Trust Policy		Worcestershire Acute Hospitals NHS Trust

SUBSTANCE MISUSE: Management of Pregnant Women

Department / Service:	Women's and Children's
Originator:	Kate Birch Named Midwife for safeguarding Marrianne Gough Specialist Midwife for Vulnerable Women Kiritea Brown Obstetric Consultant
Accountable Director:	Laura Veal
Approved by:	Maternity Governance Meeting
Approved by Medicines Safety Committee: *Where medicines included in guideline*	N/A
Date of approval:	17th November 2023
First Revision Due: This is the most current document and should be used until a revised version is in place	January 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Departments within Worcestershire Acute Hospitals Trust
Target staff categories	All Health professionals within Worcestershire Acute Hospitals

Policy Overview:

To ensure Worcestershire Acute Hospitals (WAHT) staff.

- Adopt a safe, consistent, and quality approach to the management of pregnant women who misuse illicit drugs and alcohol.
- To ensure all WAHT staff are aware of their responsibilities to identify, risk assess and support pregnant women and their families who misuse illicit drugs and alcohol.
- Staff have the knowledge and skills
- Promote a consistent approach across WAHT
- Provide clear guidance to WAHT staff in responding to substance misuse.

Substance misuse is a matter of public health and social concern and as such falls within the remit of midwives. Pregnancy is the only time in a healthy women's life that she has regular, scheduled contact with health care providers, therefore providing an opportunity for identification and intervention of substance misuse.

Key amendments to this document

Date	Amendment	Approved by:
Nov 23	*Full guideline review*	*MGM*

Contents page:

1. Introduction

Research highlights that a greater focus on socially disadvantaged women is needed to improve maternity care in England (Lindquist et al, 2014). Much has been written about the physical, psychological, and social harm associated with drug use in pregnancy. Substance misuse has increased substantially in women over the past 30years with 2-3% of children in England having a parent with drug problems (Advisory Council on the Misuse of Drugs, 2003). Almost two-thirds of women seeking drug treatment are parents but only half have custody of their children (National Treatment Agency, 2010). The key findings of the Advisory Council on the Misuse of Drugs in their report "Hidden Harm" in 2003 states that:

- Parental problem drug use can and does cause harm to children at every age from conception to adulthood.
- Effective treatment of the parent can have major benefits for the child and often requires a co-ordinated approach from a multi-disciplined team.
- Reducing the harm to children from parental drug use should become a major objective of policy and practice.

Although it remains a significant problem to society the overall trend in the proportion of adults taking illicit drugs has been essentially stable at between 8% and 9% since 2010. (Drug Strategy 2017)

Class A drug use has also remained broadly stable for the last few years (Home Office 2016), however, women with substance misuse issues continue to feature significantly in the triennial reports of maternal deaths within the UK. In the most recent report 14 women who died by suicide had co-morbid substance misuse issues and 58 women died in relation to drug or alcohol misuse (Knight, Tuffnell et al, 2015).

Substance misuse remains a key factor in many Child in Need and Child Protection cases with substance misuse featuring in at least 33% of Child Protection cases and 70% of care proceedings cases. (Munro, 2011). Analysis of Serious Case Reviews 2009-2011 in England showed parental substance misuse was apparent in 42% of families (Brandon, Sidebotham et al, 2012)

Substance misuse in pregnancy is a key public health issue, not only because of the associated negative impacts on fetal and infant outcomes but because these harms are preventable and can be remedied or at least attenuated.

Substance misusing mothers tend to be the victims of poverty and its consequences, including physical and mental ill health and poor nutrition. They are more likely to smoke and may experience increased levels of domestic violence (Drug Misuse & Dependence Clinical Guidelines, 2017: Home office, 2003: Johnson et al 2003). Differences in health outcomes amongst different socio-economic groups have been demonstrated in many areas and have provided the focus for national initiatives in the UK to reduce the observed health inequalities.

2. Objectives

- The purpose of this document is to give guidance to nurses, midwives and doctors when caring for pregnant women who are using drugs in pregnancy or are drug dependant or on a drug treatment programme.

- It also aims to achieve the co-operation of drug using women and their families in a negotiated package of care which identifies their multiple and complex needs during pregnancy.
- To reduce the risk of maternal and perinatal mortality and morbidity due to drug use
- To ensure that there is a clear pathway that reflects realistic harm reduction and minimisation strategies that are negotiated with the woman.
- To promote effective liaison between all agencies involved with the woman and her family for the delivery of good quality care.
- The key aim of health professionals should be to attract women into health and social care treatment services, provide antenatal care, stabilise and if possible, reduce and eliminate drug and/or alcohol use. Receiving good quality antenatal care is known to improve pregnancy outcomes irrespective of continued substance misuse. (CMACE, 2011; Drug Misuse & Dependence Clinical Guidelines, 2017; Drug Scope, 2005)
- To establish an open and supportive relationship with the woman and her family providing accurate and honest information regarding the risks associated with drug and alcohol use in pregnancy.
- To ensure that the complex needs of these women are recognised and acted upon. These may be social, psychological, or physical.
- To give consideration to the potential safeguarding concerns relating to existing children and the unborn child.

3. Scope of this document

This policy is intended to provide clear guidance for all Worcestershire Acute Hospitals Trust (WAHT) employees on how to identify and respond to Substance Misusers to include the following:

- All pregnant women and/or partners on drug treatment programmes (i.e., Methadone/Subutex programme)
- Women who are suspected or known to be misusing substances in pregnancy.
- Women and/or partners who disclose a previous history of substance misuse.

NB. Alcohol in pregnancy is covered in a separate policy with details for referrals addressed. See 'Alcohol in Pregnancy'

4. Definitions

Substance misuse refers to the harmful or hazardous use of psychoactive substances, including illicit drugs. It can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use. It can typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences. A higher priority is given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. (WHO)

Substance misuse refers to the overindulgence in and dependence on a drug or other chemical, leading to effects that are detrimental to the individual's physical and/or mental health and/or welfare of others.

4.1 Specific Substances

Amphetamines (also known as speed)
Is a potent central nervous stimulant, that usually looks like an off-white pinkish powder. It may be snorted, dabbed on the gums, injected, or mixed in drinks.
Potential effects:

- Increases energy levels, making users feel very 'up', energised and alert.
- Aggressive or agitated.
- Panic attacks and psychotic episodes

The high is usually followed by a long slow comedown making people feel very irritable and depressed.

Effects in pregnancy:

- Fetal development, premature labour, and miscarriage.
- Maternal and fetal tachycardia and maternal hypertension.
- Poor maternal appetite
- Reduced placental perfusion, which may result in fetal growth restriction.

Benzodiazepines- use and dependence is associated with neonatal withdrawal syndrome. Sudden withdrawal from benzodiazepines in pregnancy is not advised as this can result in severe anxiety, hallucinations, and seizures. Gradual reduction of medication to the lowest possible dose in pregnancy is advised and if possible, wean off completely.

Cocaine/Crack- Cocaine comes in 2 forms, a white powder (cocaine) which may be absorbed through any mucosal surface (e.g., snorting) and a crystal form (crack cocaine) which comes in solid blocks which may be smoked.
The drug is a powerful vasoconstrictor and is known to be associated with maternal hypertension, spontaneous abortion, and placental abruption. Intrauterine growth retardation is the most consistent finding in all studies.

"When a pregnant woman uses cocaine, it enters her bloodstream and crosses the placenta to the baby. Cocaine also collects in the fluid around the baby and is absorbed through the baby's skin. Because unborn babies continually swallow this fluid, they also swallow the cocaine. Cocaine in the baby's bloodstream reaches the baby's heart, brain, and other organs. Studies suggest that using cocaine during pregnancy may increase the risk of stillbirth, or of having a premature and/or low birth weight baby. Cocaine should therefore not be used in pregnancy." (Bumps best use of medicine in pregnancy)

Cannabis- Cannabis is the most widely used illegal drug in Britain and a popular recreational drug around the world. It is classed as a sedating and hallucinogenic drug. Short term use can lead to tiredness and lack of motivation. Regular heavy use can lead to development or worsening of mental health problems including paranoia. Cannabis smoke contains a similar range of harmful chemicals to that of tobacco smoke. It also results in a much higher carbon monoxide concentration due to the higher combustion temperature. Cannabis is often smoked with tobacco which further increases the harm.
Cannabis use in pregnancy may result in low birth weight and premature babies.

"The chemicals in marijuana (in particular, tetrahydrocannabinol or THC) pass through your system to your baby and can harm your baby's development. Some research shows marijuana use during pregnancy may make it hard for your child to pay attention or to learn; these issues may only become noticeable as your child grows older. Separate from the direct, chemical effects of marijuana on a baby, use of marijuana may affect a mother's ability to be able to properly care for her baby.

To date, the three largest longitudinal studies of the children of women who smoked marijuana once a week or more during their pregnancies have identified remarkably consistent outcomes during early development and through young adulthood. In infants, these include increased impulsivity, hyperactivity, and delinquent behaviours, as well as memory dysfunction and decreased IQ scores. During adolescence and early adulthood, fetal cannabis exposure has been linked to persistent reduction in memory and concentration, higher rates of drug use, and an increased incidence of hyperactivity, signs of depression, and psychotic and schizophrenic-like symptoms. These mental health issues are further evidenced by increased reports from both parents and schoolteachers of problematic behaviour and delinquency in cannabis-exposed kids." https://www.the-scientist.com/features/prenatal-exposure-to-cannabis-affectsthe-developing-brain-65230

Heroin-Heroin is a white crystalline powder derived from morphine. It is used illicitly as a narcotic producing a feeling of euphoria, warmth, and wellbeing. Heroin is highly addictive and people can become hooked very quickly. Heroin use in pregnancy is associated with an increased risk of low birth weight, intra uterine growth retardation, preterm births, and sudden infant death syndrome. These effects may be related to the repeated exposure of the fetus to opioid withdrawal as well as the effects of withdrawal on placental function. Additionally, the lifestyle issues associated with illicit drug use put the pregnant woman at risk of engaging in activities, such as prostitution, theft, and violence, to support herself or her addiction. Babies born to women addicted to heroin will develop an addiction and once born may go through a withdrawal process (neonatal abstinence syndrome)

"Heroin crosses the placenta in the blood and reaches the baby's heart, brain and other organs, and has been shown to affect the breathing movements and heart rate of a baby in the womb. This can result in birth defects, premature delivery, still birth, low birth weight and other complications. Taking too much heroin or heroin that contains other drugs or substances, can result in poisoning or even death of mother and baby. After the baby is born the effects of heroin use are fetal abstinence, increased risk of admission to a neonatal intensive care unit, an increased risk of sudden infant death syndrome of 10%, learning and behavioural difficulties and an increased risk of substance misuse in later life." (http://drugabuse.com) (BUMPS, July 2010).

Methadone-The most widely accepted and first line treatment for heroin dependant pregnant women. It is taken orally in liquid form and is a long-acting drug that can be taken once or twice daily. It helps individuals to stabilise their illicit drug use and associated lifestyle. Methadone in itself is an opiate drug and therefore highly addictive. It does not cure addiction but offers stability with a legal prescription. It allows an individual to engage with professionals, address the possible causes of addiction and other aspects of their lives.

Buprenorphine-Used as a substitution therapy for heroin dependence. It is a partial opioid so is addictive carrying the risk of withdrawal for both mother and baby. Research has shown that it produces lower levels of dependence and fewer withdrawal symptoms.

5. Responsibility and Duties

Lead Substance Misuse Midwife/ Locality Specialist Midwives will co-ordinate antenatal care to include:

- Receive Antenatal referrals.
- Co-ordinate antenatal care pathway; working closely with pregnant women, midwives, and obstetric team.
- Make appropriate referrals to other agencies for support i.e., Worcestershire Children First, Substance Misuse Recovery Services.
- Requesting and co-ordinating urine toxicology screening data collection.
- Provide specialist care and advice to pregnant women with drug and/or alcohol issues.
- Provide support, guidance, and training to other staff involved in the pregnant woman's care.
- liaise with Children's Social Care throughout the pregnancy and ensure all documentation is available within Badgernet to include Safeguarding Birth Plan, TCU/Substance Misuse Recovery Services referral form and paediatric/neonatal alert/referral.

5.1 Other Midwifery staff

- Identification and appropriate referral to Specialist Midwives and Obstetric Consultant. See appendix 1.
- Provide antenatal care and advice for pregnant women with drug issues with support from the Specialist Midwifery team.

6. Procedures

6.1 Antenatal Care

- The woman/pregnant person should be assured that they will receive a fully confidential service.
- All pregnant women should be asked routinely and sensitively about their current and previous history of substance misuse and **of their partner** at the booking visit.
- The woman will be informed of the possible effects and risks of her drug or alcohol use on her and her unborn child. She will be given advice, information, and support regarding reducing these risks and an individualised plan tailored to her needs will be discussed and documented.
- Women will be high risk consultant led care, and as such should be seen by Consultant Obstetrician ideally by 16 weeks, where an individualised plan of care will be made, taking into account any other obstetric risks.
- Upon disclosure of current or past **Cannabis** use a Safeguarding referral should be made to locality specialist midwife via Badger Net.
- Upon disclosure of current or past **Heroin** or **Cocaine** use a Safeguarding referral should be made to Lead Substance Misuse midwife via Badger net.
- Request for urine toxicology screening will be documented on BadgerNet.
- It is the responsibility of the Health Professional examining the pregnant woman to offer the requested urine toxicology screening. The Health Professional **must** obtain consent for the screening.

- Follow urine toxicology SOP – Appendix 2
- A routine dating and Mid T scan will be carried out. Growth scans will be performed regularly from 28 weeks as this group of women are known to have an increased risk of intrauterine growth restriction and preterm deliveries (Klee et al, 2002; Drugscope, 2006)
- Should any appointment be missed, the Locality Specialist Midwife and Named Midwife should be informed so that a home visit can be arranged as soon as possible.

6.1.1 Alerts

All known substance misusers or those in a current recovery programme must have a neonatal alert added to BadgerNet antenatally. This will show as a red alert in the alert banner at the bottom of the Badgernet initial screen, under Baby Alerts to the right of the banner.
To complete a neonatal alert, go to enter new note and type referral, select woman then scroll down to neonatal alert. Suggested text to be documented should say 'Drug exposed pregnancy' or full details of recovery programme.

6.1.2 Induction of Labour

IOL is indicated only for obstetric or medical reasons. If IOL is planned, preferably arrange for this to occur early in the day at the beginning of the week. This will ensure that infant is observed closely for signs of neonatal abstinence syndrome during the week, rather than on the weekend when experienced staff and neonatal specialist may not be readily available.

6.2 Intrapartum Care

- For the vast majority labour and delivery will be straightforward for substance misuse women, thus their care will be similar to any other woman. The duration of labour and the incidence of caesarean section are no different to a matched population. (Johnstone,1998).
- Documentation held within the social tab on Badger Net will contain relevant and up to date Information, i.e., the Drug Treatment Plan from Substance Misuse Recovery Services and the Safeguarding Birth Plan which includes any admission and discharge guidance.
- Care in labour (including pain relief) should follow the woman's preferences, hospital policy and the agreed care plan.
- Methadone/Subutex if prescribed should continue throughout labour. It will not produce a significant analgesic effect and should not replace other forms of pain relief.
- Withdrawal from opiates in labour may be shown by fetal distress e.g., abnormal CTG, increased fetal movements, meconium-stained liquor.
- Naloxone **should not** be used in the resuscitation of the baby of an opiate user as it may precipitate abrupt withdrawal symptoms for the newborn.
- As with all admissions determine if any drugs or prescribed medication has been taken. Clarify the dose, time, and mode of administration, explaining why this information is necessary.
- Liaise with agencies (drug worker, pharmacy) to ensure that there is no gap in the provision of prescribed medication due to community prescriptions not being collected whilst the woman is in hospital.

- Inform the Locality Specialist Midwife/Social Worker (if relevant) of admission and delivery. If out of hours leave a message on her mobile.

- Women who are un-booked and disclose a current history of illicit drug misuse or those being supported within a recovery programme should be seen by a senior obstetrician and an individualised plan of care implemented. Specialist midwives can be contacted for support and advise.

6.3 Postnatal Care

Delivery Midwife to commence provision of the keepsake envelope as soon as possible following delivery of the baby, i.e., photograph of mother/father and baby, baby's' foot and handprint and provision of knitted square to both mother and baby.

- Postnatal care of known drug users or women on a methadone/Subutex programme should be cared for on TCU, unless require transfer to NICU.
- Normal postnatal observations should be carried out on the mother and the normal psychological and physiological aspects of parenthood should remain the focus of care.
- Babies of women who have recently or are currently using opiates will be observed for signs of neonatal withdrawal. Symptoms usually present within the first 24 -72 hours of birth.
- The onset of benzodiazepines withdrawal can be delayed presenting at 5-10days of age.
- Neonatal withdrawal will have been discussed with the woman in the antenatal period. If the symptoms are severe the baby may require medication. Mother will be encouraged to be involved in the observation process and be given advice on how to care for and settle her baby. These babies are often fractious even if they do not require treatment and the mother will require reassurance and support.
  See Abstinence Syndrome Network Guideline and Neonatal Abstinence Syndrome (NAS) Information for Parents and Carers within Neonatal key Documents page.

6.3.1 Breastfeeding

Breast feeding can be encouraged unless contraindicated.
Most drugs of misuse do not pass into the breast milk in quantities which are sufficient to have a major effect on the new-born. Babies can suffer fetal abstinence syndrome following an interim care order being granted when the breast-feeding stops, this should be taken into consideration. Apart from all the well documented benefits, breast feeding will certainly support the mother in feeling that she is positively comforting her baby should he/she be hard to settle. There may be some effect on the baby (such as drowsiness with opiates or tranquillisers), however, the important point is that the woman is given all the information she needs to make an informed choice and having made that decision she is fully supported by professionals.

The exceptions are:

- Chaotic drug use
- Women using large quantities of stimulant drugs such as Cocaine, Crack or Amphetamines
- Women who are taking large amounts of non-prescribed benzodiazepines (because of the sedation effects) (Drugscope, 2005)
- Women who are HIV positive: see below.

Current guidelines from the British HIV Association (BHIVA) state that HIV positive mothers should be advised to formula feed exclusively from birth. Because of the very low risk of mother-to-child HIV infection, ***BHIVA guidelines advise that mothers who choose to breastfeed should be supported to do so****. The conditions are that mothers follow the antiretroviral therapy (ART) strictly, and that standard HIV tests show consistently undetectable levels of the virus in the mother. If a mother who is on effective cART (combined antiretroviral therapy), and whose levels of virus are consistently undetectable, chooses to breastfeed, this does NOT constitute a child protection concern.*

Most drug using women are very anxious that other women in the ward remain unaware of their drug use. Some members of their family may not be aware of their use. Staff should therefore maintain confidentiality and be discreet when discussing treatment.
For many substance misusing women, pregnancy is not planned (Klee et al, 2002). This often leads to late presentation, increased risks for mother and baby and the involvement of Children's Services. Many women fail to break this cycle of returning again and again with unplanned pregnancies only to have children repeatedly removed from their care. The importance of contraception and the benefits of a planned pregnancy should be discussed prior to discharge. It is crucial that these women are aware that good health, stability, and the support of health professionals before pregnancy will result in the best outcome for them and their babies.

6.3.2 Women who are on a Methadone or Subutex programme

The woman's prescription is regularly updated by Substance Misuse Recovery Services on the Substance
Misuse Management Plan, which is filed within the social tab on Badger Net.

Within working hours:

• Confirm the dose by contacting the drug worker or the community pharmacist which can be found on Substance Misuse Recovery Services management plan.
• The dose should be treated as a verbal order and confirmed by a second qualified person (doctor, pharmacist, or registered nurse/midwife)

Outside of working hours:

• Use the information from the woman's notes in conjunction with the woman's own medication if brought into hospital.

Note: Care should be taken to check that the date is recent, the label is not forged, and the prescription has not been changed since dispensing.

- If the dose cannot be confirmed by either of these methods, please contact pharmacy.
- If at all in doubt that the woman is complying with her treatment programme a urine specimen should be sent for **urgent 'full urine drug** screen'. The reason for this test should be discussed with the woman and her consent gained (as above).
- The result should confirm the presence of the woman's prescribed medication. A positive result for any other substance should be documented in the hospital notes and the Specialist Midwife informed.

6.3.3 Women admitted with a supply of prescribed Methadone or Subutex.

If the woman is admitted with a supply of methadone the woman should be advised that this should be sent to the hospital pharmacy to be destroyed. Partially used bottles of medication cannot be used or given as Treatment to Take Out (TTOs) due to the risk of contamination. Under no circumstances should the **supply be retained in the bedside locker**.

- If the woman refuses to allow her methadone to be destroyed, then she should be advised that it must be removed from the hospital and sent home. Staff should note that the woman now has a supply at home, and this should be taken into account on transfer home when considering TTOs.
- Use the ward supply of methadone mixture 1mg/1ml for administration after the dose has been prescribed by a doctor.
- If admitted with a supply of Subutex tablets these should be retained in the ward drugs trolley and if suitable will be returned to the woman on transfer home and may replace the need for TTOs
- Use the ward supply of Subutex tablets for administration after the dose has been prescribed by a doctor.
- Contact the drug worker to inform them of the woman's admission. Preparations/plans for transfer home should be discussed at this point regarding take home prescription.
- Contact the community pharmacist as soon as possible and inform them of the client's admission. This removes the risk of dual supply. (The drug worker may offer to do this)

Inform the Lead Substance Misuse Midwife/Locality Specialist Midwife and Social Worker of woman's admission.

6.3.4 Transfer Home during Office Hours

The woman may be transferred home with her own supply of Subutex tablets brought in on admission provided they are untampered and in the sealed foil container. Partly used bottles of methadone brought in on admission should not be used for TTOs due to the risk of possible contamination.

- If the woman has not handed in her own supply of Subutex or is on a methadone programme, check with her if she has a sufficient supply left at home to last until her next appointment with her usual prescriber.
- If the woman does not have a supply at home/ current prescription contact her drug worker who will arrange for a prescription to be generated.
- Document your actions clearly on Badger Net.

6.3.5 Transfer Home Out of Office Hours/ Weekends and Bank Holidays

Transfer home should always be planned. If the woman is likely to be transferred home at the weekend aim to liaise with her drug worker Thursday or Friday so that, if necessary, a prescription can be generated in advance and a follow up appointment arranged.

- Discharge the woman with her own supply of Subutex and make appropriate entry in the register. Do not use partially used bottles of Methadone for TTOs
- If this has not been possible then contact hospital pharmacy. A maximum of 3 days TTOs can be provided.
- Document your actions in the hospital notes and inform all relevant professionals (specialist midwife, drug worker, social worker, and pharmacist) as soon as possible.

6.3.6 Prescribing for women who are not on a drug treatment programme.

For all women who are admitted to hospital who are opiate dependant, methadone will be the drug of choice for a treatment programme.
Inform the Lead Substance Misuse Midwife immediately on admission and discuss with a senior drug worker from Substance Misuse Recovery Services re ongoing treatment plan.

6.4 Woman admitted with a supply of illicit substances

Note: If a supply of illicit substances is brought into the hospital they **MUST** be removed from the hospital, along with any drug paraphernalia.

- The substance should be locked away in the ward Controlled Drug Cupboard and entered in the register on a separate sheet. It is important to document it as 'AN ILLICIT SUBSTANCE BELIEVED TO BE …...'
- The hospital pharmacist should be informed at the earliest opportunity.
- The pharmacist will arrange for the substance to be removed from the premises and disposed of. The woman should be informed of this.

6.5 Referral and transfer home of women not on a treatment programme

- The Maternity Unit/Pharmacy will not provide TTO's of methadone for women who are not already in receipt of a prescription elsewhere.
- All women who are prescribed methadone as a new prescription on admission should be referred to Substance Misuse Recovery Services for on-going treatment and support. They will then aim to arrange an appointment on the day of discharge to continue the prescription or arrange to see the woman prior to discharge so that treatment can be maintained.

6.6 Opiate Withdrawal

Withdrawal symptoms are specific to the type of drug involved, the route used, the frequency of use and the quantity used. Individual sensitivity and psychological state are also important variables. The opiate withdrawal syndrome carries minimal risk of long-term harm, but it is intensely unpleasant. It is important that withdrawal symptoms are managed effectively in order to prevent illicit drug use or self-discharge.

- Signs and Symptoms of Opiate withdrawal
- Nausea & vomiting
- Diarrhoea
- Restlessness & anxiety
- Irritability & insomnia
- Muscular & joint pain
- Running eyes & nose
- Sneezing & yawning
- Sweating & flushing
- Piloerection
- Dilated pupils

Ensure Neonatal policies are referred to for possible withdrawal in the neonate.
As documented within **6.1.1 Alerts**

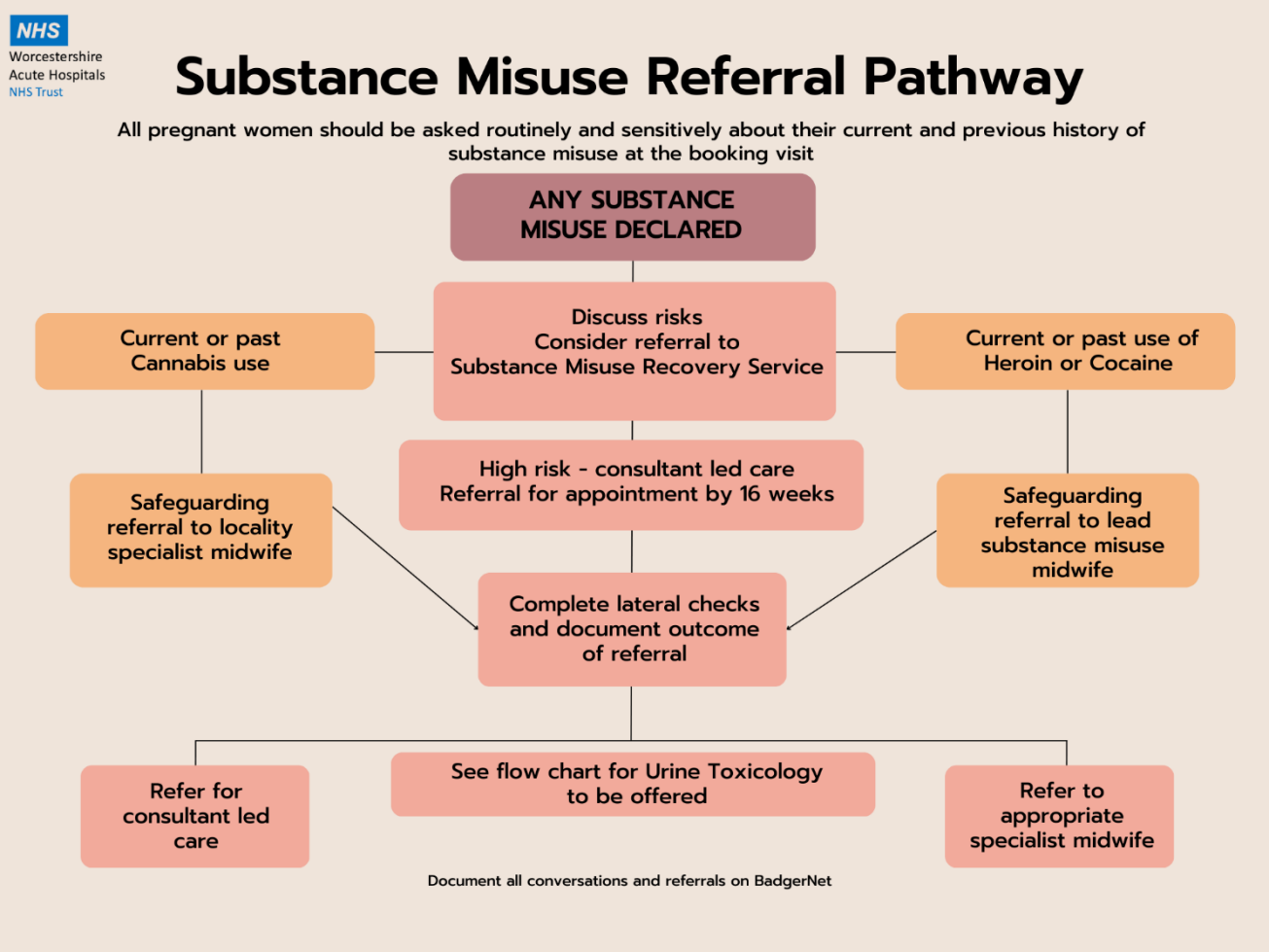
7. Useful Telephone Numbers

West Midlands Toxicology Laboratory City Hospital	0121 507 4135
Substance Misuse Recovery Services Drug and Alcohol Support	0300 303 8200
Safeguarding Team	01905 733871

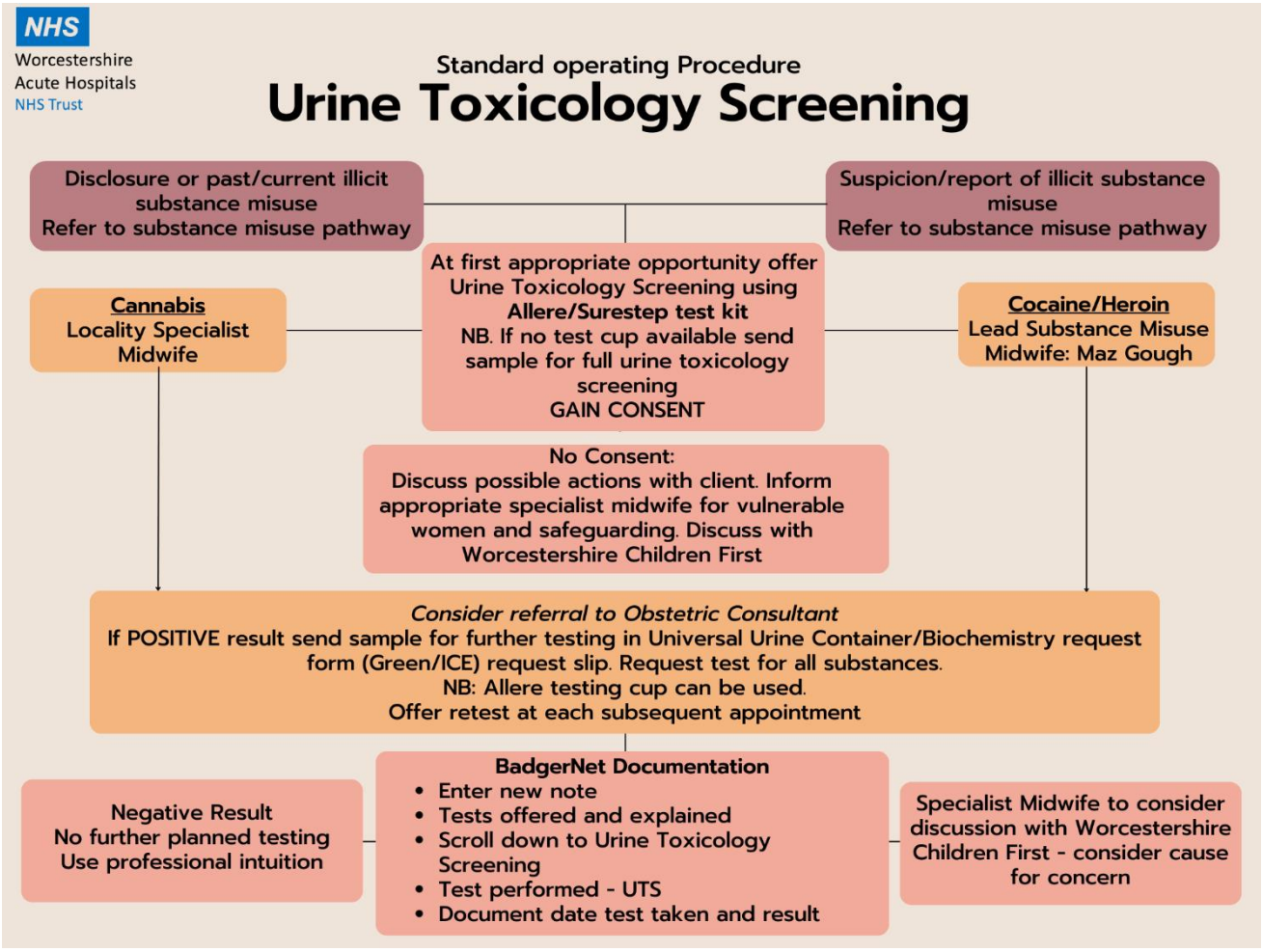
8. References

Lindquist et al 2014, Advisory Council on the Misuse of Drugs 2003, Hidden Harm, National Treatment Agency 2010, Drug Strategy 2017, Knight, Tuffnell et al 2015, Munro,2011 Brandon, Sidebottom et al, 2012, Drug Misuse and Dependence Clinical Guidelines, 2017; Home Office, 2003, Johnson et al 2003, CMACE, 2011: Drug Misuse and Dependence Clinical Guidelines, 2017: Drug Scope 2005, Bumps ,2010, Klee et al, 2002, Drug Scope, 2006

Appendix 1


NHS
Worcestershire
Acute Hospitals
NHS Trust
Substance Misuse Referral Pathway
All pregnant women should be asked routinely and sensitively about their current and previous history of substance misuse at the booking visit
ANY SUBSTANCE MISUSE DECLARED
Discuss risks
Consider referral to
Substance Misuse Recovery Service
Current or past Cannabis use
Current or past use of Heroin or Cocaine
High risk - consultant led care
Referral for appointment by 16 weeks
Safeguarding referral to locality specialist midwife
Safeguarding referral to lead substance misuse midwife
Complete lateral checks and document outcome of referral
Refer for consultant led care
See flow chart for Urine Toxicology to be offered
Refer to appropriate specialist midwife
Document all conversations and referrals on BadgerNet

Appendix 2


NHS
Worcestershire
Acute Hospitals
NHS Trust
Standard operating Procedure
Urine Toxicology Screening
Disclosure or past/current illicit substance misuse
Refer to substance misuse pathway
Suspicion/report of illicit substance misuse
Refer to substance misuse pathway
At first appropriate opportunity offer Urine Toxicology Screening using Allere/Surestep test kit
NB. If no test cup available send sample for full urine toxicology screening
GAIN CONSENT
Cannabis
Locality Specialist Midwife
Cocaine/Heroin
Lead Substance Misuse Midwife: Maz Gough
No Consent:
Discuss possible actions with client. Inform appropriate specialist midwife for vulnerable women and safeguarding. Discuss with Worcestershire Children First
Consider referral to Obstetric Consultant
If POSITIVE result send sample for further testing in Universal Urine Container/Biochemistry request form (Green/ICE) request slip. Request test for all substances.
NB: Allere testing cup can be used.
Offer retest at each subsequent appointment
BadgerNet Documentation
Enter new note
Tests offered and explained
Scroll down to Urine Toxicology Screening
Test performed - UTS
Document date test taken and result
Negative Result
No further planned testing
Use professional intuition
Specialist Midwife to consider discussion with Worcestershire Children First - consider cause for concern

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All Maternity Staff – Newsletter

This key document has been circulated to the chair(s) of the following committee's / groups for comments.

Committee
Maternity Guidelines Forum
Maternity Governance Meeting Group

Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
Nov 23	New Document – Old Document reviewed and updated	L Haynes/K Birch