Substance Misuse in Pregnancy

NGH-GU-1104

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Contributors:	Safeguarding Team

GUIDELINE

CONTENTS

1. INTRODUCTION & AIMS

Substance misuse is defined as the continued misuse of a range of mind-altering substances that affects a person's physical and mental health, social situation and responsibilities. This includes alcohol, illegal drugs (such as cannabis, heroin, and cocaine) but also substances such as aerosols, solvents and glue, and prescription drugs such as codeine or benzodiazepines. It commonly leads to physical and emotional dependency, which causes symptoms of withdrawal when the substance is stopped and thus reinforces the use of the drug. Tolerance is also common, where an increasing amount of substance is required to have the same effect.

Substance misuse is associated with a variety of significant health risks for the individual concerned –

- Psychological and neurological: anxiety, memory or cognitive loss, psychosis, physical and emotional dependence.
- Transmitted infection: hepatitis, HIV, and sexually transmitted infections.
- Long term physical health conditions: lung disease, liver disease.

Substance misuse is commonly associated with other problems, that can have a significant impact on pregnancy and the newborn child –

- Frequently seen in combination with mental health problems.
- Frequently co-morbid cigarette smoking.
- Poor housing and social circumstances.
- Domestic abuse.
- Criminal and anti-social behavior.
- Involvement of child protection / safeguarding.
- Poor antenatal care including late booking, poor attendance, or even concealment of pregnancy.
- Increased risk to the child of neglect.

As such, pregnant women with substance misuse are a high risk population group and require high risk maternity care.

In addition, it is important to recognise that substance misuse is a significant contributing factor to maternal deaths. The MBRRACE report [1] into maternal deaths in the UK between 2009 and 2013, found that 58 women died as a result of substance misuse during pregnancy or in the year following pregnancy. There was a high level of booking late for maternity care, as well as not receiving the minimum standard of expected antenatal care. Use of multiple substances was also predominant in these women. About 1% of all pregnant women are estimated to have problem drug use, and 1% have problem alcohol use.[1]

Drug use is common in the UK. In the CSEW Survey [2] of 2015/16, 3.3% of adults were classed as frequent drug users, with young people (16-24yrs) more likely to be frequent drug users compared to older adults at 4.7%. In any one year, approximately 18% of young adults aged 16 to 24yrs will have some substance misuse history, with one third of all adults having used drugs during their lifetime.

The rates of use of cannabis and alcohol in young people under the age of 18years in the UK are some of the highest in Europe.[3]

Substance misuse is a significant problem that remains stigmatised. Such patients are entitled to the same care as every other patient in the NHS, and often require additional care because of their complex needs. This care must be provided in a non-judgmental fashion.

2. SCOPE

This guideline provides information on the care of pregnant women with a current or past history of substance misuse, including alcohol. It is aimed as providing information to all staff – midwifery and medical – who care for these women during pregnancy.

It provides information on care during the antenatal, intrapartum and postnatal periods, including fetal and neonatal considerations. It aims to ensure that women with a history of substance misuse have the opportunity to receive the best care possible to minimize the effects of their substance misuse on their personal health and that of their child.

3. DEFINITIONS

Substance Misuse	The continued misuse of a range of mind-altering substances that affects a person's physical and mental health, social situation and responsibilities.
S-2-S (Substance to Solution)	Drugs and Alcohol Service in Northampton
HIV	Human Immunodeficiency Virus
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
CSEW	Crime Survey for England and Wales
SGA	Small for Gestational Age
IV	Intravenous
NICU	Neonatal Intensive Care Unit
SIDS	Sudden Infant Death Syndrome
GP	General Practitioner

4. ROLES AND RESPONSIBILITIES

The Clinical Director/ The Head of Midwifery: have the responsibility to ensure that facilities, equipment and staffing allow for the effective implementation of this guideline.

The Matrons: are responsible for ensuring that relevant new guidance is incorporated into practice and that the equipment, environment and training allow this guideline to be adhered to in practice.

Consultant Obstetrician: Is the Lead clinician who brings experience to clinical diagnosis and opinion in the care of women in pregnancy.

Registrar in Obstetrics (ST3 – ST7): Is a senior clinician, providing obstetric input on the labour ward, reviewing and making plans for women and referring to the Consultant where appropriate. All staff within Maternity Services

The Labour Ward Co-ordinator.
The Labour ward coordinator must ensure that midwives are supported and guidance provided so that safety of mother and baby is achieved.

The Community Midwife:
The midwife must establish a comprehensive plan of care to meet the needs of the woman and promote the health and well-being of the mother and baby.

The Hospital Midwife:
The midwife should provide care as per this guidance and the documented plan of management, ensuring that the continued needs of the mother and baby are met.

5. CLINICAL CONTENT

5.1 The Risks of Substance Misuse

There are a number of risks associated with substance misuse during pregnancy. The nature and extent of risk will depend on the substance involved, the route and frequency of consumption, the gestation at which it is taken, and the presence of other medical and social problems. A single episode of substance misuse during pregnancy is unlikely to cause harm to the developing fetus.

The general risks associated with substance misuse during pregnancy:

- Use of any recreational drug in the first trimester is associated with gastroschisis
- Intrauterine growth restriction – most marked when women are multiple-drug users
- Premature rupture of the membranes
- Prematurity
- Meconium stained liquor
- Fetal distress
- Neonatal Abstinence Syndrome
- Sudden Infant Death Syndrome (SIDS)

Individual substances can be associated with specific risks also. However, with many drugs, there are often confounding issues (smoking, other drugs, social problems) that limit the ability to link a particular drug with a particular problem.

Drug	Risk to Mother	Risk to Fetus or Neonate
Alcohol	Physical addiction and alcohol withdrawal Liver problems – cirrhosis, liver failure, oesophageal varices	Low birth weight with sustained heavy alcohol use Neurodevelopmental delay and intellectual impairment Fetal alcohol syndrome – growth restriction, particular facial features, learning disability, failure to thrive as

		child Binge drinking may be particularly harmful
Cannabis (usually smoked with tobacco)	Risks associated with smoking More potent varieties of cannabis – skunk – stronger association with paranoia and psychosis	SGA
Heroin	Respiratory suppression, hypoxia and respiratory arrest Blood borne viruses from IV drug use Withdrawal symptoms Poor venous access Abscess and ulcer formation related to drug injecting	Transmission of blood borne viruses Neonatal withdrawal No increased risk of congenital abnormalities
Cocaine and crack cocaine	Abruption Hypertension	Abruption SGA Stillbirth Fetal brain infarcts leading to neurological abnormalities
Amphetamines	Hypertension	SGA Fetal hypoxia is possible due to vasoconstrictor action
Benzodiazepines	Anxiety if withdrawing Seizures if withdrawing	Possible increased risk of cleft lip and palate Neurodevelopmental delay Floppy baby syndrome Neonatal withdrawal symptoms can be significant

5.2 Safeguarding Children

Substance misuse should not automatically prompt a safeguarding referral. However, a referral to children's social care must be undertaken where parental substance misuse impacts on the parents' ability to meet the needs of the child, or where there is severe substance misuse (drug or alcohol).

5.3 Antenatal Care

5.3.1 General principles of antenatal care

Include:

- Aim to stabilize the situation – medically, social and psychologically
- All women must be provided with non-judgmental care, with an aim to establish a rapport that encourages engagement between a woman and services.
- All women are screened for drug and alcohol use at the booking assessment. Be aware of under-reporting of usage
- All women with a history of substance misuse must be referred to a consultant obstetrician to formulate an appropriate care plan for the pregnancy, birth and postnatal period. However, most of the pregnancy care will be provided by the community midwife.
- Substance misuse interventions should be offered to all women during pregnancy as this is a time when women may be more inclined to engage with change. This should be provided from the first disclosure of substance misuse. These should be offered to partners also.
    - Substance to Solution (S2S) is our local organization that aids people with substance misuse including drug detox. Patients can self-refer or be referred by professionals
- Where possible, care should be provided in a flexible way to help engage the woman in her care. This may include appointments at times and places other than those usual to the woman's team.
- Comprehensive plans must be made, documented and shared with all professionals and agencies involved in the woman's care
- All professionals and agencies involved in care should be noted in the woman's pregnancy record
- Follow up all non-attendance of appointments

5.3.2 Specific antenatal care

Each patient must be assessed on their individual level and type of risk –

- Assess and document types of drug used, quantity, route of consumption as well as any past or current treatments
- Provide individualized information on the risks of drug / alcohol use in pregnancy to both mother and fetus
- Personal IV drug use, or sexual contact with IV drug users
    - Screen for Hepatitis C at booking
    - Repeat testing for hepatitis B and C and HIV should be offered with 28 week bloods
- Serial growth scans –
    - Indicated for any cocaine and amphetamine use
    - Indicated for regular alcohol use
    - Not indicated for sole methadone use or occasional cannabis use, but may be indicated for other reasons
- Stabilisation and Detox services
    - Heroin substitutes methadone or buprenorphine (Subutex) – can be initiated and stabilized during pregnancy, but dosages may need to increase in third trimester due to pharmacokinetics, and may need to decrease post-partum.
    - Complete detox from opiates should only be contemplated during the second trimester of pregnancy.
    - Alcohol – detox should only be contemplated in an in-patient setting under the joint care of specialist addiction services and a consultant obstetrician
    - Benzodiazepines – detox should be under the care of addiction specialists and use gradual dose-reduction with long-acting benzodiazepines
- Provide individualized information for postnatal plan of care, including neonatal care and social provision
- Substance misuse is not an indication for planned delivery, and decisions regarding elective delivery should be made based on obstetric indications only

5.4 Intrapartum Care

5.4.1 Where Should Labour Care be Provided?

Occasional drug misuse – for example occasional cannabis use – does not necessarily warrant admission to Labour Ward so long as there are no concerns with maternal or fetal wellbeing.

However, women with ongoing chronic substance misuse should be cared for on Labour Ward due to the potential for fetal concerns.

5.4.2 On Admission to Hospital

The following information should be obtained by the admitting midwife –

- Confirmation of drug history
- History of most recent drug use – substance, route, date and time
- Use of any substitution medications – methadone, Subutex – and the community pharmacy that dispenses the prescription
- If the woman has any of her own legally prescribed medication, follow NGH procedures on Controlled Drugs.
- Alert obstetric team, anaesthetist, midwife coordinator and neonatal team of admission
- Check base folder for safeguarding notifications and inform safeguarding team of admission, or duty social worker
- If on a drug substitution programme (methadone, subutex) inform her local pharmacy of her admission to avoid the possibility of others collecting her prescription

5.4.3 Monitoring in Labour

Maternal monitoring should be as per Trust guidelines

Fetal monitoring –

- Should be provided in line with fetal monitoring guidelines
- The majority of women should have continuous monitoring due to potential fetal concerns

- Women with no feto-maternal concerns are suitable for intermittent auscultation and include –
    - Those using a methadone substitution programme and no other drug use
    - Those with occasional drug use – for example, occasional alcohol or cannabis

5.4.4 Other Factors to Consider in Labour

- Those with a history of intravenous drug use, may have poor venous access
    - Anaesthetist to review
    - Early venous access in labour in advance of problems – may require central venous access

5.4.5 Pain Relief for Labour and Birth

Proper analgesia according to their wishes is paramount to these women. Poorly controlled pain leads to –

- Unnecessary suffering
- Self-discharge and dis-engagement from care
- Use of illicit drugs in addition to prescribed medications

Women, who use opiates, including methadone, have a reduced ability to respond to their body's natural opioids. This can often result in being more sensitive to pain, and a poor response to opiate analgesia. They often require larger doses of opiate medication to achieve effective pain-control and requests for more pain-relief should not be attributed to drug-seeking behaviour.
These women often benefit from an epidural for its superior pain relief capabilities and better fetal outcomes compared to high-dose opiates.

5.5 Postnatal Care

The postnatal period is a time of particular vulnerability for women with a history of substance misuse. In a large number of cases this period of time can include a withdrawal of care from maternity services and also the involvement of child protection services. If there is insufficient support available, these women are at significant risk of self-harm either intentionally or accidentally, and indeed this is when the majority of maternal deaths in relation to substance misuse have occurred.[1]

5.5.1 Mother

Care to be provided according to Trust guidelines.
Additional considerations:

- Change in dosage of drug substitutes may be required
- If the baby is removed from the mother's care, additional support and vigilance is required as this is a time of particular stress and vulnerability when the risk of maternal self-harm is at its highest

5.5.2 Neonatal Care – Immediate Care at Birth

Be prepared for resuscitation with all babies where chronic substance misuse is an antenatal factor.
If the baby requires admission to the NICU the following information must be provided:

- What drug and/or alcohol is used, or was used, by the woman
- Time and date of last use
- Length of time of usage
- Substitute prescriptions, where applicable
- Safe Guarding Plan, if applicable

After birth, care will be provided in the ward area with the baby's mother according to the Trust guideline on Neonatal Abstinence, unless admission to NICU is necessary.

5.5.3 Neonatal Care – Newborn Care and Neonatal Abstinence Syndrome / Withdrawal

Plans should be made once born, for the baby to under urine toxicology testing.

During pregnancy, most drugs pass via the placenta to the fetus. After delivery, the baby's supply of drugs is cut off abruptly at the point the cord is cut, and the baby can experience withdrawal symptoms.

General symptoms of withdrawal include: irritability, gastro-intestinal dysfunction, respiratory distress and hyperactivity of the autonomic nervous system
Onset of withdrawal symptoms –

- Varies from hours after birth, to 2 weeks of age
- 90% of infants who withdraw display symptoms by 96 hours after birth
- Onset can be delayed for up to 7 -10 days in cases where the woman is taking methadone in conjunction with benzodiazapines

Management of Withdrawal Symptoms – please see Neonatal Abstinence Guideline

5.5.4 Infant Feeding

In most cases, the benefits of breastfeeding far outweigh the disadvantages, even in the context of continued substance misuse. This means that breast feeding should be encouraged, even if substance misuse occurs.

The exceptions to this are

- Alcohol: avoid breastfeeding if drinking heavily (8+units per day)
- Heroin – ongoing use of large doses of heroin can lead to neonatal suppression and breastfeeding should be avoided
- Ongoing significant stimulant use (cocaine, crack, amphetamines): mother should be counselled not to breastfeed due to the risk of side effects in baby.
- High dose benzodiazepines – can cause significant neonatal sedation and breastfeeding should be avoided.
- HIV positive – advise to avoid breastfeeding to help prevent transmission to baby.

In the case of occasional drug usage, but where usage is generally considered harmful (eg. Alcohol, cocaine): Occasional usage should not mean a complete cessation of breastfeeding; milk can be expressed and disposed of for the first few hours following the consumption of drug, and then breastfeeding can be resumed after sufficient time has been allowed for the drug to clear from the mum's system.

Other points:

- Hepatitis C – breastfeeding not contraindicated but discuss risks and benefits
- Methadone treatment – breastfeeding not contraindicated and may help neonatal withdrawal, infant should be watched for sedation, methadone dose can be reduced gradually postpartum under supervision of addiction services

Always be mindful that even if a drug itself is not considered harmful in breastfeeding the effects on the mother may be significant leading to poor ability to parent and increased risk of harm to the baby, including SIDS.

5.5.5 Discharge from Hospital Midwifery Care

The following must be arranged at the point of discharge from hospital:

- Inform Substance Misuse key worker, health visitor and GP
- Inform allocated social worker is appropriate
- Ensure ongoing prescription of substitute medication is arranged and in place

Ensure adequate but relevant information is entered in the community midwives' discharge book

5.5.6 Other Drugs – New Psychoactive Substances (Previously called Legal Highs)

There are a large variety of other drugs available and new drugs will continue to be developed. They are designed to work in similar ways to existing drugs.

Examples include:

- Mephedrone (M-CAT, Meow-Meow) – stimulant like cocaine
- Spice, Black Mamba – similar to cannabis

There is no data on the use of these drugs in pregnancy, their risks and management. As such, women must be advised on the unknown impact that these drugs have on pregnancy, and each case must be managed on an individual basis.

6. REFERENCES AND ASSOCIATED DOCUMENTS

1. Knight M *et al* on behalf of MBRACE-UK. "Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. December 2015
2. Home Office. Drug Misuse: Crime Survey for England and Wales2015/16 (2nd ed). July 2016. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf

3. Home Office. Drug Strategy 2010. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf
4. NHS Lothian. Substance Misuse in Pregnancy. 2003. Available at: http://www.nhslothian.scot.nhs.uk/MediaCentre/Publications/ForProfessionals/Documents/SubstanceMisusePregnancy.pdf - although this is an old publication, it still has some useful general information
5. Department of Health (2013). *NHS Constitution: the NHS belongs to us all.* [online]. London. Department of Health. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf [Accessed 1 June 2013]

Associated Documents

- NGH Trust Guideline – "Intrapartum Care of Healthy Women and Babies"
- NGH Trust Guideline – "Electronic Fetal Monitoring"
- NGH Trust Guideline – "Maternity Care Pathway for Postnatal Care"
- NGH Trust Guideline – "Care of a Baby with Neonatal Abstinence Syndrome"
- NGH Trust Guideline – "Guideline for Management of Substance Misusers" – although this guideline does not apply to pregnant women, there is some useful information for reference
- NGH Trust Guideline – "Medicines Management Policy"

- NICE Guideline – Antenatal and Postnatal Mental Health (CG192), 2014
- NICE Guideline – Pregnancy and Complex Social Factors (CG110), 2010

Appendix 1 – Useful Contacts

- **Substance-2-Solution (S2S):** Local provision of substance misuse support

Place	Address	Phone
Northampton	Spring House, 39 Billing Road, Northampton, NN1 5BA	01604 211 304
Daventry	Danetre Hospital, London Road, Daventry, NN11 4DY	01604 211 304
Wellingborough	Oxford Street, Wellingborough, NN8 4JG	01604 211 304
Kettering	20 Carrington Street, Kettering, NN16 0BY	01604 211 304

- **Alcoholic Anonymous:** Free phone 0800 9177 650
- **Narcotics Anonymous:** 0300 999 1212
- **Talk to Frank** – national drug information
    - Website: http://www.talktofrank.com/
    - Helpline: 0300 123 6600

SUBMISSSION DOCUMENTS

7. IMPLEMENTATION AND TRAINING

Implementation

- Guideline changes will be disseminated via ward meetings, training days and STORK TALK magazine and will be available via Intranet.
- Practice implications if applicable to be discussed with a member of the Clinical Effectiveness Group and Practice Development team prior to guideline re issue.
- How to access the guidelines and expectations of all staff will be included in local induction programmes for new staff members.
  This guideline will be distributed electronically to all areas of maternity services

Training: will be provided as part of training and education sessions through Safeguarding Team.

8. MONITORING AND REVIEW

Audit

The results of the annual audit will be presented to the Maternity Clinical Effectiveness Group and the audit report will be made available to Supervisors of Midwives, midwifery and obstetric staff through the Obstetric Governance Group

If the audit standards are not being met, the Maternity Clinical Effectiveness Group will instigate the development of an action plan, which will have clear timescales and will include an assessment of the resource implications (if any).

The action plan will be presented to the Obstetric Governance Group who will be responsible for monitoring progress against the actions. The action plan will incorporated into the Governance Forward Planner and a quarterly update will be requested until all actions are completed.

Auditable Standards

- Proportion of women where drug and alcohol use is recorded at booking – target 100%
- Proportion of women with a history of substance misuse who are referred for consultant obstetric care – target 100%
- Proportion of women with a history of substance misuse who are offered interventions (Substance-2-Solution etc) – target 100%

9. COMPLIANCE STATEMENTS

Equality & Diversity

This document has been designed to support the Trust's effort to promote Equality, Diversity and Human Rights in the work place in line with the Trust's Equality and Human Rights Strategy. It has also been analysed to ensure that as part of the Public Sector Equality Duty the Trust has demonstrated that it has given 'due regard' to its equality duty and that, as far as is practicable, this document is free from having a potential discriminatory or adverse/negative impact on people or groups of people who have relevant protected characteristics, as defined in the Equality Act of 2010.

NHS Constitution

The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principals and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

Northampton General Hospital NHS
NHS Trust

FORM 1a- RATIFICATION FORM - FOR COMPLETION BY DOCUMENT LEAD Note: Delegated ratification groups may use alternative ratification documents approved by the procedural document groups.	
DOCUMENT DETAILS	
Document Name:	**Substance Misuse in Pregnancy**
Is the document new?	**No**
If yes a new number will be allocated by Governance	**N/A**
If No - quote old Document Reference Number	**?**
This Version Number:	**Version: 3**
Date originally ratified:	**October 2008**
Date reviewed:	**Aug 2011 Mar 2017**
Date of next review: a 3 year date will be given unless you specify different	**Date: April 2020** **Highlight: 3yr**
If a Policy has the document been Equality & Diversity Impact Assessed? (please attach the electronic copy)	**Yes**
DETAILS OF NOMINATED LEAD	
Full Name:	**Amanda Wells**
Job Title:	**Clinical Effectiveness Lead Midwife**
Directorate:	**Obstetrics**
Email Address:	**Amanda.wells@ngh.nhs.uk**
Ext No:	**X 3964**
DOCUMENT IDENTIFICATION	
Keywords: **please give up to 10 –** to assist a search on intranet	**Substance Misuse, Pregnancy, Heroin, Methadone, Cannabis, Cocaine, Addiction, high risk, neonatal abstinence**

GROUPS WHO THIS DOCUMENT WILL AFFECT?
(please highlight the Directorates below who will need to take note of this updated / new policy)

Anaesthetics & Critical Care	Gynaecology	Medicine
Child Health	Haematology	Nursing & Patient Services
Corporate Affairs	Head & Neck - inc Ophthalmology	Obstetrics
Diagnostics	Human Resources	Oncology
Facilities	Infection Control	Planning & Development
Finance	Information Governance	Trauma & Orthopaedics
General Surgery		Trust wide

TO BE DISSEMINATED TO: NB – if Trust wide document it should be electronically disseminated to Head Nurses/ Dm's and CD's .List below all additional ways you as document lead intend to implement this policy such as; as presentations at groups, forums, meetings, workshops, The Point, Insight, newsletters, training etc below:

Where	When	Who
Intranet	Once Ratified	MCEG
Stork Talk	Once Ratified	MCEG/SG team update

Team Meetings	Once Published	Team Leads

Northampton General Hospital NHS
NHS Trust

FORM 2 - RATIFICATION FORM to be completed by the document lead

Please Note: Document will not be uploaded onto the intranet without completion of this form

CONSULTATION PROCESS

NB: You MUST request and record a response from those you consult, even if their response requires no changes. Consider Relevant staff groups that the document affects/ will be used by, Directorate Managers, Head of Department ,CDs, Head Nurses , NGH library regarding References made, Staff Side (Unions), HR Others please specify

Name, Committee or Group Consulted	Date Policy Sent for Consultation	Amendments requested?	Amendments Made - Comments
Angela Bithray	14/3/17	Add in information of 'Legal Highs'	DONE
Emma Fathers	14/3/17	Be more clear about the need for social services referral criteria	DONE
Emma Fathers	14/3/17	Urine toxicology for babies	NOT DONE – should be covered in Neonatal guidelines rather than obstetric guideline
Paula Briody Intrapartum Matron	March 17	No comments	
Anne Richley	Mar 17	Happy with content	
Geetha Registrar	Feb 17	Happy with clear content	

Existing document only - FOR COMPLETION BY DOCUMENT LEAD

Have there been any significant changes to this document? *if no you do not need to complete a consultation process*		**YES**
Sections Amended:	YES / NO	**Specific area amended within this section**
Re-formatted into current Trust format	**YES**	
Summary/ Introduction/Purpose	**YES**	**Updated and more detail**
Scope	**YES**	**Updated**
Definitions	**YES**	**Updated**
Roles and responsibilities	**NO**	
Clinical Content	**YES**	**Updated and more detail**
Refs & Assoc Docs	**YES**	**Updated**
Appendices	**YES**	**Updated**
Implementation and Training	**NO**	
Monitoring and Review	**YES**	**Updated**

FORM 3- RATIFICATION FORM (FOR PROCEDURAL DOCUMENTS GROUP USE ONLY) **Read in conjunction with FORM 2**			
Document Name:	**Substance Misuse in Pregnancy**		
	YES / NO / NA	**Recommendations**	**Recommendations completed**
Consultation Do you feel that a reasonable attempt has been made to ensure relevant expertise has been used?	**YES**		
Title -Is the title clear and unambiguous?	**YES**		
Is it clear whether the document is a strategy, policy, protocol, guideline or standard?	**YES**		
Introduction Is it brief and to the point?	**YES**		
Purpose Is the purpose for the development of the document clearly stated?	**YES**		
Scope -Is the target audience clear and unambiguous?	**YES**		
Definitions –is it clear what definitions have been used in the	**YES**		
Roles & Responsibilities Do the individuals listed understand about their role in managing and implementing the policy?	**YES**		
Substantive Content is the Information presented clear/concise and sufficient ?	**YES**		
Implementation & Training – is it clear how this will procedural document will be implemented and what training is required?	**YES**		
Monitoring & Review (policy only) -Are you satisfied that the information given will in fact monitor compliance with the policy?	**YES**		
References & Associated Documentation / **Appendices**- are these up to date and in Harvard Does the information provided provide a clear evidence base? Are the reference provided using Harvard Referencing format?	**YES**		
Are the keywords relevant	**Yes**		

Name of Ratification GroupMCEG	Ratified Yes: Amanda Wells MCEG Lead, Sara Dexter MCEG Consultant Lead, Chris Ainsworth Deputy Head of Midwifery.	Date of Meeting:27.4.17
	Ratified No:	
	Ratified subject to amendments and chair approval	
Name of Ratification Group	Ratified Yes:	Date of Meeting:
	Ratified No:	
	Ratified subject to amendments and char approval	