person who smokes, takes more puffs of their cigarette, inhales more deeply and for longer, and smokes more of the cigarette. The number of cigarettes smoked may have reduced but the amount of carbon monoxide and toxins they are exposed to is not reduced. This is known as 'compensatory smoking'.

A woman's chance of successfully quitting is 3 times greater if they use a combination of behavioural support from a trained stop smoking practitioner and NRT compared to going 'cold turkey'

NHS Highland has Specialist Smoking Cessation Midwives and Generic Smoking Cessation Advisors covering all geographical areas. Maternity referrals are made via Badgernet.
Contact details for Smoking Cessation Midwives: nhsh.smokingcessation.north@nhs.scot
Contact details of NHS Highland smoking cessation advisors can be found at this link: https://www.smokefreehighland.scot.nhs.uk/contact/
This link also includes useful websites and links where women and professionals can obtain additional advice and information.
Motivation to quit can vary throughout pregnancy therefore women who continue to smoke should be offered CO testing at each antenatal appointment and the offer of referral reiterated.
The following chart illustrates NHS Highland's 4 week and 12 week quit rates of pregnant smokers compared to the rates for NHS Scotland as a whole:



Source: PHS 2020

1.7 Training

Midwives have a responsibility to ensure that they have the training and expertise to:

- Raise the issue of smoking with all pregnant women
- Effectively use a co monitor
- Refer on to specialist services. (NICE 2021)

Contact NHS Highland Smoking Cessation Midwives for support with any training requirements.

1.8 Nicotine replacement therapy (NRT) and pharmacotherapies

Unlike smoking, NRT delivers a therapeutic form of nicotine and no carbon monoxide is produced which is the main risk of smoking during pregnancy

Use of NRT can improve chances of stopping smoking and greatly reduce the risks of continued tobacco use (NICE 2021).

There are a variety of products which are licensed to use in pregnancy, and all are effective in helping people who smoke to stop. Products include patches, nasal spray, gum, lozenge, inhalator, microtabs and mouthspray. They differ in the amount of nicotine they contain, how it is delivered and how quickly it acts. When considering NRT for pregnant women it is important to consider the following:

- NRT is most effective when commenced at the earliest opportunity in pregnancy, for a minimum of 12 weeks duration to prevent a relapse to smoking
- Pregnant women metabolise nicotine 60% faster than non-pregnant women. Pregnant women who use 2 or more products are more successful at stopping than women who use a single product.
- Pregnant women may find it challenging to tolerate certain products due to increased skin sensitivity and nausea
- It is recommended that women use a 16-hour patch in combination with a shorter acting product.
- Varenicline (Champix) and Buproprian (Zyban) are both currently unavailable. They are medications which reduce cravings associated with stopping smoking. They are **both contraindicated** in pregnancy and breastfeeding and should be avoided. They may be suitable for partners and other family members.

(NICE 2021)

For detailed information on NRT in pregnancy see BNF- Smoking Cessation

1.9 Electronic cigarettes

- E-cigarettes allow you to inhale nicotine through a vapour rather than smoke.
- E-cigarettes don't burn tobacco, and don't produce tar or carbon monoxide
- E-cigarette vapour contains much lower levels of harmful chemicals than smoke.

While using licensed NRT is the preferable option to help pregnant women to stop smoking, many women now choose to use e-cigarettes. The evidence around the use of e-cigarettes in pregnancy

is limited, however the evidence to date shows that they are significantly less harmful than continued tobacco-use. (NCSCT 2019).
Pregnant women who use e-cigarettes containing nicotine should be referred for growth scans at 33- and 36-weeks gestation.
Useful information for professionals: Use of e-cigarettes before, during and after pregnancy
Useful information for patients: E-cigarettes in pregnancy infographic

E-cigarettes should not be recommended instead of NRT but if using an e-cigarette helps the woman to remain smoke free then she should be supported with her quit

1.10 Staying stopped after pregnancy

When baby is born, many women can feel that their reason for stopping smoking is over. It is important to remind women of the benefits of remaining a non-smoker - for both themselves and their children:

BENEFITS OF REMAINING SMOKE-FREE

For children:

- Less chance of developing asthma
- Less likely to suffer chest infections, coughs, pneumonia and bronchitis
- Less likely to develop 'glue ear' and partial deafness
- Less chance of Sudden Infant Death Syndrome ('cot death')
- Less likely to be admitted to hospital
- Less likely to become a smoker
- Less likely to suffer a burn/ accident involving cigarettes and tobacco

For the woman:

- Less likely to develop heart disease
- Less likely to suffer a stroke
- Less likely to suffer cancer of the lung, mouth, throat or bladder
- Less likely to suffer emphysema, bronchitis and other lung diseases
- Reduced risk of cancer of the pancreas, stomach, cervix or kidney
- Increased fertility
- Less likely to suffer a miscarriage
- Less likely to suffer osteoporosis or brittle bones

Remaining smoke-free in the postnatal period can be a challenge. Women should be encouraged to access smoking cessation support if they are finding it difficult to remain smoke-free

Mums looking after a new baby may feel tired, stressed and overwhelmed and their resolve to remain a non-smoker may waver. If required, they should be encouraged to obtain support. Referrals (including self-referrals) can be made via the Smokefree Highland website: https://www.smokefreehighland.scot.nhs.uk/contact/

KEY POINTS:

- Stopping smoking at any stage in pregnancy will immediately reduce the baby's exposure to carbon monoxide and the toxins in tobacco.
- Carbon monoxide is excreted quickly by the body and levels drop by half within 5-6 hours. Within 24 hours CO levels will return to that of someone who doesn't smoke.
- It should be stressed to women that it is normal practice to refer all pregnant women who smoke or have recently quit to smoking cessation services.
- Exposure to second-hand smoke carries the same risk to baby as maternal smoking.
- Carrying out CO readings at booking for all pregnant women can support open and honest discussions regarding smoking status.
- Younger women, living in areas of deprivation are more likely to smoke in pregnancy.
- The midwife can explain that it is her role to support the woman to have a safe pregnancy and a healthy baby – discussions regarding smoking in pregnancy are fundamental to this.
- There is no safe level of smoking in pregnancy. Women should be encouraged to quit smoking rather than to 'cut down'.
- The only way to eliminate carbon monoxide and toxin exposure is to quit smoking completely.
- A woman's chances of quitting are 3 times greater if they use a combination of behavioural support from a trained stop smoking practitioner and NRT compared to going 'cold turkey'
- Unlike smoking, NRT delivers a therapeutic form of nicotine and no carbon monoxide is produced which is the main risk of smoking during pregnancy (NCSCT 2019)
- E-cigarettes should not be recommended instead of NRT but if using an e-cigarette helps the woman to remain smoke free then she should be supported with her quit attempt.
- When baby is born, many women can feel that their reason for stopping smoking is over. It is important to remind women of the benefits of remaining a non-smoker - for both themselves and their children

2. Alcohol

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

Evidence

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

Advice

Staff should promote clear and consistent advice that **the safest option is to abstain from alcohol throughout pregnancy as no safe limit has been established.** Drinking in pregnancy can lead to life-long harm to the baby, with the more you drink the greater the risk. Women who find out they are pregnant after having drunk in early pregnancy should be advised to avoid further drinking.

No alcohol, no risk

Health Risks

Alcohol can have both a toxic and teratogenic effect on fetal development from the moment of conception through to birth. The effects on the fetus can vary depending on the timing, frequency and pattern of alcohol exposure with different organs and physical attributes, for example the heart, eyes and ears, developing at different rates and stages of the pregnancy. The central nervous system has a relatively long developmental window across the entire pregnancy, meaning that alcohol exposure most commonly affects neurodevelopment. (Chung et al. 2021).

Alcohol consumption during pregnancy can increase the risk of:

- Miscarriage
- Low birth weight
- Pre-term labour
- Fetal Alcohol Spectrum Disorder (FASD)

2.1 Prevalence of alcohol consumption in pregnancy

Estimating the prevalence of alcohol consumption during pregnancy is known to be problematic because women often underestimate or under-report their alcohol intake due to several factors including:

- Possible discomfort on the part of pregnant women in reporting their actual alcohol consumption to professionals
- Lack of knowledge or confusion over what constitutes a unit of alcohol

(Scottish Maternal and Infant Nutrition Survey 2018)

A population based observational study set in Scotland by Abernethy *et al* (2018) investigated the use of sampling meconium for alcohol biomarkers to determine the pattern and prevalence of alcohol consumption in pregnancy. 40% of newborn infants in the study had biomarkers of alcohol present in their meconium while 15% (1 in 7) of newborn infants in the study had sufficient levels of alcohol metabolites in their meconium to indicate exposure to alcohol at frequent binge-drinking levels (6 units or more on one occasion). As meconium develops between 12-20 weeks gestation, the findings indicate that a high number of women continued to consume alcohol whilst aware of their pregnancy.

The latest estimates from The Scottish Health Survey (2021) suggest 16% of women exceed the weekly guideline of 14 units and drink at hazardous/harmful levels.

The survey also found that adults from least deprived areas, likely professional and managerial groups with higher incomes, were more likely to drink alcohol above recommended weekly limits than those in the most deprived areas, with likely lower incomes (29% and 20% respectively).

The Scottish Maternal and Infant Nutrition Survey (2018) found that more than half of respondents (54%) did not stop drinking alcohol before they became pregnant.

Respondents were also asked about alcohol consumption when they found out they were pregnant. Most respondents (88%) reported they had not consumed alcohol since they realised. However, more than 1 in 10 (11%) indicated that they had continued to drink alcohol after they realised they were pregnant.

Lots of women continue to drink alcohol in pregnancy, 11% of women did not stop drinking alcohol when they found out about their pregnancy. Remember this when asking women at booking about their alcohol use

2.2 Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) describes a range of physical, emotional and developmental differences that may affect a person across their lifespan if they were exposed to alcohol during pregnancy. FASD is often described as a neurodevelopmental condition. This term describes a collection of disorders that are a consequence of altered development of the brain and central nervous system. It is thought to be the most prevalent neurodevelopmental condition in the UK, with conservative estimates indicating that there are 3-5 times more people affected by FASD than autism (Lange et al. 2017).

FASD is complex to assess, and this often results in misdiagnosis due to similarities with other neurodevelopmental conditions such as ADHD and autism. A full and accurate multidisciplinary assessment allows the appropriate supports to be put into place to enable an individual affected by FASD to fulfil their potential. The accurate and reliable recording of maternal alcohol use is a key component in this assessment; therefore, it is vital that midwives and other health professionals do this consistently (SIGN 2019).

Only around 1 in 13 pregnancies exposed to alcohol result in the child having FASD, with multiple, complex contributing factors at play including biological mechanisms in the pregnant woman, and the timing, frequency and pattern of alcohol exposure (McQuire et al. 2020). However, prevention of alcohol exposure in pregnancy prevents FASD.

Individuals affected by FASD have a unique profile of strengths and challenges across various cognitive domains because of their altered brain development, which often do not align with their chronological age. This means that they may function well in some areas but poorly in others. FASD may not be detected at birth but may become apparent later in life as developmental milestones are delayed or remain unmet.

FASD with sentinel facial features is sometimes referred to as ‘Fetal Alcohol Syndrome’ or FAS. The sentinel facial features include a short palpebral fissure length (the distance between the corners of the eyes), a smooth philtrum, a thin upper lip, microcephaly and short stature. Only 10% of individuals with FASD will have visible facial features, and these can attenuate with age (Chudley et al. 2007). This means that FASD is an invisible condition for most individuals affected.

Challenges of FASD
(not all individuals will be affected by all challenges)

Domain	Manifestation
• Executive function	• Difficulty transitioning from one task to another; repetition of mistakes; poor understanding of consequences
• Memory and learning	• Poor memory; poor recall of events or information; difficulty learning from past behaviour
• Cognitive ability	• Lowered IQ (though often not within the range of intellectual disability); difficulty with application of knowledge
• Academic ability	• Difficulties retaining information; adaptations to standard teaching methods required
• Low levels of self regulation	• Significant issues with sleep and feeding
• Attention	• Difficulty staying focused; difficulty shifting attention to another task
• Emotional regulation	• Easily overwhelmed; mood lability
• Impulse control	• Engagement in risky behaviours; difficulty waiting their turn
• Language skills	• Poor comprehension of non-literal language; confabulation (the production or creation of false or erroneous memories without the intent to deceive)
• Adaptive behaviour	• Delays in early feeding; difficulties with daily routines
• Social skills	• Overly friendly with strangers; inappropriate social overtures (crossing boundaries or sexually inappropriate)
• Motor and sensory issues	• Difficulty with gross and fine motor skills e.g. cutlery, laces, balance; hyper or hypo-sensitivity to smells/sounds
• Physical health	• Increased incidence of eye disorders, asthma, heart conditions, skin conditions, and renal disorders; dysmorphological features; growth restriction

Sources: Hagan et al. 2016, McDougall et al. 2020, Hanlon-Dearman 2021.

With approximately 1800 live births annually in the Highlands, it is estimated that there are at least 54-90 infants born each year and 918 people under the age of 18 affected by FASD, using the most conservative estimates.

Individuals affected by FASD in the Highlands	
Estimated incidence rate (of live births)	3-5%
Estimated number of new cases per year	54-90
Estimated number of individuals aged under 18 affected by FASD	918
Source(s): FASD Hub, Scotland	

All pregnant women should be offered a hard copy of Ready Steady Baby, with the health promotion advice of "no alcohol, no risk." A leaflet for women explaining the risk of harm to baby from drinking alcohol in pregnancy 'Help you keep your baby safe and healthy' is available on Badgernet and Health Information Resource Service (HIRS). FASD-specific resources for families can be found at https://www.adoptionuk.org/our-fasd-hub-community

FASD IS PREVENTABLE

Resources

The following resources are useful for all staff to enhance knowledge:

The Scottish Government FASD Awareness Toolkit:
https://www2.gov.scot/Resource/0043/00435992.pdf

FASD Hub Scotland:
https://www.adoptionuk.org/pages/site/scotland/category/fasd-hub-scotland

FASD: Preferred UK Language Guide:
Seashell_NationalFASD_FASDLanguageGuide.pdf

Fetal Alcohol Advisory Support and Training (FAAST) Team website:
Home - Fetal Alcohol Advisory Support & Training Team (ed.ac.uk)

TURAS Module on FASD:
https://learn.nes.nhs.scot/39148/fetal-alcohol-spectrum-disorders-fasd/fetal-alcohol-spectrum-disorders-fasd

2.3 Alcohol Brief Interventions (ABIs)

All women should be asked about their alcohol consumption at their booking appointment. (NICE 2021). The evidence of the risks of alcohol to the developing baby and the prevalence of alcohol consumption during pregnancy emphasise the need to take a proactive approach to promoting abstinence before and during a pregnancy.

% of Alcohol Brief Interventions delivered in Antenatal Settings by year					
	2014/15	2015/16	2016/17	2017/2018	2018/2019
NHS Highland	1.3%	0.5%	0.7%	0.3%	0.0%
Scotland	2.4%	3.2%	3.9%	3.0%	2.1%

Source: ISD Scotland

The midwife can explain that it is her role to support the woman to have a safe pregnancy and a healthy baby – discussions regarding drinking in pregnancy are fundamental to this.

Recent research into discussing alcohol use with pregnant women suggests a conversational approach enables honest disclosure about drinking. This includes building trust using sensitive, flexible questions and a positive tone, as compared to a fixed questionnaire-type interaction. Asking questions about "parenting capacity" at the same time is shown to decrease honest disclosure of alcohol use (Sholin *et al* 2019). It is essential that the conversation around alcohol use is carried out in a trauma-informed manner to reduce stigma and prevent causing further harm.

An alcohol brief intervention (ABI) provides a structured approach to discussing alcohol use before and during pregnancy. ABI delivery involves assessing the individual's motivation to make changes, offering a 'menu of options' to enhance their motivation and use of motivational interviewing techniques. There is always the option to exit the conversation or offer harm reduction advice (NHS Scotland 2017).

An alcohol brief intervention should be delivered to:

- Women who consume alcohol at any point during pregnancy
- Women who report pre-pregnancy alcohol consumption levels over 14 units a week, and/or drinking 6 units or more on one occasion

Antenatal record keeping of conversations around alcohol use, ABI delivery and use of the TWEAK screening tool are on Badgernet (Electronic Maternity Record).

The number of ABIs being delivered in antenatal settings in the Highlands has been falling year on year since 2014, with none performed in the year 2018/19, and has been consistently below the national average. A gap in the skills and knowledge of professionals to perform ABIs has been identified and work is ongoing tackle this through targeted training, aiming to embed ABIs into routine practice.

Alcohol Brief Intervention Care Pathway- SEE APPENDIX 3 'Talking to women about drinking during pregnancy'

Training on Antenatal Alcohol Brief Interventions is available from the Specialist Midwives for Drugs and Alcohol, please contact them directly to arrange.
Nhsh.drugsandalcoholspecialistmidwives@nhs.scot

2.4 Alcohol dependency

Alcohol dependency during pregnancy poses significant risks to both the mother and the developing fetus. If a woman is drinking at levels which cause concern about possible dependence or serious harm, then clinical judgement or a formal screening tool, such as TWEAK, should be used to inform decision making. **(SEE APPENDIX 3)**

The TWEAK tool has set questions to assess an individual's alcohol consumption for signs of dependency. There are five questions:

- T (stands for Tolerance): How many drinks does it take to make you feel drunk?
- W (stands for Worry): Have close friends or relatives worried or complained about your drinking in the past?
- E (stands for Eye-opener): Do you sometimes have a drink in the morning when you get up?
- A (stands for Amnesia): Has a friend or family member ever told you things you did or said while you were drinking that you could not remember?
- K (stands for Cut down): Do you sometimes think you need to cut down your drinking?

The maximum score on the tool is 7 points, with the score for the first two questions being a possible 2 points each and the remaining three questions being a possible 1 point each. A total score of 2 or more on the tool is an indication of potential dependent drinking and offering referral to specialist services would be appropriate.

Suddenly stopping alcohol consumption if dependent can be dangerous. Abrupt cessation can trigger severe withdrawal symptoms, which may be harmful to both the mother and the fetus. Women need specialist support to safely manage withdrawal to reduce alcohol intake gradually under professional supervision

For referral to Drug and Alcohol Recovery Services (DARS):
Osprey House, Inverness 01463 716888
This is a single point of referral. Women are telephone screened within two days and generally have an appointment within 7-10 days.

If there are concerns for the unborn child or other children refer to child protection guidance.
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 supported by an obstetrician and provided by the wider maternity care team. **SEE APPENDIX 6 - Care schedule: Substance use in pregnancy**

2.5 Breastfeeding

Women who choose to breastfeed, should be informed that alcohol can, like most other things you eat or drink, find its way into breast milk (Haastrup *et al*. 2014). Whilst evidence suggests that an occasional drink is very unlikely to harm their baby, regular exposure to alcohol in the breastmilk is linked to development delay (Gibson and Porter 2018).

- Expressing breastmilk and discarding it does not remove the alcohol but may relieve discomfort.
- Women should be advised that if they do choose to drink alcohol on occasion,
    - Plan ahead and express breastmilk in advance. This ensures that baby can be safely fed breastmilk.
    - Avoid breastfeeding for 2-3 hours per alcoholic drink and plan ahead by expressing milk *before* intending to drink.

  - DO NOT bed share or fall asleep in the sofa/chair as this has been strongly associated with the increase of sudden unexplained death in infancy (SUDI)
- Drinking alcohol reduces the ability of the mother to be aware of her baby's needs, whether breastfeeding or not. It is safer to ask someone else to care for the baby.

(The Breastfeeding Network 2021)

More information can be found on the Breastfeeding Network website
Alcohol and Breastfeeding

Key Points

- No amount of alcohol is safe in pregnancy.
- A reliable and accurate maternal history is the best screening tool for identifying risk of FASD. SIGN 156 (2019) recommends that "all pregnant and post-partum women should be screened for alcohol use with validated measurement tools by service providers who have received appropriate training in their use". See appendix 3- talking to women about drinking in pregnancy.
- The term Fetal Alcohol Spectrum Disorder (FASD) describes the range of physical, emotional, and developmental delays that may affect a person when they were exposed to alcohol during pregnancy. It is estimated that 3-5% of newborn infants are affected by FASD.
- Recent research by Sholin *et al.* (2019) into discussing alcohol use with pregnant women suggests a conversational approach leads to more honest disclosure about drinking.
- Less than 1% of all ABIs in the NHS Highland area were delivered in an antenatal setting in both 2015/16 and 2016/17.
- The Scottish Health Survey found that women from least deprived areas, likely professional and managerial groups with higher incomes, were more likely to drink alcohol above recommended weekly limits than those in the most deprived areas, with likely lower incomes.
- ABIs should be delivered to all women who…
- Women consuming alcohol during pregnancy
- Women who report pre-pregnancy levels over 14 units a week, &/or drinking 6 units or more on one occasion
- The midwife can explain that it is her role to support the woman to have a safe pregnancy and a healthy baby – discussions regarding drinking in pregnancy are fundamental to this.
- If a woman is drinking at levels which cause concern about possible dependence or serious harm, then clinical judgement must be used to inform decision making or a formal screening tool can be used e.g. TWEAK
- For referral to Drug and Alcohol Recovery Services
- Osprey House, Inverness 01463 716888
- Midwives can self-refer for **Advice and Support Sessions** with Specialist Midwives through our booking page https://outlook.office365.com/owa/calendar/nhshdrugsandalcoholspecialistmidwivesCopy@scottish.onmicrosoft.com/bookings/

  or/ email Nhsh.drugsandalcoholspecialistmidwives@nhs.scot

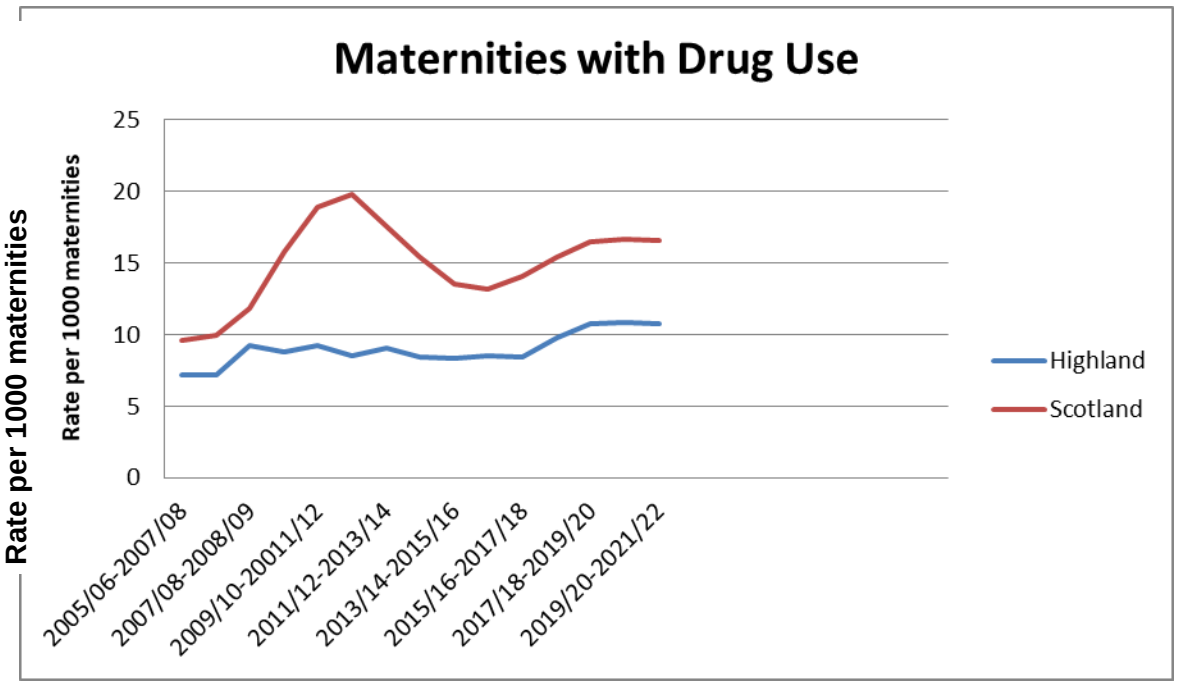
- An Antenatal Plan: additional support for mother and unborn baby should be completed and risk assessment must include the impact of the alcohol consumption on the baby. Their care should be supported by an obstetrician and provided by the wider maternity care team See appendix 6- Care schedule: substance use in pregnancy.
- Breastfeeding mothers can have occasional, small amounts of alcohol, but should not drink regularly or heavily.

3. Drugs

There has been a large increase in problem drug use both nationally and internationally since the 1980s and this increase has been disproportionately high among women of childbearing age. In the triennial report, Confidential Enquiries into Maternal Deaths and Morbidity 2017-19 (MBRRACE-UK 2021) 11 (14%) women died as a direct result of substance use. Substance use was implicated indirectly in a further 17 (15%) deaths of women who were found to have complex and chaotic lives which greatly increased their vulnerability.
Themes identified from this report:

- Most of the women had a history of multiple adversities such as childhood abuse, adult abuse, social services involvement and child removal.
- There was often a pattern of increased substance use and disengagement after children were removed.
- There were instances of poor information sharing between professionals.
- Several women died from the chronic effects of substance use inc. liver failure, pancreatitis and myocarditis.
- A number had recent overdoses of drugs either shortly before pregnancy or during pregnancy.

The rate of pregnancies recording drug use in the Highland Alcohol and Drug Partnership (HADP) area has increased. In the Highland locality, the rate has steadily increased since 2005/06 (ScotPHO 2023).



**Pregnant women who use substances may be frightened of presenting to services for fear of being judged.
Use a trauma informed approach in supporting women.
Maintaining contact with services is vital**

Pregnant women with substance use problems should be supported by a team providing co-ordinated, multidisciplinary and multiagency care. Services will fast-track women into Drug and Alcohol Recovery Services to ensure early intervention and harm prevention. A trauma-informed 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.

Staff can access the Highland Substance Awareness Toolkit which provides information in relation to substances in the Highlands.

(**SEE APPENDIX 4- Drugs: Withdrawal, risks in pregnancy and symptoms of withdrawal in newborn)**

Evidence-based safety information on drugs in pregnancy can also be found on UKTIS – Evidence-based safety information about medication, vaccine, chemical and radiological exposures in pregnancy

People from more deprived areas of our society are more likely to experience health inequalities and problematic drug use. Health inequalities disproportionately put people at higher risk of a wide range of issues, for example domestic abuse, homelessness, poor mental health and chronic infection. These families are therefore likely to have multiple, complex needs and it is essential that a co-ordinated network of support is in place to mitigate harms.

The use of a trauma-informed approach allows practitioners to establish supportive relationships with families presenting to maternity services. This promotes engagement and improves outcomes. It is important to be mindful of adversities and circumstances that may prevent families from accessing services in the usual way, and every effort should be made to meet their unique needs.'

It is important to be sensitive to the stigma experienced by families who experience problematic substance use. Using 'people-first' language can help to challenge negative attitudes and remove barriers to accessing essential care.' Guidance on this is available at Language-Matters-final.pdf (highland-adp.org.uk)

The midwife can explain that it is her role to support women to have a safe pregnancy and healthy baby- discussions regarding substance use in pregnancy are fundamental to this

Women who report current drug use at any point in pregnancy should be supported to engage with drug and alcohol recovery services. They can provide a more in-depth assessment of substance use, drug screening to confirm current use, and on-going counselling and support with reducing or stabilising use through substitute prescribing programmes.

Important aspects to discuss with families are:

- The method of drug administration. If they are using substances intravenously, then a multi-agency approach should explore present injecting techniques, discuss harm reduction and provide information on needle exchange. Drug and Alcohol Recovery Services will assist with this process and women will be encouraged to stop injecting and switch to a safer method.
- If they have previously had support with their drug use and what this involved.
- If the pregnant woman is currently receiving support; identify if they are prescribed any medication and who is prescribing this for them.
- If their partner uses drugs; identify if they are engaging with drug and alcohol recovery services and what treatment they are receiving.
- Booking an 'Advice and Support' session with the Specialist Midwives
- Assessment and completion of the 'Antenatal Plan'. This will ensure co-ordination of services and that appropriate support is in place for the family as early as possible in pregnancy.
- Whether the drug (or alcohol) use is likely to impact on the baby or any other children in the family. Child Protection processes should be followed.

Staff can contact:

Drug and Alcohol Recovery Services

- Inverness on 01463 716888

Highland Alcohol and Drug Advice and support Services (HADASS) 01463 716324

Drugs and Alcohol Specialist Midwives- Cat Clark & Hazel Inglis

Nhsh.drugsandalcoholspecialistmidwives@nhs.scot

Advice and Support Session booking link

https://outlook.office365.com/owa/calendar/nhshdrugsandalcoholspecialistmidwivesCopy@scottish.onmicrosoft.com/bookings/

3. 1 Referral pathway when working with pregnant women who use substances- SEE APPENDIX 5

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. Pre-birth planning discussions should include parents to assess risk, determine outcomes, and plan support networks. This reduces the need for emergency child protection procedures at birth

3.2 Medication Assisted Treatment (MAT) in pregnancy

Medication Assisted Treatment (MAT) can occur at any stage during pregnancy and the risks to mother and fetus are lower than continuing drug use. This promotes engagement with services and assessment of health and social needs.

The treatment of choice with women presenting in the first and second trimester is buprenorphine, because of the growing evidence of its superiority over methadone in terms of pregnancy and neonatal outcomes. However, there is a risk of precipitating opioid withdrawal when this is started. As opioid withdrawal later in the third trimester can have significant adverse effects, if a woman presents very late in pregnancy, she may be commenced on methadone because of this risk.

Commencement of MAT involves assessment and titration to reach optimum dose.

The rationale for commencing MAT:

- 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

MAT has contributed to rapid and substantial improvements in the time that service users spend focusing on their family and home life.

The clinical team should highlight to women the advantages of MAT 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 are offered as an integral part of MAT, to provide time to explore past/present drug use and how to implement changes, deal with on-going problems without resorting to using, and provide time to reinforce progress or discuss concerns. Random drug screening is an integral part of prescribing and can be an indicator of safe compliance with medication.

Information source on the use of drugs, alcohol and cigarettes (scot.nhs.uk)

HIGHLAND Substance Awareness TOOLKIT

Key Points

- Women who died as a direct/indirect result of their drug use were known to experience multiple adversity
- People from more deprived areas of our society are more likely to experience health inequalities and problematic drug use. Health inequalities disproportionately put people at higher risk of a wide range of issues, for example domestic abuse, homelessness, poor mental health and chronic infection.
- The rate of pregnancies recording drug use in Highland is steadily increasing
- Be aware that women may be frightened of presenting to services for fear of being judged
- Always use a trauma informed approach in supporting women, especially at first point of contact/booking appointment
- The midwife should ask every woman at booking about substance use
- Evidence-based safety information on drugs in pregnancy can be found on UKTIS – Evidence-based safety information about medication, vaccine, chemical and radiological exposures in pregnancy
- Pregnant women with substance use problems should be supported by a team who will provide co-ordinated multidisciplinary and multiagency care, this includes
    - RED Pathway for Consultant-Led Care
    - Anaesthetic Referral
    - Drug and Alcohol Recovery Services
    - Specialist Midwives for Drugs and Alcohol
- Women should be supported to engage with drug and alcohol recovery services
- Midwives can self-refer for **Advice and Support Sessions** with Specialist Midwives through our booking page https://outlook.office365.com/owa/calendar/nhshdrugsandalcoholspecialistmidwivesCopy@scottish.onmicrosoft.com/bookings/

  or/ email Nhsh.drugsandalcoholspecialistmidwives@nhs.scot
- Medication Assisted Treatment (MAT) can occur at any stage during pregnancy and the risks to mother and fetus are lower than continuing drug use
- The increased risk of IUGR necessitates referral for serial growth scans from 30 weeks gestation as per the Perinatal Institute GROW criteria. (NHS Highland 2022).

4. The Challenges

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

The SMR02 (Scottish Morbidity record maternity hospital discharge summary) enables information regarding smoking, alcohol consumption and drug use during pregnancy to be recorded. Questions in the SMR02 concerning weekly alcohol consumption and drug use became mandatory in April 2011 to help capture a more accurate and robust picture of alcohol and drug use during pregnancy in Scotland (ISD, 2022). Births in Scottish Hospitals 2021

DAISy is a new national database for Scotland which replaced the Scottish Drug Misuse Database (SDMD) and Drug and Alcohol Treatment Waiting Times (DATWT) data collections as well as providing new data for alcohol treatment and outcomes.

4.1 Multiagency working and information sharing

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

For pregnant women who use substances, it is important that they engage with services at the earliest stage 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 less likely to disclose information or ask for help in the first place.

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

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

The Data Sharing across the Highland Data Sharing Partnership Procedures for Practitioners (NHS Highland 2013) provides guidance for all practitioners to support a co-ordinated and seamless approach to information sharing. It provides staff with the principles governing the sharing of information, which is essential to multi-agency working and describes responsibilities and requirements for this. When a practitioner is deciding about whether or not to share data, the welfare of the child must be the main consideration. Resources around the Children and Young People (Information Sharing) (Scotland) Bill - June 2017 further support staff with information sharing is provided Getting it right for every child (GIRFEC) Practice Guidance 4- Information sharing (Scot Gov 2022)

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 children and Young People in Highland (2017 Interim update) offer further information for staff and should be accessible when working in clinical areas.

When sharing information, it is vital that all discussions and actions are well documented, including what and why information has been shared, and with whom. Advice should always be sought if there is uncertainty from Managers and Child Protection Advisors (CPA).

4.2 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 need 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 drug and alcohol recovery service, smoking cessation, mental health and others may be the first point of contact with pregnant women. Where there are any risks to the unborn child or any other children in the household these risks must be acted on appropriately.

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

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

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

When there are additional support needs such as a woman having alcohol or drug issues then, the 'Antenatal Plan: additional support for mother and unborn baby' should be completed by the named midwife. The plan should detail the impact any substance use is likely to have on the outcomes for the mother and her baby. Appropriate early support and intervention must be in place as soon as possible in pregnancy and certainly well before the baby's birth to ensure the best outcomes.

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

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

Children can experience both emotional and physical disturbances and they may exhibit symptoms of failure to thrive and anxiety. Health professionals should recognise the importance of secure parent infant 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 Infant Mental Health (prebirth - 3 years) Best Practice Guidelines (NHS Highland 2012)

Risk 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 use
- 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 (Scot Gov 2022). It is also important to consider the additional needs of children affected by disability or with communication difficulties.

All professionals should have knowledge and understanding of their local Child Protection Policy Guidelines and managers should ensure that their staff undertakes regular Child Protection training relevant to their post.

Midwives and Health Visitors have specific responsibilities for child protection as part of their role and should consult the Child Protection Training guide for managers and staff

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

4.3 Mental Health

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

At booking all pregnant women are asked a series of questions about their own mental health and that of their immediate family within the Badgernet. 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. Patient Friendly Information leaflets in relation to substances can be obtained from the Perinatal Infant Mental Health Team

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

PAMPR (Perinatal Advice Meeting & Professional Reflection) Session can be booked by any Health, Social Care or 3rd Sector colleague who have any concerns in relation to parents experiencing substance use and perinatal mental health difficulties

For more information email the Perinatal Infant Mental Health Team at nhsh.nhighlandPNIMHT@nhs.scot

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

4.4 Violence Against Women (VAW)

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

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

The Highland Violence Against Women Partnership has developed resources to support staff in their work. This includes guides on Responding to VAW; specific protocols for sexual violence, Female Genital Mutilation (FGM) and Forced Marriage; documentation to support MARAC risk identification and referral; information on support services; and TURAS NHS Education Scotland) and face to face multi-agency training programme.
For the most up to date resources, please visit the Highland Violence Against Women Partnership website, www.hvawp.scot.nhs.uk some resources are also available through HIRS (search under subject 1GBV gender-based violence).

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

4.5 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 like those of women in the wider community it is often the case that their experience of health services is not always as comparable.

It is important not to make any uninformed judgements about a woman's needs and it is always appropriate to ask each woman about their ethnicity and any cultural needs they might have. It is best practice to record the ethnicity of all women using services in Badgernet.

Many women using maternity and early year's services will need appropriate communication support. It is essential that professional interpreters are used where needed. It is generally unacceptable to use family or friends. Many of the written resources used in maternity and early years are available in alternative languages and formats and should be available on the NHS Highland website. Where the needed resources are not available in the correct language, the guidance on obtaining translated information should be followed. If a woman does not have English as her preferred language, then an interpreter should always be booked, or the telephone interpretation service used.

Face to face interpretation is available for spoken languages through Global Languages and telephone interpretation is available through Language Line. British Sign Language interpretation is also available for service users who are Deaf or hard of hearing as well as other communication support such as lip reading or note taking
NHS staff can access guidance here
http://intranet.nhsh.scot.nhs.uk/Staff/EqualityAndDiversity/AccessibilityandCommunication/Pages/Default.aspx

Highland Council staff

Translation and interpretation Services

5. The Woman's Journey

Pregnant women with substance use problems should be supported by a team providing co-ordinated, multidisciplinary and multiagency care. Services will fast-track women into Drug and Alcohol Recovery Services to ensure early intervention and harm prevention. A trauma-informed 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.

The use of a trauma-informed approach allows practitioners to establish supportive relationships with families presenting to maternity services. This promotes engagement and improves outcomes. It is important to be mindful of adversities and circumstances that may prevent families from accessing services in the usual way, and every effort should be made to meet their individual needs.

5.1. Antenatal care and booking appointment

In Highland, the woman's named community midwife is often the first point of contact in pregnancy. Using a trauma-informed approach with all women, questions about smoking, alcohol and drug use are asked at booking, then again during the lifestyle update at 28 weeks and 34 weeks.

The midwife can explain that it is her role to support women to have a safe pregnancy and healthy baby- discussions regarding substance use in pregnancy are fundamental to this

Some women may be known to drug and alcohol recovery services but others, especially non-dependent users, may be disclosing their use for the first time. They should be supported to engage with drug and alcohol recovery services.

It is important that a clear pathway of care is in place for all professionals involved with women who use drugs or alcohol:

- Red pathway/ Consultant-led care
- Referral to anaesthetist
- Specialist support and advice session- Specialist Midwives for Drugs & Alcohol
- Child protection Advice and guidance
- HPI Additional
- Antenatal plan
- Consider an Antenatal planning meeting before 24 weeks

The Care Schedule provides practitioners with a minimum number of expected contacts that pregnant women will receive; however, this should be individual for each woman. An assessment may highlight the need for many more contacts.

If the woman's named midwife is on a period of leave, then her caseload must be allocated to another named member of the team who will hold responsibility. If there are child protection concerns, then social work must be informed, and Child Protection Procedures followed.

Drugs and Alcohol Specialist Midwives- Cat Clark & Hazel Inglis
drugsandalcoholspecialistmidwives@nhs.scot

Advice and Support Session Booking
https://outlook.office365.com/owa/calendar/nhshdrugsandalcoholspecialistmidwivesCopy@scottish.onmicrosoft.com/bookings/

5.2 Booking bloods

It is important to obtain booking bloods between 8 and 10 weeks. 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. Gaining venous access can also be an issue for obtaining blood. As per NHS Highland venepuncture standard operating policy, only two attempts should be undertaken before referring onto a more experienced practitioner. However, taking this into account, if you feel you may have difficulty obtaining venous access and/or the women tells you it will be difficult securing a vein, it may be appropriate to discuss with anaesthetic colleagues before attempting venepuncture.

You're pregnant! Scans and tests (Public Health Scotland 2023) should be given to all women at first point of contact. A pre-test discussion should take place and informed consent gained from the woman. Current booking bloods include testing for:

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

5.2.1 Blood borne viruses (BBV)

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

HBV and HIV can be transmitted by sexual 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 and sharing injecting equipment.

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

The objective of the immunisation programme is to provide a minimum of three doses of hepatitis B vaccine for:

- Infants, as part of the routine childhood immunisation programme, the 6-in-1 1 (DTaP/IPV/HIB/HepB) vaccine is given at 8, 12 and 16 weeks, to protect against future exposure risks **(pre-exposure immunisation)**
- Individuals at high risk of exposure to the virus or complications of the disease **(pre-exposure immunisation)**
    - people who inject drugs intermittently
    - people who are at risk of injecting drugs e.g., people who are currently smoking heroin/and or crack cocaine and heavily dependent amphetamine users
    - people who are non-injecting drug users who are living with people who currently inject drugs
    - sexual partners of people who inject drugs

- Selective neonatal immunisation programme
    - Newborn infants who have already been exposed to the virus **(post-exposure immunisation).** Infants born to hepatitis B infected mothers identified through antenatal screening, to prevent mother to child transmission at or around time of birth.
        - Immunisation of the infant should start as soon as possible after birth, and no later than 24 hours, and be followed by a dose four and eight weeks, then a further dose at one year of age.
        - The dose at eight weeks in the selective neonatal programme will be provided as part of the 6-in-1 vaccine in the routine programme, as will additional doses given at 12 and 16 weeks.
    - Newborn infants born to a hepatitis B negative woman but known to be going home to a household with another hepatitis B infected person. In these situations, a monovalent dose of hepatitis B vaccine should be offered before discharge from hospital, in addition to routine immunisation at 8,12 and 16 weeks.

HIV can be passed from mother to baby either during pregnancy, labour, and delivery or through breastfeeding. In most cases, HIV is thought to be transmitted during the last few weeks of pregnancy or during delivery. However, the risks can be reduced by appropriate treatment. There is routine antenatal testing for HIV across Scotland. Clinical management of women who are HIV positive should be provided in accordance with national and local guidance Guidelines for the management of HIV in pregnancy and postpartum (BHIV 2020) and staff in ward areas should have access to Screening for Communicable Diseases in Pregnancy NHS Highland, 2017. The Highland policy is available on the intranet.

The risk of women who are Hepatitis C Virus (HCV) RNA positive transmitting infection to their babies in utero or during birth, is approximately 5%; the rate is twice as high for those co-infected with HIV. The baby's risk of acquiring HCV from a mother infected with HCV is not increased by mode of delivery or breast feeding. Fetal scalp monitoring may increase the risk of mother to child transmission. Routine screening for HCV in pregnancy is not recommended, NHS Highland recommends screening women who meet any of the criteria laid down in SIGN 133- Management of Hepatitis C.

- Intravenous drug use either current or in the past where needles, syringes and other drug paraphernalia has been shared

- Snorting of drugs when equipment used for snorting has been shared

- Medical or dental treatment administered abroad (including blood transfusion). In relation to pregnancy IVF treatment administered abroad should be considered a medical procedure

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 705086/706243 Karen.stockdale@nhs.scot
- A&B residents will be referred to the appropriate service within Greater Glasgow and Clyde.

5.3 Continuing antenatal care

Routine antenatal care should be provided in the woman's locality when possible and should include regular liaison with specialist services. Support can be offered by the Specialist Midwives for Drugs and Alcohol. Care should be individualised and informed by a comprehensive assessment of strengths and weaknesses 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. Be mindful of lone working
- Information about local support agencies, benefits and allowances.
- Time to discuss any concerns and reinforce progress on substance use.
- On-going multiagency collaboration and communication.
- Consider Advice and support session with Specialist Midwives
- Discussion of drug use and potential effects during pregnancy and on the newborn.
- An explanation of Neonatal Abstinence Syndrome (NAS) and the use of the assessment eat, sleep & console. There is the need for an increased postnatal length of stay for assessment of baby (min 5 days)
- Preparation for parenthood and documenting of individual birth plan, which should include discussions surrounding pain relief during labour, feeding, social support, emotional wellbeing, and partner's role.
- Consider involvement of 3rd sector agencies who can provide specialist 1:1 parenting programmes, such as PEEP and Parenting under Pressure
- Sudden infant death Prevention
- Visit to neonatal unit (NNU)

It is essential that there is collaboration with the family's health Visitor (HV) to ensure support is maintained through the transition from midwifery to health visiting care. *The Communication and*

Handover of Health and Social Information between Midwife and Health Visitor highlights that this communication process should take place from booking (NHS Highland 2018).

Any assessments should be shared with the HV who should prioritise a home visit for families with substance use issues. This 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.

5.4 Neonatal Abstinence Syndrome

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

There appears to be little correlation between the amount of maternal drug use and the severity of NAS but certain drugs do intensify the signs. Depending on the substances taken, many women will be expected to remain in hospital with their baby for a minimum of 5 days after birth as withdrawal symptoms are often not evident before this time. Practitioners should be aware of the signs and symptoms of NAS in the newborn,

It is very important that signs and symptoms of NAS are discussed with women before their EDD, as their baby is at a higher risk of being born premature. *Caring for a Baby with Drug Withdrawals* Information for parents **(SEE APPENDIX 7)** can be used to support this discussion.

Neurological	Metabolic	Gastrointestinal
Hyperirritability	Fever	Diarrhoea
Excessive crying	Coryza and Sneezing	Vomiting
Restlessness	Temperature Instability	Poor Feeding
Poor sleep	Excessive Sweating	Slow Weight Gain
Tremor	Excessive Yawning	Excoriation of bottom
Seizures		
Exaggerated Moro Reflex		
Increased Tone		

Infants at risk of NAS are nursed in the postnatal ward with their mother unless any specific indication for admission to NNU is present. Mothers should perform all routine care, allowing the midwifery team to assess their parenting skills. NAS babies are very demanding and require a lot of comforting. It is important that the infant is nursed together with his/her mother whenever possible. Babies should remain in hospital for at least 5 days to ensure they are not developing NAS.

Empowering the mother as principal caregiver and building her confidence is the key to success in managing babies without pharmacological intervention.

EAT, SLEEP, CONSOLE is a simplified approach to monitor and treat babies with NAS. The aim is to look at whether the baby can eat, sleep and be consoled. If any of these are being impacted by withdrawal, a non-pharmacological care bundle (standard comfort measures) can be utilised before resorting to pharmacological interventions. A non-pharmacological pathway is centred on promoting maternal involvement in care, minimising stimuli and increasing staff education (Sunderesan and Cox, 2023). These may include skin-to-skin contact, frequent nursing, quiet and calm environment, low lighting, swaddling, dummies etc.

EAT, SLEEP, CONSOLE focuses on three key areas:

1. Eat: is the baby feeding normally?
2. Sleep: is the baby able to sleep between feeds?
3. Console: can the baby be comforted?

If the baby feeds well, sleeps >1 hour and can be consoled within 10 minutes, it is considered well managed, and no further intervention is required.

- NAS is the likely diagnosis in an infant who demonstrates the signs and symptoms listed above and whose mother was known to have used addictive substances in pregnancy. Other common causes of extreme irritability can be generally excluded by careful history taking, clinical examination and measurement of blood sugar, calcium and magnesium.

- Pharmaceutical treatment of choice is the substance from which the infant is withdrawing and should be reserved for infants with severe NAS.

The NHS Highland policy should be referred to if required and the link is available at (NHS Highland Staff only) Management of Neonatal Abstinence Syndrome

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

Ophthalmology

Mothers on methadone, buprenorphine, tramadol, oral morphine, (not codeine) in pregnancy, regardless of whether baby develops neonatal abstinence syndrome, require ophthalmology follow up at term + 6 months. Inter-unit referral to be sent at time of birth to Jean McCulloch at: nhsh.cduophthalmology@nhs.scot

5.5 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.

Steps should be taken to address reasons for non-attendance and to determine what support can be provided to promote attendance at appointments.

Community Midwives and Drug and Alcohol Recovery Nurses can offer follow-up at home and the Specialist Midwives for Drugs & Alcohol can provide a vital link between services.

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

5.6 Ultrasound scans/GROW

As well as being offered an ultrasound scan to determine gestation, all women in Highland are given the option of a structural fetal anomaly scan at 18+0 - 20+6 weeks gestation. Substance use can be associated with structural fetal abnormality, particularly with alcohol consumption, benzodiazepine use in the first trimester, 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, for others it may reinforce a fear that their drug use is adversely affecting their baby's wellbeing, increasing anxiety and feelings of guilt. This may be a barrier for women to engage with services.

5.7 Antenatal planning meeting

An antenatal planning meeting must take place no later than 24 weeks gestation or as soon as possible, following any concerns of substance use. The purpose of this meeting is to gather multi professional information to ensure that a robust risk assessment takes place, ensuring families get the right support as early as possible and a plan of care (A/N plan) is developed in partnership with the parents. These meetings also allow discussion on whether to proceed to a pre-birth child protection planning meeting (Pre-Birth CPPM). Consider specifically what might the risk factors be for the unborn or new baby. All practitioners who are involved in supporting the family should take part in the antenatal planning meeting.

The named midwife should complete an antenatal plan. This is an assessment (my world triangle) and will be the named midwife's contribution towards a multi-agency assessment.

The discussions and decisions that occur at the antenatal planning meeting will inform the woman's individual care plan (AN Plan) and must be uploaded to Badgernet. The Lead Professional should update the Antenatal/Child's plan. Child protection procedures must be followed when required.

5.8 Admission

Admission to hospital can be an anxious time for mothers, particularly if they have encountered difficulties and increased their drug use prior to admission. They may be frightened of experiencing withdrawal symptoms if unable to maintain their normal supply.

- It is important to clarify their present medication and to
- Ascertain whether they have been using anything else on top of their prescription. If this is the case; what has been used, how often and how has it been used must be documented.

The keyworker (Drug and Alcohol Recovery Nurse) 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- Please ensure any clinical discussions, records or dispensing is carried out privately without the ability of other women and families in the ward able to overhear.

5.9 Labour and pain relief

When there are substance use concerns, women should be advised to 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/named midwife should also be informed of admission and delivery as she is the woman's main care co-ordinator. If a Lead Professional has been appointed other than the midwife, they must also be informed.

For a woman with HIV the decision about mode of delivery will be made in conjunction with her, her obstetrician and HIV specialist doctor. An elective caesarean section may be recommended as the best way to prevent HIV transmission to the baby. This will depend on clinical parameters such as viral load and the use or otherwise of anti-retroviral agents.

Care for babies born to women with BBV should follow the NHS Highland Protocol, Screening for Communicable Diseases in Pregnancy NHS Highland, 2021.
The Highland policy is available on the intranet.

If a woman is receiving Medication Assisted Treatment (MAT) this should be continued during labour and standard analgesia should also be administered. Their daily dose will not provide adequate pain relief due to saturation of opioid receptors.

Women should be reassured that they will be given adequate pain relief during labour and the options available should have been discussed antenatally. It should be remembered that some opiate users might require larger amounts of pain relief. Epidural anaesthesia should be considered.

Drug use is not a contraindication to the use of a patient-controlled analgesia (PCA) pump following caesarean section.

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 Tremors Sweating Abdominal pain Cramps Anxiety Vomiting	Bradycardia Tachycardia Increased fetal movements Meconium-stained liquor

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.

5.10 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 women with drug dependence should be encouraged to stay in hospital for a minimum of 5 days so that any signs and symptoms of Neonatal Abstinence Syndrome (NAS) can be detected. Withdrawal symptoms from methadone are often not seen until then or later. The use of the 'Eat, Sleep & Console' assessment for NAS should have been fully explained to the mother in the antenatal period and she should be involved in the process.

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

The multiagency team should be informed that the woman has given birth and details of her and her baby's health. If a mother insists on early discharge, she should discuss this with the paediatrician as she may be taking her baby home against medical advice. In this situation advice should be sought from the local child protection advisor (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 7).**

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

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

5.11 Infant feeding

The benefits of breastfeeding should be discussed with all women antenatally and breastfeeding should be encouraged. There is some evidence that drinking more than 2 units of alcohol a day whilst breast feeding may affect baby's development. An occasional drink is unlikely to harm a breast-fed baby. (Gibson and Porter 2018).

Breast feeding mums should have no more than 1 or 2 units of alcohol once or twice a week. Alcohol passes freely into the breast milk and peak levels appear 30 – 90 minutes following intake. (Haastrup *et al.* 2014)

If drug use is stable and the woman is receiving Medication Assisted Treatment (MAT) such as methadone or buprenorphine, 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. MAT's have been found in low levels in breastmilk. They have been shown to have poor oral bioavailability which means that the drug is not effectively absorbed into the blood stream in infants, which makes them suitable for breast feeding

(Anderson 2023). If a mother is receiving MAT and breastfeeding, then weaning from exclusive breastfeeding should be gradual to reduce withdrawal symptoms in the neonate.

Breastfeeding can bring comfort to the mother at a time when she may experience significant guilt regarding her drug use and potential withdrawal symptoms for the baby.

Skin to skin contact will help regulate the baby's temperature, heart rate and breathing, and will also reassure and comfort both mother and baby.

Breastfeeding should be commenced as soon as possible following delivery as recommended in the Infant Feeding Policy- Maternity (NHS Highland 2019).

The exceptions to promotion of breastfeeding are:

- If a woman is HIV positive, due to the high risk of transmission. Recent interim guidance from British HIV association (2022) states that formula feeding should be encouraged for all HIV positive women in the UK. Within NHS Highland, any HIV positive woman will receive free formula milk and associated equipment to safely formula feed their baby for the first year of life and this is funded through partnership with Waverley Care Highland
- If using large quantities of stimulant drugs such as cocaine, 'crack' or amphetamines, because of vasoconstriction effects of drugs on the baby.
- If drinking heavily or taking large amounts of non-prescribed benzodiazepines, because of sedative effects.

The advice regarding drugs in pregnancy and breastfeeding includes:

- Amphetamines – should be avoided recreationally when breastfeeding as there is a lack of clinical data surrounding the effects. Mothers should be advised to express and dump breastmilk following use for at least 24 hours
- Cocaine – is slowly metabolised and excreted over a long period. 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 72 hours post drug use. Breastfeeding and cocaine use factsheet
- Ecstasy – avoid during breastfeeding. If the mother does use she should pump and discard her milk for a minimum of 24 – 48 hours post drug use
- Cannabis – regular use should be discouraged **Cannabis Use During Pregnancy**
- Diamorphine – avoid during breastfeeding. Encourage enrolment with OST
- 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.
- Buprenorphine – generally safe to take while breastfeeding. One study has reported slow weight gain in neonates and reduction of milk supply in women.

(Jones *et al.* 2013)

IV drug use whilst breastfeeding should be discouraged because of the risks of BBV transmission to the baby.

Women who are HBV positive can breastfeed once the baby has been given their first dose of Hepatitis B vaccine and immunoglobulin (HBIG) if required. These should be administered as soon as possible after birth and no longer than 24 hours later.

Blood Transfusion Service (BTS) Highland recommends HBIG is given where applicable within 4 hours and all staff should refer to the Highland Policy for further clarity *(Screening for Communicable Diseases in Pregnancy for NHS Highland)*.

There is no evidence that the HCV is transmitted by breastfeeding and this should be conveyed to the mother.

To open discussion about infant feeding, there should be antenatal conversations with all women during pregnancy.

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.

Further advice about bottle or mixed feeding is detailed within the NHS Highland publications, *postnatal breastfeeding booklet,* and *postnatal formula Booklet* both detailed in the *Highland Information Trail* and available from HIRS.

5.12 Discharge planning meeting

A discharge planning meeting should be viewed as a supportive measure with the aim of discussing arrangements in place for going home, making practical arrangements for appointments, and establishing where the mother and baby will be staying.

The meeting should clarify for the mother and all professionals involved, including Drug and Alcohol Recovery Nurse. If there are any on-going concerns, &/or new concerns identified and any further support that maybe required, this can return to child protection planning via Quality Assurance Reviewing Officer.

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 considered.

Planned support that continues into the postnatal period is crucial as this can be a stressful time for parents.

For mothers who have been supported to reduce their drug and alcohol use during pregnancy the risk of relapse to former levels of use is high. Relapse prevention work, careful recovery 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.

5.13 Contraception

Many women who use drugs and alcohol do not see contraception as a priority as they often underestimate their fertility.

Women should be offered a form of contraception which best meets their needs. Discussion about reproductive health and contraception should take place throughout pregnancy to allow informed decision making prior to postnatal discharge.

Provision of long-acting reversible contraception (LARC) such as progesterone implants and intrauterine devices contraception should ideally occur prior to discharge.

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

Discussion should include:

- Woman's own health/contraindications
- Availability – how to access services
- Compliance- using contraception as directed
- Risk of sexually transmitted infections (STIs)
- Importance of contraceptive cover

Those involved in on-going care such as the GP and HV should be advised of discussions or choices made around contraception in order that it can be raised with the women to encourage uptake.

5.14 Prior to discharge

For women who are receiving MAT their keyworker (drug and alcohol recovery nurse) should be contacted and medical staff should advise whoever is supporting her within the community.

Medical staff will need to inform the keyworker of any changes to medication.
Liaison should be done on a weekday and discharge should not be planned for the weekend.

If the keyworker (Drug and Alcohol Recovery Nurse) 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.

5.15 Continuing postnatal care

All staff should understand that the care of a pregnant woman who uses 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 childcare risk assessment. This must include the baby or child being seen and examined regularly and the home environment being assessed as safe.

Continuing support following discharge will be delivered primarily by the community midwife who will be the main provider of care and advice in the early postnatal period along with other agencies involved with the family.

The postnatal visits may continue for an extended period following birth in order to meet the woman's needs. This will be in addition to the care provided by the HV who will undertake her primary post-birth visit between day 11 and day 14.

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

Children of parents who use drugs and alcohol will need additional and frequent assessment and support. They must **not** follow a core pathway. The HV and GP will provide continuing support to

the family to ensure that the correct level of care is provided. The importance of attending baby clinics for immunisation and developmental monitoring must be emphasised to parents and any missed appointments must be followed up promptly. Any risks or concerns must be acted on, and babies and children must be seen and assessed, and the Named Person and/or Lead Professional (if allocated) must be informed.

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

Appendix 1

Talking to women about smoking in pregnancy

This scripted conversation supports a brief, evidence-informed conversation with pregnant women who blow a high CO reading.

NHS Highland

1 explain

Explain what carbon monoxide (CO) is and why you are testing her CO reading.

'Carbon monoxide is a poisonous gas that's very harmful to your baby. It is present in exhaust fumes, faulty gas appliances and cigarette smoke. It passes via your bloodstream to your baby and deprives your baby of oxygen and nutrients. It also slows the baby's growth and development.

Fortunately, CO levels return to normal very quickly once someone stops smoking.'

2 find out

If the CO reading is 4ppm or higher, find out if she or anyone in her family/home smokes.

'A reading above 4ppm can be harmful to your baby. Do you or does anyone else in your family/home smoke?'

3 investigate

If she says that she has stopped smoking or does not smoke but the CO reading is 4ppm or higher, there are other possible reasons for this.

'As you don't smoke (any more), there are other possible reasons for this high reading:

You might be exposed to CO fumes from a faulty gas boiler, cooker, car exhaust or paint stripper. I recommend that you check these things. Call the Gas Safety Advice Line free on 0800 300 363.

If you are lactose intolerant, you can produce gases in your breath if dairy products are consumed.'

4 inform

If she smokes, give her a copy of the booklet **I-Quit: Stopping smoking when you're pregnant** and open it at pages 4/5. Tell her about how smoking harms her baby. Evidence indicates this is much more powerful than just handing over the unopened booklet. Make sure you give her a booklet to take home. I-Quit should only be given to women who smoke during pregnancy.

'Carbon monoxide passes through your bloodstream to your baby and deprives your baby of oxygen and nutrients. It also slows the baby's growth and development. It increases your risk of miscarrying and stillbirth. It is important that you stop smoking, not just cut down.

Take this booklet home with you so you can read it again or show it to your partner/family.'

QUIT YOUR WAY with our support

Talking to women about smoking in pregnancy

This scripted conversation supports a brief, evidence-informed conversation with pregnant women who blow a high CO reading.

5 explain

Explain to her that free support is available to help her stop smoking.

'It is normal practice for me to refer all pregnant women who smoke for stop smoking support. I'll ask a trained local stop smoking adviser to call you in the next few days to talk to you about smoking. The service is free and many pregnant women have found the service very useful.'

6 discuss

If you have time, open and discuss pages 2/3 and 20/21 of the **I-Quit booklet**.

'Pages 2/3 show how smoking harms your body.

Pages 20/21 show the impact of second-hand smoke.'

7 suggest

If she does not feel able to stop smoking or is reluctant to receive help, suggest she talks with the smoking cessation adviser. Research shows that support from partners, family and friends is important in determining whether a pregnant woman will be successful in her attempt to stop smoking.

'Why don't you talk this through with the adviser when she calls you?

She can also offer support to your partner or any other member of your family who would like to quit too.'

8 inform

If she has given up smoking in the last 3 months, give her the booklet **I-Quit: Stopping smoking when you're pregnant**. Ask if she would like any extra support to stay stopped.

'Here is a copy of the I-Quit booklet, in case you want any additional support to stay smoke-free.'

9 encourage

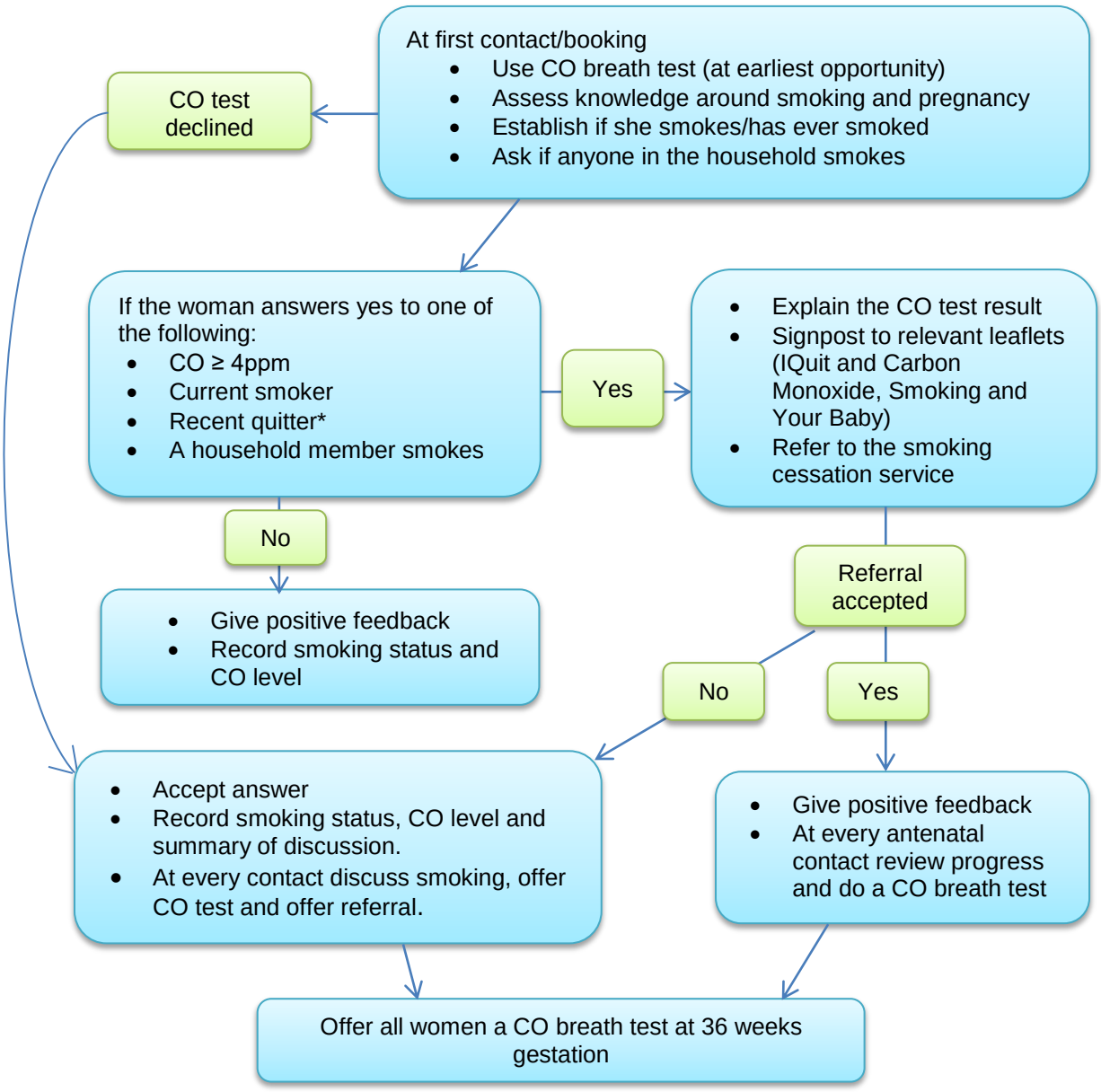
Finish the conversation with a positive, encouraging message.

'I'll look forward to hearing how you got on...'

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

NHS Highland Smoking Cessation

Maternity Referral Pathway



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

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

Appendix 3

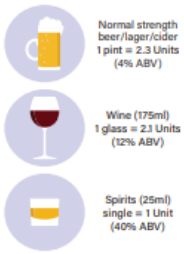
Talking to women about drinking during pregnancy

Recent research into discussing alcohol use with pregnant women suggests a conversational approach leads to more honest disclosure about drinking[1]. This includes building trust using flexible questions, and a positive tone as against a fixed questionnaire type interaction. In addition, asking questions about "parenting capacity" at the same time appears to decrease disclosure of alcohol use.

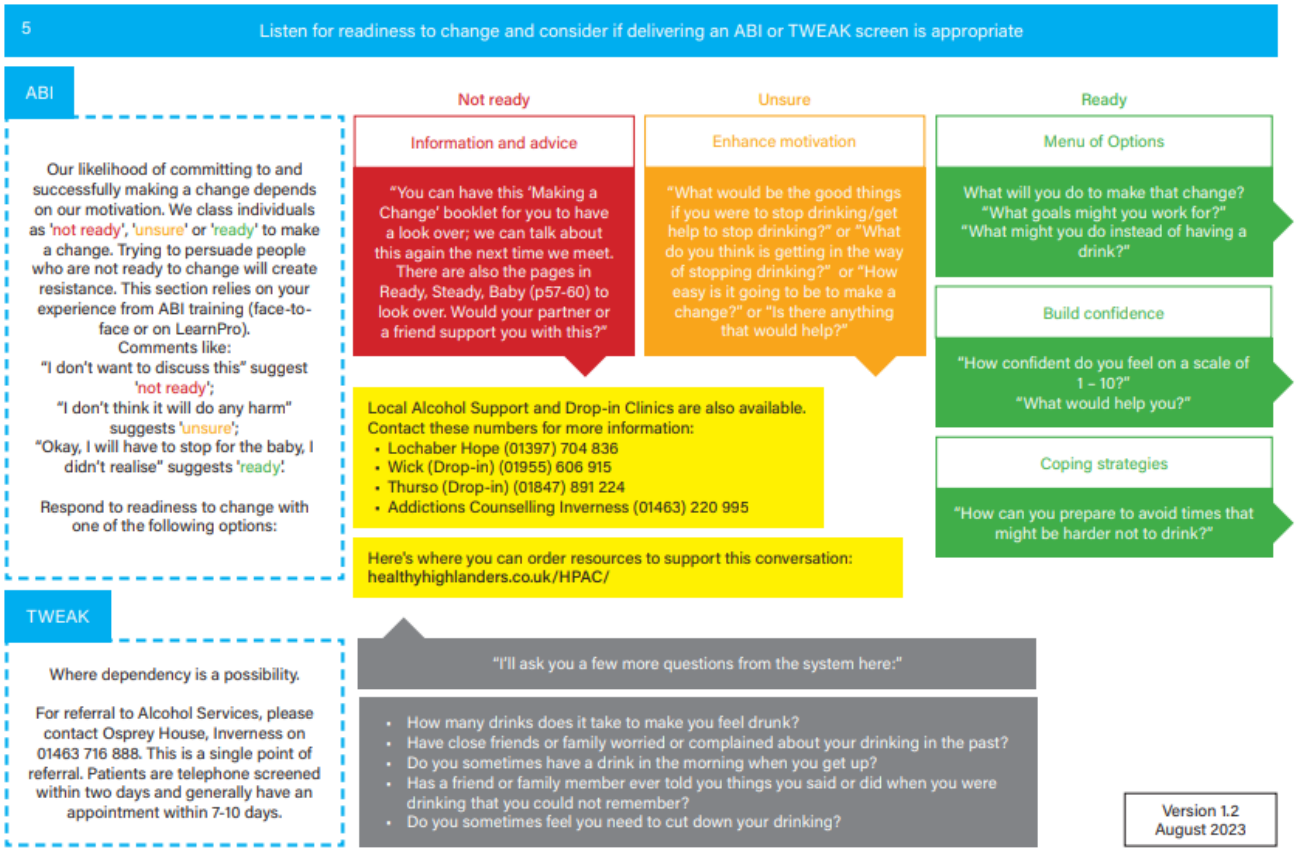
NHS Highland

1 Explain	2 Calculate pre-pregnancy drinking	3 Calculate pregnancy drinking	4 Feedback on drinking levels †congratulate if not drinking and motivate to continue with this or ^discuss risks if still drinking		
Explain that we talk about alcohol with every mum, thinking about when and where they drank before and during pregnancy.	Convert the average weekly number/type of drinks drunk pre-pregnancy to alcohol units using unit calculator.	Convert the average weekly number/type of drinks drunk since pregnancy to alcohol units using unit calculator.	† Mum is not drinking. Congratulate her on this. Check she understands the risks from drinking alcohol in pregnancy to sustain motivation for abstinence.	^ Mum is still drinking. Assess her knowledge of the risks of drinking alcohol in pregnancy, correct any mis-information, and draw attention to pages 57-60 of Ready, Steady, Baby. Deliver an ABI if drinking during pregnancy – see step 5.	^ Consider TWEAK screening if dependency is suspected, e.g. daily drinking, drinking first thing, others complaining about mum's drinking - see step 5.
"At this point we speak to everyone about alcohol. Is it okay to discuss this?"*	"First of all, can you tell me when you would drink before you were pregnant? Where would you tend to have a drink? How much would you have? We use this calculator to convert drinks into units. That lets us compare different drinks, which all contain different amounts of alcohol. That comes to x units. I'll record that on your notes (Badgernet)	"When did you last have a drink? Is where you drink the same as before? How about how much you drink now? I'll record these units too."	"That's really good you are not drinking. This is the safest option for your baby. If we look at these pages (57-60) in Ready, Steady, Baby it says 'drinking alcohol makes a miscarriage more likely. It also puts your baby's health at risk. Your baby is more likely to be born early or underweight. By remaining alcohol free in pregnancy you're reducing these risks.' That's all the alcohol questions."	"What do you know about the risks of drinking alcohol in pregnancy? If we look at these pages (57-60) in Ready, Steady, Baby it says 'drinking alcohol makes a miscarriage more likely, and puts your baby's health at risk. Your baby is more likely to be born early or underweight. How do you feel about that? Would your partner/ friend make changes to support you to make this change for your baby together?'"	"From what you have described I'd like to look at this more closely to make sure we do the best for you and your baby throughout and after your pregnancy. I'd like to ask you a few more questions, is that okay? How do you feel about getting more support to change?"

Units Guide



*Exit strategy - you or the mum can choose not to continue a discussion about alcohol at any point, e.g. "it's okay if you don't want to discuss this now. I'll leave this leaflet (Making a Change) with you."



1 Scholin L, Fitzgerald N. The conversation matters: a qualitative study exploring the implementation of alcohol screening and brief interventions in antenatal care in Scotland. BMC Pregnancy and Childbirth. 2019; (19): 316 - 326

Appendix 4 Drugs: Withdrawal, risks in pregnancy and withdrawal symptoms in newborn

OPIATES	For example: heroin, methadone, buprenorphine	
Withdrawal	**Risks in Pregnancy**	**Withdrawal Symptoms in Newborn**
• Sweating • Stomach Cramps • Muscular Pain • Runny Nose • Diarrhoea	There is growing evidence that opiate use in pregnancy is associated with visual disorders in the infant: rates of strabismus and nystagmus in infants born to mothers who use opiates (prescribed 7 non-prescribed) are significantly greater than in matched controls. 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 this 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

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, people who use these drugs often resort to taking sedative drugs (e.g., benzodiazepines or sleeping tablets) and/or alcohol to manage symptoms.	
Withdrawal	**Risks in Pregnancy**	**Withdrawal Symptoms in Newborn**
• Hunger, • Fatigue, • Periods Of Fitful Sleep • Increase In Dreaming • 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.

BENZO-DIAZEPINES	For example: diazepam, temazepam, nitrazepam	
Withdrawal	**Risks in Pregnancy**	**Withdrawal Symptoms in Newborn**
• Panic Attacks, • Distortion Of Perceptions, Feelings of Unreality, • Sweating, • Restlessness, • 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 benzodiazepines can initially be quite flat and sleep excessively. Withdrawal symptoms that may develop; include tremor, irritability, hyperactivity, 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.

CANNABIS

Cannabis is frequently used together with tobacco **(SEE SECTION 1- SMOKING).** 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 PSYCHOACTIVE SUBSTANCES

New psychoactive substances (NPS) are drugs which were designed to replicate the effects of illegal substances like cannabis, cocaine and ecstasy.

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

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

Hallucinogenic drugs – these drugs mimic substances like LSD

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

Effects

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

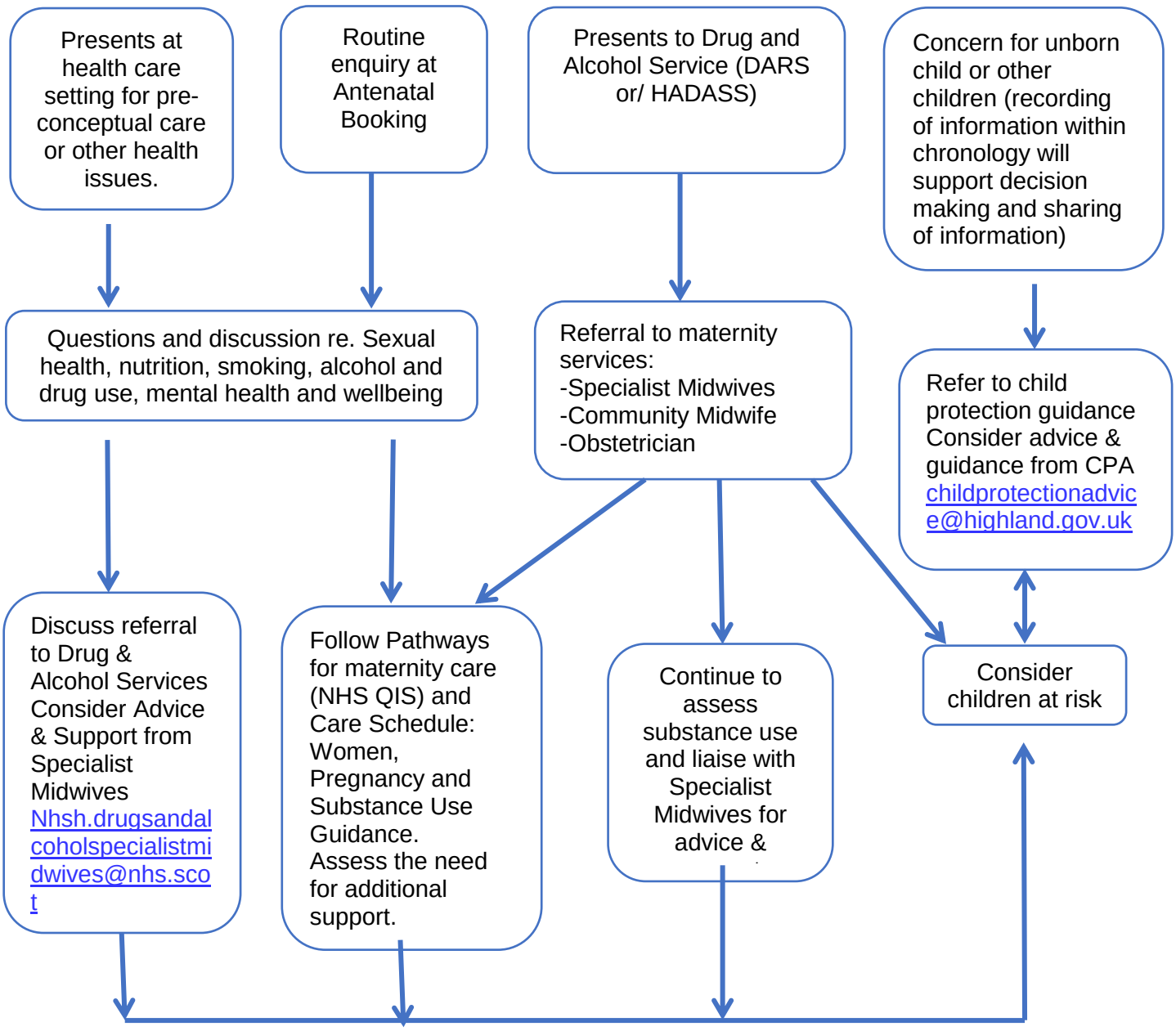
The Scottish Drugs Forum carried out a survey of drug services in 2013 which summarised

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

'Getting Our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse' 2013.

Appendix 5

Referral pathway when working with pregnant women who use substances.



Appendix 6 Care schedule: Substance use in pregnancy.

Pre-pregnancy	• Discuss general health and wellbeing, mental health and relationships, substance use (smoking, alcohol, and drugs). Give advice on healthy diet, dispense folic acid supplementation. Ensure women have details of how to contact their local community midwife. • If appropriate, offer referral to specialist services (e.g. Smoking cessation, drug and alcohol recovery services). • Offer blood borne virus testing.
First point of contact	• Using a trauma informed approach, aim for continuity of carer and promote attendance and engagement with maternity services. • Enquire about access to smart phone/device to access Badgernet.
8 -12 weeks	• Commence maternal history taking using Badgernet. • 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 • Maternal emotional health and wellbeing explored. • Undertake enquiry about smoking, alcohol and drug use • Explore partner's current drug and alcohol use. • If woman or her partner has recent history or current issues with substance use, determine involvement with drug and alcohol recovery services. • **RED PATHWAY- Consultant-led care** • **Referral to anaesthetist** • The increased risk of IUGR necessitates referral for serial growth scans from 30 weeks gestation as per the Perinatal Institute GROW criteria. (NHS Highland 2022). • Undertake assessment of mother's needs to support herself and her unborn baby, ensuring this is detailed in her records.
15 -16 weeks	• Named midwife to complete wellbeing assessment and an **Additional** HPI allocation. • Discuss the need for information sharing with the woman and seek formal agreement for multiagency working and liaison. • Consider Advice & Support session with Specialist Midwives Nhsh.drugsandalcoholspecialistmidwives@nhs.scot • Consider organising an antenatal planning meeting • Complete an Antenatal Plan: additional support for mother and unborn baby to determine strengths and pressures, and the impact of substance use on the women and her baby. Commence a single agency chronology, if appropriate. • Consider any 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). • Have early discussion with HV and promote joint visit at 32-34

	weeks. • Share information about alcohol or drug use between GP, HV, CPA and obstetrician. • If alcohol or drug use is disclosed, then care must be supported by the obstetrician working closely with drug and alcohol recovery services. • Discuss and agree care plan with woman. • Discuss and agree on-going management of substance use with woman
22 - 25 weeks	• On-going assessment of substance use and additional support needs. • If not already attended, consider **Advice and Support Sessions** with Specialist Midwives https://outlook.office365.com/owa/calendar/nhshdrugsandalcoholspecialistmidwivesCopy@scottish.onmicrosoft.com/bookings/ Or email Nhsh.drugsandalcoholspecialistmidwives@nhs.scot • Update Antenatal Plan • Antenatal planning meeting should be held before 24 weeks • Support engagement with Drug and Alcohol Recovery Services as required. • Discuss with woman and partner ○ Neonatal Abstinence Syndrome (NAS) Eat, Sleep & Console (**Appendix 7)** ○ Infant feeding- AN conversation tool ○ Mum & baby need to stay in hospital for 5 days to observe baby for potential NAS ○ Give SCBU Parental Information Leaflet on NAS (Neonatal guidelines NHSH intranet) • Promote long-acting methods (LAC) provide leaflet as per Highland Info trail.
28 weeks	• If not already attended, consider **Advice and Support Sessions** with Specialist Midwives https://outlook.office365.com/owa/calendar/nhshdrugsandalcoholspecialistmidwivesCopy@scottish.onmicrosoft.com/bookings/ Or email Nhsh.drugsandalcoholspecialistmidwives@nhs.scot • On-going assessment of substance use and continued support to engage with Drug and Alcohol Recovery Services • Pre-birth planning meeting to re-assess social circumstances/risk - update Antenatal Plan (Child's Plan/Child Protection Child's Plan-Social work) This includes all partners to the Plan and should also include the HV who will provide on-going care and assessment. • Named Midwife to undertake additional appointments as required which **must** include home assessment (consider lone working policy). • Preparation for parenthood, labour and delivery and A/N conversation tool. ○ Highland PEEP- 01463 229423

	○ Action for Children- Parents under pressure programme ○ Highland Breastfeeding Chat- via Infant Feeding Support Worker • Give details of relevant 3rd sector support agencies. See HADP directory of services
31- 32 weeks	• Discuss birth plan ○ Labour, birth, infant feeding ○ 5-day hospital stay ○ Contraception methods ○ Safe Sleep Scotland • Discuss Neonatal Abstinence Syndrome (**Appendix 7)** • Offer visit to SCBU
34 - 36 weeks	• Assessment of substance use and continued support to engage with Drug and Alcohol Recovery Services. • Joint antenatal home visit with HV
38 - 40 weeks	• Update Antenatal Plan to include any discharge planning • Close liaison with HV as per handover protocol.
Labour	• Support birth in a Consultant Led Unit with paediatric facilities for women who actively use substances, including opioid substitution therapy. • Epidural/spinal analgesia recommended • For women using opioid substitute therapy, prescribing should be continued, and additional analgesia as required • Inform Named Midwife and Lead Professional on admission and delivery. • **DO NOT GIVE NALOXONE TO BABY** as it will induce an abrupt opiate withdrawal crisis and use supportive measures or ventilation.
Delivery	• Hepatitis B vaccine for baby if mother or household member Hep B positive. • Neonatal Abstinence Syndrome (NAS) assessment and care ensuring mother is aware of the signs and need for 5-day P/N observation in hospital. See Full guidance available from SCBU • Offer support regarding infant feeding including Infant Feeding Support Worker and peers. • Accurate documentation and record keeping are essential. • Monitor substance use. Organise discharge prescription and follow up from specialist services (relapse prevention support). • Administer contraception prior to discharge if possible (LAC). • Discharge arrangements from hospital should be completed as per Child's Plan including Core Group meeting prior to discharge. Copies of discharge arrangements to CMW/GP/HV and others involved in the plan.

Postnatal	• 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 HV handover protocol is followed. Communication and handover of health and social information between midwife and HV/FNP protocol • Close assessment and support by the HV and GP must continue. • Follow up Hepatitis B immunisation for baby at 1 month old as per pre-exposure immunisation protocol. • Give details of Family Solutions/Family Group Conferencing and other support. • Offer referral to specialist breastfeeding services if required.

Appendix 7 Caring for a Baby with Drug Withdrawal Symptoms – Information for Parents

This leaflet provides you with information and advice that will help you prepare for the arrival of your baby. Hopefully after reading this you will:

- feel well-informed about baby withdrawals
- understand what your baby might need
- feel confident about how to take care of your baby.

Drugs and the newborn baby

Most drugs (including tobacco and alcohol) that you take when you are pregnant pass through the placenta and are absorbed by your baby.

If a mother is *dependent* or 'addicted' to certain drugs including prescription medication, the baby will have been exposed to these drugs during pregnancy and may develop *withdrawal symptoms* after birth. The medical name for baby withdrawal symptoms is **'Neonatal Abstinence Syndrome'**.

Unfortunately, there is no way of telling exactly how a baby will react as there are many different factors that affect withdrawal symptoms in babies. This is why we like to prepare all parents just in case. What we can say is that drug withdrawal in babies is now fairly common, so you are not alone.

Baby withdrawal symptoms occur quite often with:

- Opiate drugs (e.g. methadone, heroin, dihydrocodeine, buprenorphine)
- Benzodiazepine drugs (e.g. diazepam and temazepam), and
- Heavy alcohol use.

If your baby does develop withdrawal symptoms, these are usually easily managed and the baby will recover in time. Most infants affected by withdrawal symptoms achieve normal growth and development by around 6 months of age.

Midwives and other maternity staff as well as health visitors and GPs have experience in looking after babies and can offer good advice and help to parents.

How babies are affected

Baby withdrawal symptoms are similar to how adults feel when they suddenly stop drinking or stop taking drugs (go 'cold turkey'). However, there are important differences between the way adults are affected and the way babies are affected.

Withdrawal symptoms in babies vary a lot. You might expect to see some or all of the following symptoms:

- high-pitched crying
- excessive (long-lasting) crying
- irritability (easily disturbed or upset)
- sleeping difficulties (the baby cannot settle or sleep after a feed)
- feeding difficulties (the baby is often keen to feed but cannot suck or swallow properly)
- vomiting (unable to keep milk down)
- diarrhoea (frequent loose stools or runny poos)
- a sore red bottom (due to frequent dirty nappies)

- poor weight gain or weight loss
- restlessness (unable to lie still for any length of time)
- tremor (shakiness) and jitteriness
- skin abrasions (sores from moving around a lot)
- stuffy nose and sneezing
- rapid breathing
- fever (a high temperature).

Occasionally, babies have convulsions (fits) but this is very rare.

Most babies who have been exposed to drugs before birth will have some symptoms after birth. Some babies have only *mild* withdrawal symptoms and require no more than the usual care that all babies need. Other babies have more *severe* symptoms where they might not be able to feed or sleep properly and they lose weight rather than gain weight. These babies usually need special care in the neonatal unit and may need calming drugs to help them recover. Some babies can be irritable for weeks or months, but symptoms gradually improve with time.

It is important to remember that babies with withdrawal symptoms can have difficulty responding in the normal way to their carers, because of the way the withdrawal symptoms affect the baby's functioning. Certain forms of parent-infant contact and supportive comfort measures have been shown to help babies who have withdrawal symptoms. If your baby develops withdrawal symptoms, you will be given more advice on these. We suggest that you follow this advice so you can care for your baby confidently.

Assessing babies to see if they have withdrawal

Withdrawal symptoms in babies can begin within a few hours of birth, or as late as 10 days after, but most babies who develop withdrawal show signs within 24-72 hours after birth. Mothers who are dependent on drugs and/or alcohol are therefore asked to stay in hospital (in the postnatal ward) with their baby for at least 5 days.

In the postnatal ward, mothers are expected to care for their baby at all times and are encouraged to bond with their baby and breastfeed. We discourage breast feeding if mums are HIV positive. Mothers and babies are not separated unless this is absolutely necessary – for example, if the baby is really unwell, or is not settling in between feeds. Withdrawal symptoms in babies can be similar to other conditions and medical problems so it is important that a proper assessment is made by the healthcare professionals. If well, babies can be discharged after 5 days (even if they develop symptoms). They can be cared for by their parents, with the help and support of the midwife, health visitor and GP. Most babies need some special care and attention for a while afterwards, and the midwife, health visitor and GP will want to check on how well the baby is feeding, sleeping, putting on weight and responding to you and their environment.

Babies admitted to the neonatal unit

If a baby develops *severe* withdrawal symptoms they might be admitted to the 'neonatal unit' or 'special care baby unit'. Here they can get 'tube' feeds and calming medicine if necessary. Treatment and care aims to reduce the baby's distress and discomfort and to get the baby feeding and sleeping as normally as possible. Each baby's length of stay on the unit will vary.

Tips on caring for your baby

If your baby does develop withdrawal symptoms, we know from experience and thorough research, that there are certain things that tend to help the baby recover.

Crying and irritability

- Make sure your baby is kept in a quiet room and has calm surroundings – no bright lights or loud sounds that might upset your baby and make them more irritable
- Handle your baby gently and as little as possible – this will reduce the level of stimulation and will keep your baby calmer
- Use a dummy or pacifier ('soothers')…if you choose to use one
- If your baby has a lot of 'skin-to-skin' contact, they will cry less
- Try giving your baby a very gentle massage
- Humming, singing softly or gently rocking your baby may help

Feeding problems

- Feed your baby in a quiet place with minimal disruption
- Feed your baby on demand – frequent small feeds are normally better
- Allow time for resting in between sucking
- Burp your baby very gently when they stop sucking and after the feed
- Gently support your baby's cheeks and lower jaw to help improve their efforts to suck and swallow
- If your baby has a lot of 'skin-to-skin' contact, the baby will feed better
- Try giving your baby a very gentle tummy massage
- Keep a record of all the feeds your baby takes so that the midwife or health visitor can check whether your baby is feeding well enough, getting enough calories, and putting on enough weight

Sleeping problems

- Let your baby sleep in a quiet room, with minimal disturbance. Keep the room dim (no bright lights) and try not to pat or touch your baby too much
- Make sure your baby has a clean dry nappy – check for nappy rash and apply nappy rash cream or zinc cream if needed
- Make sure your baby has clean bedding and clothes which are free from vomit. The smell of vomit may make your baby sick again and vomit may irritate their delicate skin
- Soft, gentle music, humming or gently rocking your baby may help
- Avoid getting your baby too hot
- Never smoke in the house

Skin problems

- Regularly check and change your baby's nappy
- Change your baby's clothes frequently, especially if they sweat a lot
- Keep any areas of damaged skin clean – avoid baby lotions as your baby may suck them

Breathing problems

- Make sure no one smokes in your house, ensure there is clean air and the room is warm
- Feed your baby slowly, allowing rest periods in-between sucking
- Avoid overdressing or wrapping your baby too tightly
- Avoid putting the baby on their tummy to sleep
- Keep a close eye on your baby. If breathing difficulties continue or worsen, contact your GP, midwife or health visitor, or call 999

Other problems

If your baby has severe vomiting or diarrhoea and becomes dehydrated, contact your midwife, health visitor, GP or hospital for advice immediately.

If your baby has a convulsion (fit), dial 999 and ask for an ambulance to take your baby to hospital.

Ophthalmology

Your baby may require eye screening at 6 months of age whether or not baby develops neonatal abstinence. A referral will be arranged before you leave the hospital if it is required.

Getting support

It is very important that you get all the help and support you need. Show this leaflet to any other person (family or friends) who will be supporting you to look after your baby. There are a lot of myths about baby withdrawal symptoms and a lot of emotions surrounding mothers who use alcohol or drugs. Many parents say that they feel guilty and 'to blame' for their baby's condition and find baby withdrawal symptoms a difficult subject to talk about. This is why we like to mention it early on in the pregnancy. This way you can get some reliable information and not feel anxious about your baby.

We know that babies with withdrawal symptoms can be very difficult to look after and they can require a lot of patience and time. Experience has shown us that there are many things that you can do to calm and comfort your baby and to help improve their condition.

Acknowledgement to Isabel Seaton as author of original leaflet.

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 1st	01381 620757
Citizens Advice Bureau: Inverness Nairn Ross & Cromarty East Sutherland (Golspie) Nth West Sutherland (Kinlochbervie) Caithness (Thurso) Lochaber Skye & Lochalsh Argyll & Bute	01463 237664 01667 456677 01349 883333 01408 633000 01971 521730 01847 894243 01397 705311 01478 612032 01546 605550
Cocaine Anonymous	0800 6120225
Community Midwives: Inverness. Out with Inverness, contact GP surgery for details of local midwife.	01463 704342
Community Psychiatric Nurses for Addiction:, 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 (HADP) Directory of services Information Line Argyll & Bute	01463 704603 0844 848 3778 01546 604948
Dual diagnosis Service (Community), RNI, Inverness	01463 706958
Drug & Alcohol Recovery Services, Osprey House, Inverness. Contact for local details Argyll & Bute Community Addiction Teams	01463 716888 01546 605602
Drug Treatment & Testing Order Service (DTTO)	01463 644900
HADASS- Highland Alcohol and Drug Advice and Support Service	01463 716324
Harm Reduction Nurse, Argyll & Bute	01631 571294
Health Information & Resources, HIRS, Assynt House, Beechwood Park, Inverness	01463 704647
Highland counselling services: Inverness Encompass Counselling and support, Argyll & Bute	01463 220995 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 Recovery Services, Inverness	01463 716888
Police Scotland Non-emergency number – crime or other concerns Emergency	 101 999
Rape and Abuse Helpline, Dingwall (Lines open 7am-10pm)	080 8800 0123
Scottish Drug Misuse Database	0131 551 8221
SMART Recovery, Inverness	01463 729548
Smoke Free Highland . Ring for details of locality numbers.	0845 757 3077
SFAD (Scottish Families Affected by Alcohol & Drugs)	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
Scottish Women's Aid (National)	0131 475 2372
Smoking Cessation Midwife	01463 706370 07824417514
Women's Aid: Inverness Ross-shire Lochaber office	01463 220719 01349 863568 01397 705734

Caithness & Sutherland Argyll & Bute	08454 080 151 0870 241 3548
Youth Action Team: Inverness: Nairn, Badenoch & Strathspey North, West and Mid-Highland	01463 256603 01955 605792
Websites	
www.careinspectorate.com www.turningpointscotland.com www.knowthescore.info www.ukna.org www.sdf.org.uk www.ashscotland.org.uk https://www.nhsinform.scot/healthy-living/stopping-smoking https://nationalfasd.org.uk/ www.alcohol-focus-scotland.org.uk www.alcoholconcern.org.uk www.h-sat.co.uk www.gov.scot/policies/alcohol-and-drugs/ www.smokefreehighland.co.uk or https://www.smokefreehighland.scot.nhs.uk/ Highland Overdose Prevention & Engagement (HOPE) app Android: https://bit.ly/3tawMkA Apple: https://apple.co/39XfjEi	

Contributors

Name	Job title	Agency
Cat Clark	Smoking Cessation Midwife/Specialist Midwife- Drugs and Alcohol	NHS Highland
Dr Jandy Fernandes	Consultant Obstetrician	NHS Highland
Sarah Harwood	Clinical Nurse Manager, Osprey House, Drug and Alcohol Centre	NHS Highland
Hazel Inglis	Midwifery Development Officer/Specialist Midwife- Drugs and Alcohol	Highland Council/NHS Highland
Karen Mackay	Infant Feeding Advisor	NHS Highland
Lorna MacKenzie	Smoking Cessation Midwife	NHS Highland
Roderick Maclean	Speciality Doctor in Addiction Psychiatry	NHS Highland
Eve MacLeod	Senior Health Improvement Specialist	NHS Highland
Jo McMann	Advanced Neonatal Nurse Practitioner (ANNP)	NHS Highland
Claire MacPhee	Midwifery Development Officer	Highland Council
Jocelyn Reid	Lead Midwife Sonographer for scanning and screening	NHS Highland
Alan Richards	Advanced Neonatal Nurse Practitioner (ANNP)	NHS Highland
Debbie Stewart	Co-ordinator Highland Alcohol and Drug Partnership (HADP)	NHS Highland
Dr Leena Thomas	Consultant Obstetrician	NHS Highland
Karen Stockdale	Clinical Nurse Specialist	NHS Highland

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The Breastfeeding Network (2021) *Alcohol and Breastfeeding* [Online] Available from The Breastfeeding Network

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