

# Substance Abuse During Pregnancy: Guidelines for Screening

Revised Edition 2012

**ASK**

**ADVISE**

**ASSESS**

**ASSIST**

**ARRANGE**

# **Substance Abuse During Pregnancy: Guidelines for Screening**

Revised Edition 2012



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## 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.<sup>1</sup>

Substance abuse contributes to obstetric and pediatric complications, including Fetal Alcohol Spectrum Disorders<sup>2</sup>, prematurity, abruptio placenta and low birth weight.

Prenatal alcohol exposure is the leading preventable cause of birth defects and development disabilities in our country. Prenatal alcohol exposure can result in major organ birth defects, growth disorders and damage to multiple structures in the brain resulting in permanent and lifelong disabilities. Fetal alcohol syndrome (FAS) is one diagnosis within the spectrum of alcohol related disorders resulting from alcohol exposure during pregnancy. Statewide data on Fetal Alcohol Spectrum Disorders are not available in Washington. The prevalence of FAS in the United States is estimated at 0.2 to 1.5 per 1,000 live births.<sup>3</sup>

Abuse of prescription narcotic medications is also a growing problem and can result in complications such as Neonatal Abstinence Syndrome.

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.

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<sup>1</sup> Cawthon L. (1997). *Substance Use During Pregnancy: Prevalence, Effects and Costs*. Olympia, WA: Department of Social and Health Services.

<sup>2</sup> 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.

<sup>3</sup> U.S. Department of Health and Human Services. (2009). *Reducing Alcohol-exposed Pregnancies. A report of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect*.

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

## 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.

Addiction is characterized by:

- Inability to consistently abstain
- Impairment in behavioral control
- Craving or increased hunger for drugs or rewarding experiences
- Diminished recognition of significant problems with one's behaviors and interpersonal relationships
- Dysfunctional emotional response

[www.asam.org/DefinitionofAddiction-LongVersion.html](http://www.asam.org/DefinitionofAddiction-LongVersion.html)

**Nonmedical, Misuse, and Abuse of Prescription Medication:**<sup>4</sup>

**Nonmedical Use:** Use of prescription drugs that were not prescribed by a medical professional (i.e., obtain illicitly) or are used for the experience or feeling a drug causes.

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

**Abuse:** A maladaptive pattern of substance use, leading to clinically significant impairment or distress as manifested by one or more behaviorally based criteria.

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

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

**Neonatal Abstinence Syndrome (NAS):**

NAS is a complex of signs and symptoms in the postnatal period associated with the sudden withdrawal of maternally transferred opioid. (American Academy of Pediatrics definition)

NAS refers to a constellation of signs in the newborn due to substance or medical withdrawal. In most cases, exposure occurs during pregnancy, but it may also describe a syndrome secondary to withdrawal of opioids and sedatives administered postnatally to infants with serious illness. Opioids (naturally occurring, synthetic, and semi-synthetic) are the most frequent drugs which give rise to the typical signs.<sup>5</sup>

**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.

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<sup>4</sup> NIDA Substance Abuse Treatment Advisory, May 2006, Volume 5, Issue 2.

<sup>5</sup> University of Vermont – Management of Neonatal Opioid Withdrawal, 2009.  
[www.med.uvm.edu/VCHIP/downloads/VCHIP\\_5%20Neonatal\\_guidelines.pdf](http://www.med.uvm.edu/VCHIP/downloads/VCHIP_5%20Neonatal_guidelines.pdf)

**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 6).

**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, 4.5 percent of pregnant women used illicit substances in the last month (Substance Abuse Mental Health Services Administration, 2010).<sup>6</sup> 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, 2004).<sup>7</sup>

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.

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.

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<sup>6</sup> Substance Abuse and Mental Health Services Administration. (2010). Results From the 2009 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.

<sup>7</sup> Centers for Disease Control and Prevention. (2004). Alcohol Consumption Among Women Who Are Pregnant or Who Might Become Pregnant – United States, 2002. *Morbidity and Mortality Weekly Report*, 53, 1178–1181.



Pregnancy Risk Assessment Monitoring System population based survey data provide more information about alcohol and tobacco. In 2010, about 9 percent of mothers in Washington State smoked tobacco in the third trimester. Highest rates occurred in low-income women (about 15 percent of women on Medicaid reported smoking in the last three months of pregnancy versus 3% not on Medicaid). Alcohol use during the last three months of pregnancy was higher among women not covered by Medicaid. In 2010, about 11 percent of these women reported drinking in the last three months of pregnancy compared to about 4 percent of women on Medicaid. Fifty-six percent of Washington women drank 3 months before pregnancy. Of these women, about 45% of Medicaid women and 66% of non-Medicaid women.

It is difficult to ascertain the true extent of illicit drug use during pregnancy as reporting is voluntary and infant effects difficult to diagnose. According to the National Survey on Drug Use and Health (2010), rates of past month illicit drug use among individual age 26 and older in Washington State have been consistently among the highest in the country.<sup>6</sup> It is interesting to note that a recent study found chronic use of prescription narcotics during pregnancy increased between 1998 and 2009.<sup>8</sup>

## 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.

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<sup>8</sup> Kellogg, A, Rose, CH, Harms, RH, Watson, WJ. (2010). Current trends in narcotic use in pregnancy and neonatal outcomes. *American Journal of Obstetrics and Gynecology*, 201(3), 259.

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**

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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 10).

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**

**I**nterview-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 17–19).

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 17).

### **ASK – See Pages 17–19 for sample screening tools**

#### **How to Screen**

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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 8). As trust develops, the client who is using is more likely to disclose that use. When use is disclosed, remember that screening tools identify risk but are not diagnostic. Know how to respond, including discussing risks of use, benefits of stopping, and resources for further evaluation.

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

How screening is handled impacts pregnant women's use of prenatal care. If women fear adverse consequences or judgmental attitudes, they often delay or avoid prenatal care.<sup>9</sup>

### **Create a Respectful Environment**

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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 12).
- 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.

## **ADVISE**

### **Educational Messages for Clients**

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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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<sup>9</sup> Roberts, CM, Nuru-Jeter, A. (2010). Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care. *Women's Health Issues*, 20, 193-200.

## ASSESS

### When a Woman Denies Use

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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 10).

### When a Woman Admits Use

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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

**U**rine 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

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- 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

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- 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

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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 11.)

### 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 those who abuse substances, 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/violent behavior
- Paranoia
- Increased physical activity
- Anxiety, nervousness, panic
- Disorientation
- Depression
- Irritability
- Prescription drug seeking behavior
- Suicidal ideations or attempt
- Memory loss
- Psychosis

### Laboratory

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

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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](http://www.asam.org)) and the METH Awareness and Prevention Project of South Dakota ([www.mapps.org](http://www.mapps.org)).

### 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, panic, anxiety
- Nystagmus
- Gum or periodontal disease, including broken teeth, severe decay, infections (meth mouth)
- Skin conditions: abscesses, dry or itchy, acne type sores
- Weight loss-low BMI, malnutrition

### 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

## Consent Issues for Drug Testing

(See Page 30, Appendix E, for Washington State Department of Social and Health Services Children’s Administration Prenatal Substance Abuse Policy information, and Page 35 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.

## ASSIST AND ARRANGE

### Referral to Treatment

**D**iscuss 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 **Washington Recovery Help Line: 1-866-789-1511**. 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 C, Pages 22–28, 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 C, Pages 23–24).
- 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 19) and refer women to the Washington State Quitline (see Page 26).
- If the behavioral approach is not successful, consider pharmacotherapies for smoking cessation: Bupropion hydrochloride (Zyban®) or Nicotine Replacement Therapy, if appropriate for heavy smokers. However, there is no consensus among experts regarding use of nicotine replacement therapy or other medications during pregnancy.<sup>10</sup>

## Harm Reduction – Decrease Use

**W**omen 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.

<sup>10</sup> American College of Obstetricians and Gynecologists, 2011 Committee Opinion 503 Tobacco Use and Women's Health.

## 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

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- 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

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- 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

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- 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. A recent large study showed breastmilk reduces neonatal abstinence syndrome severity and treatment need.<sup>11</sup>
- Breastfeeding women with a positive history of drug abuse during pregnancy should be tested periodically while breastfeeding.

## Associated Issues for Pregnant Women

**P**regnant 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

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<sup>11</sup> Abdel-Latif ME, Pinner J, Clews S, Crooke F, Lui K and Oei J. (2011). Effects of Breast Milk on the Severity and Outcome of Neonatal Abstinence Syndrome Among Infants of Drug-Dependent Mothers. *Pediatrics*, 17(6), e1163-1169.

## Medical Issues

- Sexually Transmitted Infections
- HIV
- Poor nutrition and malnutrition
- 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 C 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
- Pregnant and Parenting Women Residential Chemical Dependency Treatment
- Parent Child Assistance Program
- Safe Babies Safe Moms

## Appendix A: Screening Tools for Drugs and Alcohol

### Screening Tools for Drug-Alcohol Use

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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](mailto: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

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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 bingeing 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

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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

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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.

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

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

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

BNI STEPS	DIALOGUE/PROCEDURES
<b>1. Raise subject and ask permission</b>	<ul style="list-style-type: none"> <li>➤ Hello, I am _____. Would you mind taking a few minutes to talk with me confidentially about your use of [X]? &lt;&lt;PAUSE and LISTEN&gt;&gt;</li> <li>➤ Before we start, could you tell me a little about yourself and your goals...What's important to you?</li> </ul>
<b>2. Provide feedback</b> <ul style="list-style-type: none"> <li>• Review screen</li> <li>• Make connection (no arguing)</li> <li>• For alcohol... Show NIAAA guidelines &amp; norms</li> </ul>	<ul style="list-style-type: none"> <li>➤ From what I understand, you are using [insert screening data]... We know that drinking above certain levels, smoking and/or use of illicit drugs can cause problems, such as [insert medical info]...I am concerned about your use of [X].</li> <li>➤ What connection (if any) do you see between your use of [X] and this ED visit? <ul style="list-style-type: none"> <li><b>If pt sees connection, reiterate;</b></li> <li><b>If pt does not see connection:</b> make one using medical info</li> </ul> </li> <li>➤ These are the upper limits of low risk drinking for your age and sex. By low risk we mean you would be less likely to experience illness or injury if you stay within the guidelines.</li> </ul>
<b>3. Enhance motivation</b> <ul style="list-style-type: none"> <li>• Explore Pros and Cons</li> <li>• Use reflective listening</li> <li>• Readiness to change</li> <li>• Reinforce positives</li> <li>• Develop discrepancy between ideal and present self</li> </ul>	<p>Ask pros and cons</p> <ul style="list-style-type: none"> <li>➤ Help me to understand what you enjoy about [X]? &lt;&lt;PAUSE AND LISTEN&gt;&gt;</li> <li>➤ Now tell me what you enjoy less about [X] or regret about your use of [X] <ul style="list-style-type: none"> <li>&lt;&lt;PAUSE AND LISTEN&gt;&gt;</li> <li>On the one hand you said...</li> <li>&lt;&lt;RESTATE PROS&gt;&gt;</li> <li>On the other hand you said....</li> <li>&lt;&lt;RESTATE CONS&gt;&gt;</li> </ul> </li> <li>➤ So tell me, where does this leave you? [show readiness ruler] On a scale from 1-10, how ready are you to change any aspect of your use of [X]? (See Readiness Ruler on next page.)</li> <li>➤ Ask: Why did you choose that number and not a lower one like a 1 or a 2? Other reasons for change?</li> <li>➤ Ask: How does this fit with where you see yourself in the future?</li> </ul>
<b>4. Negotiate &amp; advise</b> <ul style="list-style-type: none"> <li>• Negotiate goal</li> <li>• Benefits of change</li> <li>• Reinforce resilience/resources</li> <li>• Summarize</li> <li>• Provide handouts</li> <li>• Suggest PC f/u</li> </ul>	<p>What's the next step?</p> <ul style="list-style-type: none"> <li>➤ What do you think you can do to stay healthy and safe?</li> <li>➤ If you make these changes what do you think might happen?</li> <li>➤ What have you succeeded in changing in the past? How? Could you use these methods to help you with the challenges of changing?</li> <li>➤ This is what I've heard you say...Here's an action plan I would like you to fill out, reinforcing your new goals. This is really an agreement between you and yourself</li> <li>➤ Provide agreement and information sheet</li> <li>➤ Suggest Primary Care f/u to support plan</li> <li>➤ Thank patient for his/her time</li> </ul>





## Appendix C: Resources

### Statewide Resources

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#### Chemical Dependency Assessment and Treatment

**Washington Recovery Help Line:** 1-866-789-1511

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

**Washington State Alcohol Drug Clearinghouse:** 1-800-662-9111

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

**Alcohol and Drug Help Line Domestic Violence Outreach Project:**

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

Information about programs in Washington State addressing both domestic violence and chemical dependency.

**Washington State Division of Behavioral Health and Recovery:**

Main Line: 1-877-301-4557

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

#### Division of Behavioral Health and Recovery Certified Hospitals Providing Intensive Inpatient Detoxification Care for Chemical Using Pregnant Women (Revised 8/23/2011)

##### 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](http://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

##### 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: [sue.green@dshs.wa.gov](mailto:sue.green@dshs.wa.gov).

### **Other Special State-Funded Projects**

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#### **Safe Babies Safe Moms**

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

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

For information at the local level, contact the following:

#### **Snohomish County**

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

#### **Whatcom County**

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

#### **Benton-Franklin Counties**

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

## Parent Child Assistance Program

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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, as well as the Spokane Tribe.

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 six months postpartum, and are ineffectively connected to community services.

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

<b>County</b>	<b>Clinical Director</b>
King	Seattle Parent Child Assistance Program Nancy Whitney 206-323-9136
Pierce	Tacoma Parent Child Assistance Program Lori McDonald 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 Jolane Christian-Stoker 509-765-9239
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**

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

**Transportation to services – Medicaid covered**  
<http://hrsa.dshs.wa.gov/Transportation/index.html>

**First Steps – Maternity Support Services and Infant Case Management**  
<http://hrsa.dshs.wa.gov/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.oxfordhouse.org/userfiles/file/>

**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/dbhr/mh\\_information.shtml](http://www1.dshs.wa.gov/dbhr/mh_information.shtml)

**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 Quitline – 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>

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

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

**Websites – National**

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**The American College of Obstetricians and Gynecologists**

[www.acog.org](http://www.acog.org)

**Association of Women’s Health Obstetric and Neonatal Nurses**

[www.awhonn.org](http://www.awhonn.org)

**American College of Nurse Midwives**

[www.acnm.org](http://www.acnm.org)

**FASD Center of Excellence**

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

**National Organization on Fetal Alcohol Syndrome**

[www.nofas.org/](http://www.nofas.org/)

**American Society of Addictions Medicine**

[www.asam.org](http://www.asam.org)

**Substance Abuse Mental Health Services Administration****National Clearinghouse for Alcohol and Drug Information**

<http://store.samhsa.gov/home>

[www.samhsa.gov](http://www.samhsa.gov)

**The National Women’s Health Information Center**

Women’s health information and resources

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

## **Websites – Washington State**

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### **Parent Child Assistance Program**

[www.depts.washington.edu/fadu/](http://www.depts.washington.edu/fadu/)

### **Department of Health**

[www.doh.wa.gov](http://www.doh.wa.gov)

### **Washington State Division of Behavioral Health and Recovery**

[www.dshs.wa.gov/dbhr/](http://www.dshs.wa.gov/dbhr/)

### **Washington Recovery Help Line**

<http://warecoveryhelpline.org/>

### **Washington State Fetal Alcohol Spectrum Disorders**

[www.fasdwa.org](http://www.fasdwa.org)

### **Pediatric Interim Care Center**

[www.picc.net](http://www.picc.net)

### **TAKE CHARGE – Family Planning Program**

<http://hrsa.dshs.wa.gov/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/hsqa/emstrauma/VAW/](http://www.doh.wa.gov/hsqa/emstrauma/VAW/)

## **Spanish health educational resources**

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### **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](http://www.nacersano.org/centro/9388_9935.asp)

### **Drinking and your pregnancy**

<http://pubs.niaaa.nih.gov/publications/spanish.htm>

### **Smoking During Pregnancy**

<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 D: Definitions of Services

### Detoxification Services

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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

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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

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**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 E: Department of Social and Health Services Children's Administration Prenatal Substance Abuse Policy

The Federal Child Abuse Prevention and Treatment Reauthorization Act of 2010 requires health care providers to notify Child Protective Services of cases of infants born with and identified as affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure, or having a Fetal Alcohol Spectrum Disorder. This includes a requirement for health care providers involved in the delivery of these infants to notify child protective services of the occurrence of such condition in such infants.

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 threats to child safety, risk factors, or concerning issues and behaviors. Information about parental strengths and protective capacities observed during your interactions with the family can also be very helpful in making screening decisions.

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.

### 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: [www.dshs.wa.gov/ca/safety/abuseReport.asp?2](http://www.dshs.wa.gov/ca/safety/abuseReport.asp?2)

**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: [www.dshs.wa.gov/ca/safety/abuseReport.asp?2](http://www.dshs.wa.gov/ca/safety/abuseReport.asp?2)

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

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

- The name, address, and age of the child and parent(s) stepparents, guardians, or other persons having custody of the child.

- The nature and extent of alleged:
  - Injury or injuries
  - Neglect
  - Sexual abuse
  - Any evidence of previous injuries
- Any other information that may be helpful in establishing the cause of the child's death, injury, or injuries, and the identity of the alleged perpetrator(s).

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

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

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

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

### **What Happens After A Report Is Made?**

When a report of suspected child abuse or neglect is made, Children's Administration intake staff determines whether the situation described meets the legal definition of child abuse or neglect. In order for Child Protective Services to intervene in a family the report must meet the legal definition of child abuse or neglect or there is a safety threat(s) 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.
- Assessing factors which greatly increase the likelihood of future abuse or neglect and the family strengths which serve to protect the child.

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

### **What Services May Be Provided?**

Protective services are provided to abused/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 if available (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 staff will ask about available information, including information about safety threats and protective factors to determine if there is an allegation of child abuse or neglect or safety threat(s). If there are no allegations of child abuse or neglect or safety threats, Children’s Administration does not have the authority to conduct a Child Protective Services investigation and the referral is documented as “Information Only.”

If a decision is made not to respond, and you disagree, you may discuss your concerns with the Intake Supervisor. When a case is not appropriate for Child Protective Services, you may consult with the local Children’s Administration office for suggestions or guidance in dealing with the family.

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

### American Medical Association

“Pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician’s knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment.”

Report of American Medical Association Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 267 (1990). See also American Medical Association, *Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, Resolution 131 (1990) (“therefore be it . . . resolved that the AMA oppose legislation which criminalizes maternal drug addiction.”).

### American Academy of Pediatrics

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

### American College of Obstetricians and Gynecologists

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

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

### American Public Health Association

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

**National Perinatal Association**

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

**National Association for Perinatal Addiction Research and Education**

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

**National Council on Alcoholism and Drug Dependence**

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

**Association of Maternal and Child Health Programs**

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

## Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State

### EXECUTIVE SUMMARY

This document provides guidance to health care providers and affiliated professionals about maternal drug screening, laboratory testing and reporting of drug-exposed newborns delivered in Washington State. We created this document in response to an increasing number of requests from hospital staff and attorneys seeking information on this complex topic. We want to promote consistent practice among health care providers. This work is a collaborative effort between the Washington State Department of Health and the Department of Social and Health Services.

The Federal Child Abuse Prevention and Treatment Reauthorization Act of 2010 requires each state, as a condition of receiving federal funds under the Child Abuse Prevention and Treatment Act, to develop policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants. This differs from the existing legal duty to report suspected child abuse or neglect. 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.

Department of Health and 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/neonatal services should develop a defined policy for identifying intrapartum women and newborns for substance use/abuse. Hospital risk management, nursing and social service, medical staff, and local Department of Social and Health Services Children's Services should be involved. The hospital policy should be written in collaboration with local/regional Child Protective Services guidelines and include consent and reporting issues.
- Newborn testing should be performed only with evidence of newborn and/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 healthcare 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 care, including possible benefits and/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 and/or maternal risk indicators are present. 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 Revised Code of Washington (RCW).26.44.056. 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.



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## Introduction

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The purpose of this document is to provide consistent guidance to health care professionals and hospitals about 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 Washington State 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

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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) and/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 positive drug toxicology; her newborn is presumed to be drug exposed.

## Hospital Policy

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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/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 healthcare 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://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy>

Another referral resource is the *Pregnant Women Chemical Dependency/Abuse Resource Guide/Matrix*: [www.dshs.wa.gov/pdf/dbhr/da/PPWResourceGuide2010.pdf](http://www.dshs.wa.gov/pdf/dbhr/da/PPWResourceGuide2010.pdf)

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\* 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**

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**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 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 Appendix A):

*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**

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**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

Additional characteristics that suggest methamphetamine use: (*American College Obstetricians and Gynecologists, 2011*)

- Gum or periodontal disease including broken teeth, severe decay, infections
- Significant weight loss, low BMI, malnutrition
- Psychiatric symptoms such as anxiety, panic, hallucinations and psychosis
- Skin abscesses

## 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 Obstetricians and Gynecologists, 2005*)

Refer to Substance Abuse During Pregnancy: Guidelines for Screening for a more detailed discussion of consent issues: <http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy>

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 and/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 and/or maternal risk indicators are present.** 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. 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 has a high false 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** may be a viable testing medium in the future, but is evolving technology at present. More information is available at [www.usdtl.com](http://www.usdtl.com).

**Table 4**

**Management of a Newborn with a Positive Drug Toxicology**

- Confirm any positive test with gas chromatography/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 Appendix D 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/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**

Hospitals should contact their local Department of Social and Health Services Children’s Services 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. See Page 30 (in the Substance Abuse During Pregnancy: Guidelines for Screening, revised edition 2012) for Department of Social and Health Services Children’s Administration Prenatal Substance Abuse Policy.

## 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																			
<b>Total score</b>																				
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.

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## Additional Resources

- To order or download "The Parent's Guide to Child Protective Services (CPS)":  
[http://www.dshs.wa.gov/ca/pubs/pubcats.asp?cat=Child\\_Abuse\\_and\\_Neglect](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, Office of Healthy Communities:  
360-236-3563
- Washington State Department of Social and Health Services Children's Administration website – video and materials for mandatory reporters:  
[www1.dshs.wa.gov/ca/general/index.asp](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



## **Guidelines for Obtaining Consent from Parents for Infant Drug Testing**

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### **Set the Scene**

The healthcare 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/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, and/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, Child Protective Services 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

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### Information for parents of newborn 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 and/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 (CPS)” 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 CPS 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 CPS 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 CPS to make a safe and healthy home for your new baby.

Sincerely,

XXXXXX

Enclosure

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To submit a request, please call 1-800-525-0127 (TDD/TYY 1-800-833-6388).