

Women, Pregnancy & Substance Misuse



Good Practice Guidelines

June 2006

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Foreword

The foundations for health and wellbeing are established in the earliest moments of life (For Highland's Children 2). Pregnancy provides agencies in Highland involved with children, young people and families, with the opportunity to ensure that they are providing the best possible care to promote the wellbeing of women and their infants pre-conceptually, through pregnancy and into parenthood.

Research suggests that women who misuse substances have better outcomes, as do their infants, if they take up antenatal care early and if they use services consistently throughout pregnancy (Leach 1998; Scottish Executive 2003). There is growing evidence that there is a relatively narrow window of opportunity for intervention in a child's early years, beyond which the lack of adequate nurture is likely to have a long-term damaging effect, with children going on to live chaotic lives themselves. Research shows that 0-3 years is the maximum timescale in situations of no nurture, after which there is irreparable damage (Hidden Harm Next Steps; May 2006). Services therefore need to be accessible, welcoming and empowering for those women, just as they do for others (Advisory Council 2003). Most importantly, services need to identify and address the social, physical and emotional needs of the whole family, mindful of the risks and measures that may be required to support vulnerable women, their partners and children. The current Child Protection Reform Programme and reports such as Hidden Harm (Advisory Council on Misuse of Drugs, 2003) and Getting our Priorities Right (Scottish Executive, 2003), detail the importance of this and agencies responsibilities with regard to this important issue.

The pathway detailed in this guidance represents best practice for maternity staff across Highland. Hidden Harm Next Steps identifies best practice as

“...providing support and encouragement to parents who have sought help for their substance misuse during pregnancy so that they continue with their treatment after the birth of their child”.

Other agencies involved with pregnant women who misuse substances also have a critical role to play in supporting vulnerable women and will have an interest in this guidance. Related work on integrated assessment and information sharing across Highland will reinforce and further develop this agenda.

Summary

One of the main principles of antenatal care is that women should be the focus; they should be empowered to make decisions about their care and be provided with evidence based information and advice (Scottish Executive, 2001). This also applies to women who have problems with drug or alcohol misuse, who should have access to a full range of services within a multi-disciplinary assessment process. Good practice in maternity care can help ensure the necessary early links with families and ensure that agencies are in place so that we all work together to provide a coherent and responsive service.

Summary of guidelines:

- ◇ Pregnant women who misuse substances should be managed according to best practice as stated in 'Getting Our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse' Scottish Executive, 2003.
- ◇ Staff who are taking a booking history should always ask sensitively but routinely about all substance misuse, this includes the use of tobacco, alcohol and prescribed or illicit drugs.
- ◇ Women who are opioid users should be prescribed appropriate substitution therapy during pregnancy.
- ◇ Information on any social problems that could affect medical and social outcomes of pregnancy, including substance misuse, should be provided in all referral letters.
- ◇ Obstetricians, midwives and addiction services need to be aware of the laws and issues that relate to child protection. If they have any concerns they must contact their designated person for child protection or social services for advice.
- ◇ All staff supporting pregnant women who have drug or alcohol problems, including obstetricians, GPs, midwives, health visitors, social and addiction services, require ongoing training so that they have the knowledge and skills required to identify problems, assess severity and refer women to other appropriate, specialist services.
- ◇ Women with problem drug and/or alcohol use have potentially high-risk pregnancies and an obstetrician must manage their pregnancies. However, midwives can deliver most of their care.
- ◇ Pregnant women who have significant drug and/or alcohol use may also have other social problems and their care should reflect this. They should not be managed in isolation but by maternity services that are part of a wider multi-agency network, which should include both addiction and social services.
- ◇ The management of women who have substance misuse and mental health co-morbidity requires close supervision by specialist services during pregnancy.
- ◇ Close follow-up and multi-agency support in the postnatal period is essential for women and their babies, as relapse can be a problem at this time.
- ◇ Substance misuse may be associated with past or current experiences of violence or abuse and with psychiatric problems or psychological problems. All staff need to remain be aware of this.

1. Background

We live in a drug using society. Heroin, tobacco, prescription medicines, alcohol, cannabis and caffeine are all drugs. Almost all of us use drugs every day or every week, and in the majority of cases the substances we use are legal and the way in which we use them does not cause problems for others or ourselves. The term 'substance misuse' can be defined as: 'substance' encompassing all drugs both legal and illegal, and 'misuse' implying harm, and refers to the use of substances as part of problematic or harmful behaviour (Gorin 2004).

For some in society, substance misuse creates significant problems in functioning and in their ability to manage their day-to-day life, employment, parental and family responsibilities. The challenge for services and professionals is to be sensitive to the needs of women whilst being vigilant to the possibility that a woman may be using substances in a way that may cause harm - to herself, a developing baby or an infant/child. The answer lies in ensuring that services are provided in ways that do not undermine a woman's confidence to handle her situation or make her reluctant to disclose or come forward for help in the first place.

These guidelines for tobacco, alcohol and substance misuse have been developed to support professionals within the maternity and drug services in Highland to assist them in providing optimal care to this client group. They should be used alongside other documentation, policies and good practice guidelines already in place which support pregnant women. They are designed to clarify information about:

- ◇ the implications of substance misuse in pregnancy
- ◇ the kind of support available to women and their families
- ◇ the appropriate referral criteria and pathways

Thanks to all who have contributed through discussions and feedback on the draft guidelines, their names appear in Appendix 7.

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2. The Substances

2.1 Smoking

Stopping smoking is one of the most important things a woman can do to help her baby be born healthy and to take care of herself (Royal College of Midwives 2002). Most women are aware of the effects of smoking during pregnancy and this is often a time when they are motivated to stop. Support and advice should be given to them to consider how they might achieve this.

Information should be provided on specialist smoking cessation support services if they are available within the locality and women should be provided with information regarding telephone support:

- ◇ Smokeline 0800 848 484 offers telephone support 7 days a week from noon to midnight
- ◇ Highland Smoking Cessation Lo-call 0845 757 3077

Further support agencies can be found in Ready, Steady, Baby book (HEBS 2004) and 'Useful Contacts,' Appendix 1.

Nicotine Replacement Therapy (NRT) is now licensed for use in pregnancy and may be useful for women who are otherwise unable to stop. Any health risks to the baby from NRT use are likely to be small and far outweighed by the risks of smoking (Silagy, Lancaster, Stead et al, cited in Royal College of Midwives 2002).

The impact of smoking on public health is a national priority. However, our role is not to judge women but to provide them with information and offer support. There are a number of resources available from Health Information and Resources Department (HIRS), NHS Highland, including:

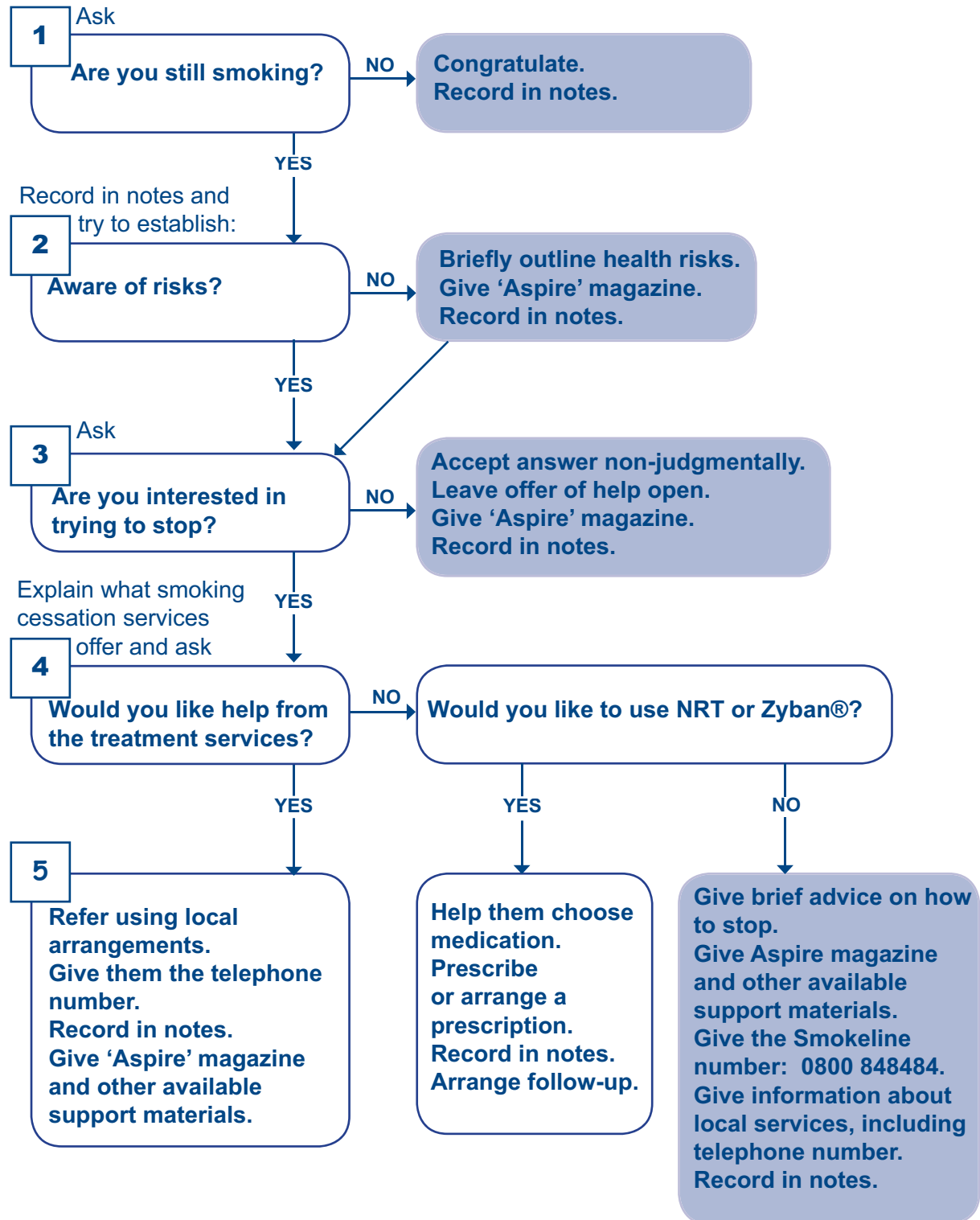
- ◇ There's no time like the pregnant - GASP
- ◇ Smoking and Pregnancy - NHS Health Scotland
- ◇ Aspire to stop Smoking - NHS Health Scotland

To further assist practitioners the following quick reference flow chart summarises the advice given in the Health Scotland/ASH leaflet 'Encouraging Smokers to Stop, What You Can Do: A guide for Health Professionals'.

2.1.2 Smoking Cessation Pathway for Health Professionals

Taken from: 'Encouraging Smokers to Stop – What You Can Do, A Guide for Health Professionals'

Health Scotland and ASH Scotland



2.2 Alcohol

“Alcohol and pregnancy do not mix. There is no evidence to show how much alcohol can safely be consumed during pregnancy.”
(Foetal Alcohol Syndrome Aware UK, 2003)

Scottish Executive advice recommends no more than 1 or 2 units, once or twice a week, but there is increasing evidence to suggest that there is no safe time to drink alcohol during pregnancy and abstinence should be recommended (Foetal Alcohol Syndrome Aware UK 2003). Alcohol can damage the foetus throughout pregnancy. During the first trimester there is risk of damage to physical structures, in the third trimester there is risk of impairment in growth and during the entire pregnancy there is risk of damage to the brain resulting in behavioural problems and cognitive deficits.

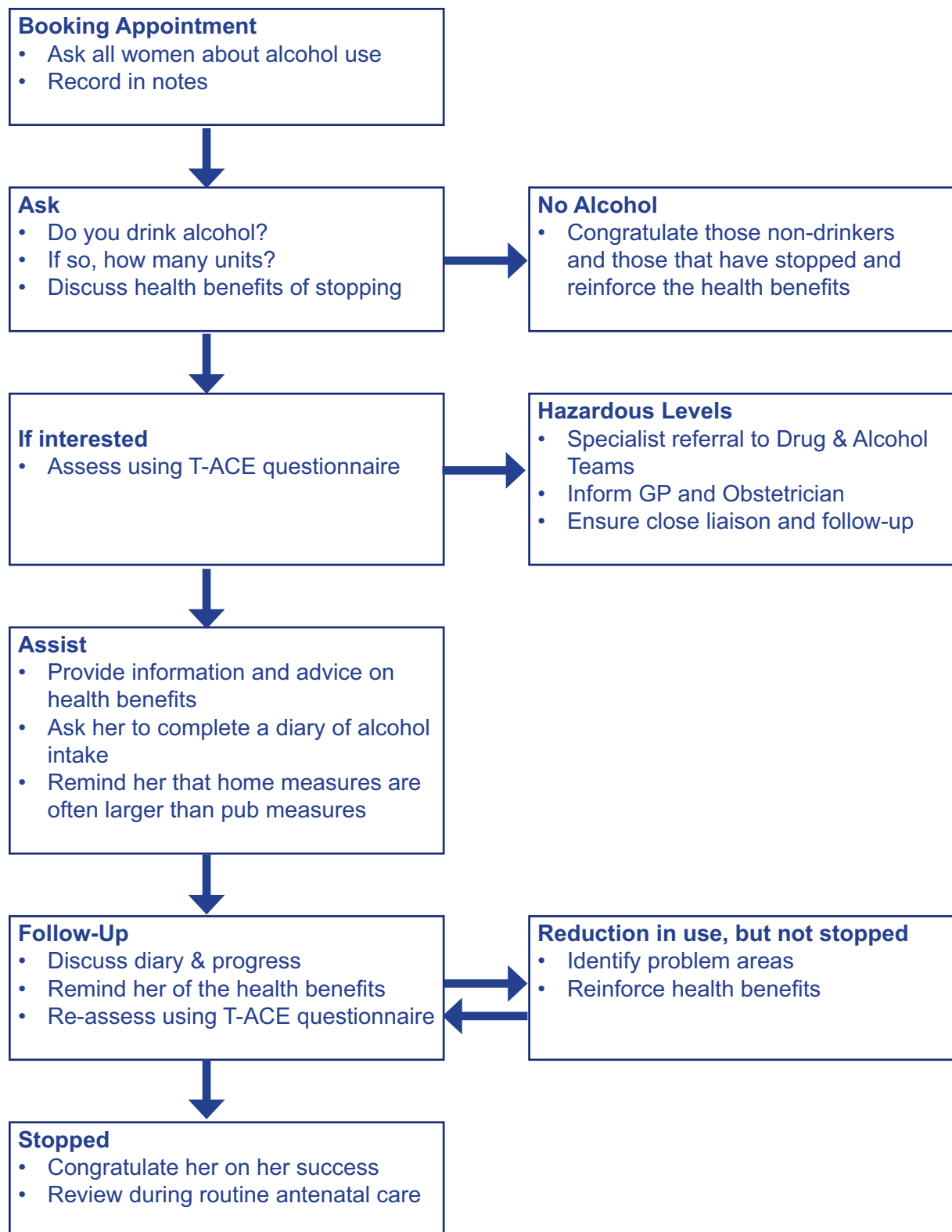
There are a number of quick assessment tools available to practitioners that will identify most women who may experience difficulties in stopping drinking. The use of the T-ACE Questionnaire should help practitioners with this assessment and the questions are listed.

2.2.1 Antenatal Screening Questionnaire

Alcohol use in pregnancy	
T-ACE	
T (tolerance) How many drinks does it take to make you feel high? Answer: '3 drinks or more' scores 2 points	
A (annoyance) Have people annoyed you by criticising your drinking? Answer: 'Yes' scores 1 point	
C (cut down) Have you ever felt you ought to cut down your drinking? Answer: 'Yes' scores 1 point	
E (eye-opener) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Answer: 'Yes' scores 1 point	
Total Score	<input type="text"/>
Date of test	<input type="text"/>
Lowest score possible = 0 Highest score possible =5	
A total score of two points or more will correctly identify most women whose drinking is hazardous, harmful or dependent.	

Motivational interviewing techniques should be considered to encourage women to discuss their alcohol use and using a diary to record drinking levels may encourage women to work towards change.

2.2.2 Alcohol Cessation Pathway



If the T-ACE questionnaire highlights a hazardous score then more detailed advice, information and support should be offered. Specialist referral is recommended for women with harmful alcohol dependence (SIGN guideline 2003) and Osprey House and locally based Community Psychiatric Nurses for Addictions (CPNAs) can offer further support and advice to women and other health workers.

If required, it should be remembered that detoxification for alcohol dependent women should normally be in an inpatient setting to ensure close monitoring of mother and baby (Plant 2001, cited in Whittaker 2003).

Drinkline 0800 917 8282 can be helpful in supporting women address their drinking, and referral to specialist agencies for support should be considered. Further support agencies can be found in Appendix 1 and in 'Ready, Steady, Baby' (Health Scotland 2004).

2.3 Drugs

There has been a huge increase in problem drug use both nationally and internationally since the 1980s and this increase has been disproportionately high among women of childbearing age (CEMACH 2004). Some pregnant women who misuse substances may be frightened of presenting to services for fear of being judged regarding their drug use, yet supporting them in maintaining contact with services is vital. They often book late and their associated lifestyle may mean that there are more urgent demands on their time (CEMACH 2004). A non-judgemental, empathic approach will enable them to feel supported in discussing their concerns regarding how their use of substances may impact on their own health and the health of their baby.

Problem drug use is often associated with socio-economic deprivation. Related problems may include a poor diet, smoking, alcohol misuse, mental health problems, domestic abuse or homelessness. It is essential that a co-ordinated, multi-agency network is in place for all women who require specialist advice or support in pregnancy and their care should reflect this.

Maternal history taking is crucial to good quality care and the booking appointment should provide the basis for planning and co-ordinating services (NHS Quality Improvement Scotland 2004). It is important to ask at booking about drug use, frequency and method of administration and also to establish if their partner is using drugs or alcohol. This assessment will better identify:

- ◇ If using intravenously, explore present injecting techniques and discuss safe practice with provision of information on needle exchanges. See Directory of Highland Drug and Alcohol Services in 'Useful Contacts', Appendix 1.
- ◇ If they have previously had help and what this involved.
- ◇ If they are presently receiving support, are they prescribed any medication and who is prescribing?
- ◇ Does their partner use drugs; is he presently supported with his drug use?
- ◇ Is an assessment of father's needs required ?
- ◇ Completion of SMR25 form, Appendix 2.
- ◇ Early liaison with all community services to maximise and clarify support.
- ◇ If appropriate, referral to social work at an early stage for assessment of needs and discussion of options for ongoing support.

Women should be encouraged to accept referral to specialist services which can provide a more in-depth assessment of substance use, drug screening to confirm present use, ongoing counselling and support with reducing or stabilising use through substitute prescribing programmes. Osprey House can provide this expert advice and guidance for professionals and can be contacted on 01463 716888. Alternatively, staff can contact the CPNAs who are based in localities along with other agencies that can offer advice and support with regard to substance misuse.

The model care pathway for substance misuse in pregnancy, adapted from the Lothian guidelines (Whittaker 2003), describes a woman's journey through pregnancy and should assist practitioners to plan care for this client group. It appears in section 4, 'The Woman's Journey'.

2.3.1 Methadone Use in Pregnancy

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

The rationale for commencing methadone:

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

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

Counselling sessions are offered as an integral part of methadone prescribing to provide time to explore past/present drug use and how to implement changes, deal with ongoing problems without resorting to using, and provide time to reinforce progress or discuss concerns. Routine drug screening is an integral part of prescribing and can be an indicator of safe compliance with medication.

3. The Challenges

3.1 The Extent of the Problem

The numbers of women of reproductive age who smoke, use alcohol or illicit drugs are growing and continued use in pregnancy is common. Approximately a third of pregnant women smoke and about 60% continue to consume alcohol (Taylor 2003, cited in Substance Misuse in Pregnancy, Whittaker 2003). The true extent of drug taking in women is unknown, as reliable figures are hard to obtain. Under-reporting means that available statistics are thought to grossly underestimate the extent of the problem (Whittaker 2003) and this is also the case in Highland (Drug Misuse Statistics Scotland 2004). It is important to review how we audit all the information collected so that more accurate data are available. This will ensure that existing services are better utilised and adequately resourced to ensure the best outcomes.

The SMR02, maternity inpatient and day case record, now includes data items for documenting alcohol consumption, and neo-natal special care discharge records, SMR11, are collected by the Information and Statistics Division (ISD). These will be replaced by the new Scottish Birth Record, which will collect more detailed information about maternal drug and alcohol use.

The completion of the form 'Monitoring of Drug Misuse in Scotland' SMR25 for every new problem drug user, can provide more realistic statistics for Highland (Appendix 2). A requirement of this pathway is that as in some other areas in Scotland, maternity and drug services will complete this form as standard practice, rather than drug services alone. This will provide more accurate data and numbers of pregnant women who use substances. This will support planning and, if necessary, identify the need for additional resources. Further information on this is available from the Scottish Drug Misuse Database, who also provide training.

3.2 Multi-agency Working and Information Sharing

Where a woman is known to be misusing substances, clear lines of communication, information sharing and multi-agency working must be in place during all stages of pregnancy and following birth as this facilitates a comprehensive assessment of needs and risks and a consistent approach to care. Within Highland, services involved with children and families are moving to a standardised approach to the assessment of risks and needs and, as it unfolds, this process will be adopted for work with substance misuse in pregnancy. All decision-making processes should be clearly documented in the records.

The sharing of information, within and across agencies, underpins good practice and should occur where substance misuse involving alcohol or drugs is present. It is important to discuss multi-agency working and the benefits of sharing information at the earliest opportunity and seek consent in writing for information to be shared with others as per agreed protocols. Evidence has shown that women normally readily give their consent if it is explained that information sharing enables agencies to provide the best possible ongoing care and support for them and their babies.

It is important that women who misuse substances engage with services at the earliest opportunity. Their initial contacts and experiences may determine their future uptake of services. If women feel that their autonomy or their future as a parent is being threatened in any way, they are unlikely or less likely to disclose information or ask for help in the first place. This will require skilful interviewing by staff. An open, honest and non-judgemental approach is essential in establishing a relationship and an explanation of professional responsibilities regarding children/child protection is also essential to provide clarity at the beginning of any relationship. Training and supervision to address these issues will be provided to support implementation across services.

The Highland Policy for Sharing Information (2003) has been developed between partner agencies (NHS Highland, Highland Council and Northern Constabulary) to provide a co-ordinated and seamless approach to information sharing. It aims to provide staff with the principles governing the sharing of information, which is essential to multi-agency working and describes responsibilities and requirements for this. It also highlights the importance of ensuring that all individual procedures established between parties for the sharing of information are consistent with this policy. There is currently work underway in Highland to further develop this policy which will also include a patient information leaflet.

The Scottish Executive leaflet, Sharing Information About Children at Risk, 2003, urged local agencies to have in place a common pro-forma for obtaining informed consent, which should be completed at initial contact. The current Highland drug services pro-forma is attached as Appendix 3 and the related work being developed will eventually replace this .

The Department of Health has produced a brief guide entitled 'Sharing information about children at risk of abuse or neglect: a guide to good practice'. This has been distributed via the Chief Medical Officer at the Scottish Executive and a copy is attached as Appendix 4 for reference.

Further guidance for staff across all Highland agencies who work with substance misusing adults is being developed in line with the recommendations in Getting Our Priorities Right and Hidden Harm, the Scottish Executive's Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs. Inter-agency Child Protection Protocols for Professionals working with Substance Misusing Adults, will be available through the Highland Child Protection Committee and Highland Drug & Alcohol Action Team.

The issue of consent is described in the preceding documents, but should consent be refused it is essential to seek advice over options that might be considered from line management and designated child protection officers. Sharing information without the consent of the individual concerned may be necessary as:

"...all service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. They should always tell parents this."

(Scottish Executive 2003)

The Highland Child Protection Guidelines: 'Working Together to Protect Children in the Highlands' (Highland Child Protection Committee 2003:25) state that if the patient or client withholds consent to disclose information, then

"...disclosure can be justified in the public interest (usually where disclosure is essential to protect the patient or client or someone else from the risk of significant harm)."

'Getting our Priorities Right,' (Scottish Executive 2003:78) recommends that substance misusing pregnant women should be asked to agree to referral to social work services and that:

"...ante-natal staff should consider whether the extent of the woman's substance problem is likely to pose risk of significant harm to her unborn baby. If significant risk seems likely, this may override the need for the woman's consent to referral."

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. To provide comprehensive guidance for staff, every area should have available a copy of:

- ◇ Nursing & Midwifery Council: NMC Code of Conduct: Standards for Conduct, Performance and Ethics, 2004
- ◇ Highland Child Protection Committee: Highland Child Protection Policy Guidelines: Working Together to Protect Children in the Highlands, Nov 2003
- ◇ NHS Highland: Policy for Sharing Information, 2003
- ◇ Scottish Executive: Getting Our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse, Edinburgh, 2003

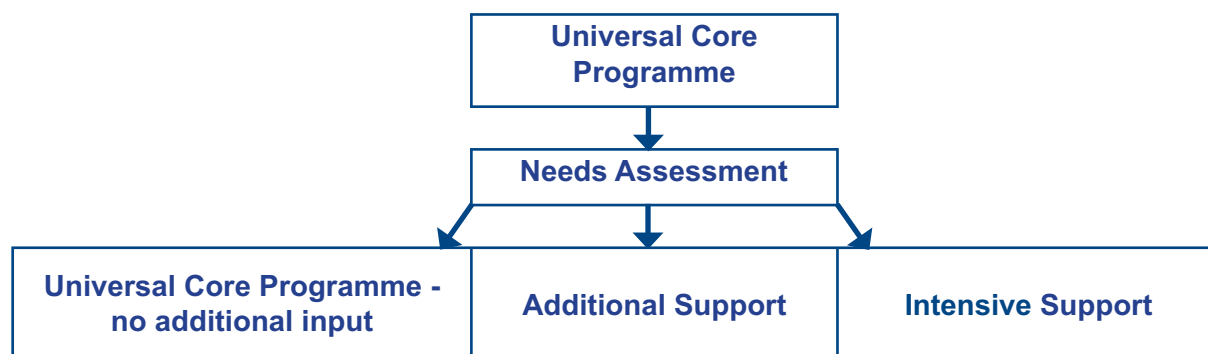
3.3 Risk Assessment

Substance misuse in itself is not a sufficient reason to assume inadequate parenting, although for some families this will be the case. The levels of risk taking must clearly be assessed as the safety and welfare of a newborn baby and other children in the home is paramount. Professionals working with women and families must have a clear understanding of all the factors that may contribute to a cause for concern, and continuous risk assessment and management should be carried out during pregnancy to ensure safety of mother and baby.

Risk is dynamic and may change at any stage from conception onwards and therefore all professionals involved with the family need to ensure that it is continuously evaluated (Scottish Executive 2001). Awareness and safety of other children in the household must always be included in this assessment.

Risk management must include all those who provide support to the family including the GP, midwife, obstetric and paediatric staff, health visitor, social worker and drugs worker. It should take account of all the factors that will affect a woman's health and should encompass her physical, psychological, social and spiritual wellbeing. In order to carry out risk assessment, professionals should consider the detailed advice given in Getting Our Priorities Right (Scottish Executive 2003) and this should be available in all clinical areas.

There are many initiatives being developed in Highland which will assist practitioners in ensuring the quality and effectiveness of the services they deliver to families are consistent and integrated across agencies. Linking health provision to meet the needs of individual families and strengthening support to those with additional or more intensive needs are the general principles of Hall 4. This will include a re-focused core universal service for all children whilst identifying those with particular health, developmental or social needs and ensuring resources are in place, see diagram below.



Care should be continuously reviewed throughout pregnancy and the development of an integrated assessment framework which is also being undertaken in Highland, will assist practitioners to improve the quality and effectiveness for those families in greatest need of support.

3.4 Child Protection

Child protection issues raise sensitive and difficult concerns. The Nursing and Midwifery Code of Professional Conduct 1st June 2002 (NMC 2002) cited in 'Working Together to Protect Children in the Highlands' 2003 (Highland Child Protection Committee, Nov 2003:25) states that:

“Where there is an issue of child protection, you must act at all times in accordance with national and local policies.”

It is important that all staff are familiar with these guidelines and that they have the details of the designated child protection person in their area. They can provide specialist advice and support for staff to discuss any concerns.

Any concerns for the welfare of a child will involve a discussion with Social Work Services who will take the lead role in the case and liaise with all professionals involved. It is important that effective lines of communication are maintained in order to ensure that families are provided with a seamless service and adequate support. Prompt follow-up and feedback must be provided between agencies and documented accurately.

3.5 Mental Health

Postnatal depression along with other mental health problems may be more common in women who use substances. They may have a history of anxiety or depression and sexual or physical abuse that can have long-term psychological, social and physical effects.

As well as the effects that this can have on the mother, which can be devastating, it can have long term implications for a child's emotional, physical and social development. Mary Hepburn states that

*“...management of women with substance misuse and mental illness co-morbidity requires especially close supervision during pregnancy.”
(CEMACH 2004:182)*

Work is currently being undertaken to develop the Scottish Intercollegiate Guidelines Network (SIGN) 60 guideline, Postnatal Depression and Puerperal Psychosis (SIGN June 2002). This will provide practitioners in Highland with a framework for good practice and ensure that pregnant and newly delivered women are provided with a cohesive system of assessment and support in the form of a care pathway for Perinatal Mental Health .

All pregnant women should be given information on postnatal depression and this can be found in 'Ready, Steady, Baby' and also in 'Talking about Post-natal Depression' available from HIRS, Assynt House.

3.6 Domestic Abuse

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

Pregnancy does not offer any protection for women in abusive relationships and because physical abuse at this time is generally focused on the abdomen, breasts and genitals it can be the cause of repeated miscarriage, antepartum haemorrhage and premature labour. The links between domestic abuse and adverse pregnancy outcomes suggest that maternity care providers should assume a proactive role in highlighting the prevalence and implications for women and children.

A woman who is misusing substances may also be experiencing domestic abuse which will add further to the social problems that she may have to deal with in her life. 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) should 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 disclosure.

If a woman is being abused this does not stop once a baby is born, in fact it may escalate. The greatest risk of moderate to severe injury is when the baby is born. No single agency is solely responsible for protecting vulnerable children; it is the responsibility of all. Abuse occurs across all social groups and the correlation between domestic abuse and child abuse must always be considered.

The Highland Domestic Abuse Strategy document, which was developed through the Highland Wellbeing Alliance, should be available in all ward, clinic and practice areas, as should NHS Highland's Protocol on Domestic Abuse for Health Care Workers. Both documents highlight the need for partnership working that should ensure that all services supporting women and families provide a co-ordinated and consistent approach. The awareness raising campaign that was held in conjunction with further domestic abuse training ensuring that all staff feel more prepared to discuss abuse and refer women accordingly.

3.7 Minority Ethnic Groups

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

It is important not to make any uninformed judgements about a woman's needs. It is always most appropriate to ask each individual we come into contact with about their ethnicity and any cultural needs they might have. It is best practice to record the ethnicity of all women using services this allows us to monitor how services are being used and what we can do to improve numbers and quality of service provided.

Within NHS Highland interpreting services are available from two sources.

1. If an interpreter is required immediately it is advisable to contact the National Interpreting Service. This is a telephone interpreting service with the cost of the call and the interpreter being paid for by NHS Highland. This National Interpreting Service can be contacted on: 0800 028 0073 or (020 7626 2929 from mobiles) Using the ID Number: 269301.
2. Face to face interpreters can be booked in advance by calling Global Language Services Ltd 01667 454658, who have been commissioned by NHS Highland and Highland Council. If you require the translation of written health related materials or have any queries about service provision please contact the Policy Manager at Assynt House on 01463 704918.

3.8 Training and Development

Staff within the maternity and drug services who have specific knowledge and training regarding pregnancy and substance misuse need to be identified, as they can be a valuable resource and support within each team.

When professionals are dealing with often difficult and challenging issues they should be aware of the skills and strategies they can use to exchange information and to negotiate behaviour change. The use of open questions and reflective listening is likely to lead to a far better understanding of the role of the behaviour in the woman's life than is interrogation and persuasion. The use of brief motivational interviewing strategies to negotiate change can be effective when working with people with substance misuse problems. This is an approach in which the role of the professional is to help the woman explore her behaviour, build her confidence and direct her towards change through identification of goals. Training courses in Negotiating Health Behaviour Change is provided by the Health Promotion Department, NHS Highland.

Scottish Training in Drugs and Alcohol (STRADA), provide an extensive range of training programmes for staff in many localities throughout Highland, details available in Appendix 1. STRADA also provide a recognised training course developed in Highland, targeting specifically women and pregnancy and this is now available in other areas in Scotland.

4. The Woman's Journey

4.1 Antenatal Care

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

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

To engage women more easily it is important that inappropriate service design does not compromise good practice. The lifestyle of someone using drugs may be chaotic due to the demands of having to maintain their drug use and additional associated problems such as financial difficulties, relationship problems, domestic violence and homelessness. Social Work Services and the criminal justice system might also be involved. Families affected by substance misuse will require a multi-agency, holistic approach and services may need to be delivered in a more effective way. Reducing the need for multiple appointments that women may find hard to keep, and by considering the option of afternoon sessions, women are more likely to engage with services. Good practice would suggest that they should be seen by their midwife, specialist drug service and social worker at one appointment.

Models for service delivery across Highland include:

- ◇ The development of a designated antenatal clinic within Raigmore
- ◇ The community midwife arranging to see women at Osprey House
- ◇ Locality based services with a community midwife with specialist skills supporting colleagues across services and carrying a caseload.

“NHS Highland should develop policies and practice particularly targeted at vulnerable women and their families, which promote health and wellbeing, pre-conceptually and into parenthood.”

A Review of Maternity Services in Highland, NHS Highland 2001:18

4.3 Booking Appointment

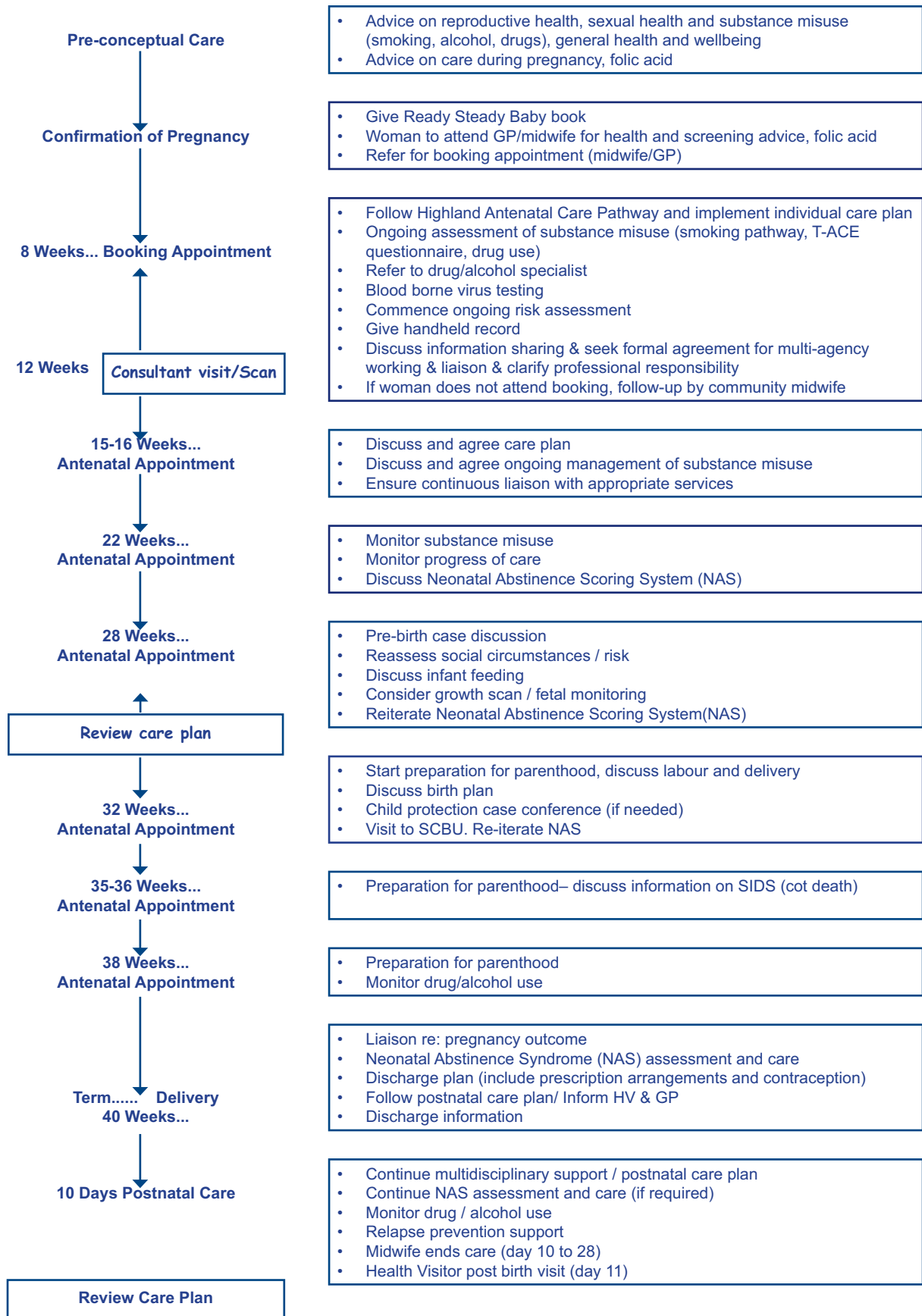
To ensure high quality maternity care, good history taking is vital (NHS QIS 2004) and the booking appointment provides an ideal opportunity to

- ◇ identify specific needs and problems a family may have
- ◇ initiate a relationship
- ◇ provide information to inform the assessment process.

MODEL CARE PATHWAY: SUBSTANCE MISUSE IN PREGNANCY

Adapted from: Whittaker A. (2003)

Individual assessment will highlight requirement of additional contacts.



Those providing antenatal care should ask sensitively but routinely about all substance use, prescribed and non-prescribed, legal and illegal (Scottish Executive 2003). There may be other professionals and agencies already involved in supporting women and their families, and therefore it is important to ask about other service input such as CPN, Osprey House, support worker, social worker, Councils on Alcohol, Alcoholics Anonymous, BLAST, housing or others. It is important that information about substance use is recorded and all referral letters should include this information.

In Highland, the community midwife or GP initially sees a woman in their local community and an assessment of needs is made.

“A clear and systemic history should be recorded and the woman’s care plan discussed within a risk assessment framework.”

(CEMACH 2004:21)

This risk assessment should take into account factors that may affect the outcome of her pregnancy and ability to care for her baby (Whittaker, 2003). The hand held maternity record should be completed and given to the woman, ensuring she has a copy of ‘Ready, Steady Baby’. These should be used as reference resources to open a discussion around physical, psychological and social needs as well as an assessment of substance use (smoking, alcohol and drugs).

Women may be known to substance misuse services but others, especially non-dependent users, may be disclosing their use for the first time. They should be given appropriate information on harm reduction which may lead to a change in their drug use (Whittaker 2003). It is also important that a clear pathway of care is in place for all professionals involved with women who use substances can follow. The Model Care Pathway provides practitioners with a minimum number of expected contacts they should have with pregnant women, but an individualised will highlight the need for many more contacts.

4.4 Booking Bloods

It is important to obtain booking bloods at the initial contact. 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 (Macrory 1997).

‘A Guide to Routine Blood Tests Offered During Pregnancy’ issued by NHS Health Scotland should be given to all women as early in pregnancy as possible. A pre-test discussion should take place and the woman should be asked to sign a consent form before testing. Current booking bloods include testing for blood group, full blood count, rubella status, syphilis, hepatitis B (HBV) and Human Immunodeficiency Virus (HIV).

4.5 Blood Borne Viruses (BBV)

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

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

Hepatitis B immunisation has been recommended for current injecting drug users for many years (Scottish Executive, 2003) but because drug users are at particular risk of acquiring Hep B vaccination is also recommended for the following:

- ◇ those who inject intermittently
- ◇ those who are likely to 'progress' to injecting eg those who are currently smoking heroin/and or crack cocaine and heavily dependent amphetamine users
- ◇ non-injecting users who are living with current injectors
- ◇ sexual partners of injecting users
- ◇ children of injectors including new born babies

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

HIV can be passed from mother to baby either during pregnancy, labour and delivery or through breastfeeding. In most cases, HIV is thought to be transmitted during the last few weeks of pregnancy or during delivery (NAM 2005). There is now routine antenatal testing across Scotland.

Hepatitis C (HCV) is not easily transmitted through sexual intercourse and the incidence is thought to be around 6%, although sexual practices that involve blood-to-blood contact would increase risk (STRADA, 2004). It is easily transmitted through injecting drug use (Scottish Exec 2003) and 61% of IV drug users are infected with HCV. HCV testing for women who are injecting or have in the past injected drugs should be offered as part of routine booking bloods in Highland (Scottish Executive, 2003). Mary Hepburn states in Sex, Drugs and HIV Task Group update, The Royal College of GPs, December 2003 that:

“HBV, HCV and HIV infections can all be transmitted by heterosexual intercourse and all can be transmitted from mother to baby perinatally. For all 3 viruses there are now either treatments for the infection or interventions that will reduce the risk of vertical transmission. There are therefore advantages for pregnant women in knowing their status.”

All staff in ward areas should have access to 'Screening for Infectious Disease in Pregnancy - Information for Health professionals' NHS Health Scotland.

4.6 Referral to Secondary Obstetric Services

Following booking in the community, women in Highland are referred to a Consultant Obstetrician who will see them at their nearest Maternity Unit. The hospital booking will include a discussion of the booking blood results and an ultrasound scan to confirm an Expected Date of Delivery (EDD) will be performed. Women will be given details about the pattern of antenatal care that best suits their needs and offered further screening and surveillance appropriate to their stage of pregnancy.

An Obstetrician should see all women who misuse substances at this initial hospital visit and ongoing follow up and assessment should be discussed. The related medical and social problems that may be associated with their substance misuse may also mean that their pregnancy will be high risk (CEMACH, 2004). Professional collaboration is essential for ongoing care and assessment of risk and should be agreed at the earliest opportunity.

Although most pregnant women in Highland receive the majority of their antenatal care within the community, this client group may also require additional support from the multi-agency specialist services as previously discussed, either at Raigmore Hospital or within their local area. Their pregnancies should continue to be managed by midwives but should be supervised by an obstetrician (CEMACH 2004). Information leaflets and contact numbers should be given to women who are identified as requiring extra support and some examples are detailed in Appendix 1.

4.7 Ongoing Antenatal Care

Routine antenatal care should be provided in the woman's locality but with regular liaison with specialist services. It should be individualised and informed by an integrated assessment of risks and needs and might include:

- ◇ Provision of information and education about general health including nutrition and dental care
- ◇ Information about local support agencies, benefits and allowances
- ◇ Time to discuss any concerns and reinforce progress re substance misuse
- ◇ Ongoing multi-agency collaboration and communication
- ◇ Discussion of drug use and potential effects during pregnancy and on the new born, an explanation of Neonatal Abstinence Syndrome and the use of the Neonatal Abstinence Scoring System Assessment Form (Appendix 5)
- ◇ Preparation for parenthood, including discussion of pain relief during labour, breastfeeding, social support, partner's role
- ◇ Sudden infant death syndrome
- ◇ Explanation of, and visit to, Special Care Baby Unit (SCBU) services

Liaison with the family's health visitor is essential to ensure that information, support and collaboration are developed and maintained. The importance of building relationships and establishing trust with health 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.

4.8 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 (Scottish Executive 2003) and symptoms normally present within the first 24-72 hours after birth, but may present up to a week later. There appears to be little correlation between the amount of maternal drug use and the severity of NAS, and practitioners should be aware of the signs and symptoms of NAS, as not all maternal drug use may have been reported.

It is very important that signs and symptoms of NAS are discussed with a woman well before her baby is due as these babies are often born premature. The following signs and symptoms have been reported in babies born to opiate and benzodiazepine dependent women, including polydrug use. They describe the more severe range and are taken from the Lothian Substance Misuse Guidelines (Whittaker 2003).

Signs and Symptoms of NAS:

- ◇ Irritability (marked tremor, easily startled, increased reflexes and excessive crying)
- ◇ Hyperactivity (excessive body movements, face scratching)
- ◇ Hypertonicity (increased muscle tone and rigidity)
- ◇ A fairly continuous high-pitched cry
- ◇ Inability to settle or sleep after feeds
- ◇ Excessive sucking (including first sucking)
- ◇ Increased appetite
- ◇ Poor feeding ability (hungry but difficulty in sucking, swallowing and successfully completing a feed)
- ◇ Regurgitation and vomiting
- ◇ Frequent loose stools or diarrhoea (which causes peri-anal excoriation)
- ◇ Poor weight gain or weight loss
- ◇ Repetitive sneezing, yawning, hiccoughs, nasal stuffiness
- ◇ Tachypnoea (rapid shallow breathing)
- ◇ Respiratory depression
- ◇ Increased pulse and heart rate
- ◇ Temperature instability, fever (>37.5 C), sweating and dehydration
- ◇ Mottling (discolouration of skin)
- ◇ Excoriation from excessive movement (usually seen around the buttocks, back of the head, shoulders and heels)
- ◇ Seizures occur rarely (5% of infants) and may present up to 30 days after birth

It is important to assess all infants with the use of the Neonatal Abstinence Scoring System and ensure paediatric involvement if required. The assessment should be carried out twice a day after feeding which will reduce the bias that may occur if the baby were hungry (NHS Lanarkshire 2002). All babies who present with NAS will be referred to social work services for assessment and support. All NAS babies will also be followed up by the Neonatal Family Support Service once home.

4.9 Missed Appointments

All those involved in providing support in the antenatal period should ensure that all missed appointments are communicated between services and documented in the records, with steps taken to identify if there are reasons for non-attendance that can be resolved. Community midwives and CPNAs for addictions are able to offer follow-up at home and provide a vital link between services.

However, it should be explained from the outset that:

- ◇ if appointments are not kept professionals involved will become concerned about the family
- ◇ compliance is seen as part of the support being offered.

Maternity care providers must seek advice from designated child protection officers or consider direct referral to Social Work Services if they have any concerns.

4.10 Ultrasound Scans

All women are offered an ultrasound scan to determine gestation and this should prove reassuring. Substance misuse may be associated with structural foetal abnormality, particularly with alcohol consumption, benzodiazepine use in the first trimester and cocaine or amphetamine use. For those women, detailed anomaly scanning should be considered and discussed (Whittaker 2003).

Further scans may be useful if growth is not maintained, which is often the case. While some women will be reassured by frequent scanning and may request it, for others it may reinforce a fear that their drug use is adversely affecting their baby's wellbeing, increasing anxiety and feelings of guilt (Macrory 1997).

4.11 Pre-birth Case Discussion

“Women with identified risk or multiple social needs may benefit from attending an organised care plan review meeting.”

(Whittaker 2003)

A multi-disciplinary review provides the opportunity for a full assessment and case discussion, and all professionals who are involved in supporting the family should take part in this care plan review. The need to reassess social circumstances and risk is important in identifying further support mechanisms may need to be put in place for the family. This should include (Macrory 1997; Whittaker 2003):

- ◇ Accommodation and home environment
- ◇ Provision of basic necessities, financial situation
- ◇ Physical health risks
- ◇ Family's social network and support systems
- ◇ When is intervention necessary?
- ◇ What are the parents' perceptions of the situation?
- ◇ History of children in the family
- ◇ Attendance at appointments for antenatal care, social care, specialist drug services
- ◇ The pattern of parental drug/alcohol use and procurement
- ◇ Discussion of partner/fathers needs and any assessments required

This discussion should form part of the woman's individual care plan and should be documented in her medical notes. The main carer provider, usually the community midwife or GP, should ensure that these discussions have taken place and documented accordingly.

4.12 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? It is also necessary to complete the 'Substitute Prescribing Data Sheet', see Appendix 6, for all admissions. This data sheet includes useful information that will assist ward staff through the process of prescribing.

The prescriber and others involved should be phoned to advise of admission and to receive up-to-date information on progress, present medication, dispensing arrangements and results of recent drug screening tests. The 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, this should avoid withdrawal symptoms.

4.13 Confidentiality within the Ward

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

4.14 Labour and Pain Relief

Most labours and births will be straightforward (Johnstone 1998, cited in Whittaker 2003) but babies may be born prematurely and of low birth weight. Where there are substance misuse concerns, women should give birth at Raigmore Hospital 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 woman's named community midwife should also be informed of admission or delivery as she is the woman's main care co-ordinator.

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. Paediatric care for babies born to women with BBV should follow the protocol 'NHS Health Scotland Screening for Infectious Diseases in Pregnancy' (NHS Highland 2003).

If a woman is on methadone this should be continued during labour and standard analgesia should also be administered. A daily dose of methadone will not provide adequate pain relief due to saturation of opioid receptors. Women should be reassured that they will be given adequate pain relief during labour and the options available should have been discussed antenatally. It should be remembered that some opiate users might require larger amounts of pain relief if tolerance has developed. Drug misuse is not a contra-indication to the use of a patient controlled analgesia (PCA) pump following caesarean section (Whittaker 2003). Routine care during labour should apply, with careful observation of mother and foetus for signs of withdrawal. These may present:

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

Naloxone (an opiate antagonist) must not be given to reverse opioid induced respiratory depression in the newborn, as it will induce an abrupt opiate withdrawal crisis. Supportive measures or ventilation should be used (Whittaker 2003).

4.15 Postnatal Care

All mothers and babies should be transferred to the postnatal ward unless there is a medical reason for admission to SCBU and separation should be avoided whenever possible. Following delivery all known drug dependent women should be encouraged to stay in hospital for a minimum of 72 hours so that any signs and symptoms of Neonatal Abstinence Syndrome can be picked up (Whittaker 2003). The use of the Neonatal Abstinence Scoring System form, Appendix 5, should have been fully explained to the mother in the antenatal period and she should be involved in the scoring process. This form should be kept in the ward office for reasons of confidentiality. All Babies of mothers who injecting drugs require a course of Hep B to be started as soon as possible after birth as indicated under section 4.5 of this document.

The multi-agency team should be informed that the woman has given birth and given details of the woman's condition and that of her baby. 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. 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 and this is a time when mothers can be supported and taught skills to comfort their babies. Any parent can find it difficult to meet the demands of a new baby and it is not specific to women who use substances. 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 (Fife Council 1999) and Introducing baby massage may assist mothers to feel they are positively supporting and interacting with their babies.

Withdrawal symptoms from methadone and benzodiazepines may not be evident until several days or weeks following birth. Parents and community staff caring for the family need to be vigilant to this.

4.16 Infant Feeding

The benefits of breastfeeding should be discussed with all women antenatally, 'Breastfeeding Policy' (NHS Highland). If drug use is stable and the woman is on prescribed methadone, she should be informed that the advantages of breastfeeding her baby outweigh the disadvantages. Apart from well-documented evidence of the benefits of breastfeeding, it may also help to reduce withdrawal symptoms experienced by the baby, as small quantities of drugs may be passed via the breast milk.

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 can also help the baby regulate its temperature, heart rate and breathing, and be reassuring and comforting to both mother and baby. Breastfeeding should be commenced as soon as possible following delivery as recommended in the Highland breastfeeding policy. The exceptions to promotion of breastfeeding are:

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

(Whittaker 2003)

Injecting drug use whilst breastfeeding should be discouraged because of the risks of BBV transmission. Women who are HBV positive can breastfeed once the baby has been given his/her first dose of hepatitis B vaccine and immunoglobulin (HBIG). 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 policy for NHS Highland, 2003 (under review). There is no evidence that the HCV is transmitted by breastfeeding and this should be conveyed to the mother (Scottish Executive 2003).

To open up discussion about infant feeding the booklets 'Ready, Steady, Baby' and 'Off to a Good Start' (HEBS 2003) available from HIRS should have been given out to all women. Women should make an informed choice on how to feed their baby and those who decide to bottlefeed should be supported in this.

4.17 Discharge Planning Meeting

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

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

4.18 Contraception

Many women do not see contraception as a priority as they often underestimate their fertility. By providing an open discussion around reproductive health care before going home, women can be enabled to make choices regarding their future sexual health as once discharged they frequently do not access services. Provision of contraception should ideally occur prior to discharge and long acting reversible methods such as progesterone implants and intrauterine devices are proving more popular and appropriate (CEMACH 2004).

When providing information it is important to give contact details that are relevant to the area where the woman lives and ensure that they understand the important role of their GP and Highland Sexual Health Service.

Discussion should include:

- ◇ Personal choice
- ◇ Individual's own health/contra-indications
- ◇ Availability – how to access services
- ◇ Compliance
- ◇ Risk of sexually transmitted infections (STIs)

To ensure follow-up and appointments as necessary, other services involved in ongoing care should be advised of discussions or choices made.

4.19 Prior to Discharge

For those women who are on prescribed methadone, their keyworker should be contacted and medical staff should advise whoever will be taking over the prescribing for substance misuse within the community. Medical staff need to inform the prescriber of any changes to medication and when to take over prescribing. Liaison should be done on a weekday as the woman's own GP or prescriber will not be available at weekends. If the prescriber cannot be contacted, a maximum of a 3-day prescription should be provided, with a chemist identified, contacted and advised about arrangements. Prescriptions are issued under supervised consumption that is taken in sight of the pharmacist on the pharmacy premises or dispensed daily to be consumed elsewhere.

4.20 Ongoing Postnatal Care

Postnatal care should enable a woman and her family to make an effective transition into parenthood, and inter-agency communication and collaboration are essential in ensuring thorough child care risk assessment.

The community midwife will be the main provider of support and advice in the early postnatal period along with input from other agencies involved with the family. These visits may continue for up to 28 days following birth and will be additional to those of the health visitor, who performs her post-birth visit on or around day 11. For this client group, ongoing support in the postnatal period is essential with multi-agency collaboration and integration of services, to ensure that women are followed-up closely. The health visitor and GP will provide ongoing support to the family and ensure that the correct level of care is provided.

5. Conclusion

Maintaining any behaviour change takes effort and risk of relapse is common following birth as this can be a particularly stressful time. All professionals must continue to re-assess the needs of the family and offer appropriate support through links with community agencies and networks.

Co-ordinated and non-judgemental support for women can help them to reduce the harm to themselves and their children. This gives them the confidence to start their journey as a parent with self-esteem, optimism and a sense of their own abilities.

“Pregnancy is a crucial time for a woman misusing substances, and for her child. Substance misuse can harm a foetus yet pregnancy can act as a strong incentive to make a positive change to substance-misusing behaviour.”

(Scottish Executive 2003:75)

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Agency	Tel No
Antenatal Clinic, Raigmore Hospital, Inverness	01463 704278
APEX Scotland Progress2Work service, to assist recovering drug misusers back to employment	01463 717033
Benefits Agency	01463 663500
BLAST! Drugs Project, 94 Church Street, Inverness. For information, advice and guidance for young people, communities and professionals across Highland	01463 715454
Childline	0800 1111
Citizens Advice Bureau	01463 235345
Community Midwives, Inverness Outwith Inverness, contact local GP surgery for details	01463 704342
Community Psychiatric Nurses for Addictions, (CPNAs) Osprey House for local details	01463 716888
Domestic Abuse National Helpline Domestic Abuse Campaign Co-ordinator, NHS Highland gillian.gunn@hnb.scot.nhs.uk	0800 027 1234 01463 704940
Directory of Highland Drug and Alcohol Services, Highland Drug and Alcohol Action Team (HDAAT) www.hdaat.org.uk Information line	01463 704865 0844 848 3778
Drugline Scotland	0800 776600
Drug & Alcohol Services, Osprey House, Inverness. Contact for local details	

Agency	Tel No
Police, Northern Constabulary, Inverness, for local details. Emergency 999	01463 715555
Policy Development Manager, NHS Highland	01463 704826
Rape and Abuse Helpline, Dingwall	080 8800 0123
Scottish Drug Misuse Database	0131 551 8221
Social Work Services (Highland Council) Emergency out of hours	01463 703456 08457 697284
STRADA –Scottish Training on Drugs & Alcohol www.projectSTRADA.org	0141 330 2335
Streetwise Highland, a directory of services for people who are homeless or at risk of homelessness in the Highlands. www.streetwise-highland.org	
Substance Misuse Co-ordinator, NHS Highland, Inverness. Information for clients and professionals	01463 704969
Women's Aid, Inverness Ross-shire Lochaber office Lochaber Freephone Caithness & Sutherland	01463 220719 01349 863568 01397 874216 0845 4080151 0800 619 2541
Scottish Women's Aid	0131 475 2372

SMR25 Appendix 2

SMR25 - Assessment Report

This form should be completed for 'new' clients. New clients are clients who, at the time of presenting, are not currently in contact with a service that provides specialist assessment of a client's drug misuse care needs.

Fill in this form when either:

- **Assessment is completed**

For the purposes of returns to the SDMD, a clear statement of the type and level of the individual's needs and an agreed set of goals marks the completion of the assessment. Where this is not realistic, the end of assessment is marked by the date a decision was made on treatment e.g. prescription for methadone. The nature and timing of the assessment process varies across services and between individuals. The goal for any assessment at any service is to inform decisions about treatment care and support with a view to matching services to the assessed needs of the individual.

OR

- **The dataset is completed**

It is possible that the full SMR25 dataset may be collected from a client before the assessment is complete.

OR

- **As much information as possible has been collected**

It may sometimes not be possible to complete all data items. The client may have lost contact with the service before assessment has been completed. This should be recorded on the form and the information that has been collected should be used to complete the form.

8) INJECTING/ SHARING DETAILS

EVER	Yes	No	IN THE PAST MONTH	Yes	No
Injected	<input type="checkbox"/>	<input type="checkbox"/>	Injected	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no go to section 10</i>					
Always used new equipment first	<input type="checkbox"/>	<input type="checkbox"/>	Always used new equipment first	<input type="checkbox"/>	<input type="checkbox"/>
Used a needle or syringe that someone else has used	<input type="checkbox"/>	<input type="checkbox"/>	Used a needle or syringe that someone else has used	<input type="checkbox"/>	<input type="checkbox"/>
Lent someone else a needle or syringe which client has used	<input type="checkbox"/>	<input type="checkbox"/>	Lent someone else a needle or syringe which client has used	<input type="checkbox"/>	<input type="checkbox"/>
Used the same spoon, filter or water as someone else	<input type="checkbox"/>	<input type="checkbox"/>	Used the same spoon, filter or water as someone else	<input type="checkbox"/>	<input type="checkbox"/>
Age first injected	<input type="text"/> <input type="text"/> years				

9) BLOOD BORNE VIRUSES

Tested for:

	Yes	No	Date of last test
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	m m y y y y
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Yes No

Has client been at risk since last test?

Has client **completed** a course of vaccination for Hep B?

10) ALCOHOL PROFILE (PAST MONTH)

Consumed alcohol? Yes *show details* No *go to section 11*

How often did client have an alcoholic drink?

Every day 2 - 3 days per month
 5 - 6 days per week about one day a month
 3 - 4 days per week less often
 1 - 2 days per week

In a typical day how many units did the client usually have? units

11) SOCIAL PROFILE (CURRENT)

ACCOMMODATION

Owned/ Rented

Supported accommodation (drug related)

Residential rehabilitation

In prison

Homeless - Temporary/ Unstable accommodation/ Hostel

Homeless - Roofless

Other (*specify*) _____

LEGAL SITUATION

Tick all that apply

None

Case pending

DTTO

On probation/ subject to supervision order

In Prison

Other (*specify*) _____

LIVING SITUATION

Tick all that apply

With spouse/ partner

With parents

Alone

Other (*specify*) _____

LIVING WITH OTHER DRUG USERS

Yes

No

Did not wish to answer

HAS CLIENT BEEN IN PRISON IN PREVIOUS 12 MONTHS?

Yes No Did not wish to answer

How long since release _____

Name of Prison of release _____

EMPLOYMENT/ EDUCATION

Employed (paid or unpaid)

Support into employment

Unemployed

Never employed

Long term sick/ disabled

School

Excluded from school

Full time education/ training

In Prison

Other (*specify*) _____

DRUG USE FUNDED BY

Tick all that apply

Employment

Crime

Debt

Other (*specify*) _____

Benefits

Sex work

Did not wish to answer

12) DEPENDENT CHILDREN

Does client have dependent children Yes No

If yes provide age of each child in table below

	Child one	Child two	Child three	Child four	Child five	Child six
Living with own children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Own children living elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living with partner's children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is client or their partner pregnant? Yes No

13) CURRENT CONTACT WITH SERVICE

Is client still in contact with this service Yes No

Please provide details below

Received required support

Disciplinary

Unplanned

Deceased

Referred to other service

If referred, name of service _____

Date of referral/ discharge/ contact ended

14) LOCAL USE

SMR25 - Key Information

What information should be collected - Where possible, all data items should be completed. All submitted forms must contain initials (plus fourth letter of surname), date of birth and gender. Without these items Information Services Division (ISD) cannot process this form.

Completion Advice –

- **Section 2 Co-occurring Health Issues** – Significant issues that have led the client to present to your service, other than for their drug use. Please do not specify 'drug use' as this is assumed to be the main issue i.e. not a co-occurring health issue.
- **Section 6 Prescription Drug Profile – Include:** any drug used in the treatment of drug misuse or dependence, i.e. substitute prescribing, drugs to treat withdrawal symptoms, anti-depressants and anti-psychotics.
- **Section 7 Illicit Drugs Profile** – Please indicate if the client has used illicit drugs in the last month. Include solvents, tranquillisers and over the counter medicines taken inappropriately. Do not record alcohol in this section.
- **Section 10 Alcohol Profile** – Although this is now a separate section, SMR25 should not be completed for **alcohol only** clients. Ensure that the form is only completed for clients who have presented at your service for drug misuse, and that details of the misuse are recorded in the preceding section(s).
- **Section 12 Dependent Children** - Includes children (both biological and non-biological) who are dependent on the client. Please insert the age of each child into the table provided.

Detailed Guidance – Detailed guidance on completing the SMR25, including data definitions are available on the Drug Misuse Information Scotland website at www.drugmisuse.isdscotland.org/sdmd/

Completed Forms – Keep the carbonised copy of the form for your records and send the completed top copy to the SDMD team, in the pre-paid addressed envelopes provided.

Ordering Forms and Envelopes – A supply of SMR25 forms can be obtained by logging onto www.drugmisuse.isdscotland.org/sdmd/ or alternatively by calling 0131 275 6348.

Enquiries – For further information or guidance please call 0131 275 7097.

Confidentiality – ISD is fully committed to the processing of all personal data securely and in accordance with the requirements of data protection legislation. For more information go to www.drugmisuse.isdscotland.org/sdmd/

Consent form for information sharing

To enable us to provide you with the best support possible we ask your agreement to share information with other agencies or professionals involved in your care.

It is important for us to keep each other informed of your progress and ensure you are being provided with appropriate information, advice and support at different stages of your pregnancy or following the birth. It can also be helpful for us to share information and ask each other for advice as we work in different specialist areas.

I give my permission for information to be shared with other professionals and agencies involved in my care.

Name of client	
Address	
.....		
Date of Birth	Date consent form signed
Signature	
Signature of member of staff	
Designation	

Sharing information about children at risk of abuse or neglect

A Guide to Good Practice

All staff have a responsibility to act to make sure that all children are protected from harm. Your responsibility to children is not limited to responding to requests for information from other professionals or agencies. All NHS staff are responsible for acting on concerns about a child – even if the child is not your patient.

If there is reasonable concern that a child may be at risk of significant harm this will always override a professional or agency requirement to keep information confidential.

Staff caring for adults should always ask whether there are dependant children at home who may be endangered by adult's condition. This includes sharing information prior to the birth of a child to ensure protective plans are in place from the moment of birth.

If staff are concerned that action is not being taken on information they have given, they should discuss this with the contacts below.

Staff should involve parents or parents-to-be in decisions about the disclosure of information unless this would increase the risk to the child, parents and staff.

When any professional or agency approaches another to ask for information they should explain:

- What information they need (in plain English)
- Why they need it
- What they will do with the information
- Who else may need to be informed if concerns about a child persist

If a professional or agency is asked to provide information, they should never refuse solely on the grounds that all their information is confidential. They should consider:

- What information the service user has already given permission to share
- Any perceived risk to a child would warrant breaching confidentiality
- Any relevant information on risk to the child would allow another agency to offer appropriate help and services or take action to reduce the risk to the child
- Whether to ask advice from their line manager, Child Protection staff or Information or Caldicott Guardians

Staff should record when, what and why information has been shared, and with whom (or why sharing was refused) as they may have to justify their decision at a later date. Staff should also keep clear, legible and up-to-date records of their contact with parents and children, including:

- What information is held and any consent to information being shared
- The assessment, care plan and any changes as a result of reviews
- The date and identity of the person sharing and recording the information.

Insert local contact information below

Insert local contact information below

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Always seek advice if you are unsure

Never refuse to provide information without considering the risks of not sharing

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

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

SUBSTITUTE PRESCRIBING DATA SHEET

Personal Details

Name

Address

Date of Birth

Prescription Details

Methadone Dose

Dispensing details (Daily supervised; daily; twice weekly etc)

Other prescribed drugs and dose

Contact Details

Main contact/Key worker

When available:

Tel no:

Prescriber

Tel no:

Dispensing chemist

Tel no:

Alternative Contact

When available:

Tel no:

SUBSTITUTE PRESCRIBING DATA SHEET

Ward Staff:

- Patients on methadone can become upset and distressed if they miss their usual dispensing time – this may be because they are anxious about physical withdrawals, which can be a problem if dispensing is delayed. It is worthwhile checking what time of day they normally take their methadone and dispensing as close to this time as practicable.
- Good liaison and planning prevents the ward and other services being faced with managing potentially very distressed or aggressive patients.
- Remember that prescribers may not be available out of hours or at weekends.

On Admission

- Confirm prescription details as soon as possible with keyworker/prescriber
- Advise prescriber and/or keyworker of reason for admission and treatment plans.
- Advise chemist of admission and clarify if daily dose has been dispensed.
- Where appropriate (admission for longer than one day), cancel remainder of prescription.

On Discharge

- As soon as discharge date is agreed, inform keyworker/prescriber of date and what discharge medication will be provided.
- Provide prescriber with a brief overview of treatment and patient's physical condition – of particular relevance would be any issues with mobility or other ongoing problems/needs that may make it difficult for them to attend appointments or the chemist.
- Remember some prescribers may not be available over weekends.

Unplanned Discharge (AMA)

- Advise against unplanned discharge as an immediate transfer of prescribing cannot always be guaranteed
- Inform patient that it is their responsibility to contact prescriber/keyworker as soon as practicable to arrange for their next prescription.
- Contact prescriber/keyworker at earliest opportunity to alert them to discharge.

¹Prescribers: Osprey House 01463 716888
GP (independently, or with keyworker support)
DTTO (Drug Treatment and Testing Order) 01463716324

Name	Job Title	Agency
Sally Amor	Child Health Commissioner/ Public Health Specialist	NHS Highland
Dr Diana Black	Associate Specialist, Osprey House	NHS Highland
Sam Brogan	Senior Childcare & Family Resource Officer	Highland Council
Helen Bryers	Senior Midwife	NHS Highland
Mary Burnside	Community Midwife/Acting Team Leader, Black Isle	NHS Highland
Suzy Calder	Strategy & Implementation Manager, Highland Drug & Alcohol Action Team	HDAAT
Fiona Campbell	Community Midwife	NHS Highland
John Glenday	Shared Care/Harm Reduction Co-ordinator	NHS Highland
Jane Groves	Health Promotion Specialist	NHS Highland
Wendy Jessiman	Lecturer in Midwifery Studies	University of Stirling
Karen Marnoch	Midwife, Raigmore Hospital	NHS Highland
Lorna MacAskill	Midwife, Raigmore Hospital	NHS Highland
Helen MacDonald	Infection Control Nurse	NHS Highland
Cathy MacKay	Child Protection Designated Person, Raigmore Hospital	NHS Highland
Dougie Montgomery	Lead Nurse/Substance Misuse Co-ordinator	NHS Highland
Natalie Morel	Policy Manager	NHS Highland
Hilary Munro	Midwife, Raigmore Hospital	NHS Highland
Julia Nelson	Health Development Officer - Early Years	NHS Highland
Sue Roddick	Acting Integration Manager	Highland Council
Rona Scott	Midwifery Team Leader, Skye	NHS Highland
Dr Valerie Wareham	Consultant Obstetrician & Gynaecologist	NHS Highland
Nanette Wallace	Graphics Production Officer (Design and Formatting)	NHS Highland
Sandie Young	Child Protection Advisor	NHS Highland
Catherine Zawalnyski	Professional Advisor - Children & Families, Ross & Cromarty	NHS Highland

