Substance Use Disorders During Pregnancy:

Guidelines for Screening & Management

Revised Edition 2016

Includes Quick Reference Guide!

SCREEN and ASSESS

BRIEF INTERVENTION

REFERRAL to TREATMENT

MANAGEMENT

Washington State Department of Health

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Substance Use Disorders During Pregnancy: Guidelines for Screening & Management

Revised Edition 2016

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Preface

Substance use disorders during pregnancy have been identified as critical to the health of mothers and babies from all socioeconomic groups. Substance use contributes to obstetric and pediatric complications, including Fetal Alcohol Spectrum Disorders,[1] prematurity, abruptio placenta, stillbirth, and low birth weight.[2]

Given that any exposure during pregnancy can result in harm, substance **use** even in the absence of addiction is of concern during pregnancy and warrants attention.

Prenatal alcohol exposure is the leading preventable cause of birth defects and development disabilities in our country. Prenatal alcohol exposure can result in major organ birth defects, growth disorders and damage to multiple structures in the brain resulting in permanent and lifelong disabilities. There is no known safe level of alcohol consumption during pregnancy. Despite some recent research suggesting otherwise; the standard of care remains avoidance of all alcohol use during pregnancy.[3] Use of multiple substances is common and compounds the potential impact on the pregnancy and can make treatment more challenging.

Abuse of prescription opioid medications is a growing problem and can result in same complications as other opioids of abuse. Opioid abuse/misuse during pregnancy increases the risk of obstetrical complications such as stillbirth, low birth weight, preterm birth, infection (most often Hepatitis C), sexually transmitted infections Neonatal Abstinence Syndrome and sudden infant death syndrome.[2]

Stimulants such as cocaine and methamphetamine can have potential effects on central nervous system, cognitive function and behavior. The effects may be subtle and transient.[4]

Marijuana use by adults is now legal in Washington State. There are health risks to infants of mothers who use medical or recreational marijuana. The main psychoactive component in marijuana (THC) passes from mother to child during pregnancy and through breast milk.[6] Emerging research also suggests there is an association between marijuana and decreased fetal growth, development and executive functioning and mood disorders in children.[2] THC stays in the body of mothers and babies for a long time, babies can test positive for THC weeks after being exposed.[6] Babies exposed to THC can have problems with feeding.[7]

Tobacco, though not the focus of this best practice document, has major negative effects on pregnancy and birth outcome. These include low birth weight, preterm birth, still birth, placental dysfunction. Recent research shows tobacco use during pregnancy is associated with cognitive function and behavior disorders as well as certain birth defects.[8]

Among women who abuse substances, there is a high rate of co-morbidity. These include mental health disorders such as anxiety, depression, bipolar, post-traumatic stress disorder. Women with mental health conditions who also abuse substance frequently have more severe addictions.

In addition, many addicted women are homeless, low income, and victims of interpersonal violence. Frequently there is history of child abuse/neglect and/or sexual assault.[2, 9] Unintended pregnancy rates are higher in this population making it difficult to intervene prior to pregnancy.

Treatment for substance use disorders during pregnancy can be more effective than at other times in a woman's life. Providers play a key role in influencing the health behaviors of pregnant women in their care. Pregnant women often describe their healthcare providers as the best source of information and generally follow their advice.

We know that Fetal Alcohol Spectrum Disorders and the deleterious effects of drugs are preventable. If we are successful in preventing exposure and these adverse effects, substantial cost savings may be realized, including health care, foster care, special education, and incarceration costs.[10]

We want to thank all those who assisted in the development and updates of these guidelines. Reduction of perinatal drug and alcohol dependency and its devastating effects can be achieved through improved identification of alcohol and drug use prior to or early in pregnancy and utilization of consistent evidence-based medical protocols. Early identification is the first step toward engaging substance dependent women into treatment. Primary prevention efforts in family planning and primary care settings aimed at identification prior to pregnancy are also of critical importance in achieving a significant reduction in perinatal drug use. We hope this information will help all health care professionals working with pregnant women enhance their skills and improve care for women and infants.

Substance Use/Disorders Screening and Management During Pregnancy

Quick Reference Guide

Ask-Screen (see algorithm, page 5)

- Ask **all** pregnant and postpartum women at the first visit and at mid-second trimester. Verbal screening is the standard of care (see interview and self- administered tools, page 25).
- Ask about use/abuse prior to pregnancy recognition as well as current use.
- Develop an office protocol to ensure that all women are screened in a respectful and non-judgmental manner. Normalize the process and model your approach (see practice preparation tips, page 10). Explain why all women are asked about use/abuse.
- Protect confidentiality.
- Remember, how screening is handled impacts the pregnant woman's use of prenatal care.

Assess-Intervene

- Provide feedback on screen results (see interview tips/scripts, page 12).
  - Positive screen: How the use/abuse affects her health, pregnancy, and life.
  - Readiness to change behavior/accept treatment: "Would you like help to stop?"
  - Signs of acute withdrawal or intoxication.
- Assess and validate women's reaction and discuss her feelings and thoughts. Assess her ability to change.
- Level of risk – use/abuse/addiction. Screening alone does not diagnose a substance abuse disorder. Naloxone to diagnose opioid dependence is **contraindicated** in pregnancy (find definitions on page 7).
- If acute alcohol or sedative withdrawal, refer to inpatient management. If opioid dependence, refer for inpatient or outpatient stabilization depending on comorbidities and presence of withdrawal (see signs/symptoms, page 16).
- May include urine testing (see toxicology screen interpretation information, page 33).
- Assess for mental illness conditions and violence (see associated issues information, page 23).

Advise – Everyone, even women who deny use/abuse

- Ask what she knows about effect of substance on pregnancy/newborn.
- Express concern about level of use (if appropriate) **"I know you want a healthy pregnancy and baby, it's important you don't use any _____ while pregnant because…"**
- Share medical advice related to use/abuse and impact on pregnancy and outcome. Advise all women, even non-users.
- Advise to stop all use. If physically dependent, refer for appropriate resources to stop safely. **"I'm glad you let me know you've using _____because it may harm your baby."**

Assist and Arrange (find conversation tips for those not ready to change on page 12)

- Offer help based on her readiness to change. **"We both have the same goals, healthy pregnancy and baby."** Ask what she will do and agree on a plan.
- Praise all efforts to change.
- Refer for specialty assessment: addiction, mental illness based on level of addiction.
- Refer to addiction treatment for stabilization and treatment: **Washington State Recovery Helpline 1-866-789-1511.** Find more information about treatment options and models on page 33.
- Make other referrals as appropriate (see referral resource information, page 36).
- Obtain consent/release for coordination with substance abuse and mental health treatment providers.
- Provide overdose education and information on where to obtain Naloxone kits if using opioids.

Quick Reference Guide

Manage pregnancy medical issues (more information on page 18)

- Screen for untreated medical problems, injuries, and infections as appropriate.
- Screen for mental illness and interpersonal violence and refer.
- Routine blood work and labs plus hepatitis, TB, STI, and HIV.
- For opiate users, confirm enrollment or refer to methadone or buprenorphine maintenance.
- Schedule random urine tox screens to monitor how the woman is doing. Use positive screens as opportunity to talk (see toxic screens interpretation information, page 32).
- Schedule more frequent visits to identify additional medical and psychosocial problems early.
- Monitor fetal growth, development, and well-being based on current use or abstinence (see PATHWAY, page 22). Monitor comorbidities/pregnancy complications.
- Discuss possible efcts on the newborn.
- Discuss contraceptive methods and make a plan. Consider LARC as first line option. Insert immediate postpartum if possible.
- Obtain consent for tubal ligation after delivery if the woman chooses this method.
- Discuss breastfeeding and alcohol and drug use issues.
- Coordinate with addiction and mental health treatment providers.

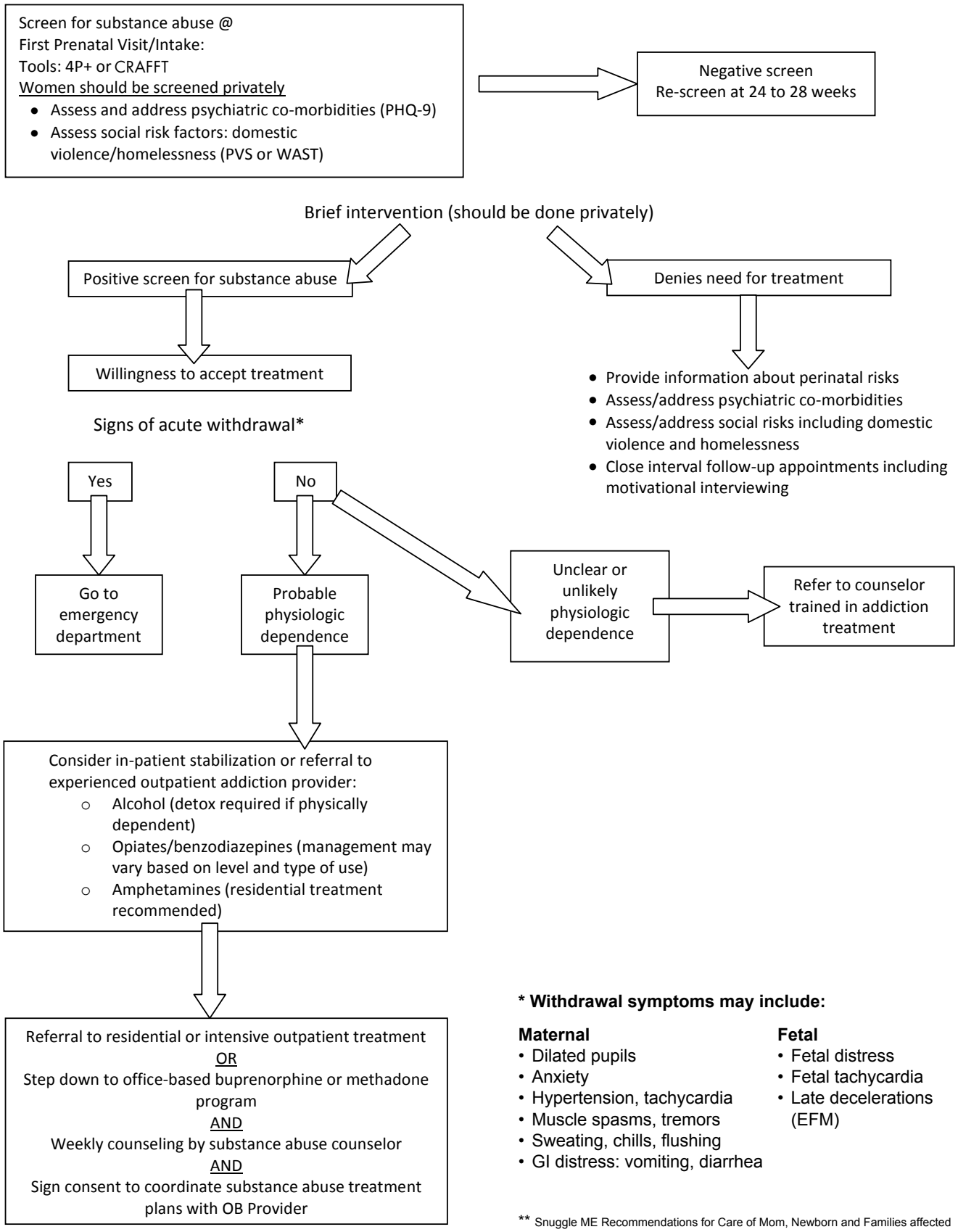
Manage Intrapartum

- Complete history and physical exam.
- Repeat hepatitis screen, serologic test for syphilis, and HIV rapid test.
- Repeat urine toxicology.
- Alert pediatric and nursing staff.
- Alert social services if necessary.
- Continue methadone or buprenorphine on schedule – consider split dosing.
- Determine method of delivery depending on obstetrical indicators.
- Pain management: assure pain will be managed. Maximize and schedule non-opioid analgesia, and provide adequate opiod analgesia when indicated. Anticipate opioid-dependent women will require higher doses of opioid pain medication but for the same duration. Epidural anesthesia can be used per hospital protocol (see more information on intrapartum pain management, page 19).

Post-partum

- Encourage continuation in a therapeutic drug treatment program; coordinate with programs.
- Encourage and provide appropriate contraceptive method: consider LARC as first line option and consider starting before discharge.
- Close follow up for pain management.
- Coordinate with treatment – may need dose adjustment.
- Consider more frequent postpartum visits.
- Support breastfeeding as appropriate. Breastfeeding is typically recommended in methadone maintenance but is contraindicated if the woman is HIV positive or using illegal drugs or marijuana.
- Breastfeeding women with a positive history of drug use during pregnancy should be tested periodically while breastfeeding.
- Coordinate with social services for a safe discharge plan.
- For guidance on testing and reporting substance exposed newborns, consult the Guidelines for Testing and Reporting Drug-Exposed Newborns in Washington State: http://here.doh.wa.gov/materials/guidelines-drug-exposed-newborns
- See page 23 for referral resources to consider.

Screening and Brief Intervention Algorithm**



*** Withdrawal symptoms may include:**

Maternal
- Dilated pupils
- Anxiety
- Hypertension, tachycardia
- Muscle spasms, tremors
- Sweating, chills, flushing
- GI distress: vomiting, diarrhea

Fetal
- Fetal distress
- Fetal tachycardia
- Late decelerations (EFM)

** Snuggle ME Recommendations for Care of Mom, Newborn and Families affected by Perinatal Addiction; retrieved online August 28, 2014

Purpose

The American College of Obstetrics and Gynecology recommends that all pregnant and non-pregnant women should be routinely asked about use of tobacco, alcohol, marijuana and other drugs, as well as non-medical use of prescription medications.[11] The purpose of this Washington State Department of Health document is to:

- Improve provider ability to effectively screen and identify pregnant women with substance use disorders
- Provide guidelines for screening and follow-up
- Provide sample screening tools
- Provide recommendations related to drug testing of pregnant women and newborns
- Provide referral resource information for Washington State

The Centers for Disease Control and Prevention suggests that all patients be asked about alcohol and substance use regularly.

Definitions (DSMS now uses the term Substance Use Disorders)

Use refers to any use of alcohol or drugs.

Abuse is a recurring pattern of alcohol or other drug use which substantially impairs a person's functioning in one or more important life areas such as familial, vocational or employment, psychological, legal, social or physical. Any use by a youth is considered abuse.

Dependence is primarily a chronic disease with genetic, psychological, and environmental factors influencing its development and manifestations including physical and physiological dependence as evidenced by withdrawal. Psychological dependence is evidenced by a subjective need for a specific psychoactive substance such as alcohol or a drug. Women who abuse substances or are dependent require different interventions than men. Dependence is used as a formal term for addiction, but can be confused with purely physiological dependence.

Misuse: Incorrect use of a medication by patients who may use a drug for a purpose other than prescribed, take too little or too much of a drug, take it too often, take it for too long, or taken at doses or via routes not prescribed. Misuse does not apply to off-label prescribing—prescribing a medication for a condition other than the condition for which the Food and Drug Administration approved the medication—when such use is supported by common medical practice, research, or rational pharmacology.

Addiction or Addictive Process: A complex, progressive behavior pattern having biological, psychological, sociological, and behavioral components. The addicted individual has pathological involvement in or attachment to a behavior (substance use); is subject to a compulsion to continue to use and has reduced ability to exert personal control over the use.

Addiction is characterized by:

- Inability to consistently abstain
- Impairment in behavioral control
- Craving or increased hunger for drugs or rewarding experiences

- Diminished recognition of significant problems with one's behaviors and interpersonal relationships
- Dysfunctional emotional response
  www.asam.org/research-treatment/definition-of-addiction

Nonmedical, Misuse, and Abuse of Prescription Medication: [12]
Nonmedical Use: Use of prescription drugs that were not prescribed by a medical professional (i.e., obtain illicitly) or are used for the experience or feeling a drug causes.

Substance-Exposed Newborn is one who tests positive for substance(s) at birth, or the mother tests positive for substance(s) at the time of delivery, or the newborn is identified by a medical practitioner as having been prenatally exposed to substance(s).

Substance-Affected Newborn is one who has withdrawal symptoms resulting from prenatal substance exposure or demonstrates physical or behavioral signs that can be attributed to prenatal exposure to substances and is identified by a medical practitioner as affected.

Neonatal Abstinence Syndrome (NAS):
NAS refers to a constellation of signs/findings in the newborn that are due to substance/medication withdrawal. (American Academy of Pediatrics definition)

NAS refers to a constellation of signs in the newborn due to substance or medical withdrawal. In most cases, exposure occurs during pregnancy, but it may also describe a syndrome secondary to withdrawal of opioids and sedatives administered postnatally to infants with serious illness. Opioids (naturally occurring, synthetic, and semi-synthetic) are the most frequent drugs which give rise to the typical signs.[13]

Screening: Methods used to identify risk of substance use/disorder during pregnancy and postpartum, including self report, interview, and observation. All pregnant women should be screened, ideally at every encounter, for substance use, abuse, and dependency. Rescreening should be done if risk factors are present or if the woman has a history of alcohol or drug use.

Testing: Process of laboratory testing to determine the presence or absence of a substance in a specimen. Universal testing may be used as a screening tool in some practices, but is not recommended (see Page 10).

Assessment: Comprehensive evaluation of a client's risk for substance use disorder during pregnancy and postpartum. The following are characteristics of assessment:

- Includes collecting objective and subjective information
- May include screening and lab testing
- Should be timely and culturally appropriate
- May result in a diagnosis and plan for intervention

Role of the Health Care Provider

It is the responsibility of every practice to make sure that all pregnant and postpartum women are screened for substance use. Physicians, nurses, and others involved in prenatal care play an important role in the reduction of substance use during pregnancy. For clients who require intervention for substance use, a team approach is recommended, including the primary provider, clinic nurse, social worker, public health nurse, chemical dependency treatment provider, and the client herself.

For the health care team to screen clients effectively, members of the team must be educated about when and how to screen, how to assist the woman who admits use, and about associated issues in the substance using or abusing woman's prenatal and postpartum care.

Steps to Implementing Screen and Intervention Model

- Create a team
- Develop a plan for privacy and confidentiality protection
- Choose screening tools to be used
  - Consider building into EMR or scan paper results into EMR
  - If the tool is free, require permission or purchase
  - Train staff on use of tool
- Line up resources for treatment and referrals
- Determine roles:
  - Who will do what, where, and when
  - Orient/train staff
- Explore additional billing options: tobacco ad SBIRT
- Evaluate process and make changes

Benefits of Universal Screening, Interviews and Observation

Universal screening provides the practitioner with the opportunity to talk to every client about the risks of alcohol, illicit drugs, prescription drugs, tobacco, and other substances and risky behaviors. Structured screening, built into the care of every pregnant woman, helps eliminate "educated guessing," which is heavily dependent on practitioner bias and attitudes. With education and practice, the provider's skill and comfort with confronting these issues improves, interviewer bias is eliminated, and the stigma of substance use and abuse is reduced. The practice of universal screening increases the likelihood of identifying substance users and allows for the earliest possible intervention or referral to specialized treatment.

Screening is conducted by interview, self-report, and clinical observation. Screening takes only about 30 seconds for most clients who do not have a substance use problem and 5–10 minutes for the 10–15 percent of clients who do. This small investment actually saves time by answering questions that might come up later, and by reducing care time for a patient in whom obstetrical complications can be prevented through early identification of this risk factor. In addition, screening and education of every client enhances clients' awareness of the risks of substance use or abuse during pregnancy and may prevent use or abuse in future pregnancies.

Studies examining brief interventions for smoking and alcohol use among pregnant women, and for illicit drug use in the general population, have shown small but statistically significant results of the effectiveness of such interventions.[14]

Urine Toxicology Not for Universal Screening

Urine toxicology may be useful to follow up a positive interview screen. For more information about the benefits and limitations of urine toxicology (see Page 15).

The American College of Obstetricians and Gynecologists 1994 Technical Bulletin concluded that urine testing has limited ability to detect substance use and therefore does not recommend universal urine toxicologies on pregnant women as a screening method. In its subsequent Committee Opinion (2008), the American College of Obstetricians and Gynecologists asserted that universal screening questions, brief intervention and referral to treatment was the best practice.

Screening Tools

Interview-based or self-administered screening tools (written or computer generated) are the most effective way to determine risk or allow self reporting. Brief questionnaires have demonstrated effectiveness for assessing alcohol and drug use during pregnancy. Examples of tools that have been validated for this population and take 5–10 minutes or less include the 4Ps, CRAFFT, T-ACE, TWEAK, 4 P's Plus, SBIRT (see Appendix A, Pages 25–28).

Use a screening tool with every client, not just those in whom substance use is suspected. Women should be screened for alcohol, illicit drugs, tobacco, misuse of prescription drugs, and other substances, including use prior to pregnancy. If the screening tool focuses on alcohol (for example, the T-ACE) another tool should be administered to screen for additional substances. The 4 P's Plus is a tool that covers both alcohol and drugs.

SCREEN: ASK AND ASSESS – See Pages 25–28 for sample screening tools

How to Screen

Substance use disorder screening during pregnancy should be part of routine health care. Health care providers or other staff members who screen clients will benefit from training in brief intervention focused on promoting behavior change. The screening should be performed by the health care provider or other staff member who has knowledge of substance use during pregnancy. Results of the screen should be discussed with the client in a non-judgemental, supportive manner, and documented in the chart. If the client is screened by someone other than the primary obstetric provider, the provider should review the results of the screen and give appropriate follow-up messages to the client.

This approach decreases subjectivity, discomfort and bias. Ideally, pregnant women should be screened at each encounter, and minimally, once each trimester. Include inquiries into substance use problems in family members. Know how to respond to both positive and negative responses to screening tools (see Page 11). As trust develops, the client who is using is more likely to disclose that use. When use is disclosed, remember that screening tools identify risk but are not diagnostic. Know how to respond, including discussing risks of use, benefits of stopping, and resources for further evaluation.

Recent addiction research has identified physical, sexual, and emotional abuse as frequent precursors to substance use in women; therefore, pregnant women should also be screened for risk of domestic violence. In addition to brief structured screening tools, asking about foster care during childhood or history of foster care for the woman's own children may lead to discussion of the potential for substance use.

How screening is handled impacts pregnant women's use of prenatal care. If women fear adverse consequences or judgmental attitudes, they often delay or avoid prenatal care.[15] Washington State Department of Health has created guidance for health care professionals to assist in normalizing conversations about marijuana (see pages 48–50).

Create a Respectful Environment

A few minutes spent engaging the woman and using a supportive approach to screening can open the door to referral and treatment. In order to elicit an honest response, a safe and respectful environment is essential.

- Assume that all women want a healthy baby. However, do not assume that all women know when they became pregnant or welcome the current pregnancy.
- Educate support staff about the importance of a positive and nonjudgmental attitude in establishing a trusting relationship and welcoming environment.
- Observe and protect provider and client confidentiality. For example, know the issues surrounding consent for testing clients and newborns (see Page 17).
- Ask every question in a health context. This lessens the stigma associated with the topic, and expresses concern for the health of the mother and baby. Tell her you have a common goal of healthy pregnancy and baby.
- Be empathetic, nonjudgmental and supportive when asking about use; consider the client's needs and life situation. Allow the patient to talk; be an active listener.
- Offer culturally appropriate screening in the client's primary language.

ASSESS: Intervene

When a Woman Denies Use

Many women do abstain from drugs and alcohol, especially during pregnancy. Acknowledge this wise choice and review the benefits of abstinence from substances. Continue to screen throughout pregnancy and postpartum, ideally at each encounter, but at least once per trimester. In some situations, women may deny use but a constellation of signs and symptoms suggest abuse. In this case it may be prudent to re-screen frequently or conduct lab testing (see Pages 15–16).

When a Woman Admits Use

Many women are able to abstain during pregnancy, so the woman who admits to current use of significant amounts is likely to have severe addiction and may be using substances to help her cope with psychosocial stressors in her life. The woman may feel safe enough to share with the medical provider about her use but may not be ready to take the next step of a comprehensive assessment and treatment. Review use patterns, share score on the screener and talk about the effects. Assess readiness to change and her ability to change.

The Stages of Change model developed by Prochaska and DiClemente (1992) is one approach to understanding the steps to changing drug or alcohol use during pregnancy.

Stages of Change

The stages of change are:
1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Relapse

Pre-contemplation. The woman is not considering change during the pre-contemplation stage.

- She may not believe it is necessary (examples: used during last pregnancy and nothing happened, or her mother used while pregnant with her and she is okay).
- She may not know or understand the risks involved.
- She has tried many times to quit without success, so has given up and doesn't want to try again.
- She has gone through withdrawal before and is fearful of the process or effects on her body.
- She feels strongly that no one is going to tell her what to do with her body.
- She has mental illness or developmental delay and does not have a good grasp of what using drugs and alcohol during pregnancy means—even when information is given to her.
- She has family members or a partner, whom she depends on, who use. She may not contemplate changing when everyone else continues to use.

The woman in pre-contemplation may present as resistant, reluctant, resigned, or rationalizing.

Resistant: *"Don't tell me what to do."*
Provider Response: Work with the resistance. Avoid confrontation and try to solicit the women's view of her situation. Ask her what concerns her about her use and ask permission to share what you know, and then ask her opinion of the information. Accept that the process of change is a gradual one and it may require several conversations before she feels safe about discussing her real fears. This often leads to a reduced level of resistance and allows for a more open dialogue. Try to accept her autonomy but make it clear that you would like to help her quit or reduce her use if she is willing.

Reluctant: *"I don't want to change; there are reasons."*
Provider Response: Empathize with the real or possible results of changing (for example, her partner may leave). It is possible to give strong medical advice to change and still be empathetic to possible negative outcomes to changing. Guide her problem solving.

Resigned: *"I can't change; I've tried."*
Provider Response: Instill hope, explore barriers to change.

Rationalizing: *"I don't use that much."*

Provider Response: Decrease discussion. Listen, rather than responding to the rationalization. Respond to her by empathizing and reframing her comments to address the conflict between wanting a healthy baby and not knowing whether "using" is really causing harm.

Contemplation. The woman is ambivalent about changing her behavior. She can think of the positive reasons to change but also is very aware of the negative sides of change (see above).

Provider Response: Health care providers can share information on the health benefits of changing for the woman and fetus. The woman in contemplation will hear these benefits, but is very aware of the negative aspects of change on her life. Help the woman explore goals for a healthy pregnancy, and problem solve how to deal with the negative aspects of quitting alcohol and drug use and remaining abstinent.

Preparation. The woman's ambivalence is shifting toward changing her behavior. She is exploring options to assist her process. She may be experimenting by cutting down, or has been able to quit for one or more days. Although her ambivalence is lessening, it is still present and may increase when she is challenged by those around her, triggered by the environment, or is under other types of stress she has handled by using in the past.

Provider Response: Acknowledge strengths; anticipate problems and pitfalls to changing, and assist the woman in generating her own plan for obtaining abstinence. Problem solve with her regarding barriers to success. Work on plans for referral to treatment.

Action. The woman has stopped using drugs or alcohol.

Provider Response: Acknowledge her success and how she is helping her infant and herself; have her share how she has succeeded and how she is coping with the challenges of not using. Offer to be available for assistance if she feels that she wants to use drugs or alcohol again. Provide assistance with treatment referrals. Discuss triggers, stressors, social pressures that may lead to relapse and help the woman plan for them.

Relapse. The woman may relapse; incidence of relapse for those who are abusing or addicted is high.

Provider Response: If relapse has occurred, guide the woman toward identifying what steps she used to quit before. Offer hope and encouragement, and allow the woman to explore the negative side of quitting and what she can do to deal with those issues. (How did she deal with those issues in the past? Explore what worked and didn't work for her.) Offer to provide assistance in finding resources to help her return to abstinence.

ADVISE

Educational Messages for Clients

Assume that all women have some knowledge of the effects of drugs, alcohol, and cigarettes on pregnancy. Ask what the woman knows, affirm what she knows, and ask to share information which can fill in missing pieces or clarify misconceptions. This respectful approach can lay the groundwork for further discussion now and at later visits. It provides an opportunity to educate the client and her partner about the adverse effects of tobacco, drugs, and alcohol, and the benefits of stopping use at any time during pregnancy or postpartum. It's important to educate about modifiable

factors affected by recovery, such as more stable early life environment and decreased ongoing exposure. These messages can be reinforced through pre-pregnancy, pregnancy, and postpartum discussions not only by the primary obstetric provider, but by the community childbirth educator, outreach worker, community health nurse, and other health care staff.

ASSIST AND ARRANGE

If a woman wants to change, offer help based on her readiness to change. **"We both have the same goals, healthy pregnancy and baby."** Summarize the conversation and ask her what she will do. Agree on a plan. Continue to praise all efforts to change throughout the pregnancy. Refer for specialty assessment: addiction, mental illness- based on level of addiction. Refer to addiction treatment for stabilization and treatment.

The Washington State Recovery Helpline (1-866-789-1511) provides treatment resources by insurance and location. Find more information about treatment options and models in Appendix E on page 34. Make other referrals as appropriate using the referral resource list on page 36. Obtain consent for coordination with substance use disorder and mental health treatment providers.

Referral to Treatment

Discuss the benefits of treatment and offer to provide the woman with a referral to a local chemical dependency treatment center. If the woman is unwilling to make that commitment, ask if she would like some information to take with her if she should change her mind. Schedule the next prenatal visits, continue to maintain interest in her progress and support her efforts in changing. Monitor and follow up on any coexisting psychiatric conditions. Women who are being treated with opioids in a legitimate pain management program or are adhering to an opioid maintenance program should not be referred to an addiction specialist.

Know the resources in your area, or find out by calling the **Washington Recovery Help Line:** 1-866-789-1511. Resources may include:

- First Steps Maternity Support Services and Infant Case Management for low income women
- County substance use disorder services
- Twelve-step programs
- Hospital treatment programs
- Mental health programs
- Special pregnancy related programs

Maintain a current list of local resources (see page 36 for statewide resources).
If possible, make the appointment while the patient is in the office.

- Discuss the possible strategies for her to stop; for example, individual counseling, 12-step programs, and other treatment programs. Studies have shown that people given choices are more successful in treatment.
- Utilize an advocate or special outreach services if available – Safe Babies Safe Moms, Parent Child Assistance Program, Maternity Support Services, Nurse Family Partnership (see Appendix E, Page 34).
- Tailor resources according to client needs and health insurance coverage.
- If immediate chemical dependency treatment or other support is not available, the primary provider or designated staff might meet with the woman weekly or biweekly to express concern and to acknowledge the seriousness of the situation.

- Maintain communication with the chemical dependency treatment provider to monitor progress.
- Establish rules and goals, such as reducing use, with the woman and her significant others. See the section below on Harm Reduction.
- For tobacco users, provide the American College of Obstetricians and Gynecologists brief intervention (see Page 27) and refer women to the Washington State Quitline (see Page 37).
- If the behavioral approach is not successful, consider pharmocotherapies for smoking cessation: Bupropion hydrochloride (Zyban©) or Nicotine Replacement Therapy, if appropriate for heavy smokers. However, there is no consensus among experts regarding use of nicotine replacement therapy or other medications during pregnancy.[16]

MANAGEMENT

Laboratory Testing

Urine toxicology determines the presence or absence of a specific substance in a urine specimen. It may be useful as a follow up to a positive interview screen. It should not be used in place of written or verbal screening because it cannot diagnose a drug use-disorder or its severity.[16] Urine testing needs verbal informed consent at a minimum and clear discussion about how data will be used. Due to the many limitations of biologic testing, it is more likely that fetal exposure will be identified through a structured interview.[11]

Benefits of Lab Testing

- Confirmation tests after positive screen can confirm presence of drug
- Determines the use of multiple drugs
- May provide evidence that newborn is at risk for withdrawal

Limitations of Lab Testing

- Negative results do not rule out substance use.
- A positive test does not tell how much of a drug is used or how often.
- A positive test does not identify user characteristics such as intermittent use, chronic use, or addiction.
- Alcohol, which is the most widely abused substance and has the greatest impact on the fetus, is the hardest to detect due to its short half-life.
- A woman who knows she will be tested may delay access to prenatal care because of fear of potential repercussions.
- False positive results can be devastating for a drug-free client. They can be as high as five percent.[17]
- Urine toxicology has no value in identifying or minimizing the teratogenic effects that occur early in pregnancy.
- Women may avoid detection by abstaining for 1–3 days prior to testing, substituting urine samples, or increasing oral beverage intake just before the testing to dilute the urine.
- Specific tests, panels, and methods vary from site to site and can be challenging to correctly interpret.

Indicators for Testing

Some risk indicators are more indicative of substance use than others. If positive risk indicators are identified at any time during pregnancy or postpartum, rule out other identifiable causes, re-screen, test, or provide assessment as appropriate. (See also Signs and Symptoms of Substance Use Disorder below.)

High Risk Factors

- Little or no prenatal care
- Inappropriate behavior (e.g., disorientation, somnolence, loose associations, unfocused anger)
- Physical signs of substance use disorder or withdrawal
- Smell of alcohol or chemicals
- Recent history of substance use disorder or treatment

Risk Factors Requiring Further Assessment Before Urine Toxicology Testing

- History of physical abuse or neglect
- Intimate partner violence
- Mental illness
- Previous child with Fetal Alcohol Spectrum Disorders or alcohol-related birth defects
- Fetal distress
- Placenta Abruptio
- Preterm labor
- Intrauterine Growth Restriction (IUGR)
- Previous unexplained fetal demise
- Hypertensive episodes
- Stroke or heart attack
- Severe mood swings
- History of repeated spontaneous abortions

Signs and Symptoms of Substance Use Disorder

Because of the frequency of complications seen in those who abuse substances, it is important that the clinician be alert for clinical and historical cues that may indicate the possibility of substance use disorder. Based on clinical observation, laboratory testing for substance use may be indicated in order to provide information for the health care of the mother and newborn.

Behavior Patterns

- Sedation
- Inebriation
- Euphoria
- Agitation
- Aggressiveness/violent behavior
- Paranoia
- Increased physical activity
- Anxiety, nervousness, panic
- Disorientation
- Depression
- Irritability
- Prescription drug seeking behavior
- Suicidal ideations or attempt
- Memory loss
- Psychosis
- Erratic behavior

Physical Signs

- Markedly dilated or constricted pupils
- Rapid eye movements
- Tremors
- Track marks or abscesses or injection sites
- Inflamed or eroded nasal mucosa, nose bleeds
- Increased pulse and blood pressure
- Increased body temperature
- Hair loss
- Hallucinations, panic, anxiety
- Nystagmus
- Gum or periodontal disease, including broken teeth, severe decay, infections
- Skin conditions: abscesses, dry or itchy, acne type sores
- Weight loss-low BMI, malnutrition

Laboratory	Medical History
• MCV over 95 • Elevated MCH, GGT, SGOT, Bilirubin, Triglycerides • Anemia • Positive urine toxicology for drugs • STI testing (retest in third trimester if at risk) • HepC	• Frequent hospitalizations • Gunshot or knife wound • Unusual infections (cellulitis, endocarditis, atypical pneumonias, HIV) • Cirrhosis • Hepatitis • Pancreatitis • Frequent falls, unexplained bruises • Chronic mental illness

Compiled from American College of Obstetricians and Gynecologists Technical Bulletin #194 (July 1994), American Society of Addiction Medicine (301-656-3920 or www.asam.org)

Consent Issues for Drug Testing

(See Page 42, Appendix G, for Washington State Department of Social and Health Services Children's Administration Prenatal Substance Abuse Policy information.)

The importance of clear and honest communication with the woman regarding drug testing cannot be overstated. The health care team should act as advocate for mother and infant. This relationship is more difficult to establish if a woman is notified of testing after the fact. Therefore, all women should be told of planned medical testing. The rationale for testing should be documented in the medical record. If a patient refuses testing, this should be documented and testing should not be performed.

- No uniform policy or state law exists regarding consent for newborn drug testing.
- Hospitals should report all positive toxicology screens (mother or infant) to Child Protective Services. Reporting of this information, in and of itself, is not an allegation of abuse or neglect. The health care team acts as advocate for mother and newborn.
- If there exists reasonable cause to believe leaving a newborn in the custody of the child's parent or parents would place the child in danger of imminent harm, a hospital may choose to place an administrative hold on the newborn and notify Child Protective Services per RCW.26.44.056.
- All women should be informed about planned medical testing, the nature and purpose of the test, and how results will guide management, including possible benefits or consequences of the test. Drug testing is based on specific criteria and medical indicators, not open-ended criteria such as "clinical suspicion" that invite discriminatory testing.
- If the woman refuses testing, maternal testing should not be performed. However, testing of the newborn should occur if medically necessary (if newborn has symptoms or is at risk) or if newborn or maternal risk indicators are present.

For guidance on testing newborns, consult *Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State*:
http://here.doh.wa.gov/materials/guidelines-drug-exposed-newborns

Harm Reduction – Decrease Use

Women with a diagnosis of dependence (addiction) can't control their use. When abstinence is not possible, harm reduction assists a woman to take steps to reduce use and harm to herself and her fetus. Explore if there are ways she can cut down on use and enroll in outpatient treatment, or attend recovery meetings, to begin to learn more options to reduce use. Opiate withdrawal can cause harm (miscarriage, preterm delivery, intrauterine demise) and women who experience opiate withdrawal symptoms need medical help. Support any reduction in use. Though drug or alcohol abstinence is the goal, any steps made toward reducing use or harmful consequences related to use are very important.

Harm Reduction Strategies

- Evaluate and refer for underlying problems.
- Encourage the woman to keep track of substance use.
- Reduce dosage and frequency of use.
  - Recommend reducing her use by a small amount each day; if this is not possible, any decrease in use is beneficial.
  - Intersperse use with periods of abstinence.
  - Use a safer route of drug administration.
  - Find a substitute for the substance.
  - Avoid drug/alcohol using friends and environments.
- Discuss contraceptive options for after the delivery and make a plan.
- Provide education on overdose and where to get Naloxone kit. (See appendix for link to information.)

Pregnancy Management Issues

A woman who uses substances during pregnancy is at risk for a variety of complications. Brief team huddles may be useful to coordinate management. The following interventions should be considered in the course of her care.

Gender Responsive Treatment Principles

For creating a strength-based model of care that is also trauma informed.[18]

- Acknowledge the importance and role of socioeconomic issues and differences among women.
- Promote cultural competence specific to women.
- Recognize the role and significance of relationships in women's lives.
- Address women's unique health concerns.
- Endorse a developmental perspective.
- Attend to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
- Recognize that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.
- Adopt a trauma-informed perspective.
- Use a strength-based model.

Prenatal

- Review medications and OB history.
- Screen and assess for psychiatric co-morbidities, including immediate risk for self-harm and violence.
- Screen for eating disorders
- Screen for immediate risk for serious intoxication or withdrawal
- Screen for intimate partner violence.
- Screen for social service needs: housing, food, support. Refer as needed.
- Obtain routine blood tests plus hepatitis and tuberculin test and HIV if not included in routine protocol.
- Periodically screen for sexually transmitted infections. Assess risk for tuberculosis (TB).
- For opiate addiction, refer to a methadone or buprenaphine maintenance program. Medication Assisted Treatment (MAT) is standard of care.
- Schedule more frequent visits to identify medical and psychosocial problems early. May not need intense medical care.
- Order and repeat appropriate tests as needed.
- Monitor pregnancy and fetal development.
- Discuss possible effects of drugs on the newborn. Advise if newborn has NAS there will be extended stay. Discuss potential need for dose adjustment for women on methadone or buprenorphine.
- Advise about reporting drug-exposed newborn.
- Discuss contraceptive methods and make a plan. Consider immediate postpartum IUD or implant insertion if desired.
- Obtain consent for tubal ligation after delivery if the woman chooses this method. Washington State RCW allows expedited consent of women with alcohol or drug use during pregnancy for tubal ligation, so the normal 30-day consent requirement can be waived: http://www.hca.wa.gov/medicaid/billing/Documents/guides/sterilization_mpg.pdf
- Discuss breastfeeding and alcohol and drug use issues.
- Conduct random urine toxicologies to monitor use or how well the woman is doing with treatment. Expect an occasional positive urine toxicology and use this as an opportunity to talk about her progress.

Intrapartum

- Perform complete history and physical, including recent drug use.
- Repeat hepatitis screen, serologic test for syphilis, and HIV (rapid test).
- Repeat urine toxicology.
- Alert pediatric and nursing staff.
- Alert social services if necessary.
- Determine method of delivery depending on obstetrical indicators.
- Intrapartum pain management: take into consideration the woman's substance use history and recovery status. Assure the woman that pain will be managed.

Adequate pain management should be available to all laboring mothers who desire it. A substance use disorder history should not be considered a contraindication to the normal use of pain medications in labor. Take into consideration the woman's substance use disorder history and recovery status. Maximize and schedule non-opioid analgesia and anticipate that opioid-dependent women will need additional opioids at an increased dose for the same duration.

Epidural anesthesia can be used as per hospital routine and is a proven effective pain management strategy for laboring women. Buprenorphine and methadone used for maintenance will not produce any analgesia. That dose may be split during labor and immediately postpartum for safety.

Methadone is used for the treatment of opiate dependence in pregnancy. It has been shown to improve obstetric and fetal outcomes for women abusing opiates. Maintenance therapy prevents the fetal harms associated with opiate withdrawal. You may also encounter women maintained—buprenorphine (Suboxone, Subutex)—as a treatment for opiate dependence. This medication is an agonist-antagonist at the opiate receptor and partially blocks opioids.

Pregnant women maintained on methadone or buprenorphine for the treatment of opiate dependence will be less responsive to opiate pain medications. In situations in which opiates might routinely be used (for example, early labor), higher doses may be needed to achieve adequate effect. In the case of a cesarean delivery or other surgical intervention, high affinity opiates such as hydromorphone or fentanyl should be provided via patient controlled anesthesia. The woman may require doses several times higher than needed in non-opiate tolerant clients. The dose via patient controlled anesthesia may be increased until adequate pain relief is achieved. Care providers may be anxious about the high dosages required. If the woman is alert and has a normal respiratory rate, then caregivers can be reassured that the client has not been overdosed. Furthermore, aggressive pain management will not worsen addiction and may help postpartum medical course go more smoothly.

Narcotics with mixed agonist/antagonist properties are contraindicated for pain relief in opioid dependent patients, as these drugs may precipitate withdrawal. Examples include pentazocine (Talwin), butorphanol (Stadol), and nalbuphine (Nubain). If inadvertent administration occurs, and patient has withdrawal symptoms, a high affinity opioid agonist (hydromorphone or fentanyl) should be given to alleviate withdrawal symptoms.

Postpartum

- Encourage continuation in a therapeutic drug treatment program.
- Encourage and provide appropriate contraceptive method: birth control pills, patches or ring, implant, Depo-Provera, intrauterine device, sterilization, emergency contraceptive pills, condoms, others. Provide before-hospital discharge if appropriate or feasible.
- Support breastfeeding as appropriate and should be recommended if stable in treatment and no current illicit use. Breastfeeding is not contraindicated and is typically recommended in buprenorphine or in methadone maintenance. It is contraindicated if the woman is HIV positive or using illegal drugs. Transferred amounts of methadone or buprenorphine are insufficient to prevent symptoms of neonatal abstinence syndrome. Neonatal abstinence syndrome can occur after abrupt discontinuation of methadone.[19]
- Breastfeeding women with a positive history of drug abuse during pregnancy should be tested periodically while breastfeeding.
- AAP 2012 Breastfeeding and the Use of Human Milk references marijuana, along with other substances, as potential concern for long-term neurodevelopment and thus use of street drugs, including marijuana, are contraindicated while breastfeeding. It is a clinical decision as to whether or not a woman who continues to use marijuana should continue to breastfeed.

With this approach, the provider can assess how much the woman is using. http://pediatrics.aappublications.org/content/129/3/e827.full
In the July 2015 Committee Opinion, ACOG cites the insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding and, in the absence of such data, marijuana should be discouraged. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Marijuana-Use-During-Pregnancy-and-Lactation

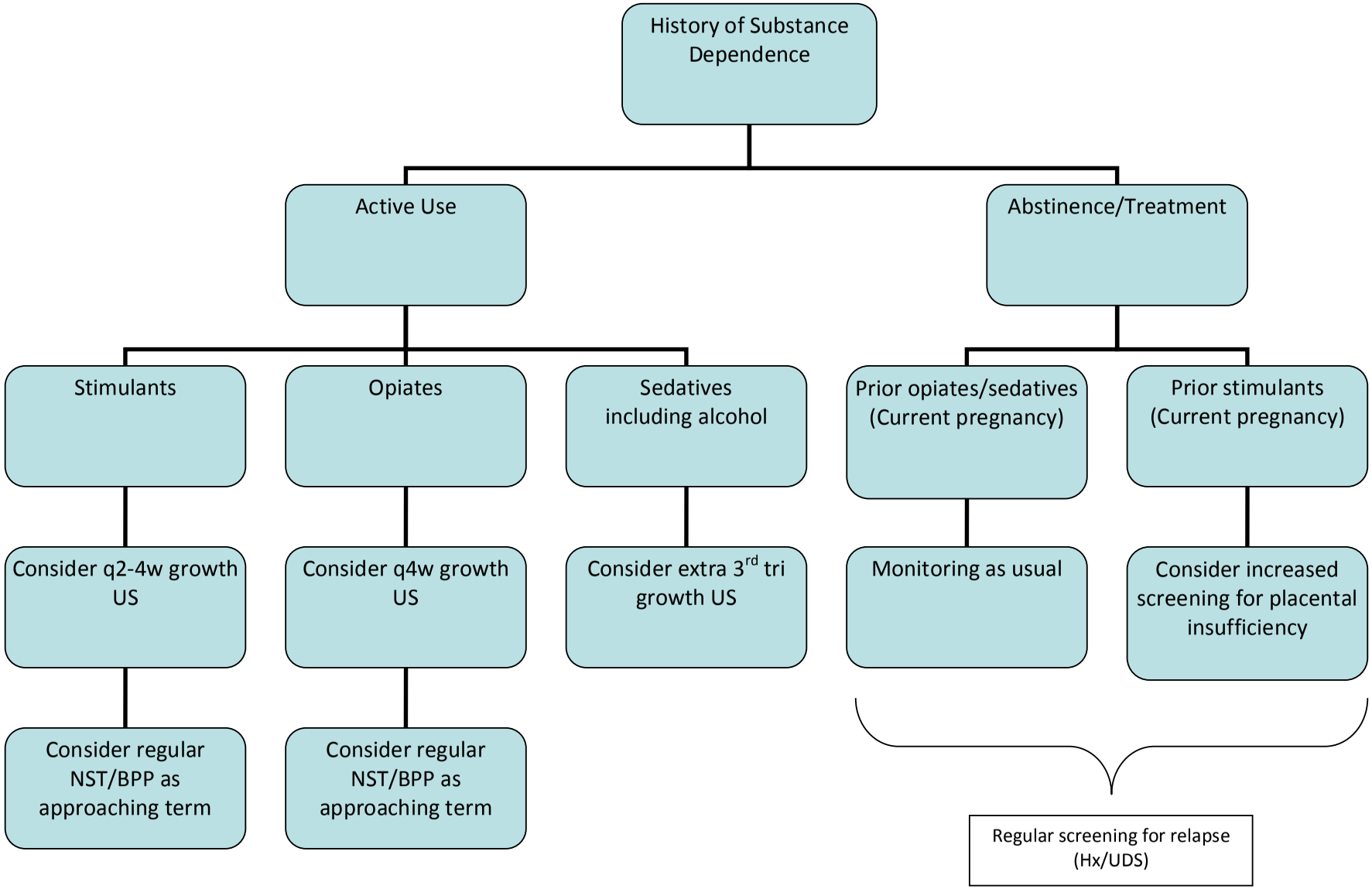
- For guidance on testing newborns, consult *Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State*: http://here.doh.wa.gov/materials/guidelines-drug-exposed-newborns

Relapse – From SAMSHA's Keys for Clinicians: Addressing Specific Needs of Women[22]

Maintaining supportive connections with women helps to maintain retention. Using supportive phones calls is a very effective strategy and can help to improve transitions for women. Women-specific predictors of relapse include:

- Interpersonal problems and conflicts.
- Low self-worth that is connected to intimate relationships and parenting.
- Severe untreated childhood trauma.
- Strong negative effect.
- Symptoms of depression.
- Greater difficulty in severing ties with other people who use.
- Failure to establish a new network of friends.
- Lack of relapse-prevention coping skills.

Pregnancy Monitoring Pathway Example*



*Adapted from presentation by Abigail Plawman, MD. Author, 2013. Advanced Practice Acute & Primary Care Conference, Seattle, WA

Associated Issues for Pregnant Women

Pregnant women who need treatment for substance use disorders often have different issues than men and non-pregnant women. Pregnancy further complicates treatment needs. Issues to consider include:

Psychosocial Issues

- Family history of substance use disorder
- Physical or sexual abuse as a child
- History of sexual assault
- Interpersonal violence
- Partner with substance use disorder issues
- Cultural barriers to care
- Unresolved childhood parenting issues such as parental substance use, incarceration, and dysfunctional family relationships (ACES)
- Homelessness or insufficient resources (transportation, child care, nutrition)
- Mental health conditions (there is a high rate of co-occurring disorders)

Medical Issues

- Sexually Transmitted Infections
- HIV
- Poor nutrition, malnutrition and eating disorders
- Psychological disorders such as post traumatic stress disorder, depression, anxiety, panic, personality disorder, eating disorders, chronic severe mental illness
- Other medical problems such as hepatitis, liver disease, and pancreatitis
- Tobacco use
- Dental disease
- Unintended pregnancy
- Breastfeeding challenges and barriers

Potential Referrals

Having a care team and close follow up is important. See Appendix E for specific referral information.

- Additional specialized medical care, such as HIV management
- Childbirth preparation class
- Transportation to services
- Public assistance, medical assistance, food stamps
- WIC Nutrition Program
- First Steps Services, including Maternity Support Services and Infant Case Management
- Child care (day care, foster care)
- Peer directed prenatal and postpartum support groups
- Parent skill-building services
- Home management skill-building services
- Education and career building support
- Safe and sober housing access
- Legal services
- Child Protective Services
- Adoption counseling

- Pediatric follow-up for special care infant
- Mental health services
- Chemical Using Pregnant Women intensive inpatient care programs
- Domestic violence counseling and services
- Infant development follow up with occupational or physical therapy
- Pregnant and Parenting Women Residential Chemical Dependency Treatment
- Parent Child Assistance Program
- Safe Babies Safe Moms
- Nurse Family Partnership

Appendix A: Screening Tools for Drugs and Alcohol

Screening Tools for Alcohol Use

Maternal drinking during pregnancy can adversely impact the fetus with effects ranging from mildly impaired cognitive, behavioral, or psychological functioning to Fetal Alcohol Syndrome, characterized by developmental and cognitive disabilities, growth deficiency, and a pattern of distinct facial features. There is currently no known "safe" level of alcohol exposure to the fetus.

Because there is no safe limit of alcohol consumption during pregnancy, and all women have the potential for drinking some alcohol, health care providers should screen for alcohol use during pregnancy. Women should be encouraged to abstain. Problem drinkers should be supported in changing their behavior through harm reduction, support groups and treatment. Screening tools that focus on the amount a woman can drink at one sitting without feeling "high" can uncover tolerance if her intake is greater than 2–3 drinks per sitting. Tolerance suggests that a woman may be addicted or habituated to the use of alcohol and it may be difficult for her to change behavior. For women, more than 4 drinks per sitting is binge drinking and puts the fetus at the highest risk of having an alcohol-related birth defect.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. In Washington, Medicaid will reimburse providers for SBIRT if they have had at least 4 hours of training. Online training is available. For more information, go to: www.wasbirt.com/content/training

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care

http://www.samhsa.gov/sbirt

BU SBIRT tools
www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-screening-tools/

Oregon tools
http://sbirtoregon.org/screening.php

Screening Tools*						
Tool	**Description/Time it takes to complete**	**Sensitivity**	**Screens for**	**Validation**	**Training Available**	**Cost**
AUDIT-C	3 questions/ approximately 1-2 mins http://www.integration.samhsa.gov/images/res/tool_auditc.pdf	67%-95% Sensitive 85% specificity Positive predictive value 92%-100%	EtOH use	For prenatal patients Sensitivity varies widely in different studies	No	Free
CRAFFT	Validated for use in patients aged 15-24 6 questions/ approximately 2-3 mins http://ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf	76% sensitivity 94% specificity	EtOH and drug use	Recently for prenatal patients	No	Free
4P's Plus	5 questions with follow-up if positive; 2-5 mins Parents, partners, past, present, pregnancy http://aia.berkeley.edu/media/pdf/chasnoff_4ps.pdf	87% sensitivity 76% specificity	All substance	For prenatal patients	Yes	Requires permis-sion for use
Substance Use Risk Profile Pregnancy Scale	3 questions/ approximately 2 mins http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/SubstanceUseRiskProfile.pdf	91% sensitivity 67% specific	EtOH and THC	Recently developed Specifically for prenatal patients	No	Free
T-ACE	4 questions/ approximately 1-2 mins http://www.mirecc.va.gov/visn22/T-ACE_alcohol_screen.pdf	69%-88% sensitivity 1%-89% specificity	EtOH only – for heavy use	For prenatal patients	No	Free
TICS	2 questions/ <1 min http://www.mirecc.va.gov/visn22/TICS.pdf	80% sensitivity 80% specificity Negative predictive value 92.7%	EtOH and drug use	Easy to implement in primary care setting	No	Free

TWEAK	5 questions/ approximately 1-2 mins http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/74_TWEAK.pdf	71%-91% sensitivity 73%-83% specificity	EtOH only – effective for heavy use	For prenatal patients	No	Free
SBIRT	Screening, brief intervention, referral to treatment: 1-3 questions http://www.integration.samhsa.gov/clinical-practice/sbirt#why? Select validated screen: SAMSHA recommends AUDIT, ASSIST or DAST-10	AMA, SAMHA recommends based on evidence	ETOH and drugs	Primary care and specialty Easy to implement; Medicaid covers	Webinar	Free
DAST-10	10 items/approximately 3-5 mins/self report http://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf	41%-95% sensitive 68%-99% specific	drugs	Adults and adolescents in primary care. Not validated for prenatal patients.	No	Free

Abbreviations: ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test); AUDIT-C (Alcohol Use Disorders Identification Test); CRAFFT, T-ACE and TWEAK are acronyms based on their respective screening questions; TICS (Two-Item Conjoint Screening Tool); WHO (World Health Organization).

*Adapted from Goodman, DJ and Wolff, KB. 2013. Screening for Substance Abuse in Women's Health: A Public Health Imperative. *Journal of Midwifery and Women's Health.* 50, 278-287.

ASK – 1 minute

Ask the patient to choose the statement that best describes her smoking status:

- ☐ A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.
- ☐ B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
- ☐ C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
- ☐ D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
- ☐ E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke-free throughout pregnancy and postpartum.

If the patient is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assist, and Arrange.

ADVISE – 1 minute

Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus.

ASSESS – 1 minute

Assess the willingness of the patient to attempt to quit within 30 days.

If the patient is willing to quit, proceed to Assist.
If the patient is not ready, provide information to motivate the patient to quit and proceed to Arrange.

ASSIST – 3 minutes +

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation (e.g., identify "trigger" situations).
- Provide social support as part of the treatment (e.g., "we can help you quit").
- Arrange social support in the smoker's environment (e.g., help her identify "quit buddy" and smoke-free space).
- Provide pregnancy-specific, self-help smoking cessation materials.

ARRANGE – 1 minute +

Assess smoking status at subsequent prenatal visits and, if patient continues to smoke, encourage cessation.

Data from Melvin C, Dolan Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. Tobacco Control 2000; 9:1-5. American College of Obstetricians and Gynecologists Educational Bulletin No. 260, September 2000.

Appendix B: Brief Negotiated Interview and Active Referral to Treatment Algorithm

The BNI-ART Institute (Brief Negotiated Interview and Active Referral to Treatment) is a program of the Boston University School of Public Health and the Youth Alcohol Prevention Center in collaboration with Boston Medical Center. Among its tools is a two-sided card that summarizes the process of a brief intervention and referral to treatment.

See Readiness Ruler on next page.

BNI STEPS	DIALOGUE/PROCEDURES
1. Raise subject and ask permission	➢ Hello, I am _____. Would you mind taking a few minutes to talk with me confidentially about your use of [X]? **<<PAUSE and LISTEN>>** ➢ Before we start, could you tell me a little about yourself and your goals…What's important to you?
2. Provide feedback • **Review screen** • **Make connection (no arguing)** • **For alcohol… Show NIAAA guidelines & norms**	➢ From what I understand, you are using [insert screening data]… We know that drinking above certain levels, smoking and/or use of illicit drugs can cause problems, such as [insert medical info]…I am concerned about your use of [X]. ➢ What connection (if any) do you see between your use of [X] and this ED visit? **If pt sees connection, reiterate;** **If pt does not see connection:** make one using medical info ➢ These are the upper limits of low risk drinking for your age and sex. By low risk we mean you would be less likely to experience illness or injury if you stay within the guidelines.
3. Enhance motivation • **Explore Pros and Cons** • **Use reflective listening** • **Readiness to change** • **Reinforce positives** • **Develop discrepancy between ideal and present self**	Ask pros and cons ➢ Help me to understand what you enjoy about [X]? **<<PAUSE AND LISTEN>>** ➢ Now tell me what you enjoy less about [X] or regret about your use of [X] **<<PAUSE AND LISTEN>>** On the one hand you said… **<<RESTATE PROS>>** On the other hand you said…. **<<RESTATE CONS>>** ➢ So tell me, where does this leave you? [show readiness ruler] On a scale from 1-10, how ready are you to change any aspect of your use of [X]? ➢ Ask: Why did you choose that number and not a lower one like a 1 or a 2? Other reasons for change? ➢ Ask: How does this fit with where you see yourself in the future?
4. Negotiate & advise • **Negotiate goal** • **Benefits of change** • **Reinforce resilience/resources** • **Summarize** • **Provide handouts** • **Suggest PC f/u**	What's the next step? ➢ What do you think you can do to stay healthy and safe? ➢ If you make these changes what do you think might happen? ➢ What have you succeeded in changing in the past? How? Could you use these methods to help you with the challenges of changing? ➢ This is what I've heard you say…Here's an action plan I would like you to fill out, reinforcing your new goals. This is really an agreement between you and yourself ➢ Provide agreement and information sheet ➢ Suggest Primary Care f/u to support plan ➢ Thank patient for his/her time

Readiness Ruler

1 2 3 4 5 6 7 8 9 10

Not ready Very ready

Boston University School of Public Health. BNI-ART Institute interview algorithm. Available at: http://www.ed.bmc.org/sbirt/docs/aligo_adult.pdf

Appendix C: Screening Tools for Depression and Intimate Partner Violence

Depression

Edinburgh Postpartum Depression Scale (EPDS) for detection of postpartum depression. To see the tool: www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Postpartum Depression Screening Scale (PDSS) is a checklist to identify women at risk for developing postpartum depression. For more information about this tool and link to journal article, go to: www.wpspublish.com/store/p/2902/postpartum-depression-screening-scale-pdss

Patient Health Questionnaire (PHQ-9) is a self-administered brief depression severity measure. For a link to the tool, go to: www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Center for Epidemiologic Studies Depression Scale (CES-D) is a 20-item instrument developed by NIMH to detect major or clinical depression in adolescents and adults in community samples. The questions are easy to answer and cover most of the areas included in the diagnostic criteria for depression. For a link to the tool, go to: http://counsellingresource.com/lib/quizzes/depression-testing/cesd

ACOG District II Perinatal Depression Screening Toolkit
http://mail.ny.acog.org/website/DepressionToolKit.pdf

Intimate Partner Violence

American College of Obstetricians and Gynecologists
Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings
www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/~/media/Departments/Violence%20Against%20Women/Reproguidelines.pdf

Health Cares About Intimate Partner Violence
Information about IPV, screening, how to screen, links to resources, advocacy tools, and how to order educational materials: www.healthcaresaboutipv.org

National Health Resource Center on Domestic Violence
Fact sheets, free patient and provider materials, training videos, and technical assistance: www.futureswithoutviolence.org/health/national-health-resource-center-on-domestic-violence/

For Washington State information and resources refer to *Intimate Partner Violence and Pregnancy Screening, Resources and Referrals* provider guide for Washington State at http://here.doh.wa.gov/materials/violence-pregnancy-resources

Appendix D: Interpreting Urine Toxicology Screens – UNC Health Care

General Information	**Toxicology Laboratory:** 966-6338 *or* 966-2361		
	• Before ordering a urine toxicology screen, review the patient's medication record to ensure it is accurate and up-to-date • Sensitivities, cross-sensitivities, false positives, and false negatives may vary based on assay; contact the laboratory for specific information • False positives and negatives are possible on initial urine screens but can be ruled out on confirmation screens • Contact the laboratory if results of urine toxicology screen are abnormal, or not as expected • Currently, assays are unable to determine a reliable relationship between dose and urine concentration		
Included in Standard Urine Toxicology Screen	**Substance** ***(compound targeted by assay)***	**Window of Detection**	**Notes & Clinical Pearls**
	Amphetamines *(d-amphetamine, d-methamphetamine)*	3 – 72 hours	• Cross reactivity possible with many prescription (e.g., pantoprazole (Protonix)) or over-the-counter products (e.g., pseudoephedrine); contact lab for details • Must specify with laboratory if testing for ecstasy (metabolites are present for < 24 hours) or ephedra
	Barbiturates *(Secobarbital)*	1 – 21 days	
	Benzodiazepines *(Nor-diazepam)*	72 hours	• Assay unable to distinguish between specific benzodiazepines; contact toxicology laboratory if screening for a specific agent • Windows of detection depend on specific agents; shorter-acting benzodiazepines (e.g., alprazolam, lorazepam) have shorter windows of detection while longer-acting agents (e.g., diazepam) are present for longer • Temazepam and oxazepam are hepatic metabolites of diazepam and may be positive in confirmation screens for diazepam
	Cannabinoids *(THC metabolites)*	0 – 21 days	• Window of detection generally depends on duration of use; single uses are generally detectable for 2 to 4 days; moderate use for one week or more; chronic use may last up to several weeks • After discontinuing marijuana, cannabinoids distribute from the tissue and may result in positive screens for over days to weeks; results may also be affected by underlying fluid status (i.e., dehydration vs. fluid overload) • A positive result cannot be explained by passive smoke inhalation; also unlikely with hemp ingestion
	Cocaine *(Benzoyl ecgonine)*	12 – 72 hours	• Positive result can occur due to topical anesthetic use
	Methadone	72 hours	• Can measure chronic use with the urine concentration of the methadone metabolite, EDDP (ethylene dimethyl diphenyl pyrrolidine)
	Opiates *(Codeine, Morphine)*	2 – 5 days	**Specific medications and interpretation of results** *(Confirmation Screens)* • **Codeine**: expect codeine and morphine on urine screen. Codeine alone is possible if patient is deficient in CYP2D6 pathway. Small amounts of hydrocodone may also be present. Morphine alone generally indicates heroin use • **Morphine**: expect morphine on urine screen; high doses may result in small amounts of hydromorphone (< 5%) due to an alternate metabolic pathway. • **Hydrocodone**: expect hydrocodone on urine screen; may also produce small quantities of hydromorphone, the primary metabolite of hydrocodone. • **Hydromorphone**: expect **only** hydromorphone on urine screen • **Oxycodone**: may not be detected on initial urine drug screen (i.e., about 75% sensitivity), so confirmation may be necessary; other opioids should not be seen on urine screen • **Oxymorphone**: Sold as Opana, but it is also a metabolite of oxycodone, and is seen with chronic oxycodone use • Synthetic and semi-synthetic opioids (e.g., fentanyl, oxycodone, buprenorphine) may not be reliably detected on urine screen; must specifically order test for detection of fentanyl
	Propoxyphene	2 – 7 days	• No longer prescribed in the United States
Specific	Fentanyl		• Not included in opiate screening; must be specifically requested
	Phencyclidine (PCP)	5 – 7 days	
	LSD		Not used if collected after ≥ 8 hours, due to rapid metabolism
	Tramadol		Infants can have withdrawal

Downloaded online October 1, 2014.
Adapted February 2016.

Appendix E: Resources

Statewide Resources

Chemical Dependency Assessment and Treatment

Washington Recovery Help Line: 1-866-789-1511
Provides statewide 24-hour referral information about treatment, counseling, mental health, and domestic violence issues; assists with crisis intervention techniques and referral; provides support services by county and city for teens and adults. Assistance for providers and clients.

Washington State Alcohol Drug Clearinghouse: 1-800-662-9111
Provides continually-updated substance abuse resources; information on programs, personnel, referrals, and copies of printed materials. Call for a copy of the Directory of Certified Chemical Dependency Treatment Services in Washington State.

Alcohol and Drug Help Line Domestic Violence Outreach Project:
Alcohol and Drug Help Line: 206-722-3700 or 1-800-562-1240
Information about programs in Washington State addressing both domestic violence and chemical dependency.

Washington State Division of Behavioral Health and Recovery:
Main Line: 1-877-301-4557
Information related to the Department of Social and Health Services supported alcohol and drug treatment programs.

Division of Behavioral Health and Recovery Certified Hospitals Providing Intensive Inpatient Detoxification Care for Chemical Using Pregnant Women (Revised October 2014)

GRAYS HARBOR COUNTY
Grays Harbor Community Hospital
Harbor Crest Behavioral Health
1006 North H Street, Aberdeen, WA 98520
Jack Gronewald, Director
Phone: 360-537-6254 Fax: 360-537-6492
jgronewald@ghcares.org
www.harborcrestbh.org
1st and 2nd trimester, no opiate dependent

KING COUNTY
Swedish Medical Center – Ballard Campus
Addiction Recovery Services
5300 Tallman Avenue NW, P.O. Box 70707, Seattle, WA 98107-1507
Phone: 206-781-6048 Fax: 206-781-6183

SNOHOMISH COUNTY
Providence Drug and Alcohol Services
Providence General Medical Center
916 Pacific Avenue, P.O. Box 1067, Everett, WA 98206
Cheryl Sackrider, Director
Phone: 425-258-7390 Intake Line: 425-258-7578 Fax: 425-258-7379

If you have questions, contact Donlisa Scott at 360-725-3724 or 1-877-301-4557 or email at donlisa.scott@dshs.wa.gov.

Other Special State-Funded Projects

Safe Babies Safe Moms

The Safe Babies Safe Moms Program serves substance abusing pregnant, post-partum, and parenting women and their children from birth-to-three at project sites in Snohomish, Whatcom, and Benton-Franklin Counties.

Safe Babies Safe Moms provides a comprehensive range of services that include chemical dependency treatment referral, intensive case management services and transitional housing support services. Safe Babies Safe Moms assists women in accessing needed community resources and transitioning from public assistance to self-sufficiency. Safe Babies Safe Moms also offers: (1) parenting education; (2) child development activities; and (3) behavioral health related services.

For information at the local level, contact the following:

Snohomish County
Targeted Intensive Case Management
Pacific Treatment Alternatives
Contact: Christy Richardson
425-259-7142

Whatcom County
Targeted Intensive Case Management
Growing Together/Brigid Collins
Contact: Kathryn Lyons
360-734-4616

Benton-Franklin Counties
Targeted Intensive Case Management
Benton-Franklin Health District
Contact: Shelley Little
509-582-0834

Parent Child Assistance Program

The Parent Child Assistance Program provides advocacy and intensive case management services to high-risk substance abusing pregnant and parenting women and their young children in King, Pierce, Spokane, Grant, Yakima, Cowlitz, Skagit, Kitsap, Clallam, Clark, Grays Harbor/Pacific and Thurston counties.
http://depts.washington.edu/pcapuw/

Parent Child Assistance Program services include:

- Referral and support for substance use disorder treatment and relapse prevention for 3 years beginning at enrollment during pregnancy or up to six months postpartum.
- Assistance in accessing and using local resources such as family planning, health care, domestic violence services, parent skills training, child welfare, childcare, transportation, and legal services.
- Linkages to health care and appropriate therapeutic interventions for children.
- Regular home visitation and timely advocacy based on client needs.
- Resources for clean and sober housing: The Willows transitional housing is for mothers with co-occurring disorders, and their children.

For more information, contact:

University of Washington Fetal Alcohol and Drug Unit
Therese Grant, PhD, Director
206-543-7155

Women are eligible for Parent Child Assistance Program if they abuse alcohol or drugs during pregnancy, and are pregnant or up to six months postpartum, and are ineffectively connected to community services.

Contact numbers for making a referral to the Parent Child Assistance Program:

County	Clinical Director	
Clallam	First Step Family Support Center Christina Miko	360-457-8355
Clark	Community Services Northwest Amy Morrison	360-448-2121
Cowlitz	Family Health Center Tabatha O'Brien	360-425-9600
Grant	Grant County Prevention and Recovery Center Wendy Hanover	509-765-5402, ext. 5486
Grays Harbor/ Pacific	Children's Advocacy Center of Grays Harbor Margaret Cabell	360-249-0005, ext. 14
King	Evergreen Recovery Centers Charlene Takeuchi	206-323-1300, ext. 2237
Kitsap	Agape Unlimited Mary Allison Brown	360-377-0370
Pierce	Evergreen Recovery Centers Shermoin Claray	253-475-0623
Skagit	Brigid Collins Family Support Center Elizabeth Morgan	360-866-6669, ext. 323
Spokane	New Horizons Care Centers Denise Joy	509-838-6092
Yakima	Triumph Treatment Services Lashaunda Harris	509-248-1800

Other Related Washington State Resources for Pregnant Women

Adoption counseling
www.dshs.wa.gov/ca/adopt/index.asp

Child Protective Services
www.dshs.wa.gov/ca/general/index.asp

Domestic Violence Hotline – 1-800-562-6025
24-hour line provides information and referrals.

Family Planning TAKE CHARGE Program – 1-800-770-4334
Information and referral resources for family planning.

First Steps – Maternity Support Services and Infant Case Management
www.hca.wa.gov/medicaid/firststeps/pages/index.aspx

Home management, education and career building support
See Parent Child Assistance Program and Safe Babies Safe Moms

Learn About Marijuana
Alcohol and Drug Abuse Institute at the University of Washington
http://learnaboutmarijuanawa.org/factsheets/reproduction.htm

Legal services
Sources of Free Legal Info on Washington Sate Law
http://lib.law.washington.edu/ref/legalinfo.html

Mental Health Services
www.dshs.wa.gov/dbhr/mh_information.shtml

Nurse-Family Partnership
Nurse home visitors work with low-income women who are pregnant with their first child
www.nursefamilypartnership.org/locations/Washington

Parent skill-building services
See First Steps and other special state services section – Parent Child Assistance Program and Safe Babies Safe Moms

Pediatric follow up for special care infant
Children's Hospital and Regional Medical Center
http://www.seattlechildrens.org/

Public assistance and medical assistance
Family Health Hotline – 1-800-322-2588
Provides information and referrals for public assistance maternity support services, maternity case management, prenatal care, family planning and pediatric care.

Safe and sober housing
www.oxfordhouse.org/userfiles/file/

StopOverdose.org
Website for prevention of Opioid overdoses through Naloxone:
http://stopoverdose.org/faq.htm

StopOverDose overdose education site:
http://stopoverdose.org/index.htm

Tobacco Quitline – 1-800-784-8669
For assistance quitting tobacco use.
www.doh.wa.gov/YouandYourFamily/illnessanddisease/tobaccorelated/quittingtobacco.aspx

Washington Law Help
www.washingtonlawhelp.org

Washington State Child Care Resource and Referral Network
http://www.childcarenet.org/

Washington State Department of Public Health – Children with Special Health Care Needs
www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds.aspx

WIC Nutrition Program
www.doh.wa.gov/YouandYourFamily/WIC.aspx

Websites – National

American College of Nurse Midwives
www.midwife.org

American Society of Addiction Medicine
www.asam.org

Association of Women's Health Obstetric and Neonatal Nurses
www.awhonn.org

CDC Fetal Alcohol Spectrum Disorders homepage (plus FASD applications for mobile devices)
www.cdc.gov/ncbddd/fasd

Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, SAMHSA: TIP Protocol 40
http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

FASD Center for Excellence
www.fasdcenter.samhsa.gov/

KAP Keys for Clinicians Substance Abuse Treatment: Addressing the Specific Needs of Women, TIP 51
http://store.samhsa.gov/product/Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA14-4844

Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, SAMHSA: TIP 43
http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

Motivational Interviewing (including online training)
http://www.hca.wa.gov/medicaid/familyplan/Pages/takecharge.aspx

National institute on Drug Abuse – Commonly Abused Drugs
http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts

National Organization on Fetal Alcohol Syndrome
http://www.nofas.org/

Substance Abuse Mental Health Services Administration (SAMHSA)
National Clearinghouse for Alcohol and Drug Information
http://store.samhsa.gov/home
www.samhsa.gov

SAMHSA Medication-Assisted Treatment of Opioid Use Disorder pocket guide
http://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf

The American College of Obstetricians and Gynecologists
www.acog.org

The National Women's Health Information Center
Women's health information and resources.
www.womenshealth.gov/

Websites – Washington State

Department of Health
www.doh.wa.gov

Domestic Violence Information
Resources and tools for providers
www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/ViolenceAgainstWomen.aspx

Interagency Guideline on Prescribing Opioids for Pain
developed by Agency Medical Directors Group 2015
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Parent Child Assistance Program
http://depts.washington.edu/pcapuw/

Pediatric Interim Care Center
www.picc.net

TAKE CHARGE – Family Planning Program
http://www.hca.wa.gov/medicaid/familyplan/Pages/takecharge.aspx

Washington Recovery Help Line
http://warecoveryhelpline.org/

Washington State Division of Behavioral Health and Recovery
https://www.dshs.wa.gov/mental-health-and-addiction-services

Washington State Fetal Alcohol Spectrum Disorders
www.fasdwa.org

WithinReach
website that connects families to food and health resources
www.parenthelp123.org

Health Education Materials

Substance Free for My Baby
http://here.doh.wa.gov/materials/substance-free-for-my-baby

Steps to Help You Quit Smoking: How Other Moms Have Quit
http://here.doh.wa.gov/materials/steps-to-quit-smoking-moms

What to Expect When Your Baby Has Withdrawal
http://here.doh.wa.gov/materials/substance-free-for-my-baby

Spanish Health Educational Resources

Birth Defects and Developmental Disabilities
http://www.cdc.gov/ncbddd/defaultspan.htm
http://www.nacersano.org/

Illicit Drug Use During Pregnancy
http://www.nacersano.org/centro/9388_9935.asp

Drinking and your pregnancy
http://pubs.niaaa.nih.gov/publications/spanish.htm

Substance Free for My Baby
http://here.doh.wa.gov/materials/substance-free-for-my-baby

Steps to Help You Quit Smoking: How Other Moms Have Quit
http://here.doh.wa.gov/materials/steps-to-quit-smoking-moms

What to Expect When Your Baby Has Withdrawal
http://here.doh.wa.gov/materials/substance-free-for-my-baby

National Hispanic Prenatal Helpline – 1-800-504-7081
The National Hispanic Prenatal Helpline is a component of the Maternal and Child Health Bureau's campaign emphasizing early and regular prenatal care. The primary goal of the Bureau's campaign is to increase utilization of prenatal care services and to promote the benefits of prenatal care. The National Hispanic Prenatal Helpline is designed for Hispanic women planning a pregnancy; Hispanic expectant mothers or mothers of newborns; partners, relatives or friends of expectant mothers; and providers working with Hispanic families.

The bilingual (English and Spanish) Helpline has three main functions: 1) to answer questions about prenatal issues in both English and Spanish and in a culturally appropriate manner; 2) to give referrals to local prenatal care services that have the capability of serving Hispanic consumers; and 3) to send out written information to callers about prenatal issues in Spanish and English. The Helpline operates Monday through Friday from 9 a.m. to 6 p.m. EST.

Additional Professional Materials

US Department of Agriculture Food and Nutrition Service
Substance Use Prevention Screening, Education, and Referral Resource Guide for Local WIC Agencies
http://www.nal.usda.gov/wicworks/Topics/ResourceManual.pdf
A USDA handbook addressing WIC's role in preventing substance use disorder, predictors, screening methods and tools and resources, updated September 2013.

The Outpatient Treatment Guide manual for Care of Opioid-Dependent Pregnant Women with Buprenorphine. 2013. Maine Dartmouth Family Medicine Residency, Dartmouth Medical School.
www.mainedartmouth.org/pdf/OConnorAltoOutpatientTreatmentManualOpioidDependentPregnant_V2.pdf

Snuggle ME Project: Embracing Drug Affected Babies and their Families in the First year of Life To Improve Medical Care and Outcomes in Maine
Evidenced- based recommendations for care of mom, newborn and families affected by perinatal addiction.
www.maine.gov/dhhs/mecdc/documents/SnuggleME-Project.pdf

National Institute of Drug Abuse
Screening for Drug Use in General Medical Settings: Quick Reference Guide
www.drugabuse.gov/sites/default/files/pdf/screening_qr.pdf

Additional Tools: Screening, Assessment, and Drug Testing
www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/additional-tools-screening-assessment-drug

SAMSHA – HRSA Center for Integrated Health Solutions
SBIRT: Training and Other Resources
www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources

Appendix F: Definitions of Services

Detoxification Services

Assists clients in withdrawing from drugs, including alcohol.

Acute Detox – Medical care and physician supervision for withdrawal from alcohol or other drugs.

Sub-Acute Detox – Non-medical detoxification or patient self-administration of withdrawal medications ordered by a physician and provided in a home-like environment.

Outpatient Treatment Services

Provides chemical dependency treatment to patients less than 24 hours a day.

Intensive Outpatient – A concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families.

Outpatient – Individual and group treatment services of varying duration and intensity according to a prescribed plan.

Outpatient Child Care – A certified outpatient chemical dependency treatment provider may offer on-site child care services approved by the Department of Social and Health Services, offering each child a planned program of activities, a variety of easily accessible, culturally and developmentally appropriate learning and play materials, and promoting a nurturing, respectful, supportive, and responsive environment.

Residential Treatment Services – Length of stay is variable and based on need identified by American Society of Addiction Medicine

Intensive Inpatient – A concentrated intervention program up to 30 days, including but not limited to individual, group and family therapy, substance abuse education, and development of community support systems and referrals.

Recovery House – A program of care and treatment up to 60 days with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities.

Long-Term – A treatment program up to 180 days with personal care services for individuals with chronic histories of addiction and impaired self-maintenance capabilities. This level of disability requires personalized intervention and support to maintain abstinence and good health.

Appendix G: Department of Social and Health Services Children's Administration Prenatal Substance Abuse Policy

The Federal Child Abuse Prevention and Treatment Act (CAPTA) as amended by the Keeping Children and Families Safe Act of 2003 requires health care providers to notify Child Protection Services (CPS) of cases of newborns identified as being AFFECTED by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

Washington State statute does not authorize Children's Administration (CA) to accept referrals for CPS investigation or initiate court action on an unborn child.

In Washington State, health care providers are mandated reporters and required to notify CPS when there is reasonable cause to believe a child has been abused or neglected. If a newborn has been identified as substance exposed or affected, this may indicate child abuse/neglect and should be reported. It is critical that mandated reporters provide as much information regarding concerning issues/behaviors, risk factors or positive supports that were observed during the interaction with the family.

How Do I Make A Report?

Children's Administration offices within local communities are responsible for receiving and investigating reports of suspected child abuse and neglect. Reports are received by CPS Intake staff either by phone, mail or in person and are assessed to determine if the report meets the legal definition of abuse or neglect and how dangerous the situation is.

Children's Administration offers several ways to report abuse::

Daytime: Contact local Children's Administration Child Protective Services office. An intake phone number for a local Child Protective Services office can be located on the following link: https://fortress.wa.gov/dshs/f2ws03apps/caofficespub/offices/general/OfficePick.asp

Nights and Weekends: Call the Child Abuse and Neglect Hotline at 1-866-ENDHARM (1-866-363-4276), which is Washington State's toll-free, 24 hour, 7 days a week hotline where you can report suspected child abuse or neglect.

Additional information about reporting abuse and neglect of children can be located at: www.dshs.wa.gov/ca/safety/abuseReport.asp?2

As A Mandated Reporter, What Information Will I Be Asked To Provide?

Mandated reporters will be asked to provide as much of the following information as they are able:

- The name, address, and age of the child and parent(s), stepparents, guardians, or other persons having custody of the child.
- The nature and extent of alleged:
  - Injury or injuries
  - Neglect
  - Sexual abuse
  - Any evidence of previous injuries

- Any other information that may be helpful in establishing the cause of the child's death, injury or injuries, and the identity of the alleged perpetrator(s).

It is important to provide as much information about why you have reasonable cause to believe there is child abuse or neglect. This information will assist Department of Social and Health Services at intake or during the course of a Child Protective Services investigation if the case screens in. Examples include:

- Issues, i.e., substance use, mental health that may impact a child's safety.
- Parents' resources and strengths that can help the parents care for and protect the children.
- Parents' response to interventions, etc.
- Names of family members.
- Whether the child may be of Indian ancestry for Indian Child Welfare planning, if applicable.
- Parent(s) attitude about their newborn.
- If the mother participated in prenatal care.
- Extended family and family strengths which can help the parent(s) to care for and protect children and their family.
- Parent(s) resources and family strengths.
- Rationale for toxicology testing.

If you are in doubt about what should be reported, it is better to make your concerns known and discuss the situation with your local Child Protective Services office or Child Abuse and Neglect Hotline.

If a crime has been committed, law enforcement must be notified. The name of the person making the report is not a requirement of the law; however, mandated reporters must provide their name in order to satisfy their mandatory reporting requirement.

What Happens After A Report Is Made?

When a report of suspected child abuse or neglect is made, Children's Administration intake staff determines whether the situation described meets the legal definition of child abuse or neglect. In order for Child Protective Services to intervene in a family, the report must meet the legal definition of child abuse or neglect or there is an imminent risk of serious harm to the child.

Referrals which are determined to contain sufficient information may be assigned for investigation or Family Assessment Response (FAR).

Child Protective Services interventions include the following:

- Determining the nature and extent of abuse and neglect.
- Evaluating the child's condition, including danger to the child, the need for medical attention, etc.
- Identifying the problems leading to or contributing to abuse or neglect.
- Evaluating parental or caretaker responses to the identified problems and the condition of the child and willingness to cooperate to protect the child.
- Taking appropriate action to protect the child.
- Assessing factors which greatly increase the likelihood of future abuse or neglect and the family strengths which serve to protect the child.

If a child is of Indian ancestry social services staff must follow requirements of the Federal Indian Child Welfare Act (ICWA), state laws, and the RCW.

Family Assessment Response (FAR) where currently implemented. For additional information and implementation schedule, see website www.dshs.wa.gov/ca/about/far.asp.

FAR is a differential response model to provide an alternative pathway for families with accepted reports of child abuse and neglect that are low to moderate risk.

- Evaluating the Child's condition, including danger to the child, the need for medical attention, etc.
- Identifying the problems leading to or contributing to abuse or neglect.
- Evaluating parental or caretaker responses to the identified problems and the condition of the child and their willingness to cooperate to protect the child.
- Taking appropriate action to protect the child.
- Allowing the family to take the lead in assessing strengths and needs.
- Identifying the services and supports that will be most helpful in reducing the risk of future child abuse and neglect-including reaching out to the local community for help to support the family in times of stress.

What Services May Be Provided?

Protective services are provided to abused/neglected children and their families without cost. If the situation meets the criteria for intervention, it may be assigned as either an investigation or, in some areas, it may be screened for a Family Assessment Response (FAR). Learn more about FAR at www.dshs.wa.gov/ca/about/far.asp. Other rehabilitative services for prevention and treatment of child abuse are provided by the Department of Social and Health Services and other community resources (there may be a charge for these services) to children and the families, such as:

- Day care
- Foster family care
- Financial and employment assistance
- Parent aides
- Mental health services, such as counseling of parents, children, and families
- Psychological and psychiatric services
- Parenting and child management classes
- Self-help groups
- Family preservation services

What Happens If A Report Does Not Meet The Definition Of Child Abuse Or Neglect?

When Children's Administration receives information that does not meet the definition of child abuse or neglect and Children's Administration does not have the authority to investigate, intake staff documents this information in the systems database as an "Information Only" referral.

When Children's Administration receives information about a pregnant woman who is not parenting other children and is allegedly abusing substances, intake staff documents this information and available information about risk and protective factors in an "Information Only" referral. This referral is then forwarded to First Steps Services.

When Children's Administration receives information about a substance-exposed but not substance-affected newborn, intake staff will ask about available information, including information about safety threats and protective factors to determine if there is an allegation of child abuse or neglect or safety threat(s). If there are no allegations of child abuse or neglect or safety threats, Children's Administration does not have the authority to conduct a Child Protective Services investigation and the referral is documented as "Information Only." If a decision is made not to respond, and you disagree, you may discuss your concerns with the Intake Supervisor. When a case is not appropriate for Child Protective Services, you may consult with the local Children's Administration office for suggestions or guidance in dealing with the family.

CA Practices and Procedures – Prenatal Substance Abuse Policy Definitions

A Substance-Exposed Newborn is one who tests positive for substance(s) at birth, or the mother tests positive for substance(s) at the time of delivery or the newborn is identified by a medical practitioner as having been prenatally exposed to substance(s).

A Substance-Affected Newborn is one who has withdrawal symptoms resulting from prenatal substance exposure and/or demonstrates physical or behavioral signs that **can be** attributed to prenatal exposure to substances and is identified by a medical practitioner as affected.

Appendix H: Medical and Public Health Statements Addressing Prosecution and Punishment of Pregnant Women

American Medical Association

"Pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician's knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment." Report of American Medical Association Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 267 (1990). *See also* American Medical Association, *Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, Resolution 131 (1990) ("therefore be it . . . resolved that the AMA oppose legislation which criminalizes maternal drug addiction.").

American Academy of Pediatrics

"The [Academy] is concerned that [arresting drug addicted women who become pregnant] may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment." American Academy of Pediatrics, Committee on Substance Abuse, *Drug Exposed Infants*, 86 Pediatrics 639, 641 (1990).

American College of Obstetricians and Gynecologists

"Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes." American College of Obstetricians and Gynecologists, Committee on Ethics, *Committee Opinion 473 Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 Obstetrics & Gynecology 200 (2011).

"Pregnant women should not be punished for adverse perinatal outcomes. The relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses." American College of Obstetricians and Gynecologists, Committee on Ethics, *Committee Opinion 321 Maternal Decision Making, Ethics and the Law*, 106 Obstetrics & Gynecology 1127 (2005).

American Public Health Association

"Recognizing that pregnant drug-dependent women have been the object of criminal prosecution in several states, and that women who might want medical care for themselves and their babies may not feel free to seek treatment because of fear of criminal prosecution related to illicit drug use . . . [the criminal justice matter requiring punitive sanctions are inappropriate." Further "[affirms the use of health care strategies to foster the welfare of chemically dependent women and their children by expanding access to prenatal care and to reproductive health care generally." American Psychological Association, *Resolution on Substance Abuse by Pregnant Women*, (Aug. 1991).

National Perinatal Association
"The NPA opposes criminal prosecution of women solely because they are pregnant when they used alcohol or drugs . . . No evidence exists to show that [prosecution] either prevents prenatal drug or alcohol exposure or improves the infant's health... It undermines the relationship between the health care providers and their patients and may keep women from giving accurate and essential information vital to their care." National Perinatal Association, *Substance Abuse Among Women*, Position Statement (updated as of Mar. 23, 2010).

National Association for Perinatal Addiction Research and Education
"From a health-care perspective, it appears likely that criminalization of prenatal drug use will be counterproductive. It will deter women who° use drugs during pregnancy from seeking the prenatal care which is important for the delivery of a health baby . . . The threat of criminal prosecution alone will not deter women in most instances from using drugs during pregnancy. These women are addicts who become pregnant, not pregnant women who decide to use drugs and become addicts." National Association for Perinatal Addiction Research and Education. *Criminalization of Prenatal Drug Use: Punitive Measures Will Be Counterproductive* (1990).

National Council on Alcoholism and Drug Dependence
"[A] punitive approach is fundamentally unfair to women suffering from addictive diseases and serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the best interests of infants and children by involving the sanctions of the criminal law in the case of a health and medical problem." National Council on Alcoholism and Drug Dependence, *Policy Statement: Women, Alcohol, Other Drugs and Pregnancy* (1990).

Association of Maternal and Child Health Programs
"The threat of criminal prosecution prevents many women from seeking prenatal care and early intervention for their alcohol or drug dependence, undermines the relationship between health and social service workers and their clients, and dissuades women from providing accurate and essential information to health care providers. The consequence is increased risk to the health and development of their children and themselves." Association of Maternal and Child Health Programs Law and Policy Committee, *Statement Submitted to the Senate Finance Committee Concerning Victims of Drug Abuse: Resolution on Prosecution* (1990).

Appendix I: A Guide for Medical Professionals about Tobacco, Marijuana, and E-Cigarettes in Pregnant & Breastfeeding Women

The Washington State Department of Health has created the Substance Free for My Baby handout for healthcare providers to use with patients. This resource is based on the most current evidence about tobacco, marijuana, and e-cigarette use during pregnancy and breastfeeding. We hope the guidance below assists you in normalizing conversations about marijuana and e-cigarettes so you can talk about them the same way you talk with patients about tobacco and alcohol use.

As a healthcare provider, you play a crucial role in getting this information to your patients. Thank you for helping us work towards a safer and healthier Washington.

Key points about tobacco, marijuana and e-cigarette use during pregnancy and breastfeeding

- Safe limits of these substances have not been established and many experts think there is no safe level of use.
- Physicians generally advise total abstinence from all nonessential medications and chemicals during pregnancy and breastfeeding.
- Well-established evidence reveals the adverse effects of tobacco, nicotine and alcohol on pregnancy outcomes and infant health.
- Conclusive evidence about the risks of marijuana and E-cigarette is still emerging but enough evidence exists to promote abstinence during pregnancy and breastfeeding.
- Medical providers should avoid predicting outcomes as statistical odds do not predict specific case results. (USA Substance Use Prevention for Local WIC Agencies, 2013)
- Public health messages are conservative and based on current evidence and potential for risk.

Current research and information during pregnancy and breastfeeding

Marijuana

- Use is legal at age 21 under Washington State law. (RCW 69.50.4013)
- The active ingredient (THC) passes from mother to child during pregnancy and through breastmilk.
- Infants exposed to THC can have problems with feeding and may have delayed mental and physical development.
- The American Academy of Pediatrics states that using marijuana is contraindicated while breastfeeding. Women should be advised to avoid marijuana use while nursing. (Breastfeeding and the Use of Human Milk, Pediatrics, 2012.)
- Marijuana may impair the mother's ability to make the best choices for the health and safety of her baby and herself.

E-cigarettes

- Are legal at age 18 under Washington State law.
- Carry many of the same risks as regular cigarettes.
- Often contain nicotine.
- Nicotine use prenatally increases the risks of:
  - SIDS
  - Pregnancy complications
  - Premature birth, low birth weight, or still birth
  - Poor lung development
- Small amounts of liquid nicotine can be fatal to infants and children.

Hookah smoking:[20] A hookah is an eastern tobacco pipe or water pipe

- Carries many of the same risks as smoking tobacco.
- Sessions lasting an hour involve 200 puffs. Smoking an average cigarette involves 20 puffs.
- Contains 90,000 milliliters (ml) of inhaled smoke compared with 500–600 ml of inhaled smoke from a cigarette.
- Preparations of tobacco-based shisha and "herbal" shisha contain carbon monoxide and other toxic agents known to increase the risks for smoking-related cancers, heart disease, lung disease and meningococcal meningitis.

Breastfeeding and smoking

According to the American Academy of Pediatrics, maternal smoking is not a categorical contraindication to breastfeeding. Breastmilk remains the recommended food for a baby even if the mother smokes tobacco.

Nicotine

- Use increases the risk of:
  - SIDS
  - Poor lung development
  - Asthma
  - Coughs, colds, and ear infections
- Providers should strongly encourage quitting, cutting back and other measures to decrease risk. Mitigating factors include smoking outside, smoking after breastfeeding and wearing "smoking jackets" Although nicotine may be present in the milk of a mother who smokes, there are no reports of adverse effects on the infant due to breastfeeding.

Secondhand smoke

- Exposes baby and mother to nicotine and other harmful chemicals
- Carries small cancer causing particles and nicotine which sticks to floors, walls, clothing, carpeting furniture and skin creating additional exposure risks.

Recommended patient resources

- **Washington State Tobacco Quitline:** 1-800-QUIT-NOW (1-800-784-8669) or 1 855-DEJELO-YA for help with tobacco and marijuana.
- **Washington Recovery Helpline:** 1-866-789-1511 for drug and alcohol treatment resources by county.

Provider resources

- The PHS publication, **Treating Tobacco Use and Dependence: A Clinical Practice Guideline, 2008 Update** describes the 5 A's intervention in detail and provides a chapter about special populations, including pregnant women (Fiore 2008).
- **Smoking Cessation During Pregnancy: Guidelines for Intervention**
  A handbook designed for healthcare professionals, includes information on using motivational interviewing techniques and the 5 As, tips for dealing with relapse, developing quit plans, pharmacotherapy information and additional resources.
- **Substance Use Prevention Screening, Education, and Referral Resource Guide for Local WIC Agencies**
  A USDA handbook addressing WIC's role in preventing substance use disorders, patterns and predictors, screening methods and tools and resources.

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Footnotes

[1] Fetal Alcohol Spectrum Disorders is the latest, federally accepted umbrella term used to refer to all conditions caused by prenatal alcohol exposure, such as fetal alcohol syndrome, fetal alcohol effects, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects.

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