

Substance Abuse During Pregnancy: Guidelines for Screening

Revised Edition 2009

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Contents

Preface.....	1
Purpose.....	2
Definitions.....	2
Scope of the Problem.....	3
Role of the Health Care Provider.....	4
Benefits of Universal Screening.....	4
Urine Toxicology Not for Universal Screening.....	5
Screening Tools.....	5
How to Screen.....	5
Create a Respectful Environment.....	6
Educational Messages for Clients.....	6
When a Woman Denies Use.....	6
When a Woman Admits Use.....	6
Laboratory Testing.....	9
Benefits of Lab Testing.....	9
Limitations of Lab Testing.....	9
Indicators for Testing.....	9
Signs and Symptoms of Substance Abuse.....	10
Consent Issues for Testing.....	11
Referral to Treatment.....	11
Harm Reduction – Decrease Use.....	12
Pregnancy Management Issues.....	13
Prenatal.....	13
Intrapartum.....	13
Postpartum.....	14
Associated Issues for Pregnant Women.....	14
Appendix A: Screening Tools for Drugs and Alcohol.....	16
Appendix B: Resources.....	19
Appendix C: Definitions of Services.....	26
Appendix D: Department of Social and Health Services Children’s Administration Prenatal Substance Abuse Policy.....	27
Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State.....	30
Bibliography.....	44

Preface

Substance abuse during pregnancy has been identified as an issue critical to the health of mothers and babies from all socioeconomic groups. We estimate that in Washington State, between 8,000 and 10,000 infants born each year are exposed prenatally to illegal drugs or alcohol. Of these infants, between 800 and 1,000 are drug or alcohol affected. Since there are no defined safe limits during pregnancy, any use should be avoided. Substance abuse contributes to obstetric and pediatric complications, including Fetal Alcohol Spectrum Disorders¹, prematurity and abruptio placenta. Prenatal alcohol exposure is the leading preventable cause of birth defects and development disabilities in our country. Each year, as many as 40,000 babies are born with Fetal Alcohol Spectrum Disorders, costing the United States about \$4 billion. An estimated 320 to 1,000 children are born with Fetal Alcohol Spectrum Disorders each year in Washington State.

Treatment for substance abuse during pregnancy can be more effective than at other times in a woman's life. Providers play an important role in influencing the health behaviors of pregnant women in their care. Pregnant women often describe their health care 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.

In spring of 1998, House Bill 3103 was passed and signed into law by Governor Gary Locke. As a result, the Department of Health was directed to develop screening criteria for identifying pregnant women at risk of delivering a drug-affected baby. The screening criteria were developed as guidelines based upon input from key informant surveys, and the House Bill 3103 Advisory Workgroup. They include material from the 1997 publication *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*, published by the National Center for Education in Maternal and Child Health.

We want to thank all those who assisted in the development 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.

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.

Purpose

The American College of Obstetrics and Gynecology 2008 Committee Opinion number 422 *At Risk Drinking and Illicit Drug use: Ethical Issues In Obstetric and Gynecologic Practice* and American College of Obstetricians and Gynecologists Committee Opinion No. 343, August, 2006, Psychosocial Risk Factors: Perinatal Screening and Intervention recommend that all pregnant women be questioned thoroughly about substance abuse. 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 or abuse issues
- 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

Definitions

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 dependent use which is a primary 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.

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.

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.

Screening: Methods used to identify risk of substance abuse 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 5).

Assessment: Comprehensive evaluation of a client’s risk for substance abuse 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

Scope of the Problem

Substance use is found throughout all social and economic tiers. As the growth of prescription opiate use increases, more working and middle class pregnant women are affected. Women who use often show no social signs of problems and may be fearful of disclosure.

A Department of Health & Human Services survey (National Survey on Drug Use & Health) regularly measures substance use among women in the United States. Although accurate data are difficult to obtain on this topic, the survey estimated that in 2005–2006 almost 10 percent of women aged 18–49 (6.4 million women) were estimated to use illicit drugs. In the same survey, 4 percent of pregnant women used illicit substances in the last month (Substance Abuse Mental Health Services Administration, 2008).¹ With regard to prenatal alcohol and drug use, population-based studies indicate that during the previous month, 10.1 percent of pregnant women reported drinking any alcohol, 1.9 percent of pregnant women reported binge alcohol use (Centers for Disease Control [CDC], 2004).²

In Washington State, it is difficult to estimate the number of alcohol and drug exposed and affected infants. Accurate, population-based, available data sources are limited and often combine episodic use of alcohol and drugs with chronic addiction. In 1997, Department of Social and Health Services Research and Data Analysis used existing data to create the following estimates.

¹ Substance Abuse and Mental Health Services Administration. (2008). Results From the 2006 National Household Survey on Drug Abuse: Volume 1: Summary of National Findings. Rockville, MD: U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

² Centers for Disease Control and Prevention (CDC). (2004). Alcohol Consumption Among Women Who Are Pregnant or Who Might Become Pregnant – United States, 2002. Morbidity and Mortality Weekly Report, 53, 1178–1181.

Washington State data combines episodic use and chronic addictive patterns to reveal that 8,000–10,000 infants are born each year exposed to alcohol or drugs. Exposure means any exposure to a potentially harmful substance including tobacco. Of the infants exposed, 800–1,000 are alcohol or drug affected. This means that the infants are diagnosed at or after birth as having signs and symptoms and other measurable effects due to drug or alcohol use by their mothers. No additional data are available at this time.

Pregnancy Risk Assessment Monitoring System population based survey data provide more information about alcohol and tobacco. From 2004–2006, about 11 percent of mothers in Washington State smoked tobacco in the third trimester. Highest rates occurred in low-income women (about 17 percent of women on Medicaid reported smoking in the last three months of pregnancy). Alcohol use was higher among women not covered by Medicaid. About 11 percent of these women reported drinking in the last three months of pregnancy compared to about 6 percent of women on Medicaid.

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.

Benefits of Universal Screening

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.

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 9).

The American College of Obstetricians and Gynecologists 1994 Technical Bulletin concluded that urine testing has limited ability to detect substance abuse 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 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 T-ACE, TWEAK, 4 P's Plus (see Appendix A, Pages 16–18).

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 (see Page 16).

ASK – See Pages 16–18 for sample screening tools

How to Screen

Screening is a skill, and staff should be trained in interview techniques. 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.

Make substance screening a routine part of prenatal care services. 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 abuse problems in family members. Know how to respond to both positive and negative responses to screening tools (see Page 7). 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.

Create a Respectful Environment

Supportive inquiry about use of drugs or alcohol 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 11).
- 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.
- Be empathetic, nonjudgmental and supportive when asking about use; consider the client's needs and life situation.
- Offer culturally appropriate screening in the client's primary language.

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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, then fill in the missing pieces and clarify misconceptions. This is an excellent 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. 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.

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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 Page 9).

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 remarkable 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.

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.

Laboratory Testing

Urine toxicology determines the presence or absence of a drug in a urine specimen. It may be useful as a follow up to a positive interview screen.

Benefits of Lab Testing

- Confirms the presence of a drug
- Determines the use of multiple drugs
- Determines if a 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.
- 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.
- 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.

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 Abuse on Page 10.)

High Risk Factors

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

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

Behavior Patterns

- Sedation
- Inebriation
- Euphoria
- Agitation
- Aggressiveness
- Paranoia
- Increased physical activity
- Anxiety and nervousness
- Disorientation
- Depression
- Irritability
- Prescription drug seeking behavior
- Suicidal ideations or attempt

Laboratory

- MCV over 95
- Elevated MCH, GGT, SGOT, Bilirubin, Triglycerides
- Anemia
- Positive urine toxicology for drugs
- STI testing

Physical Signs

- 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
- Nystagmus
- Gum or periodontal disease (meth mouth)
- Skin conditions: abscesses, dry or itchy, acne type sores
- Weight loss-low BMI

Medical History

- Frequent hospitalizations
- Gunshot or knife wound
- Unusual infections (cellulitis, endocarditis, atypical pneumonias, HIV)
- Cirrhosis
- Hepatitis
- Pancreatitis
- Diabetes
- 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) and the METH Awareness and Prevention Project of South Dakota (www.mappsd.org).

Consent Issues for Drug Testing

(See Page 27, Appendix D, for Washington State Department of Social and Health Services Children's Administration Prenatal Substance Abuse Policy information, and Page 30 for Department of Health Guidelines for Testing and Reporting Drug Exposed Newborns Exposed in Washington State.)

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 are encouraged to 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 may still occur if medically necessary or if newborn or maternal risk indicators are present.

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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 co-existing psychiatric conditions.

- Know the resources in your area, or find out by calling the Alcohol and Drug Help Line at 1-800-562-1240. Resources may include:
- First Steps Maternity Support Services and Infant Case Management
- County substance abuse services
- Twelve-step programs
- Hospital treatment programs
- Mental health programs
- Special pregnancy related programs

Maintain a current list of local resources (see Appendix B, Pages 19–25, 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 (see Appendix B, Pages 20–21).
- 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 18) and refer women to the Washington State Quit Line (see Page 23).
- If the behavioral approach is not successful, consider pharmacotherapies for smoking cessation: Bupropion hydrochloride (Zyban®) or Nicotine Replacement Therapy, if appropriate for heavy smokers.

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. Praise 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 one-half 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 using friends.
- Discuss contraceptive options for after the delivery and make a plan.

Pregnancy Management Issues

A woman who uses substances during pregnancy is at risk for a variety of complications. The following interventions should be considered in the course of her care.

Prenatal

- Obtain routine blood tests plus hepatitis and tuberculin test and HIV if not included in routine protocol.
- Periodically screen for sexually transmitted infections.
- Refer to methadone maintenance program for opiate addiction or medical detox if applicable.
- Schedule more frequent visits to identify medical and psychosocial problems early.
- 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.
- Order and repeat appropriate tests as needed.
- Monitor pregnancy and fetal development.
- Discuss possible effects of drugs on the newborn.
- Discuss contraceptive methods and make a plan.
- Obtain consent for tubal ligation after delivery if the woman chooses this method.
- Discuss breastfeeding and alcohol and drug use issues.

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 abuse history and recovery status.

Adequate pain management should be available to all laboring mothers who desire it. A substance abuse history should not be considered a contraindication to the normal use of pain medications in labor. Epidural anesthesia can be used as per hospital routine and is a proven effective pain management strategy for laboring women.

Pregnant women maintained on methadone 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 care givers can be reassured that the client is not overdosed.

You may encounter women maintained on a new medication, buprenorphine (Suboxone, Subutex) as a treatment for opiate dependence. This medication is an agonist-antagonist at the opiate receptor and can block the effects of opiate medication. Prenatal consultation with an addiction medicine specialist, anesthesiologist or pain medicine specialist is advised to make a plan for pain relief in such clients.

Avoiding sedatives such as benzodiazepines and cyclopyrrones (Ambien, Sonata, Lunesta) is advised. This will decrease the risk of respiratory suppression in patient receiving high doses of opiates. Sedatives have also been associated with relapse to substance abuse.

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.
- Support breastfeeding as appropriate. Breastfeeding is not contraindicated in methadone maintenance, depending on the dose, but is contraindicated if the woman is HIV positive or using illegal drugs.
- Breastfeeding women with a positive history of drug abuse during pregnancy should be tested periodically while breastfeeding.

Associated Issues for Pregnant Women

Pregnant women who need treatment for substance abuse 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 abuse
- Physical or sexual abuse as a child
- History of sexual assault
- Domestic violence
- Partner with substance abuse issues
- Cultural barriers to care
- Unresolved childhood parenting issues such as parental substance use, incarceration, and dysfunctional family relationships

Medical Issues

- Sexually Transmitted Infections
- HIV
- Poor nutrition
- 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 B for specific referral information.

- 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

Appendix A: Screening Tools for Drugs and Alcohol

Screening Tools for Drug-Alcohol Use

The 4 P's Plus© is a screen for substance use in pregnancy that was developed and tested by Dr. Ira Chasnoff. He found that this screen effectively identified pregnant women at highest risk for substance use during pregnancy. For permission and rights to use this tool, contact Dr. Ira Chasnoff by emailing him at: ichasnoff@aol.com

Chasnoff IJ, et al. (2005) The 4P's Plus© Screen for Substance Use in Pregnancy: Clinical Application and Outcomes. *Journal of Perinatology*, 25:368-374.

Screening Tools for Alcohol Use

Maternal drinking during pregnancy can adversely affect the fetus with effects ranging from mild cognitive impairment and impaired mental functioning to Fetal Alcohol Syndrome, characterized by growth deficiency, central nervous system disorders, 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 all women for alcohol use during pregnancy. Women who drink any alcohol should be encouraged to abstain. Women who are problem drinkers should be supported in changing their behavior through harm reduction, support groups and treatment. Problem drinking and binge drinking can be determined through screening. 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. More than 5 drinks per sitting is binge drinking and puts the fetus at the highest risk of having an alcohol-related birth defect.

T-ACE

Sockol RJ, et al. 1989. The T-ACE questions: Practical prenatal detection of risk drinking: *AM Journal of Obstetrics and Gynecology* 160(4).

Chang G. (2001) Alcohol-Screening Instruments for Pregnant Women. *Alcohol Research and Health*, 25 (3), 204-209.

1. How many drinks does it take for you to feel high? (**T**olerance)
2. Have people **A**nnoyed you by criticizing your drinking?
 - A) Yes
 - B) No
3. Have you ever felt you ought to **C**ut down on your drinking?
 - A) Yes
 - B) No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)
 - A) Yes
 - B) No

Scores

Any woman who answers more than two drinks on question 1 is scored 2 points. Each yes to the additional 3 questions scores 1. A score of 2 or more is considered a positive screen, and the woman should be referred to a specialist for further assessment.

Note: A woman could drink 2 drinks per day during pregnancy (safe level is undetermined) and not get a positive screen using this tool. She may not be at risk for alcoholism, but because of her pregnancy she's drinking at an unsafe level.

TWEAK

Russell M. 1994. New assessment tools for risk drinking during pregnancy. *Alcohol Health & Research World* 18(1)

Chang G. (2001) Alcohol-Screening Instruments for Pregnant Women. *Alcohol Research and Health*, 25 (3), 204-209.

1. How many drinks does it take for you to feel high?
2. Does your partner (or do your parents) ever worry or complain about your drinking?
 - A) Yes
 - B) No
3. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye-opener)
 - A) Yes
 - B) No
4. Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?
 - A) Yes
 - B) No
5. Have you ever felt that you ought to cut down on your drinking?
 - A) Yes
 - B) No

Scores

A woman receives 2 points on question 1 if she reports that she can hold more than 5 drinks without falling asleep or passing out.

A positive response to question 2 scores 2 points, and a positive response to each of the last 3 questions scores 1 point each.

A total score of 2 or more indicates that the woman is a risk drinker and requires further assessment.

Note: Drinking at any level during pregnancy is unsafe, even if the woman scores negative with this tool.

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: Resources

Statewide Resources

Chemical Dependency Assessment and Treatment

Alcohol and Drug Help Line: 1-800-562-1240

Provides statewide referral information about treatment, counseling, and support services by county and city for teens and adults. Assistance for providers and clients.

Crisis Line: Alcohol and Drug Help Line: 206-722-3700 or 1-800-562-1240

Provides statewide confidential assistance for people with alcohol and drug problems, mental health, and domestic violence issues; assists with crisis intervention techniques and referral.

Teen Line: Alcohol and Drug Help Line: 206-722-4222 or 1-800-562-1240

Assists providers, teens and parents in statewide referrals and information related to chemical dependency, rape, and other issues. Volunteer teen counselors M-F, 4-8 p.m., as available.

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 Alcohol and Substance Abuse:

Main Line: 1-877-307-4557

Information related to the Department of Social and Health Services supported alcohol and drug treatment programs.

Division of Alcohol and Substance Abuse Certified Hospitals Providing Intensive Inpatient Care for Chemical Using Pregnant Women (Revised 11/19/2007)

GRAYS HARBOR COUNTY

Grays Harbor Community Hospital

HarborCrest Behavioral Health

1006 North H Street; Aberdeen, WA 98520

Larry Kahl, Director

Phone: 360-533-8500

Fax: 360-537-6492

1st and 2nd trimester, no opiate dependent

www.harborcrestbh.org

KING COUNTY

Swedish Medical Center – Ballard Community Hospital

Addiction Recovery Services

5300 Tallman Avenue NW, P.O. Box 70707; Seattle, WA 98107-1507

Cathy Clapp, BHS Director

Phone: 206-781-6350

Fax: 206-781-6183

**Division of Alcohol and Substance Abuse Certified Hospitals Providing Intensive Inpatient Care
for Chemical Using Pregnant Women (Revised 11/19/2007) – continued**

SNOHOMISH COUNTY

Providence Recovery Program

Behavioral Health Services

Providence General Medical Center

916 Pacific Avenue, P.O. Box 1067; Everett, WA 98206

Cheryl Sackrider, Director

Phone: 425-258-7390

Fax: 425-258-7379

Valley General Hospital

Behavioral Health Services

14701 – 179th Avenue SE, P.O. Box 646; Monroe, WA 98272-0646

David Anderson, Program Manager

Phone: 1-800-533-3046

THURSTON COUNTY

St. Peter Chemical Dependency Center

4800 College Street SE, Lacey, WA 98503

Adult Admissions

Phone: 360-493-7575 or 1-800-332-0465

Fax: 360-493-5088

If you have any questions or changes to this information, please contact Sue Green at 360-725-3732, or email: greensr@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

Pregnant and Parenting Women Housing Support Services
Catholic Community Services
Contact: Bob LeBeau
425-258-5270

Pregnant and Parenting Women Residential Treatment
Evergreen Manor
Contact: Linda Grant
425-258-2407

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

Pregnant and Parenting Women Housing Support Services and Residential
Treatment
Casita del Rio
Contact: Beth Dannhardt
509-248-1800

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, and Clallam counties.

Parent-Child Assistance Program services include:

- Referral and support for substance abuse treatment and relapse prevention for 3 years beginning at enrollment during pregnancy
- 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 6 months postpartum, and are ineffectively connected to community services.

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

County	Clinical Director
King	Seattle Parent-Child Assistance Program Nancy Whitney 206-323-9136
Pierce	Tacoma Parent-Child Assistance Program Julie Youngblood 253-475-0623
Spokane	New Horizons Counseling Services Denise Joy 509-838-6092
	Spokane Tribe of Indians Kaye Brisbois 509-258-7502
Grant	Grant County Prevention and Recovery Center Noemi Amezcua 509-765-5402
Yakima	Triumph Treatment Services Lashaunda Harris 509-248-1800
Cowlitz	Drug and Alcohol Prevention Center Jan Caliman 360-425-9600
Skagit	Skagit Recovery Center Alan Erickson 360-428-7835
Kitsap	Agape Unlimited Lena Takeudni 360-373-1529
Clallam	First Step Family Support Center Susan Norland 360-457-8355

Other Related Washington State Resources for Pregnant Women

Washington State Child Care Resource and Referral Network

<http://www.childcarenet.org/>

Child Care for First Steps Clients

<http://fortress.wa.gov/dshs/maa/firststeps/Provider%20Page/First%20Steps%20Childcare.htm>

Transportation to services – Medicaid covered

<http://fortress.wa.gov/dshs/maa/Transportation/Brochure.pdf>

First Steps – Maternity Support Services and Infant Case Management

<http://fortress.wa.gov/dshs/maa/firststeps/>

WIC Nutrition Program

<http://www.doh.wa.gov/cfh/WIC/>

Parent skill-building services

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

Home management, education and career building support

See Parent-Child Assistance Program and Safe Babies, Safe Moms

Safe and sober housing

<http://www.dshs.wa.gov/dasa/>

Legal services

Sources of Free Legal Info on Washington State Law

<http://lib.law.washington.edu/ref/legalinfo.html>

Washington Law Help

<http://www.washingtonlawhelp.org/WA/index.cfm>

Mental Health Services

<http://www1.dshs.wa.gov/mentalhealth/>

Child Protective Services

<http://www.dshs.wa.gov/ca/general/index.asp>

Adoption counseling

<http://www.dshs.wa.gov/ca/adopt/index.asp>

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.

Domestic Violence Hotline – 1-800-562-6025

24-hour line provides information and referrals.

Tobacco Quit Line – 1-800-784-8669

For assistance quitting tobacco use.

Family Planning TAKE CHARGE Program – 1-800-770-4334

Information and referral resources for family planning.

Pediatric follow up for special care infant

Children’s Hospital and Regional Medical Center

<http://www.seattlechildrens.org/default.asp>

Washington State Department of Public Health – Children with Special Health Care Needs

<http://www.doh.wa.gov/cfh/mch/CSHCNhome2.htm>

Web sites - National

The American College of Obstetricians and Gynecologists

www.acog.org

Association of Women's Health Obstetric and Neonatal Nurses

www.awhonn.org

American College of Nurse Midwives

www.acnm.org

FASD Center of Excellence

<http://www.fascenter.samhsa.gov/publications/publications.cfm>

National Organization on Fetal Alcohol Syndrome

www.nofas.org/

American Society of Addictions Medicine

www.asam.org

Substance Abuse Mental Health Services Administration

National Clearinghouse for Alcohol and Drug Information

www.health.org

The National Women's Health Information Center

Women's health information and resources

<http://www.womenshealth.gov/>

Web sites – Washington State

Parent-Child Assistance Program

www.depts.washington.edu/fadu/

Department of Health

www.doh.wa.gov

Washington State Division of Alcohol and Substance Abuse

www.dshs.wa.gov/dasa/

Washington State Fetal Alcohol Spectrum Disorders

www.fasdwa.org

Pediatric Interim Care Center

www.picc.net

TAKE CHARGE – Family Planning Program

<http://fortress.wa.gov/dshs/maa/FamilyPlan/Take%20Charge/TC.index.htm>

WithinReach

website that connects families to food and health resources

<http://www.parenthelp123.org>

Domestic Violence Information

resources and tools for providers

www.doh.wa.gov/vaw

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>

<http://www.cdc.gov/ncbddd/Spanish/fas/spfasask.htm>

Smoking During Pregnancy

http://www.scielo.cl/scielo.php?pid=S0717-73482007000100004&script=sci_arttext

<http://www.pediatradefamilia.com.ar/rincon.htm>

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.

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

The Federal Child Abuse Prevention and Treatment Act as amended by the Keeping Children and Families Safe Act of 2003 requires health care providers to notify Child Protective Services 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 to accept referrals for Child Protective Services investigation or initiate court action on an unborn child.

In Washington State, health care providers are mandated reporters and required to notify Child Protective Services 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 or neglect and should be reported. It is critical that mandated reporters provide as much information regarding concerning issues and 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 Child Protective Services 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. 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 day-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: <http://www.dshs.wa.gov/ca/safety/abuseReport.asp?2>

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

Reports to Child Protective Services or a law enforcement agency must contain the following information if known:

1. The name, address and age of the child and parent(s)
2. The nature and extent of the child abuse or neglect
3. Any information about previous incidences of abuse or neglect
4. Whether the family is of Indian ancestry

It is extremely important to provide information about risk and protective factors. This information will assist the intake worker in determining whether the situation meets the legal definition of child abuse or neglect or risk of imminent harm.

Examples include:

- Parent(s) attitude about their newborn;
- Did the mother participate 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) socioeconomic status;
- Parent(s) resources and family strengths;
- Rationale for toxicology testing;
- Previous history of mental health disorder or postpartum mood disorder;
- History of substance use;
- History of substance abuse treatment;
- Parent(s) response to interventions, etc.

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 risk of imminent harm to the child.

Referrals which are determined to contain sufficient information may be assigned for investigation or other community response.

Child Protective Services investigations 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, and;
- 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, state laws, and the Washington Administrative Code.

What Services May Be Provided?

Protective services are provided to abused or neglected children and their families without cost. 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:

- Home support specialist services
- 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 will ask about available information, including information about risk and protective factors to determine if there is an allegation of child abuse or neglect or imminent risk of harm. If there are no allegations of child abuse or neglect or imminent risk, 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.

Children’s Administration 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 or demonstrates physical or behavioral signs that CAN BE attributed to prenatal exposure to substances and is identified by a medical practitioner as affected.

Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State

EXECUTIVE SUMMARY

The purpose of this document is to provide guidance to health care providers and affiliated professionals about maternal drug screening and laboratory testing and reporting of drug-exposed newborns delivered in Washington State. This document was written in response to an increasing number of requests from hospital staff and attorneys seeking information on this complex topic. This work is a collaborative effort between the Washington State Department of Health and the Department of Social and Health Services.

One impetus for this effort to promote consistent practice among health care providers is a recent change in federal law. In 2003, Congress enacted the Keeping Children and Family Safe Act which requires each state, as a condition of receiving federal funds under the Child Abuse Prevention and Treatment Act, to develop policies and procedures “to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.” This includes a requirement that health care providers involved in the delivery or care of such infants notify Child Protective Services of the occurrence of such condition in infants. This differs from the existing legal duty to report suspected child abuse or neglect in that the federal law specifies that such reports of prenatal substance exposure shall not be construed to be child abuse or neglect and shall not require prosecution of the mother.

The Department of Health and the Department of Social and Health Services cannot provide legal counsel on this topic, but the following key points are included in this guidelines document:

- Each hospital with perinatal and neonatal services should work with hospital risk management, nursing services, social service, medical staff, and local Department of Social and Health Services Children’s Services to develop a defined policy for identifying intrapartum women and newborns for substance use or abuse. The hospital policy should be written in collaboration with local and regional Child Protective Services guidelines and include consent and reporting issues.
- Newborn testing should be performed only with evidence of newborn or maternal risk indicators.
- Newborn drug testing is done for the purpose of determining appropriate medical treatment.
- No uniform policy or state law exists regarding consent for newborn drug testing.
- Hospitals are encouraged to 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.

- Health care providers remain mandated reporters of child abuse and neglect under state law and are required to notify Child Protective Services when there is reasonable cause to believe a child has been abused or neglected. The presence of other risk factors or information combined with a positive toxicology screen may require that a report of child abuse or neglect be made to Child Protective Services in any given case.
- 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 may still occur if medically necessary or if newborn or maternal risk indicators are present. The Department of Health strongly recommends that each institution develop, in collaboration with its attorneys, justification and process for newborn testing. The justification and process for newborn testing will be specific to the written policy of each institution.
- 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. The Department of Health recommends that each institution develop in collaboration with its attorneys the justification and process for placing administrative hold on a newborn. Child Protective Services may obtain custody of the newborn by court order or a law enforcement transfer of protective custody and may then give permission to test the newborn in order to safeguard the newborn’s health.

Table of Contents

Introduction..... 33

Indicators for Testing 33

Hospital Policy 33

Table 1: Newborn Risk Indicators 34

Table 2: Maternal Risk Indicators 34

 Consent Issues for Testing..... 34

Table 3: Newborn Drug Testing 36

Table 4: Management of a Newborn with Positive Drug Toxicology 37

 Reporting to Children’s Administration 37

References and Resources 38

Guidelines for Obtaining Consent from Parents for Infant Drug Testing 40

Sample Parent Letter: Information for parents whose newborn has been placed on administrative hold 42

Neonatal Abstinence Scoring System 43

Introduction

The purpose of this document is to provide consistent guidance to health care professionals and hospitals related to maternal screening* and testing** and reporting drug-exposed newborns born in Washington State hospitals.

This document is a collaborative effort between the Department of Health and Department of Social and Health Services, two separate agencies. The Washington State Department of Health is responsible for preserving public health, monitoring health care costs, maintaining minimal standards for quality health care delivery, and planning activities related to the health of Washington citizens. The Department of Social and Health Service is the state umbrella social service agency. Its mission is to improve the quality of life for individuals and families in need by helping people achieve safe and self-sufficient, healthy and secure lives.

Indicators for Testing

Maternal drug testing is based on specific criteria and medical indicators, not open-ended criteria such as “clinical suspicion” that invite discriminatory testing. Evidence-based risk indicators should also be used as a guide for performing drug toxicologies on newborns. Due to the limited time window for detection of drugs, difficulties in collecting specimens, as well as costs incurred for testing, all newborns with evidence of newborn risk indicators (Table 1) or maternal risk indicators (Table 2) should be tested for drug exposure, unless a different medical cause is identified. Laboratory testing of newborns should be done for the purpose of determining appropriate medical treatment. It is unnecessary to test a newborn whose mother has a positive drug toxicology; her newborn is presumed to be drug exposed.

Hospital Policy

Each hospital should work with risk management attorneys, nursing, social service, and medical staff to develop a defined policy for identifying intrapartum women and newborns for substance use or abuse. This policy should address specific evidence-based criteria for testing the woman and her newborn, timing of tests, test types, and consent issues. The justification and process for newborn testing will be specific to the written policy of each institution. All health care providers should be informed of the policy and educated in its use. Health care professionals may need additional education regarding how to approach and motivate women to make an informed choice regarding testing.

For in-depth guidance for screening, identifying and referring women for treatment please refer to the *Substance Abuse During Pregnancy: Guidelines for Screening* best practice booklet located online at:

http://www.doh.wa.gov/cfh/mch/documents/screening_guidelines.pdf

Another referral resource is the *Pregnant Women Chemical Dependency/Abuse Resource Guide/Matrix*.

http://www.doh.wa.gov/cfh/mch/documents/dasa_resource_guide_1_02.doc

* Screening: methods used to identify risk of substance abuse during pregnancy and postpartum, including self-report, interview and observation.

**Testing: process of laboratory testing to determine the presence of a substance in a specimen.

Table 1

Newborn Risk Indicators

It is not necessary to test a newborn with signs of drug withdrawal whose mother has a positive drug test. This newborn may be presumed drug-exposed. This does not preclude doing a separate test of the child if medically indicated.

Newborn characteristics that may be associated with maternal drug use include: (*American College of Obstetricians and Gynecologists, 2008*)

- Positive maternal toxicology screen
- Jittery with normal glucose level
- Marked irritability
- Preterm birth
- Unexplained seizures or apneic spells
- Unexplained intrauterine growth restriction
- Neurobehavioral abnormalities
- Congenital abnormalities
- Atypical vascular incidents
- Myocardial infarction
- Necrotizing enterocolitis in otherwise healthy term infants
- Signs of neonatal abstinence syndrome: marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis (Finnegan, 1986; see Page 43)

Note: Neonatal signs of fetal dependence may be delayed as long as 10–14 days, depending upon the half-life of the substance in question.

Preterm infants are less likely to overtly exhibit at-risk behaviors in spite of substance exposure. Immature organ systems may modify test results.

Table 2

Maternal Risk Indicators

Maternal characteristics that suggest a need for biochemical testing of the newborn include: (*American College of Obstetricians and Gynecologists, 2008*)

- No prenatal care
- Previous unexplained fetal demise
- Precipitous labor
- Abruptio placentae
- Hypertensive episodes
- Severe mood swings
- Cerebrovascular accidents
- Myocardial infarction
- Repeated spontaneous abortions

Consent Issues for Testing

Controversies still exist regarding the extent to which maternal consent is required prior to toxicology testing of either the mother or the newborn. No uniform policy or state law exists regarding consent for newborn drug testing. This is a complex issue and hospitals, with advice from their risk management staff and legal counsel,

should determine when it is necessary to obtain specific consent to test newborns and their mothers. A positive drug test is not in itself a diagnosis, nor does substance abuse by itself prove child neglect or inadequate parenting capacity. (*American College of Obstetricians and Gynecologists, 2005*)

Refer to *Substance Abuse During Pregnancy: Guidelines for Screening*, for a more detailed discussion of consent issues:

<http://www.doh.wa.gov/cfh/mch/documents/ScreenGuideline.pdf>

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 newborn. This relationship is more difficult to establish if a woman is notified of testing after the fact. Therefore, all women should be informed about planned medical testing. Explain and document the nature and purpose of the test and how results will guide management, including possible benefits or consequences of the test.

The rationale for testing and the parental discussion should be documented in the medical record. If the woman refuses testing, this should be documented and maternal testing should not be performed. In *Ferguson v Charleston, SC, 532 US 67 (2001)* the Supreme Court ruled that testing without maternal consent for the purposes of criminal investigation violated the mother's Fourth Amendment rights. (*Lester, 2004*)

However, testing of the newborn may still occur if newborn or maternal risk indicators are present. The Department of Health strongly recommends that each institution develop, in collaboration with its attorneys, justification and process for newborn testing. 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. The Department of Health recommends that each institution develop in collaboration with its attorneys the justification and process for placing administrative hold on a newborn. Child Protective Services may obtain custody of the newborn by court order or a law enforcement transfer of protective custody and may then give permission to test the newborn in order to safeguard the newborn's health.

See Table 3 for information about newborn drug testing. The procedure for obtaining samples for testing is institution-specific. See attached policy samples for guidance.

Comprehensive guidelines for hospital care of the drug-exposed newborn are beyond the scope of this document. See Table 4 for basic information about newborn management.

Table 3

Newborn Drug Testing

About Newborn Urine Toxicologies:

- Correlation between maternal and newborn test results is poor, depending upon the time interval between maternal use and birth, properties of placental transfer, and time elapsed between birth and neonatal urine collection.
- The earliest urine of the newborn will contain the highest concentration of substances.
- Failure to catch the first urine decreases the likelihood of a positive test.
- Threshold values (the point at which a drug is reported to be present) have not been established for the newborn.
- Fetal effects cannot be prevented by newborn testing.
- Newborn urine reflects exposure during the preceding one to three days.
- Cocaine metabolites may be present for four to five days.
- Marijuana may be detected in newborn urine for weeks, depending on maternal usage.
- Alcohol is nearly impossible to detect in newborn urine.

Other Methods of Newborn Drug Testing

Meconium: Meconium in term infants reflects substance exposure during the second half of gestation; preterm infants may not be good candidates for meconium testing. The high sensitivity of meconium analysis for opiate and cocaine and the ease of collection make this test ideal for perinatal drug testing. Meconium analysis is available for mass screening with an enzyme immunoassay kit or by radioimmunoassay. Cost of analysis per specimen approximates the cost of urine toxicology. (*J Pediatrics* 2001; 138:344-8)

Breast milk: Breast milk is not a viable alternative for drug testing.

Hair: Hair testing has high sensitivity for detecting perinatal use of cocaine and opiate but not for marijuana. Hair testing is restricted to a few commercial laboratories and the cost of testing is higher than for meconium. (*J Pediatrics* 2001; 138:344-8) Hair also has a high positive rate because of passive exposure to minute quantities of illicit substances in the environment. (*American College of Obstetricians and Gynecologists*, 2008)

Umbilical cord segments has high sensitivity for detecting perinatal use of opiates, methamphetamines, cocaine and marijuana. More information is available at www.usdtl.com.

Table 4

Management of a Newborn with a Positive Drug Toxicology

- Confirm any positive test with gas chromatography or mass spectroscopy, particularly if opiates are found.
- Consider the fact that intrapartum drugs prescribed to control labor pain can be detected in meconium.
- Notify newborn’s provider for diagnostic work-up.
- Use the Neonatal Abstinence Scoring tool to document symptoms of narcotic withdrawal. See Page 43 for sample.
- Newborn assessment should include newborn health status, maternal drug use history and current family situation. Document assessment of family interaction (or lack of interaction). Include positive observations as well as areas of concern.
- Notify social worker or other designated staff member to coordinate comprehensive drug and alcohol assessment and outside referrals, including Child Protective Services. If designated staff member is not available, reporting to Child Protective Services is the responsibility of all health care providers. Child Protective Services after hours, weekends and holidays intake telephone number is: 1-800-562-5624.

Note: Child Protective Services may use a patient’s chart as documentation in court. A release of information is not required.

Reporting to Children’s Administration – See Page 27

Hospitals should contact their local Department of Social and Health Services Children’s Administration office and request an in-service on mandatory reporting and other Children’s Protective Services processes. The hospital’s risk management staff should attend the in-service. After the in-service, parties may have a better idea of points needing clarification. Starting at the local level is important for developing key relationships and ensuring smooth and consistent procedures.

References and Resources

- American Academy of Pediatrics Committee on Drugs. 1998. Neonatal Drug Withdrawal. *Pediatrics*; 101:1079-1088.
- American Academy of Pediatrics Committee on Substance Abuse. 1998. Tobacco, Alcohol and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse. *Pediatrics*; 101:125-128.
- American Academy of Pediatrics Committee on Substance Abuse. 2001. Alcohol Use and Abuse: A Pediatric Concern. *Pediatrics*; 108: 185-189.
- American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2007. *Guidelines for Perinatal Care, Sixth Edition*. Elk Grove Village IL.
- American College of Obstetricians and Gynecologists. 2008. *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, American College of Obstetricians and Gynecologists Committee Opinion, Number 422.
- American College of Obstetricians and Gynecologists. 2005. Substance Use: Obstetric and Gynecologic Implications. In *Special Issues in Women's Health*. American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women.
- Weiners and Finnegan LP (2002). Drug Withdrawal in the Neonate in *Handbook of Neonatal Intensive Care, 5th Edition*. Merenstein and Gardner, eds. CV Mosby: 163-178.
- Finnegan LP. 1986. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Rubaltelli FF, Granati B, eds. *Neonatal therapy: an update*. New York: Excerpta Medica:122-46.
- Lester BM, et al. 2004. Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*.
<http://www.harmreductionjournal.com/content/1/1/5>
- Montgomery, D Plate, C, Alder, SC, Jones, M, Jones, J and Christensen, RD (2006). Testing for fetal exposure to illicit drugs using umbilical cord tissue vs meconium, *J of Perinatology*, 26, 11-14.
- Ostrea EM, et al. 2001. Estimates of illicit drug use during pregnancy by maternal interview, hair analysis, and meconium analysis. *Journal of Pediatrics*;138:344-8.
- Washington State Department of Health. 2002. *Substance Abuse During Pregnancy: Guidelines for Screening*.
<http://www.doh.wa.gov/cfh/mch/documents/ScreeningGuidelines.pdf>

Additional Resources

To order or download “The Parent’s Guide to Child Protective Services” (mentioned in letter on Page 42):

http://www/dshs.wa.gov/ca/pubs/pubcats.asp?cat=Child_Abuse_and_Neglect

Swedish Medical Center, Seattle:

Center for Perinatal and Pediatric Excellence – 206-215-2073

Washington State Department of Health:

Maternal and Infant Health Program – 360-236-3563

Washington Department of Social and Health Services Children’s Administration

Web site – video and materials for mandatory reporters:

<http://www1.dshs.wa.gov/ca/general/index.asp>

Child Protective Services:

After hours, weekends and holidays intake – 1-800-562-5624

Washington State Hospital Association: 206-216-2531

Deaconess Perinatal/Neonatal Education Center, Spokane, Washington:

1-877-777-0246

Guidelines for Obtaining Consent from Parents for Infant Drug Testing

Set the Scene

The health care provider's attitudes and feelings about maternal substance use, as well as the environment in which this discussion takes place, often influences the success or failure of obtaining parental consent for infant drug testing. Often the way the subject is approached will be the major determinant in obtaining consent.

- Be aware of your own beliefs and values that may interfere with your ability to remain neutral and non-judgmental.
- Assess the environment for privacy and when possible, discuss the issue in a non-emergent setting.
- Attend to your non-verbal behavior including body stance, facial expression, eye contact, muscle tension, and arm and hand positioning.

Introduce the Topic

- Begin with open ended questions. Ask the mother how she is doing and what she needs.
- Reflect back to the mother what she has just stated and respond to any questions.
- Inform the mother that there is another topic you need to discuss.
- Give reasons and describe in a non-judgmental manner why you want to test her infant for evidence of maternal drug use during pregnancy (see script below).
- If the testing is requested by Child Protective Services, inform the mother of this and bring the focus back to the health of the mother and infant.
- Ask if she has any questions; if yes, answer them to the best of your ability.
- Ask permission for consent: "Do we have your permission to test the baby?" If yes, thank the mother for her cooperation and reinforce that she is working in the best interest of her child.
- Review what the testing process involves for the baby.

If the Parent is Angry, Resistant, Agitated or Defensive

- Determine if the parent is intoxicated or has mental health issues that will interfere with her ability to comprehend.
- Stay calm.
- Do all of the steps described above: bring the focus back to the health of the infant, re-explain that her cooperation with this step shows that she is interested in the health of her baby.
- Allow more time for the parent to talk about what is happening and her concerns. Reassure as appropriate.
- Be matter-of-fact about the issue while remaining supportive and non-judgmental.
- Refer to your agency's policies regarding drug testing and Child Protective Services protocols.

Sample Scenario:

Hello Mary, how are you doing today? Do you have any questions or concerns you'd like to talk about?

(Patient responds and her questions concerns are addressed.)

Those are good questions, Mary. Now I have something else to discuss with you that will help us provide the best care for your baby. This may be uncomfortable to discuss but it is very important.

(Give patient time to respond.)

There is some concern about your drug use during this pregnancy and the impact it has had or may have on your baby. I know you want the best for your baby and wouldn't purposefully do anything to hurt her. When a woman uses drugs when she is pregnant or breastfeeding, there is a risk to the baby's health. We would like to get your permission to test your baby for drugs so we can give her the best medical care. Will you sign a consent form to test your baby?

If parent responds "Yes":

I know this is scary but it's the best decision for your baby. Here is the consent form. Is there anything you'd like me to know or do you have any questions?

(Patient Response)

Okay, do you want to hear how this done and what you may be asked to do?

If parent responds "No":

(Use the same steps as above until the patient refuses.)

I can't imagine how scary this sounds to you and I hope we can come to an agreement about you consenting but if we can't I am still required to do what I think is needed to make sure your baby is given appropriate medical care. Can we talk about this more?

(Client nonresponsive or says "No")

This facility and I are required to notify Child Protective Services when there is concern about the effect a parent's drug use has on the health of an infant. What happens now is staff here will contact Child Protective Services to let them know the situation. Your baby may then be placed on an administrative hold. When Child Protective Services gains custody, they can then give permission to test the baby. It would be great if we get consent and test now and begin any treatment your baby may need. What do you think?

(If the patient still refuses, follow the agency protocols and do what is necessary to keep the baby in the hospital and complete the testing after Child Protective Services has approved).

"OK, I hear you saying no to drug testing for your baby. I'll let the staff here know of that decision and we'll take it from here. It's important for you to know that your baby may still get tested for drugs. We would do that to protect your baby's health. We'll keep you informed about what will happen next."

Sample Parent Letter

Information for parents whose newborn has been placed on administrative hold

Hospital Letterhead

Dear Parent:

This letter tells about what is happening to you and your newborn. People who care for you and your baby have concerns about your drug or alcohol use and the impact it has on your baby. For this reason, your newborn has been placed on an administrative hold at the hospital. This means that you may not leave the hospital with your baby at this time.

The enclosed purple booklet “Parent’s Guide to Child Protective Services” provides some important information that will help you through this time. Please take a few minutes to read it. You may ask your questions to the person from Child Protective Services who will come and speak with you at the hospital, or at your house if you have already left the hospital.

Each person’s situation is different, and the social worker from Child Protective Services will explain what will happen next. This social worker will talk with you and develop a plan for keeping your newborn safe. This person will give you information about services for you and your new baby. This may include dates and times of appointments or meetings that you need to attend.

We know this is a difficult time. Your nurses and hospital social worker want to help you in your efforts to ensure the health and safety of your baby. Please ask questions and let your nurses and social worker know your thoughts and feelings.

We believe the best place for a new baby is with the family. We hope you will work with Child Protective Services to make a safe and healthy home for your new baby.

Sincerely,

XXXXXX

Enclosure

NEONATAL ABSTINENCE SCORING SYSTEM

Morphine Sulfate		Dose																		
System Date/Time	Signs and Symptoms	Score																		
Central Nervous System Disturbance	Crying: Excessive high pitched	2																		
	Crying: Continuous high pitched	3																		
	Sleeps <1 hour	3																		
	Sleeps <2 hours after feeding	2																		
	Sleeps <3 hours after feeding	1																		
	Hyperactive Moro reflex	2																		
	Markedly hyperactive Moro reflex	3																		
	Mild tremors: Undisturbed	3																		
	Moderate–severe tremors: Undisturbed	4																		
	Mild tremors: Disturbed	1																		
Moderate–severe tremors: Disturbed	2																			
Increased muscle tone	2																			
Excoriation (specify area)	1																			
Myoclonic Jerks	3																			
Generalized convulsions	5																			
Metabolic, Vasomotor, and Respiratory Disturbances	Sweating	1																		
	Fever 37.2 – 38.3° C (99 – 101° F)	1																		
	Fever >101° F (>38.4° C)	2																		
	Frequent yawning (>3)*	1																		
	Mottling	1																		
	Nasal stuffiness	1																		
	Sneezing (>3)*	1																		
	Nasal flaring	2																		
Respiratory rate (>60/min.)	1																			
Respiratory rate (>60/min. with retractions)	2																			
Gastrointestinal Disturbances	Excessive sucking	1																		
	Poor feeding	2																		
	Regurgitation) more than or equal to two	2																		
	Projectile vomiting) times during or after feeding	3																		
	Loose stools	2																		
Watery stools	3																			
Total score																				
Initials of scorer																				

* As they have occurred in the entire scoring period (i.e., within the previous 2 or 4 hours, whatever the scoring interval is)

Adapted from Finnegan, L.P. 1986. Neonatal abstinence syndrome: assessment and pharmacotherapy. In F.F. Rubatelli and B. Granadi (ed.) Neonatal therapy: an update. Excerpta Medica, NY.

Bibliography

- American College of Obstetricians and Gynecologists Committee Opinion (2005). *Smoking Cessation During Pregnancy*, Number 316.
- American Academy of Pediatrics Committee on Substance Abuse. 2001. Alcohol Use and Abuse: A Pediatric Concern. *Pediatrics*; 108: 185-189.
- American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2002. *Guidelines for Perinatal Care, Fifth Edition*. Elk Grove Village IL.
- American College of Obstetricians and Gynecologists. 2008. *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, American College of Obstetricians and Gynecologists Committee Opinion, Number 442.
- American College of Obstetricians and Gynecologists. 2005. Substance Use: Obstetric and Gynecologic Implications. In *Special Issues in Women's Health*. American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women.
- Barry KL, Fleming MF, Manwell LB. (1997). *TREAT Yourself Well*. Wisconsin Research Network, 1-16.
- Cawthon L. (1997). *Substance Use During Pregnancy: Prevalence, Effects and Costs*. Olympia, WA: Department of Social and Health Services.
- Chang G. (2001) Alcohol-Screening Instruments for Pregnant Women. *Alcohol Research and Health*, 25 (3), 204-209.
- Chasnoff IJ, Neuman MA, Thornton C, and Callaghan BA. (2001). Screening for substance abuse in pregnancy: a practical approach for the primary care physician. *American Journal of Obstetrics and Gynecology*, 184(4), 752-758.
- Chasnoff IJ, et al. (2005) The 4P's Plus© Screen for Substance Use in Pregnancy: Clinical Application and Outcomes. *Journal of Perinatology*, 25:368-374.
- Chavkin W, Wise P, Elman D. (1998). Policies towards pregnancy and addiction, *Annals New York Academy of Sciences*, 846, 335-340.
- Compton P, Monahan G, and Simmons-Cody H. (1999). Motivational interviewing: an effective brief intervention for alcohol and drug abuse patients. *The Nurse Practitioner*, 24(11), 27-49.
- Diekman S, Floyd L, Decoufle P, Schulkin J, Ebrahim S, Sokol R. (2000). A survey of obstetrician-gynecologists on their patients' alcohol use during pregnancy. *Obstetrician-Gynecologist Survey*, 95(5), 756-763.
- Ernst CC, Grant TM, Streissguth AP, Sampson PD. (1999). Intervention with high-risk alcohol- and drug-abusing mothers: II. 3-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 19-38.
- First Steps Plus. (1995). *Reference Guidelines: Medical Detoxification of Pregnant Women*. Yakima, WA: Department of Social and Health Services.
- Grant TM, Ernst CC, Streissguth AP. (1999). Intervention with high-risk alcohol- and drug-abusing mothers: I. Administrative strategies of the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 1-18.

- Grant T, Ernst C, Streissguth A, & Stark K. (2005). Preventing alcohol and drug exposed births in Washington State: Intervention findings from three Parent-Child Assistance Program sites. *American Journal of Drug and Alcohol Abuse*, 31(3), 471-490.
- Hanna EZ, Faden VB, Dufour MC. (1994) The motivational correlates of drinking, smoking, and illicit drug use during pregnancy. *Journal of Substance Abuse*, 6, 155-167.
- Horrigan T, Schroeder A, Schaffer R. (2000). The triad of substance abuse, violence, and depression are interrelated in pregnancy. *Journal of Substance Abuse Treatment*, 18, 55-58.
- Lester BM, et al. 2004. Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*; <http://www.harmreductionjournal.com/content/1/1/5>
- Mitchell J (chair, consensus panel). (1993). *Pregnant, Substance-Using Women*. Rockville, MD: US Department of Health & Human Services: Center for Substance Abuse Treatment.
- Morse B, Gehshan S, Hutchins E. (1998). *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*. Arlington, VA: National Center for Education in Maternal and Child Health.
- Ostrea EM, et al. 2001. Estimates of illicit drug use during pregnancy by maternal interview, hair analysis, and meconium analysis. *Journal of Pediatrics*;138:344-8.
- Prochaska JO, DiClemente CC, Norcross JC. (1992). In search of how people change: applications to addictive behaviors. *Am. Psychologist*, 47(9), 1102-1114.
- Sullivan E, Fleming M. (1997). *A Guide to Substance Abuse Services for Primary Care Clinicians*, Rockville, MD: US Department Health and Human Services, Center for Substance Abuse Treatment.
- Wakefield M (ed). (2000). Smoking and pregnancy: research findings from the smoke-free families program. *Tobacco Control*, supp III, vol 9, 1-94.
- Wilson L (director), Dempsey M, Beetem N (eds). (1997). *Substance Abuse in Pregnancy*. Missouri Department of Health, Division of Maternal, Child and Family Health: Office for Substance Abuse Prevention.
- Windsor R, Oncken C, Henningfield J, Hartmann K, and Edwards N. (2000). Behavioral and pharmacological treatment methods for pregnant smokers: issues for clinical practice. *Journal of American Medical Women's Association*, 55(5), 304-310.



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