The Role of Plans of Safe Care in Ensuring the Safety and Well-Being of Infants with Prenatal Exposure, Their Families and Caregivers

A Discussion Draft in Development of A Technical Assistance White Paper

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Strengthening Partnerships, Improving Family Outcomes

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This white paper is intended to generate discussion among State and local policymakers and practitioners. The ideas are framed by Children and Family Futures staff and informed by our work with numerous communities on the practice and public policy issues affecting children of parents with substance use disorders. The views do not reflect the official position or agreement with these ideas from any of the funding organizations of Children and Family Futures.
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**Introduction**

To fully address the practice and policy challenges of infants with prenatal substance exposure, an intensely collaborative effort is required as no single agency has the resources, the information base, or the lead role to address the full range of needs of all substance-affected newborns and their families. This magnitude of scope and complexity in interagency networking are important aspects of the context for substance-exposed infant policy and its implementation. This white paper is intended to generate discussion among State and local policymakers and practitioners who implement the Child Abuse Prevention and Treatment Act (CAPTA). The guide suggests key questions to consider, highlights resources and provides State policy and practice examples.

More than 500,000 infants are born each year with some exposure to substances during pregnancy. These include infants of mothers who used tobacco (13.4 percent), alcohol (9.3 percent), or illicit drugs (5.3 percent) during pregnancy.\(^1\) Due to identification challenges and data collection gaps, the number of infants exhibiting the narrower criteria of “affected by substance abuse or withdrawal symptoms or a fetal alcohol spectrum disorder,” as specified in CAPTA, is unknown. For many of these children, this exposure may have lifelong effects such as attention deficits and neurodevelopmental challenges such as executive functioning.

Many Federal and State programs aim to reduce substance use during pregnancy and their potential effects on infants and children. But there is no single Federal, State or local agency that is charged with providing a comprehensive response or coordinating across multiple agencies. In fact, legislation and administrative guidelines on addressing the potential risks to infants and young children involve more than a dozen Federal agencies, and dozens more at State and local levels. These agencies and professionals represent services including health care, social services, treatment for substance use disorders, mental health, child welfare, developmental disabilities, home visiting, education, and more.

This discussion draft is organized to provide background and context on the legislation creating the Plan of Safe Care requirement as well giving detailed guidance on considerations in the development and implementation of Plans of Safe Care within communities. These considerations include components of Plans of Safe Care, defining drug- and alcohol-affected infants, and developing differential pathways for the diverse populations of pregnant women and new mothers, including identification of the necessary appropriate multi-agency support. In the section of this paper on *Developing Plans of Safe Care*, we reference assessment tools that were created in the late 1980s during the cocaine epidemic that are excellent tools to adapt as States define their approach. Examples of States’ Plan of Safe Care documents are provided in the Appendices.
Child Abuse Prevention and Treatment Act (CAPTA) Legislative Summary: Provisions related to Prenatal Substance Exposure

CAPTA was created in 1974 to provide Federal funding to States to support prevention, assessment, investigation, prosecution, and treatment activities related to child abuse and neglect. Since its initial creation, there have been three substantial changes under CAPTA pertinent to this population of infants with prenatal substance exposure.

The Keeping Children and Families Safe Act of 2003 created new conditions for States to receive their grant allocations under CAPTA. The grant conditions were intended to provide needed services and supports for infants, their mothers, and their families and to ensure a comprehensive response to the effects of prenatal exposure.

The committee report on H.R. 14 (2003), the House version of the Keeping Children and Families Safe Act, stated that the requirement was intended to “identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child.” The authors of this bill called for...

“the development of a safe plan of care for the infant under which consideration may be given to providing the mother with health services (including mental health services), social services, parenting services, and substance abuse prevention and treatment counseling, and to providing the infant with referral to the statewide early intervention program funded under Part C of the Individuals with Disabilities Education Act for an evaluation for the need for services provided under Part C of such Act.”

Thus, the law intended that the function of Child Protective Services (CPS) regarding these infants is protecting a child who may be at increased risk of maltreatment, regardless of whether the State had determined that the child had been abused or neglected as a result of prenatal exposure.

The legislation required that Governors of States receiving a CAPTA grant assure the Federal government that they have Policies and Procedures for:

- 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;
- 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 except that such notification shall not be construed to establish a definition under Federal law of what constitutes child abuse or require prosecution for any illegal action;
- A plan of safe care for the infant born with and identified as being affected by illegal substance abuse or withdrawal symptoms; and,
- The immediate screening, risk and safety assessment, and prompt investigation of such reports.
The CAPTA Reauthorization Act of 2010, as Amended by P.L. 111-320, made further changes were made to the prenatal exposure issues to include identification of infants affected by a Fetal Alcohol Spectrum Disorder (FASD) and added to the requirement of the development of the plan of safe care infants affected by FASD. It also added the following reporting requirements to the Annual State Data Reports:

- The number of children referred to a child protective services system born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder; and,
- The number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral, and the number of children referred to agencies providing early intervention services under Part C of the Individuals with Disabilities Education Act.

The Comprehensive Addiction and Recovery Act of 2016 (CARA) was signed into law on July 22, 2016 (S. 524) including Title V, Section 503, “Infant Plan of Safe Care.” These changes were made in the context of attention generated by the nation’s prescription drug and opioid epidemic, which has focused State agencies on the requirement that a Plan of Safe Care be implemented for these infants.

The legislation makes four important changes to CAPTA in relation to this group of families:

- Removes the term, “illegal” in regard to infants affected by substance abuse;
- Requires that the Plan of Safe Care address the needs of both the infant and the affected family or caregiver;
- Increases States’ accountability by specifying specific data to be reported by States:
  - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder;
  - The number of infants for whom a plan of safe care was developed;
  - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver; and,
- Increases the monitoring requirements by the Federal government regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

The current statute regarding this population is detailed in Appendix 1: Current Legislative Language Regarding CAPTA Provisions Related to Prenatal Substance Exposure.
Developing Plans of Safe Care

The development of the Plan of Safe Care for each family must involve an assessment of the immediate safety factors, strengths and challenges for the infant and family/caregiver. The plans are based on a preference that infants, mothers, and families can remain together. Reasons for placing an infant in protective custody would be based on immediate safety concerns that are present and not mitigated by sufficient familial protective factors to provide for the infant’s safety. If the mother and infant are residing in or enter a residential treatment program, which can mitigate immediate safety concerns, removal of the infant from the mother’s care can be avoided. Regardless of the immediate placement decisions, the Plan of Safe Care must include specific follow-up plans that support the family and focus on the longer-term well-being of the infant and family/caregiver.

Specific definition on what is to be included and who is to develop, implement and monitor Plans of Safe Care were not specified in the 2003 and 2010 amendments to CAPTA or in CARA 2016. While legislative intent in the 2003 CAPTA included care for the infant’s mother, recognizing that her care and the safety of the infant are intertwined, in practice, it does not seem that Plans of Safe Care have been consistently implemented for infants or their families/caregivers.

Guidance on these questions was provided in the Children’s Bureau’s Child Welfare Policy Manual, in response to a question that was posed on September 27, 2011. The question states:

Which agency is responsible for developing the plan of safe care and what is a plan of safe care, as required by section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (CAPTA)?

Answer: The statute does not specify which agency or entity (such as hospitals or community-based organizations) must develop the plan of safe care; therefore, the State may determine which agency will develop it. The plan of safe care should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant’s safety. There may be Federal confidentiality restrictions for the State to consider when implementing this CAPTA provision.


The Administration for Children and Families released Information Memorandums on April 13, 2016 (https://www.acf.hhs.gov/sites/default/files/cb/pi1603.pdf) and August 26, 2016 (http://www.acf.hhs.gov/sites/default/files/cb/im1605.pdf) that provide further guidance related to CAPTA including Plans of Safe Care and their development, implementation, and monitoring as well as State Plan documentation requirements.

The Plan of Safe Care moves beyond the immediate safety factors to the infant’s ongoing health, development and well-being. It specifically incorporates the mother’s (and potentially the
father’s) need for treatment for substance use and mental disorders, appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure, and services and supports that strengthen the parent’s capacity to nurture and care for the infant and to ensure the infant’s continued safety and well-being. The plan also ensures a process for continued monitoring with the family and accountability of responsible agencies such as substance use disorder treatment, home visiting, public health and health care providers for the infant and family/caregiver. Communities throughout the nation have begun grappling with how to implement these directives. Current examples of strategies communities have used to address these CAPTA requirements and develop protocols for Plans of Safe Care can be found in Appendix 2: Sample Plan of Safe Care and CAPTA Implementation Protocols, Strategies, and Forms.

Principles Inherent in a Plan of Safe Care

Many of the factors to be included in the plan are identified by various professionals throughout the woman’s pregnancy, at the time of birth and at discharge from the hospital. For example, a mother’s post-partum care would typically be included in the hospital discharge plan. It is clear that many of the factors included in assessments, case planning and treatment plans are included in a Plan of Safe Care and are included in processes conducted in communities at present and the Plan of Safe Care should be the basis for coordinating those services and treatment plans. The table below suggests principles that should guide the development and implementation of Plans of Safe Care.

<table>
<thead>
<tr>
<th>Table 1: Principles to Guide Plans of Safe Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inter-disciplinary across health and social service agencies based on the results of a comprehensive, multidisciplinary assessment that is coordinated across agencies to address the infant’s and parents’ physical, social-emotional health and safety needs</td>
</tr>
<tr>
<td>• Family-focused to meet the needs of each family member as well as the overall family functioning and well-being by building on each family members’ strengths, challenges and parenting capacity for the mother and father⁵</td>
</tr>
<tr>
<td>• Assesses immediate safety factors and risk of future maltreatment, including:</td>
</tr>
<tr>
<td>o <strong>Safety</strong>: Deciding if a child is in danger of immediate maltreatment (Decision to remove)</td>
</tr>
<tr>
<td>o <strong>Risk</strong>: Determining the possibility that a child may be maltreated in the future (Decision to open a child welfare investigation case)</td>
</tr>
<tr>
<td>o <strong>Strengths</strong>: Assessing the family’s qualities and resources available to care for the child</td>
</tr>
<tr>
<td>o <strong>Protective Capacities</strong>: Determining if the parent and family have the ability or support system available to provide an environment that keeps children free from harm</td>
</tr>
<tr>
<td>• Completed when possible prior to the birth of the infant to facilitate engagement of parent(s), and communication among providers; or, when not possible, prior to discharge of the infant from the hospital</td>
</tr>
<tr>
<td>• Facilitated referrals to substance use disorder treatment and other health and social supports to ensure family members are able to participate in services</td>
</tr>
<tr>
<td>• Designates a lead agency responsible for oversight and monitoring of the plan including both needs of the infant and needs of the family/caregiver recognizing that parents’ ability to do their part in carrying out such a plan will be equally as important as any role for public or private services</td>
</tr>
</tbody>
</table>
Table 1: Principles to Guide Plans of Safe Care

- Specifies with whom the child will be discharged and ensures protective capacity of the parents and/or other family members are sufficient to care for the infant
- Includes provisions for frequency and the entity responsible for follow-up with families including providing home visiting services when appropriate
- Specifies the details of referrals of the child to developmental intervention
- Is easily accessible to relevant agencies with the appropriate privacy safeguards

Several key aspects differentiate a Plan of Safe Care for an infant with prenatal substance exposure and the family/caregivers from a typical safety plan developed by child welfare services which assesses for factors that have already occurred in a family and have been brought to the attention of the child welfare agency. Clearly, if it is determined that immediate safety factors are present and protective capacity is not clear to provide for the infant, the family should be moved into the investigation caseload of child protective services. In such instances, it is imperative that the infant’s caregivers (e.g. kin, foster parents) also be involved in discharge planning and caring for an infant with any medical concerns, as may occur for infants who experience a withdrawal syndrome or Fetal Alcohol Syndrome. Some of the important factors to consider when assessing safety and risk include:

- Mothers’ or fathers’ child welfare-related history that indicates unresolved substance use disorders related to a prior case of child abuse or neglect;
- Prior abuse and/or neglect reports related to substance use;
- Siblings’ substance exposure prenatally or in the family environment;
- Evidence of co-occurring mental health concerns that may affect immediate parenting capacity such as post-partum depression and substance use;
- Mother’s willingness to seek treatment and parenting instruction; and,
- Family environmental challenges related to parental substance use disorders. Access to sufficient income and resources, employment history, and lack of health access to a medical home can all interact with substance use disorders, and can result in effects on infants in the home, including neglect.

The plan requires collaborative efforts among health care providers and community agencies and the family that ensures efficient communication across service systems, agencies and professionals. However, at present there is not sufficient communication among professionals to ensure that families of infants with prenatal substance exposure have sufficient supports and that infants with prenatal substance exposure have follow-up services to ensure their safety. Guidance and tools to assist with developing cross-system practice and communication protocols can be found in the section below, Clarifying Roles and Responsibilities across Agencies, and Appendix 3: Template for Creating Pathways of Communication.

In the table here, which suggests components of the Plan of Safe Care, the areas of assessment to develop the plan are delineated (Table 2: Components of Plans of Safe Care for Infants, Family and Caregivers). This is followed by a table specifying the common safety, risk and protective factors that would be considered for families in which the child is accepted for child welfare services for assessment or investigation (Table 3: Factors Commonly Included in Assessments).
Conducted by Child Protective Services). Table 2 and Table 3 should both be considered in developing the plan.

**Table 2: Components of Plans of Safe Care for Infants, Family and Caregivers**

<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>SERVICES AND SUPPORTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother Post-Partum Care</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Health | • Pregnancy and Post-partum care  
• Medical home is designated that is consistent with the family’s insurance plan and has responsibility for the primary care needs for the pregnant woman and family. Medical homes are often designated in States with Medicaid managed care plans  
• Medication management is assessed and the Medical Home provider has responsibility to oversee including liaison with methadone or other medications used in assisting treatment  
• Pain management  
• Contraception and pregnancy prevention  
• Support with breastfeeding |
| Substance Use and Mental Disorders Prevention, Intervention and Treatment | • Timely access to treatment is ensured by referrals and appropriate feedback across agencies  
• Engagement and retention outreach services and on-going recovery supports  
• Appropriate treatment ensuring gender-specific, family focused, accessible, medication assisted treatment, and trauma services  
• Mental health services including symptoms of depression and anxiety  
• Intervention for domestic partner and family violence  
• Substance use and mental health treatment for other family members and indicated |
| Parenting/Family Support | • Coordinated care management  
• Home visiting follow-up services including infant care, parent/infant bonding, nurturing parenting guidance and skill development, safe sleep practices, and parental supports  
• Child Care in developmentally appropriate programming when needed by the family  
• Income support and safety net benefits eligibility determination and employment support  
• Safe and stable housing determinations are made  
• Need for transportation is determined |
## Table 2: Components of Plans of Safe Care for Infants, Family and Caregivers

<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>SERVICES AND SUPPORTS</th>
</tr>
</thead>
</table>
| Infant    | - Linkage to a medical home for infant primary health care is provided  
- Need for high-risk infant follow-up care is determined  
- Referral to specialty health care as needed  
- Developmental screening and assessment  
- Referral to developmental pediatrician as needed  
- Referral to early intervention services for assessment, services and follow-up  
- Early care and education program to ensure developmental intervention and supports are provided by a program with expertise in young children who experienced prenatal substance exposure |

## Table 3: Factors Commonly Included in Assessments Conducted by Child Protective Services

<table>
<thead>
<tr>
<th>Immediate Safety Factors</th>
<th></th>
</tr>
</thead>
</table>
| • Physical harm or threat of children in the home  
• Previous maltreatment of other children  
• Sexual abuse allegations of other children in the home  
• Failure to protect older children from harm  
• Questionable explanation of injuries  
• Refuses access to monitor the child or threatens to take the child out of the CPS agency’s jurisdiction  
• Immediate needs of child not met  
• Hazardous living conditions  
• Impairment by substance abuse and parent is not active in treatment or recovery  
• Domestic violence  
• Child is danger to self/others  
• Emotional/developmental/cognitive impairment |

| Risk of Child Neglect Factors   | Current complaint includes neglect of other children in home  
• Prior investigations  
• Household has previously received CPS  
• Number of children involved in the child abuse/neglect incident  
• Age of younger child in household  
• Primary caretaker provide physical care inconsistent with child needs  
• Primary caretaker has a past or current untreated mental health problem  
• Primary caretaker has historic or currently alcohol or drug problems and is not actively in treatment or recovery  
• Characteristics of children in the household  
• Unsafe housing |
**Table 3: Factors Commonly Included in Assessments Conducted by Child Protective Services**

<table>
<thead>
<tr>
<th>Risk of Child Abuse Factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Current complaint is for child abuse of other children in the home</td>
<td></td>
</tr>
<tr>
<td>• Number of prior abuse investigation</td>
<td></td>
</tr>
<tr>
<td>• Household has previously received CPS</td>
<td></td>
</tr>
<tr>
<td>• Prior injury to a child resulting from child abuse or neglect</td>
<td></td>
</tr>
<tr>
<td>• Primary caretaker’s assessment of incident</td>
<td></td>
</tr>
<tr>
<td>• Domestic violence in the household in the past year</td>
<td></td>
</tr>
<tr>
<td>• Primary caretaker characteristics</td>
<td></td>
</tr>
<tr>
<td>• Primary caretaker has a history of abuse or neglect as a child</td>
<td></td>
</tr>
<tr>
<td>• Secondary caretaker has historic or current alcohol or drug problem and is not actively in treatment or recover</td>
<td></td>
</tr>
<tr>
<td>• Characteristics of children household</td>
<td></td>
</tr>
</tbody>
</table>

**Defining Drug- and Alcohol-Affected**

The CAPTA legislation calls for a response to drug- and alcohol-affected infants, but there is not a clear definition and diagnostic criteria of the terms “affected by” substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.” That leaves the task of defining this group up to States with guidance provided by the Administration on Children, Youth and Families (ACYF).

It is certainly easier to make that determination when an infant experiences a withdrawal syndrome. Yet, infants prenatally exposed to stimulants or alcohol without the full expression of Fetal Alcohol Syndrome may be “affected by” that exposure as evidenced by impaired growth, pre-term labor, or subtle neurodevelopmental signs that are more difficult to define in the newborn and infancy stages. Similarly, infants prenatally exposed to tobacco may be born with low birth weight and may be at increased risk for impaired respiratory functions and neuro-behavioral concerns. But, in the absence of immediate safety concerns or high risk potential of child abuse or neglect, the infant may not be appropriate for child welfare services while still needing on-going health monitoring and potentially needing other supportive services.

There are also challenges with operationalizing “withdrawal symptoms” resulting from prenatal drug exposure” as infants who are prenatally exposed to illegal substances, as well as legal substances (e.g. alcohol, benzodiazepines, opioid-based medications, medications prescribed for the treatment of opioid use disorders or other conditions) can experience a withdrawal syndrome and those withdrawal symptoms may be complicated by smoking during pregnancy.
Although the legislation is clear that these situations fall under the CAPTA requirements of developing a Plan of Safe Care, some communities may be challenged by implementing the regulations in situations in which the infant’s withdrawal syndrome is due to the legitimate use of medications or result from legal substance use (e.g., alcohol, tobacco, and marijuana in States in which it is legal). This may be particularly challenging in States in which prenatal substance exposure is grounds for criminal prosecution or as a basis to substantiate child abuse/neglect.

We would suggest that States look to the intent of the 2003 CAPTA legislation—“identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child”—for clarity on how they are to define, identify, intervene and ensure the safety of infants and their families with prenatal substance exposure in the immediate post-partum period and throughout infancy.

Pediatricians and health care professionals should be consulted for establishing the State’s definition. A definition agreed upon by the various State and local agencies and stakeholders is warranted to assure that the full spectrum of intervention and supports are provided to ensure the safety of the infant and family and, in the absence of immediate safety concerns, that the supports are provided to the mother, infant and family to maintain the mother/infant/family bond.

The following factors may be taken into account in developing that definition.7

<table>
<thead>
<tr>
<th>Table 4: Factors to Consider in Identifying an Infant Affected by Substance Abuse, Withdrawal or Fetal Alcohol Spectrum Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>In conjunction with known substance use during pregnancy, signs of prenatal exposure detectable at birth and early infancy are assessed including:</td>
</tr>
<tr>
<td>a. Facial characteristics of fetal alcohol syndrome8</td>
</tr>
<tr>
<td>b. Withdrawal as defined by a diagnosis of neonatal abstinence syndrome9</td>
</tr>
<tr>
<td>c. Irritability</td>
</tr>
<tr>
<td>d. Irregular and rapid changes in state of arousal</td>
</tr>
<tr>
<td>e. Low birth weight</td>
</tr>
<tr>
<td>f. Prematurity</td>
</tr>
<tr>
<td>g. Difficulties with feeding due to a poor suck</td>
</tr>
<tr>
<td>h. Irregular sleep-wake cycles</td>
</tr>
<tr>
<td>i. Decreased or increased muscle tone</td>
</tr>
<tr>
<td>j. Seizures or tremors</td>
</tr>
</tbody>
</table>

States may want to consider the use of medical fragility or Medically Fragile Infants when defining this population of infants, as this is consistent with the Maternal and Child Health Bureau definition of children with special health care needs (CSHCN); *children who have or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition and...*
require health care and related services of a type or amount beyond that required by children generally. Appropriate interventions, including family-centered services and care coordination, should be considered in the context of this definition.

Similar to the CAPTA language and intent, we do not suggest that this definition is grounds to substantiate child abuse or neglect, though we recognize that a minority of States have statutes in which this may be the case. Regardless of statute, careful determinations of immediate safety concerns and longer-term risk and protective factors must be assessed to determine appropriate interventions and services for families.

As States and communities define their approach to these infants, there is a need to understand the various groups of families who may be in these categories, how to best meet the intent of CAPTA and what entity should be charged with the development, implementation and monitoring of the Plan of Safe Care.

Populations of Families and Pathways of Interventions

The challenges in implementing CAPTA provide opportunities for States to respond to the various groups of families with an infant identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a FASD. A five-stage framework, set forth in a 2009 SAMHSA publication and included in the 2012 White House Office of National Drug Control Policy strategic plan, specifies five stages which need to be part of comprehensive reform to effectively respond to pregnant women, mothers, their families and infants with prenatal exposure:

1) **Pre-pregnancy**—public education to reduce substance use during pregnancy including tobacco, alcohol, and other drugs;
2) **Prenatal**—screening and engagement of pregnant women in treatment when indicated;
3) **At Birth**—universal screening at birth to both deter substance use and to ensure infants who may be at increased risk and their families receive the intervention and supports that are needed to ensure their safety and well-being;
4) **Infancy, toddlerhood, and early childhood**—screening, assessment and intervention during infant and toddler stages (0-3 years) to remediate any developmental concerns and early identification and support for pre-school developmental care and education (3-5); and,
5) **Middle childhood and adolescence**—ongoing support and age-appropriate interventions for children and adolescents (5-18) who may have neurodevelopmental or other effects.

In the context of the five-stage framework, the following discussion identifies potential populations of families who require a Plan of Safe Care and the multi-agency pathways that States may provide to ensure that the plan is implemented. The Plan of Safe Care is focused at two points of identifying families and providing services: Pregnancy and Birth.
Identification during Pregnancy

Identification of substance use during pregnancy will not trigger a risk and safety investigation by child welfare, who would not intervene prior to the birth of the infant, unless there are concerns about older children in the home or a concurrent open CPS case involving other children. However, the prenatal care provider, substance use treatment agency or home visiting provider may develop a Plan of Safe Care in advance of the birth. The plan should include hospital notification to CPS when the birth has occurred, confirmation that a Plan of Safe Care has been developed and is being implemented and identification of the local agency who is responsible after the release of the infant from the hospital. There may also be opportunities for the prenatal care provider to collaborate with CPS in advance of the birth (e.g., in the month prior to the expected due date) to establish or refine the Plan of Safe Care.

Identification at Birth

Identification at the time of the birth of an infant born with or affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder, should trigger the CAPTA-required response of notification to CPS and development, implementation and monitoring of the Plan of Safe Care.

The ability to recognize drug or alcohol exposure in infants and substance use disorders among new mothers who weren’t identified during prenatal care or didn’t participate in prenatal care provides the best opportunity for engaging them in treatment and needed supportive services. For these women in particular, effective screening and testing practices will be critical to identifying the potential needs of the infant. The screen itself can be conducted through interview and self-report using questionnaires or valid screening instruments at the birth event. There may be additional follow-up assessments and tests that may include a toxicology panel for both newborns and their mothers. Some states such as Maine, Massachusetts, and Washington have existing in-depth guides for screening and testing examples of which can be found in Appendix 4: Sample Prenatal and Birth Screening and Assessment Protocols.

In certain states, consent may be required when ordering a toxicology panel for mothers. The table on the following page is offered as suggested populations of pregnant women and new mothers who meet the requirement for a Plan of Safe Care (i.e., affected by substance abuse, withdrawal or FASD). We also suggest the appropriate community agency for developing, implementing and monitoring the plan. These scenarios require effective communication protocols are established and implemented across agencies and professionals. We would refer State and local agencies to the resources of the National Center on Substance Abuse and Child Welfare (www.ncsacw.samhsa.gov) for assistance in developing communication protocols as well as Appendix 3—Template for Creating Pathways of Communication which is a tool we have used with communities to assist to develop efficient communication protocols. In addition to the importance of efficient communication underlying...
these practices, making clear a community’s underlying assumptions about providing services with these families and principles is warranted; a suggested frame for the development of common principles about these services follow after the table below (Table 5: Populations and Intervention Pathways).

These community principles however are implemented in the context of the State’s legislation. All States have statutes identifying persons who are required to report suspected child maltreatment to an appropriate agency, such as child protective services, a law enforcement agency, or a State’s toll-free child abuse reporting hotline. Although the table identifies various systems responsible for a Plan of Safe Care, the table should not be interpreted to mean that entities and individuals are not required to report suspected maltreatment regarding the newborn or other children in the family if warranted.

### Table 5: Populations and Intervention Pathways

#### During Prenatal Period

<table>
<thead>
<tr>
<th>Populations of Pregnant Women</th>
<th>Plan of Safe Care Lead Agency/Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and is not known to have a substance use disorder</td>
<td>Prenatal care provider in concert with pain specialist or other physician</td>
</tr>
<tr>
<td>2. Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is actively engaged in treatment for a substance use disorder</td>
<td>Prenatal care provider in concert with opioid treatment program or waivered prescriber of buprenorphine and/or therapeutic treatment provider</td>
</tr>
<tr>
<td>3. Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, not actively engaged in a treatment program</td>
<td>Prenatal care provider or high-risk pregnancy clinic in concert with substance use disorder treatment agency</td>
</tr>
</tbody>
</table>

#### Identification at Birth and Infant is Determined to be Affected

<table>
<thead>
<tr>
<th>Population of New Mothers</th>
<th>Plan of Safe Care Lead Agency/Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Receiving medication for chronic pain or medication that can result in a withdrawal syndrome, and is not known to have a substance use disorder and voluntarily participates in services</td>
<td>Home visiting agency or community-based child welfare agencies providing prevention services</td>
</tr>
<tr>
<td>5. Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is actively engaged in treatment for a substance use disorder.</td>
<td>Opioid Treatment Providers or therapeutic substance use disorder treatment provider</td>
</tr>
<tr>
<td>6. Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, not actively engaged in a treatment program</td>
<td>Child welfare services</td>
</tr>
</tbody>
</table>
Clarifying Roles and Responsibilities across Agencies

It is clear that child welfare agencies cannot be charged with the sole responsibility for responding to prenatal substance exposure and infants who are affected by prenatal substance abuse, withdrawal or FASD. In fact, while data are largely incomplete, only a small percentage of these families are identified and are referred to the child protection system and fewer than half of the States include prenatal substance exposure in their statutes defining child abuse or neglect. Child welfare agencies typically cannot intervene until birth, and many do not receive timely notifications of drug- or alcohol-exposed births from hospitals and medical providers, even though it is a state requirement for receipt of CAPTA funds. Thus, multiple providers and agencies in addition to child protection must be part of the response system with these families.

There are more than $400 billion of Federal expenditures that benefit children, which is allocated across many agencies. That array of resources underscores the critical roles that could be played by many agencies and providers at all five stages of the intervention framework. Despite these resource allocations and potential expansion of substance use disorder treatment through the Affordable Care Act and parity legislation requiring substance use and mental health treatment benefits on par with medical care provisions, there remains a dramatic gap in substance use disorder treatment. This gap is particularly apparent for family-centered care and medication assisted treatment for opioid use disorders. Therefore, States need a two-pronged approach to achieve a multi-agency response to prenatal exposure:

1) A State-level strategic plan that sets forth broad system policies and practices, addresses barriers to multi-agency responses, sets and monitors benchmarks to improve outcomes for these families, and ensures the support of agencies’ leadership; and,

2) Local-level implementation plans to ensure the necessary policies, practice and communication protocols are in place that ensure a continuum of services, including Plans of Safe Care for infants, their families and caregivers. Local implementation should be grounded in the knowledge base of successful implementation and the need for staff competency, organization support and effective leadership.

CAPTA requires that grants to States are provided to implement a State plan that contains an assurance in the form of a certification by the Governor that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program that includes provisions for infants affected by substance use. Therefore, implementation of the State’s plan should be developed and monitored by a State-level authority, reporting directly to the governor and charged with convening authority to work across agencies and providers. That State-level entity is needed to develop a strategic, multi-year response to the problems of prenatal substance exposure. Details on the charge to the State-level team, suggested membership, data collection and monitoring considerations and the specific tasks to be
accomplished by the team in each of the points of intervention framework are specified in Appendix 5—State-Level Strategic Plans.

At the local government level, a multi-disciplinary approach is needed that draws on professional expertise across agencies and includes an initial response and triage process that assesses risk and protective factors but does not presume child abuse or neglect. This multi-disciplinary approach includes the development of a team comprised of partnering agencies, birth parents, family members and agencies, including, but not limited to, hospitals, private medical providers, maternal and child health, including home visiting, substance use treatment and mental health services, and early intervention services. The charge to the local community implementation team, suggested membership and tasks to be accomplished at the various intervention points is specified in Appendix 6—Community Level Plan of Safe Care for an Infant and Family/Caregiver.

While there are a number of challenges ranging from identification of those in need of a Plan of Safe Care to the development, implementation and monitoring of the plan, it is clear that addressing the challenges is critical to the well-being of these infants and their families. Using strong, cohesive cross-systems collaborations to make comprehensive and considerate Plans of Safe Care will give children and their families the best opportunity to thrive by offering each family member the services necessary to create and participate in healthy, nurturing families.
Citations


4. In 2010, the law was amended to include the needs of infants born with and identified as being affected by *illegal* substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.


6. An example of a comprehensive assessment instrument is modeled after the Newborn Assessment developed in Kansas City and adapted by Los Angeles County which can be found at: http://ican4kids.org/documents/CANProtocol/ap15.Hospital.pdf. The Kansas City, MO example can be located at: https://dss.mo.gov/cd/info/cwmanual/section2/ch6/sec2ch6sub2.htm

7. Ibid. Adapted from the American Humane Association (2016)


There are several estimates on the gap between treatment need and receipt of treatment, most are in the range that 10-11% of persons who need treatment receive it. State of Health (2014) Despite Obamacare, Big Gap in Substance Abuse Treatment, Accessed March 25, 2016 from: http://ww2.kqed.org/stateofhealth/2014/04/11/despite-obamacare-big-gap-in-substance-abuse-treatment/

Appendix 1: Current Legislative Language Regarding CAPTA Provisions Related to Prenatal Substance Exposure

The bolded text in the following reflects changes from S.524, Comprehensive Addiction and Recovery Act of 2016, Section 503, Infant Plan of Safe Care.

Section 103. NATIONAL CLEARINGHOUSE FOR INFORMATION RELATING TO CHILD ABUSE. [42 U.S.C. 5104]

a. ESTABLISHMENT. – The Secretary shall through the Department, or by one or more contracts of not less than 3 years duration let through a competition, establish a national clearinghouse for information relating to child abuse and neglect.

b. FUNCTIONS. – The Secretary shall, through the clearinghouse established by subsection (a) –

(5) maintain and disseminate information about the requirements of section 106(b)(2)(B)(iii) and best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

Section 106. GRANTS TO STATES FOR CHILD ABUSE OR NEGLECT PREVENTION AND TREATMENT PROGRAMS. [42 U.S.C. 5106a]

A State plan… shall contain a description of the activities that the State will carry out using amounts received under the grant to achieve the objectives of this subchapter, including…

(B) an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes –

(ii) 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 being 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 of such infants, except that such notification shall not be construed to –

(I) establish a definition under Federal law of what constitutes child abuse or neglect; or

(II) require prosecution for any illegal action;

(iii) the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –

(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

(iv) procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports;…

(xxii) provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.);

(d) ANNUAL STATE DATA REPORTS. – Each State to which a grant is made under this section shall annually work with the Secretary to provide, to the maximum extent practicable, a report that includes the following:

(15) The number of children referred to a child protective services system under subsection (b)(2)(B)(ii) [Note: this section is above related to notification to CPS and referrals to other appropriate services].
(16) The number of children determined to be eligible for referral, and the number of children referred, under subsection (b)(2)(B)(xxi), to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.).

(17)(A) The number of infants identified under subsection (b)(2)(B)(iii).
   (B) The number of infants for whom a plan of safe care was developed under subsection (b)(2)(B)(iii);
   (C) The number of infants for whom a referral was made for appropriate services, including services for the affected family or caregiver, as may be necessary under subsection (b)(2)(B)(iii).

SEC 114—MONITORING AND OVERSIGHT.
The Secretary shall conduct monitoring to ensure that each State that receives a grant under section 106 is in compliance with the requirements of section 106(b), which –
(1) shall-
   (A) be in addition to the review of the State plan upon its submission under section 106(b)(1)(A); and
   (B) include monitoring of State policies and procedures required under (ii) and (iii) of section 106(b)(2)(B); and
(2) may include –
   (A) a comparison of activities carried out by the State to comply with the requirements of section 106(b) with the State plan most recently approved under section 432 of the Social Security Act;
   (B) a review of information available on the Website of the State relating to its compliance with the requirements of section 106(b);
   (C) site visits, as may be necessary to carry out such monitoring; and
   (D) a review of information available in the State’s Annual Progress and Services Report most recently submitted under section 1357.16 of title 45, Code of Federal Regulations (or successor regulations).

Appendix 2: Sample Plan of Safe Care and CAPTA Implementation Protocols, Strategies, and Forms

Communities throughout the Nation have begun grappling with how to implement the directives outlined in the Child Abuse Prevention and Treatment Act (CAPTA) and address various challenges in the definition, development, implementation and monitoring of Plans of Safe Care. Current examples of strategies communities have used to address these requirements and develop protocols for Plans of Safe Care are included in this appendix.

The following table summarizes strategies that have been implemented by States to address the CAPTA provisions, including:

- Notification to Child Protective Services (CPS) by healthcare professionals of an infant identified to be affected by substance use, withdrawal or a Fetal Alcohol Spectrum Disorder;
- Development and implementation of a Plan of Safe Care for such infants and their affected family members or caregivers; and,
- Data collection and reporting on the number of infants and affected family members or caregivers in which a Plan of Safe Care is developed and a referral to services is made.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Arkansas</th>
<th>Georgia</th>
<th>Louisiana</th>
<th>Maryland</th>
<th>Maine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific guidance to birth hospitals on what information to gather and include in the CAPTA notification</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Welfare based coordinator or specialized unit to respond to CAPTA notifications and other reports involving prenatal substance exposure</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Specific guidance to CPS hotline on what information to gather on and in responding to CAPTA notifications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Different CPS/child welfare response pathways for CAPTA notifications</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Different response pathways for development and implementation of the Plan of Safe Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Based Meetings or a coordinated approach across systems</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Feed-back loop to monitor notifications routed for non-CPS intervention</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Data system has capacity to track notifications and regarding prenatal substance exposure</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

For detailed information and sample forms, see the sample protocols and documents that follow. *Note: The protocols and documents:*

- Were developed prior to the passage of Section 503 of the Comprehensive Addiction Recovery Act of 2016 (CARA) and may not reflect the removal of the term “illegal” (substances) in determining which infants affected by substance use come under the purview of the CAPTA provisions
- Are publicly available
- Represent sample documents and are not endorsed by Children and Family Futures

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Louisiana: [https://stellent.dcf.s.la.gov/LADSS/getContent?mimeType=application%2Fpdf&docName=091285&rendition=web&noSaveAs=true&id=115923](https://stellent.dcf.s.la.gov/LADSS/getContent?mimeType=application%2Fpdf&docName=091285&rendition=web&noSaveAs=true&id=115923)
Upon receipt of a referral from the Child Abuse Hotline concerning an infant born with and affected by Fetal Alcohol Spectrum Disorder (FASD), the Division of Children and Family Services (DCFS) FASD case manager or designee met with the family named in the referral to conduct an FASD assessment. Based on the assessment, DCFS and the family will move forward with the selected actions below to comprise an appropriate plan of safe care for the family.

☐ Supportive Services Case accepted
Family is in need of supportive services to strengthen family functioning and ensure the health and safety of the child(ren). By signing this form the family agrees to participate in the selected services offered below:

☐ Work with an assigned primary family service worker
☐ Work with an assigned a secondary FASD family service worker
☐ Accept referral to Genetics if applicable
☐ Consider a referral to Developmental Disability Service (DDS) if applicable
☐ Accept a referral to specialized day care if applicable
☐ Participate in a recommended FASD support group
☐ Participate in a recommended FASD parenting class
☐ Accept a referral to drug and/or alcohol assessment if applicable
☐ Accept a referral to drug and/or alcohol recovery center if applicable
☐ Accept a referral to Access to Recovery (ATR) if applicable

☐ Supportive Services Case not recommended
Family has support systems in place and child and the home environment appear safe at this time. By signing this form the family accepts responsibility for contacting DHS to request services if the need arises.

☐ Supportive Services case refused
Family does not want services rendered and/or offered by the Department of Human Services, Division of Children and Family Services. By signing this form, the family acknowledges that FASD and the services designed to support families affected by FASD have been explained and information has been given to the family about local and statewide services that may be available.

☐ Hotline report needed
DHS FASD case manager feels the home environment presents safety concerns for the child/children in the home. The family has been notified that a hotline report will be made.

Printed Name of Client: ____
_________________________ Client Signature: ________________
_________________________ Date: ________________

Printed name of FASD representative: ____
FASD Representative Signature: ____
Date: ________________

CFS-101 (01/2013)
DIVISION OF FAMILY AND CHILDREN SERVICES

Plan of Safe Care

Date of Plan:

Family Information

Child (ren) and age(s):
Primary Caregiver and age:
Secondary Caregiver and age:

Description of the impact of substance abuse of the infant and all other children in the home:

Plan of Safe Care Meeting

Date of meeting:
Participants including name of agency:
Family Needs Identified:
   Infant:
   Other Children in the home:
   Primary Caregiver:
   Secondary Caregiver:

Recommendations Based on Need(s) Identified:
   Infant:
   Other Children in the home:
   Primary Caregiver:
   Secondary Caregiver:

Roles/Responsibilities of Participants (Describe a participant’s action step(s) in addressing and following up to ensure child safety and well-being and the enhancement of the caregivers’ ability to protect and care for their children):
DIVISION OF FAMILY AND CHILDREN SERVICES
CHILD WELFARE POLICY MANUAL

<table>
<thead>
<tr>
<th>Chapter:</th>
<th>(5) Investigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Title:</td>
<td>Developing a Plan of Safe Care for Infants Prenatally Exposed to Substances or a Fetal Alcohol Spectrum Disorder (FASD)</td>
</tr>
<tr>
<td>Policy Number:</td>
<td>5.8</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>October 2015</td>
</tr>
<tr>
<td>Previous Policy #:</td>
<td>2104, 2106</td>
</tr>
</tbody>
</table>

CODES/REFERENCES

O.C.G.A. § 19-7-5 Reporting of Child Abuse and Neglect
O.C.G.A. § 15-11-30 Rights and Duties of Legal Custodian
O.C.G.A. § 15-11-101 Medical and Psychological Evaluation Orders When Investigating Child Abuse and Neglect
O.C.G.A. § 49-5-8 Powers and Duties of Department of Human Services
O.C.G.A. § 49-5-41 Persons and Agencies Permitted to Access Records
45 CFR Parts 1355.38(a)(5), 1356.21(b)(3)(i), 1356.21(d), 1356.21(k), and 1356.67
Title IV-E of the Social Security Act Sections 471(a)(15)(D), 472(a)(1), and 472(f)
Child Abuse and Treatment Prevention (CAPTA) Reauthorization Act of 2010 as Amended by P.L. 111-320
J.J. v. Ledbetter-Release of Information of Confidential Records
Health Insurance Portability and Accountability Act (HIPAA) of 1996

REQUIREMENTS

The Division of Family and Children Services (DFCS) shall:

1. Develop and implement a Plan of Safe Care during an investigation for infants identified by medical personnel as being affected 1 by prenatal exposure to illegal substances or a Fetal Alcohol Spectrum Disorder (FASD); and

2. Adhere to requirements outlined in policy 5.7 Investigations: Case Management Involving Caregiver Substance Use or Abuse prior to closing a case involving caregiver substance use/abuse.

PROCEDURES

For investigations involving infants affected by prenatal exposure to illegal substances or a FASD, in addition to investigative activities outlined in policy 5.2 Investigations: Conducting an Investigation, the Social Services Case Manager (SSCM) will:

1. Assess the level of substance use/abuse by the mother and the impact of the substance use/abuse on the family, including the ability to meet the infant’s needs and any other needs of other children in the home.

2. Assess the needs of the infant, including the infant’s general functioning and development and the effects of the illegal substances or alcohol on the infant.

---

1 Affected means that medical personnel has identified the infant as experiencing symptoms of withdrawal as a result of the mother’s use of a controlled substance or alcohol during pregnancy; OR the infant has tested positive for the presence of a controlled substance or a metabolite thereof in his/her body, blood, urine or meconium that is not the result of medical treatment. Affected also applies if medical personnel has identified the infant as exhibiting harmful effects in his/her physical appearance or functioning that is attributed to the mother’s drug or alcohol use, which is otherwise known as prenatal abuse.
NOTE: Obtain medical records and any other pertinent information from medical providers to assist in determining the specific care needs of the infant.

3. Assess all household members, including the capacity of the adults to protect and meet the needs of the infant and any other children in the home.

4. Complete and submit the Children 1st referral for the infant and any other children in the home who meet the criteria for Babies Can’t Wait for a developmental screening and/or assessment at the initiation of the assessment (see policy 5.11 Investigations: Children 1st and Babies Can’t Wait).

5. Refer the mother of the prenatally exposed infant to Ready for Work (RFW) within 72 hours of the initial home visit for a substance use disorder assessment:
   a. Complete an Authorization for Release of Information form with the mother;
   b. Contact the RFW provider to obtain an appointment date and time for the assessment to be completed and inform the mother;
   c. Complete the Ready for Work Referral and Confirmation of Appointment for Substance Use Disorder Assessment Form;
   d. Provide a signed copy of the form to the mother to bring to the assessment; and
   e. Provide a signed copy to the RFW provider.

   NOTE: When the mother is a Temporary Assistance for Needy Families Recipient (TANF), the mother has to sign the form acknowledging her understanding that the failure to attend alcohol and other drug assessment appointments may be considered failure to comply with her TANF Family Service Plan requirements.

6. Review the RFW substance use disorder assessment findings upon receipt from the RFW provider.

   NOTE: The RFW substance use disorder assessment will be completed by the RFW provider within 14 calendar days of the receipt of the completed Ready for Work Referral and Confirmation of Appointment for Substance Use Disorder Assessment Form.

7. Prepare for the Plan of Safe Care meeting:
   a. Analyze all information gathered, including:
      i. The mother’s illegal substances or alcohol use/abuse and the impact on the care and protection of the infant;
      ii. The mother’s individual functioning, including mental health, life management, relationships, parenting, etc.;
      iii. The infant’s care needs;
      iv. Functioning of other household members; and
      v. Current formal or informal supports.
   b. Initiate a staffing with the Social Services Supervisor to discuss information obtained and any recommendations, participants to include in the meeting, etc.; and
   c. Schedule the meeting and invite all identified participants.

8. Conduct the Plan of Safe Care meeting within five business days of receiving the RFW substance use disorder assessment findings:
   a. Engage the family, informal supports and formal supports (e.g., Babies Can’t Wait, medical professionals, substance abuse professionals, and RFW staff).
   b. Discuss recommendations for the plan of safe care to address:
      i. The well-being needs of the infant, including any special care needs and plans to address them, general day-to-day plan for caring for the infant, etc.;
      ii. The mother’s understanding of the special care needs of the infants and ability to provide such care;
iii. The mother’s substance use/abuse, including relapse planning;
iv. The impact of the substance abuse/use on the mother’s ability to protect and care for the infant and any other children in the home; and
v. The ability of any secondary mother(s) in the home to protect and care for the child(ren).

c. Identify and obtain agreement regarding responsible party for referrals, provision of services for the mother, infant and other children in the home. Identify the plan for ensuring the special needs of the infant are met.
d. Complete the written Plan of Safe Care using the Plan of Safe Care form.

**NOTE:** The written Plan of Safe Care is a plan of action to address the needs of the mother, infant and any other children in the home. The Plan of Safe Care must be uploaded in Georgia SHINES External Documentation.

9. Refer the mother for substance abuse treatment and/or any other recommendations from the substance abuse disorder assessment to mitigate any child safety concerns identified;

10. Refer or follow up with medical or other service providers regarding services for the infant;

11. Ensure implementation of the Plan of Safe Care by following up with the family and other parties involved in the plan.

12. Prior to closing a case involving caregiver substance use/abuse follow requirements and procedures outlined in policy 5.7 Investigations: Cases Involving Caregiver Substance Use or Abuse.

### PRACTICE GUIDANCE

#### Fetal Alcohol Syndrome Disorder (FASD)

The Child Abuse Prevention and Treatment Act (CAPTA) requires that healthcare providers identify and make referrals to CPS of newborns affected by prenatal drug exposure and that “plans for safe care” (safety, family and case plans that promote health and well-being) be developed for newborns affected by prenatal drug exposure or a Fetal Alcohol Spectrum Disorder.

FASD diagnostic conditions include:

- **Type I:** Fetal Alcohol Syndrome with confirmed maternal exposure.
- **Type II:** FAS without confirmed maternal exposure.
- **Type III:** Alcohol-related birth defects (ARBD)
- **Type IV:** Alcohol-related neurodevelopmental disorder (ARND).

Symptoms of FASD can include facial abnormalities, growth deficiencies, skeletal deformities, organ deformities, central nervous system handicaps and behavioral problems. These symptoms can have lifelong implications for children who were exposed to alcohol in the womb; however, some FASD children who receive special education and adequate social services are more likely to reach their developmental and educational potential than those who do not receive those services.

#### Prenatally Exposed Infants

Prenatally Exposed Infants are infants identified by a medical professional as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug abuse and/or exposure or a Fetal Alcohol Spectrum Disorder.

**NOTE:** Reports involving prenatal exposure or prenatal substance abuse that do not meet the definition of being “affected” must be assessed for other areas of child maltreatment and safety based on the mother’s functioning and child vulnerabilities related to substance use/abuse (see policy 4.1 Intake: Receiving Intake Reports for definition for prenatal abuse).
Ready for Work
Ready for Work is a part of the Division of Addictive Diseases under the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). The Division of Addictive Diseases is responsible for the prevention, treatment and recovery services. DBHDD has contracted with RFW providers to provide gender specific drug/alcohol screening, assessment, referral and treatment services for mothers in order to reunite them with their children and/or maintain family permanency; to keep children safe; to develop safe, nurturing and stable living environments for children as rapidly and responsibly as possible; and to provide addictive disease services to promote self-sufficiency and gainful employment of Georgia’s women who struggle with addiction. RFW does not provide treatment for fathers, but when assessing the mother, there will be an assessment of the mother’s needs as related to other household members. If treatment or services are needed for a father, then RFW will provide a referral for the particular service.

Rights and Duties of Legal Custodian
Per O.C.G.A. § 15-11-30, a legal custodian has the right to physical custody of a child, the right to determine the nature of the care and treatment of such child, including ordinary medical care, and the right to provide care, protection, training, and education and the physical, mental, and moral welfare of such child, subject to the conditions and limitations of the order and to the remaining rights and duties of such child’s parent or guardian.

Safe or Unsafe
Children are considered safe when there are no identified present danger situations or impending danger safety threats, or mother protective capacities are sufficient to control existing danger.

Children are considered unsafe when there is an identified present danger situation or impending danger safety threats, and mother protective capacities are insufficient to control existing danger.

Safety is not subject to degree; a child is either considered safe or unsafe. A child is not somewhat safe or conditionally safe when considering the circumstances of the home as the center of attention when making that judgment.

Substance Abuse
When substance use or abuse is alleged, determine if the mother’s use or abuse is impacting their ability to provide care and protection of their children. Urinalysis or hair follicle drug screens provide information concerning the presence of substances or un-metabolized substances, but do not provide information regarding parenting or ensure the safety or well-being of children. Child safety decisions regarding present danger situations and impending danger safety threats should be based on the specific mother protective capacities (see policy 5.7 Investigations: Case Management Involving Caregiver Substance Use or Abuse).

<table>
<thead>
<tr>
<th>FORMS AND TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization for Release of Information</td>
</tr>
<tr>
<td>Consent for State Criminal Records Check</td>
</tr>
<tr>
<td>Family Functioning Areas and Risk Assessment Tool</td>
</tr>
<tr>
<td>Georgia Impending Danger Safety Threat Assessment</td>
</tr>
<tr>
<td>Georgia Safety Plan</td>
</tr>
<tr>
<td>Georgia’s Six Family Functioning Areas Tool</td>
</tr>
</tbody>
</table>
I. STATEMENT OF POLICY

It is the policy of the Department of Children and Family Services to investigate all reports of substance exposed newborns. DCFS responsibility under federal and state law is to assure there are plans for the safe care for these vulnerable newborns.

II. PROCEDURES

This policy describes the special features of investigations involving drug and/or alcohol affected newborns, subsequent investigations of newborns with allegations of drug and/or alcohol exposure and drug/alcohol abuse allegations involving an infant who was harmed as a result of drug and/or alcohol exposure via breastfeeding. It is to be used in addition to Parts 1 through 10.

A. INVESTIGATION PLAN

The development of the investigative plan between the worker and the supervisor is required as per Section 4-500.D, Development of the Investigative Plan. The plan must include contacting the reporter and a review of prior Department history with particular attention to, and documentation of prior substance exposed newborns or other allegations of dependency due to substance abuse.

The plan shall also include the required contacts and activities for a Level One investigation for the Drug and/or Alcohol Affected Newborn allegation as well as any other allegations involving the newborn and any other children in the home either at the time of intake or during the investigation. The plan for a Drug/Alcohol Abuse allegation shall include medical verification of the drug/alcohol exposure. These requirements are in Section 4-520, Investigation Levels, and in Appendix 4-D, Minimum Contact Requirements. The following should also be included in the plan:

5 Verification of the prenatal drug and/or alcohol exposure may be provided by the physician and the hospital medical records;
5 Verification of prescription/legal use of the controlled substance by the mother (i.e. methadone or similar prescribed drugs) if applicable to case circumstances;
5 Documentation of the verification of the prescription/legal use of the controlled substance by the mother, including methadone or similar prescribed drug shall be obtained and attached to the CPS ACESS record;
5 Determination of the condition and any special needs of the newborn and any other children in the home;
5 Plan of Safe Care (determined with a present and impending danger safety assessment and, if necessary, a safety plan);
5 Review of the Departmental History to determine if the mother has a prior valid finding of drug and/or alcohol affected newborn; and
5 Contact with the biological father to determine his ability to care for the child and his knowledge regarding the mother’s substance use during her pregnancy.

*B. INITIATING THE INVESTIGATION

INITIAL CONTACTS

1. **Reporter**

The Child Protective Services (CPS) worker shall contact the reporter prior to initiation of the investigation to obtain any additional information needed about the condition of the mother and the newborn. If the reporter is unavailable or cannot be contacted prior to the initiation of the investigation, documentation of all attempts to contact the reporter shall be documented on the interview page in ACESS. In addition, a written report and the availability of the CPS-2 Form shall be discussed, if the reporter has not already provided a written report. The CPS-2 form shall be attached to the ACESS case prior to the closure of the case.

2. **Hospital/Medical Personnel**

When the investigation is initiated while the mother is hospitalized, the worker shall contact the charge nurse prior to interviewing the mother in order to advise hospital staff of the initiation of the investigation and to obtain information that may assist with the interview of the mother. The worker shall obtain the following information from the hospital medical staff:

5 The current condition of the newborn, gestational age (40 weeks is full term), birth weight, information on the alcohol/drug exposure, symptoms of withdrawal, medical problems, and any non-drug related concerns for the newborn;
5 Their observations of the mother’s behavior including possible alcohol/drug-related behavior, any pertinent statements by her, her care, bonding behavior or interest in the baby;
5 Any visits/interest in the mother and/or the newborn by father of the newborn, family, and friends along with their observations of the interaction between these persons and the newborn;
5. Conducting Investigations of Reports of Child Abuse and or
Neglect in Families

5. Conducting Investigations of Reports of Child Abuse and or
Neglect in Families

Documentation of the interviews with hospital staff shall contain observations of the
mother and/or father being under the influence of drugs or alcohol while the newborn is
in the hospital or have concerns about their ability to provide safe care for the newborn
at home. This documentation should be on the Observation Page in ACESS.

3. Mother of Newborn

Every attempt shall be made to prioritize the response in these cases to enable contact
with the mother prior to discharge from the hospital. If the Department receives the
report after the Mother’s discharge from the hospital, this shall be documented on the
Case Activity Sheet in ACESS.

There are times when the Department is not notified of the newborn’s positive drug
and/or alcohol screen until after the mother and newborn has been discharged or the
positive screen is not available at the time of discharge. In these types of situations, the
newborn and mother must be contacted within the Priority1 response priority to assess
safety and the plan of safe care.

If departmental history indicates the mother has a prior valid history with the Department
of an alcohol or drug exposed newborn, the CPS worker shall complete interviews as
required per policy to assess safety of the newborn and to assess the mother’s
protective capacities through information gathered in the six areas of assessment.

The interview with the mother (as well as later interviews with other professionals and
any other caretakers) shall include obtaining as much information as possible about the
mother's substance use, including both drugs and alcohol and any previous or current
substance abuse treatment. If the mother denies or appears to minimize her
drug and/or alcohol use, a family member or appropriate collaterals may be the best
resource for this information. It is recommended that all primary caregivers for the
infant be assessed for substance abuse. Assessment of substance use of other
persons in the home is essential for determining whether the newborn may be safely
cared for in his home.
The exploration of the mother’s plan for herself and her newborn shall include information about the newborn’s father and their current relationship, his interest and expected involvement with the newborn and any other children in the home, and any other caretakers available to assist her.

4. Father of the Newborn

The investigation contacts shall include an interview with the father of the newborn to determine his potential involvement in the care of the newborn and his knowledge regarding the mother’s substance use during pregnancy.

If he resides in the home or may be involved in the care of the newborn, he shall be assessed to obtain information regarding his use of drugs and/or alcohol. When indicated by the interview, self-report or other case information he shall be referred for a substance abuse assessment and/or services.

If the father is unknown or has not been identified, the worker is expected to discuss with the mother the importance of identifying the child’s biological father. Although he may not be involved with the mother, he may be a resource for child support. His family may be willing to assist her with the infant or become a placement resource if needed. Also, he and/or his family may be able to provide her with important genetic and family medical information. Information regarding the paternal family including names, relationships, addresses and a way to contact them should also be documented in ACESS.

5. Professional Collateral Contacts

Collateral contacts shall be made immediately or as soon as possible to provide more information regarding the mother’s substance use and her ability to provide safe care for the newborn. Contact with the mother’s obstetrician should be made to determine if the mother had positive drug screens during the pregnancy and if he/she discussed treatment options.

The second professional collateral shall include a hospital and/or home health staff person, social worker, Substance Abuse Clinician if the mother is currently participating in a substance abuse program or other professional staff who has observed the interaction between the mother and the newborn.

Additional collaterals may also include a professional or non-professional person (family member or friend) who has knowledge of the parents or family’s capacity to provide for the safety and wellbeing of the newborn and any other children in her care. The
decision regarding the additional appropriate collaterals shall be determined in consultation with the supervisor as per Section 4-520 B.

C. OTHER INVESTIGATION INTERVIEWS AND ACTIVITIES

A home visit is required to determine the suitability and safety of the home environment for both the newborn and any other children the mother is parenting. The CPS worker should document their observations of the family home on the Observation Page in ACESS. Observations should include whether the parent has prepared for the newborn with items such as a baby bed, diapers, clothing bottles and formula. If the mother/father has not prepared for the newborn, a discussion is required regarding their intention and financial ability to obtain the items needed for the baby. If the mother/father is unable to financially obtain the items needed for the newborn, the worker shall determine if departmental funds are available to assist the family. Department Staff shall ensure that safe sleeping arrangements are discussed with the parent and documented in the ACESS record.

The worker is expected to assess mental health issues and domestic violence within the family during the investigation. Other adult caretakers who are living in the home and will be caretakers shall also be assessed for their substance use, mental illness and domestic violence.

If the parent(s) is currently participating or has previously participated in a Substance Abuse treatment program, the worker shall obtain a release of information to contact the treatment facility to obtain information regarding the parent’s participation, compliance and drug screen results while in treatment. If the parent is currently participating in substance abuse treatment, the worker shall discuss with the Supervisor the clinician’s assessment and any treatment and/or referral recommendations. Whenever possible, the clinician should be included in planning for any needed treatment and referral; and, education for the mother, father and/or family about addictive disorders. The clinician may also act as a liaison with the worker and the treatment resource during the investigation and later with service providers. Information received from the substance abuse treatment facility and clinician shall be included in interviews in the ACESS program and documentation shall be attached to the ACESS case.

* The worker is expected to document the type of drug and/or alcohol dependencies alleged for each household member in the investigation case on the Drug/Alcohol Identification Page in ACESS by selecting the appropriate drug from the Drug Category list. **

Additional contacts and activities other than the minimum required for the investigation should be completed as needed to determine present and impending danger and/or case recommendations to reasonably assure both the safety of the newborn and access to available services to address his needs.
D. SAFETY ASSESSMENT

The Present Danger Assessment begins immediately and must be completed with Supervisory consultation and approval within 24 hours of initial contact. The worker must enter the present danger assessment and, if necessary, the present danger plan into ACESS within 72 hours of the initial face-to-face contact. When the worker enters the Present Danger assessment into ACESS, the activity date field shall be recorded as the date the assessment and, if necessary, the present danger plan was actually completed rather than the date of ACESS entry. When the supervisor approves the assessment and plan, the activity date field shall be the date of the consultation with the worker rather than the date the assessment was approved in ACESS. The present danger safety assessment includes the safety of the newborn in the hospital. Refer to *CW** Policy 4-516 Safety Assessments for detailed information regarding assessing the safety of drug and/or alcohol affected newborns.

The high risk safety protocol also applies to cases alleging drug and/or alcohol affected newborns. Child Welfare Managers must participate in a staffing with the worker and supervisor within 3 business days or 96 hours, whichever occurs first, of the completion of the Present Danger Assessment.

If the decision is that the infant is safe, the investigation shall continue according to policy which requires among other things, a substance abuse assessment by a substance abuse clinician within 30 days. If the timeframe cannot be met due to a lack of available resources, the safety of the child must be reassessed weekly by the worker, documented in the Department record, and approved by the Supervisor.

If at any time a parent(s) responsible for the child’s care is not compliant with the safety or case plan, the child’s safety must be reassessed.

If the newborn is determined to be safe after the present danger assessment is conducted, a mandatory referral to Family Services is required within 5 days of initial contact. The transfer staffing should take place prior to the newborn leaving the hospital if possible. The FS worker will be responsible for weekly contact with the family until the substance abuse evaluation can be completed.

Whenever there are supports to the mother and/or treatment services available, the newborn may be able to be discharged to his mother’s care with a plan that includes necessary services and careful monitoring of the child’s safety. Services such as home health, Homebuilders (where available), substance abuse treatment and assistance from a spouse/partner or family member may provide sufficient safety for the newborn to remain with his family.

Workers should not assume that an out of home placement is necessary for all drug and/or alcohol affected newborns.
If the Present or Impending Danger assessment indicates that the child is unsafe, a safety plan must be put into place immediately. The safety plan may be either an in-home safety plan, an instanter safety plan, or an out of home safety plan (foster care through court order). If an in-home safety plan is determined to be appropriate, BGC shall be consulted by close of business the following working day to assess the need for the instanter safety plan or protective order (LA Ch.C. Article 618) or the filling of a petition. If an in-home safety plan is in place, the case must be transferred to FS and a staffing must be held with the Child Welfare Manager within 72 hours of the completion of the safety plan.

For cases in which the Department has a prior valid substance exposed newborn and the newborn can be safely maintained in the home with a protective order or an instanter safety plan order, the worker shall contact BGC immediately to determine the appropriate court intervention. If the child cannot be safely maintained in the home with an in home safety plan, the worker shall request custody of the newborn.

If the Instanter Custody Order is granted and at the Continued Custody hearing, the newborn is returned to the parents, the CPS Worker shall be responsible for transferring the case to Family Services within 24 hours of the continued custody hearing. The CPS Worker, CPS Supervisor, Foster Care Worker, Foster Care Supervisor, Family Services Worker and Supervisor, and Child Welfare Manager for CPS/FS shall attend the transfer staffing. The need for an Instanter Safety Plan Order shall be discussed at the Staffing. The CPS Worker shall request a petition be filed with the court of jurisdiction to court order Family Services. If the Court does not order Family Services, the CPS Worker shall encourage the parents to cooperate with Family Services. If the parents refuse to cooperate, the reason the parents refuse to cooperate shall be documented in the ACESS record.

Court intervention shall be requested when families refuse to participate in completing the substance abuse assessment or Family Services and the present/impending danger safety assessments indicate the newborn is unsafe and an in-home safety plan cannot assure safety.

The Impending Danger Safety assessment shall occur within 30 days of receipt of the case. If an impending danger plan is necessary, the plan shall be approved by the supervisor and attached to the ACESS case. When the worker enters the Impending Danger assessment into ACESS, the activity date field shall be recorded as the date the assessment and, if necessary, the impending danger plan was actually completed rather than the date of ACESS entry. When the supervisor approves the assessment and plan, the activity date field shall be the date of the consultation with the worker rather than the date the assessment was approved in ACESS.
E. RISK ASSESSMENT AND CASE RECOMMENDATIONS

The worker in consultation with the supervisor shall assess the potential risk of longer-term harm to the newborn and any other children in the home using the Structured Decision Making Initial Risk Assessment as per policy Section 4-525 D., Assessment of Risk. It is accessed via the SDM hyperlink on the navigation bar of the ACESS investigation case. The information obtained during the investigation used to complete risk factors R5 through R16 is documented on the Observations page of the ACESS investigation case.

F. FINAL FINDING STAFFING

When the allegation is drug affected newborn, the final finding validity decision is determined by the physician’s statement or laboratory confirmation of the evidence of the prenatal drug exposure (effects, withdrawal and/or positive toxicology report) and that the drug exposure was the result of illegal drug use by the mother.

An allegation of alcohol affected newborn is also determined by the physician’s verification of the effects on the newborn, diagnosis of Fetal Alcohol Syndrome, or a positive toxicology report for the newborn.

* If there is a diagnosis from a physician of Neonatal Abstinence Syndrome (NAS) or Fetal Alcohol Spectrum Disorders (FASDs), the diagnosis should be documented in ACESS in the Diagnosis section located in the Drug/Alcohol Category. **

When the infant was exposed to drugs and/or alcohol via breastfeeding, the physician will also verify the harm to the infant. This information may be known at intake.

The investigation decision making must also include appropriate allegations of the drug and/or alcohol newborn as well as other children in the home. If the worker finds abuse/neglect of these children, the appropriate allegations shall be included in the investigation.

If the mother obtained the drug legally, the finding for drug affected newborn is invalid. Documentation of the verification of the prescription/legal use of the controlled substance by the mother, including methadone or similar prescribed drug shall be obtained and attached to the CPS ACESS record.

G. SERVICE REFERRAL AND TRANSFER STAFFINGS BETWEEN PROGRAMS

Families with a drug and/or alcohol affected newborn identified during the DCFS investigation process are referred to Family Services for continued assessment unless the newborn has been placed in foster care. A transfer staffing shall be held to include the CPS Worker, CPS Supervisor, FS Worker, FS Supervisor, and if required, the Child Welfare Manager.
If the newborn is placed in foster care, the transfer staffing should be held as soon as possible but within timeframes allowed in foster care policy. The CPS Worker, Child Protection Services Supervisor, Foster Care Worker and Supervisor and the Child Welfare Manager should be attendance at the transfer staffing.

When the case is transferred to either Family Services or Foster Care, the CPS Worker and Supervisor should participate in the 30 day staffing for Family Services or the pre-FTC staffing with Foster Care.

The CPS worker/supervisor is expected to provide the following if available at the time of the transfer staffing:

5. Print out of the ACESS investigation case
5. CW Safety Assessment (present and impending danger assessments)
5. Any present and/or impending danger safety plans (DCFS CW Present Danger Safety Plan or Impending Danger Safety Plan) when completed with the family
5. DCFS CW Form 10 or other investigation information for emergency referrals
5. Initial Structured Decision Making (SDM) Risk Assessment.

The CPS Worker should discuss the following available information during the staffing and should be further documented in the Assessment of Family Functioning (AFF) process by the Family Services or Foster Care Worker:

1. The infant’s drug or alcohol exposure as verified by toxicology and meconium reports of infant, toxicology reports on mother, or observable harmful effects as verified by a physician
2. Parental protective capacities (including any diminished protective capacities) of mother and any other adult caregivers both in and out of the home
3. Review of safety assessments (current and impending danger) and safety plan, as applicable
4. SDM Initial Risk Assessment include information such as previous assessments and reports with valid findings, history of child abuse/neglect, mental illness and substance abuse in applicable domains
5. Status of substance abuse assessment of mother and when indicated, father or other adult caregiver
6. Pre-natal care history and mother’s substance use during this pregnancy and any indication of substance use during any previous pregnancies (include information in Child’s Needs)
7. Post-natal information including the infant’s current condition and/or special needs or disabilities
8. Recommendations for care and any referrals at discharge such as home health
9. Information on Parent’s mental health concerns such as post-partum depression and any co-occurring disorder
10. Evidence of preparation for the infant, such as a crib and clothing
11. Presence of other children in the home and their current care and condition
12. Family system, strengths, involvement of infant’s father and other family members, any history of agency involvement (investigations with valid findings, FS, FC, etc.), and parental ability to use services to improve conditions
13. Services and/or referrals, including Early Steps or Maternal, Infant and Early Childhood Home Visiting services, provided during the investigation
14. Assessment of parental attachment (bonding and ability to parent infant and any other siblings) of the mother, and fathers of the infant and other children in the home
15. Name and contact information for the father and other relatives of the infant/children in the home

The case may be closed without a referral to FS in the following circumstances:

5. Custody has been transferred to a relative or other person as the permanent plan, the mother will not be caring for the infant and will not have unsupervised visitation with the infant; or

5. The mother has surrendered the infant for adoption.

Additionally, service needs are to be discussed during validity and transfer staffings.

H. ADDITIONAL SERVICE REFERRALS

1. Early Intervention Program

The newborn must be referred to an early intervention program to assure compliance with the Federal Child Abuse Prevention and Treatment Act requirement for referral for children under age three who are at risk for a developmental delay and/or is a victim of abuse/neglect.

If the health care provider does not refer the newborn to an early intervention program, the worker is expected to refer the family to the Office of Public Health (OPH) Early Steps Program as per policy Section 4-800 C. 2., Early Intervention Services for Children Under Age Three. The worker is expected to follow-up with Early Steps to assure the referral was received to determine if services have been initiated or the child is on the waiting list for services. The worker should document the confirmation of the referral to Early Steps an Interview form in ACESS.
2. **Emergency Referrals**

Families should be referred for emergency services with DCFS or Family Resource Centers as needed when the plan of safe care is a newborn’s family.

A referral for substance abuse treatment services shall be initiated during the investigation when the mother is not already in a treatment program. Staff may use the ACESS Request for Services tool and/or local procedures for referrals to identify potential service providers.

3. **Homebuilder Services**

Homebuilders may be an appropriate referral for the newborn’s family both when the newborn is discharged to his family’s care and with an out of home placement when the permanency plan is for reunification of the family. The services may prevent an out of home placement or permit a newborn in foster care to be cared for by his biological family during the time a Homebuilders worker is in the home. Homebuilders may be appropriate when the services are available, the foster parent or other person can provide transportation for the newborn to visit with his family for the period of time that the worker is in the home, working with the family and the permanency plan is reunification.

I. **CASE CLOSURE WITH COMPLETION OF THE INVESTIGATION**

The case is closed once the following are completed:

5. Investigation contacts and activities completed;
5. The investigation findings, decisions, recommendations, and the plan of safe care are documented in ACESS;
5. Creation of the Form 10 in ACESS for all final findings;
5. The parent/caretakers notified of the findings;
5. Appropriate referrals completed;
5. Report to the District Attorney completed when the finding is valid; and
5. Case transferred as needed.

III. **FORMS AND INSTRUCTIONS**

[CPS-2](#)Written Report Form for Mandated Reporters of Child Abuse Neglect
[CW Form 5-CSP](#) Court Ordered Safety Plan
[CW Form 5-ID](#) Impending Danger Safety Plan
[CW Form 5-PD](#) Present Danger Safety Plan
**IV. REFERENCES**

* Refer to Section 4-512 Initiation of the Investigation with the Parent or Caretaker **
Refer to Section 4-555, Local Office Follow-up Notifications
Refer to Section 4-560 (Case Closure – Invalid, Unable to Locate, Client Non-cooperation Final Findings)
Refer to Section 4-565 (Valid Final Finding Activities, Referral to District Attorney and Case Closure)
Refer to Section 4-570 (Valid Final Finding Status Activities/Referral and Transfer to Family Services)
Refer to Section 4-580 as appropriate for the investigation finding
Purpose: The Bureau has the responsibility to respond to reports from health care providers that an infant has been born that is affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure to either legal or illegal drugs regardless of whether the infant is abused or neglected. Once a report is received the Department must assure a plan of safe care for the infant.

Legal Base: Sec. 1. 22 MRSA §4004-B (See Appendix I)

Intake: Reports of drug-affected infants will be received at the centralized Child Protective Services Intake Unit and recorded in the same manner as all reports.

All reports from health care providers alleging that an infant has been born that is affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure (legal or illegal substances) will have the report type of "drug affected baby." This type of report is selected even if there are also allegations of suspected abuse.

All reports of the type "drug affected baby" are appropriate and are sent to the District.

Intake will gather the following information from the healthcare provider making the report:

- Which substances affected the infant?
- What is the impact of the drugs on the infant?
- Withdrawal
- Long-term
  - Medical care the infant is now receiving
  - Medical care the infant will require in the immediate future
  - Plan of care for the infant at discharge
    - Is the mother receiving substance abuse or other services and if so who are the providers?
    - Was the mother under the influence of substances at the time of admission? At the time of birth?

The Intake caseworker will seek to obtain information on the following risk factors:

- Homelessness/transience
- No preparation by mother and/or father for the infants care and protection
- Other children of the mother in the care of others (long term)
The intake caseworker will seek to obtain information about the presence of protective factors:

- Is actively engaged in substance abuse and/or other services
- Received prenatal care
- Demonstrates appropriate responsiveness to the infant
  - There is evidence of a support system for the infant and mother (family, church, community based services)
- Successfully parenting other children

Once the report is received and recorded the report will be sent to the appropriate District.

**District Responsibilities**

- Upon receipt of a report of a drug affected baby **absent** allegations of abuse or neglect, the unit supervisor will either (in final decision)
  - Refer it to a CIP agency
  - Refer it to Public Health Nursing
- Upon receipt of a report of drug affected baby that includes allegations of abuse and neglect, the case will be opened as a Safety Assessment.

Cases where the infant and/or the mother has had, does have, or is likely to have medical needs should be referred to Public Health Nursing or the visiting nursing program serving the area where the family is residing.

No matter who does the fact finding the following **determinations** must be made.

- That the infant was affected by or addicted to one or more substances
- Whether the infant received appropriate medical care immediately after birth
- That there is or is not a safe plan of care for the infant in the immediate future.

When a Safety Assessment is completed the above determinations must be made and recorded in the Decision Window.

The district will clearly communicate to the referral source the requirement to record in their records the above determinations. They will also be informed that:

If a family refuses to work with the CIP or visiting nurse agency, the agency must report that immediately to the District Office. If that occurs the report will be opened by the District and an assessment process will take place and be documented in the narrative log of the report. The assessment requires that enough information be gathered to make the above three determinations.

Sec. 1. 22 M.R.S.A. § 4004-B is enacted to read:

§ 4004-B. Infants born affected by substance abuse or after prenatal exposure to drugs.
The Department shall act to protect infants born identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure (whether or not the prenatal drug exposure was to legal or illegal drugs), regardless of whether the infant is abused or neglected. The Department shall:

A. Receive reports of infants who may be affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure;

B. Promptly investigate all reports received of infants born who may be affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure;

C. Determine whether each infant reported is affected by illegal substance abuse or suffers from withdrawal symptoms resulting from prenatal drug exposure;

D. Determine whether the infant is abused or neglected and, if so, determine the degree of harm or threatened harm in each case;

E. For each infant whom the Department determines to be affected by illegal substance abuse or to be suffering from withdrawal symptoms resulting from prenatal drug exposure, develop, with the assistance of any health care provider involved in the mother's or the child's medical or mental health care, a plan for the safe care of the infant, and, in appropriate cases, refer the child or mother, or both, to a community organization or voluntary preventive service;

F. For each infant whom the Department determines to be abused or neglected, comply with section 4004, subsection 2, paragraphs E and F.

Sec. 2. 22 M.R.S.A. § 4008, sub-§ 3," I and J are enacted to read:

I. Any government entity that has a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect. For purposes of this paragraph, "government entity" means a federal government entity, a state government entity of any state, and a local government entity of any state or locality, or an agent of a federal, state or local government entity; and

J. To a juvenile court when the child who is the subject of the records has been brought before the court pursuant to Title 15, Part 6 (the Maine Juvenile Code).

Sec. 3. The bold heading of 22 M.R.S.A. § 40II - A is amended to read:

§ 4011 - A. Reporting of suspected abuse or neglect or prenatal exposure to drugs.

Sec. 4. 22 M.R.S.A. § 4011 - A, sub-§ I - A is enacted to read:

I-A. Reporting of infants with prenatal exposure to drugs. Any health care provider involved in the delivery or care of an infant whom the provider knows or has reasonable cause to suspect has been born affected by illegal substance abuse or suffering from withdrawal symptoms resulting from prenatal drug exposure (whether or not the prenatal drug exposure was to legal or illegal drugs) shall notify the Department of that condition in the infant.

The report required by this sub-section shall be made in the same manner as reports of abuse or neglect required by this subchapter.

A. For purposes of this sub-section, "health care provider" means a person described in items (1) through (10), (15), (17) through (20), or (22) of subsection 1, or any person who assists in the delivery or birth of a child for compensation, including, but not limited to, a midwife.

B. This subsection, and any notification made pursuant to this subsection, shall not be construed to establish a definition of what constitutes abuse or neglect.
This subsection, and any notification made pursuant to this subsection, shall not be construed to require prosecution for any illegal action, including but not limited to the act of exposing a fetus to drugs or other substances.
DEPARTMENT OF HUMAN RESOURCES
SOCIAL SERVICES ADMINISTRATION
311 W. SARATOGA STREET
BALTIMORE, MARYLAND 21201

DATE: September 16, 2011
CIRCULAR LETTER: SSA# 12-17
TO: Directors, Local Department of Social Services
     Assistant Directors of Services
FROM: Carnitra D. White
     Executive Director
     Social Services Administration
RE: Maryland Substance Exposed Infant Care Plan
PROGRAMS AFFECTED: In-Home Family Services
ORIGINATING OFFICE: In-Home Family Services
BACKGROUND: The CAPTA Reauthorization Act of 2010 (P.L. 111-320) requires Statewide policies and procedures that address the needs of infants affected by illegal substance abuse or a Fetal Alcohol Spectrum Disorder (FASD). This policy directive supersedes the previous policy directive SSA# 09-21.
ACTION REQUIRED OF: In-Home Family Services
REQUIRED ACTION: Operationalize the revised policies and procedures involving the provision of services to substance exposed infants and their families Statewide beginning October 1, 2011.
ACTION DUE DATE: October 1, 2011
CONTACT PERSONS: Steve Berry, Program Manager
                  In-Home Services
                  410-767-7018
I. PURPOSE:

The “Keeping Children and Families Safe Act” of 2003 (P.L.108-36) that amended and reauthorized the Child Abuse Prevention and Treatment Act (CAPTA) included three requirements regarding the identification and referral of infants affected by illegal drug use. “The CAPTA Reauthorization Act of 2010” (P.L.111-320) adds to these requirements infants born and identified as affected by Fetal Alcohol Spectrum Disorder.

This revised legislation requires states to have in place Statewide policies and procedures to address the needs of infants born with and identified as being affected by

1) illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure; or

2) a Fetal Alcohol Spectrum Disorder.

Health care providers involved in the delivery or care of such infants are required to notify the child protective services system except that such notification shall not be construed to establish a definition under Federal law of what constitutes child abuse; or to require prosecution for any illegal action (CAPTA, § 106(b)(2)(A)(ii)).”

The CAPTA provisions also require states to develop

- procedures for immediate screening, risk and safety assessment, and prompt investigation of such reports; and

- a plan of safe care for the infant

SSA has distributed three Circular Letters (SSA# 04-16 in June 2004; SSA# 08-6 in January 2008; and SSA# 09-21 in June 2009) to clarify questions that arose about the differences in terminology between Maryland law and CAPTA. The purpose of this policy directive is twofold:

1) to clarify the policies and procedures that govern the Statewide implementation of the Maryland Substance Exposed Infants Care Plan; and

2) to provide guidance to child protective services staff in responding to reports regarding substance exposed infants.
II. PHILOSOPHICAL FRAMEWORK

Child Protective Services (CPS) is a child-centered, family-focused service in which the protection and safety of the child is the primary goal. In all CPS cases, including those in which substance use on the part of a parent is a factor, it is necessary to assess risk to the child and to determine whether the child may remain safely in the home while treatment and services are provided to ameliorate the conditions which place the child at substantial risk of harm.

A basic principle of the child welfare system is that children grow and develop best in a loving family that provides nurturing care. Inherent in this principle is the need to make reasonable efforts to keep families together and to place children out of their homes only if their safety and well-being cannot be ensured within their families.

Alcohol and illegal substance use, either during pregnancy or after the birth of an infant, does not in and of itself constitute evidence of abuse or neglect in Maryland. Parents use alcohol and/or drugs, including legal and illegal drugs, to varying degrees. In some cases, parents may remain able to care for their child without harming the child. It is commonly acknowledged, however, that the abuse of alcohol and/or drugs by parents increases the concern for the immediate safety of the child and for the risk of harm to the child. When the problem is identified, a careful evaluation needs to be made of the impact that the alcohol and/or drug use might have on the parent’s capacity to care for the child and the ability to ensure the child’s safety and well-being. Such an evaluation will determine whether the child is at substantial risk of harm.

III. SUBSTANCE EXPOSED INFANT CARE PLAN PROCESS

Local departments of social services (LDSS) shall identify a coordinator who will implement the Substance Exposed Infant Care Plan within their agency. The coordinator shall form a team of staff who have experience working with families with alcohol and drug abuse problems and who have a working knowledge of child protective services including investigation, continuing services, and foster care services.

The coordinator shall also form a team with all partnering agencies, including hospital(s), the health department’s divisions of maternal and child health and of addictions and mental health, treatment providers and other agencies who share these clients. This team shall meet on a regular basis to coordinate services for substance exposed infants, their mothers, and families, and to identify resources, barriers to care, and gaps in services. The team’s goal is to streamline services so that agencies do not duplicate services or work at cross purposes.
The team shall also determine how the mother’s alcohol and/or drug use problem can be assessed in an expedited manner. In some jurisdictions the Temporary Cash Assistance (TCA) addictions specialist can be utilized to complete an alcohol and drug assessment. In the larger jurisdictions LDSS staff shall explore with hospital and local health department addictions staff how these assessments can be completed, treatment plans developed, and referrals made to the appropriate level of care in the quickest way possible. When Family Involvement Meetings are scheduled, it is recommended that the addictions specialist who has completed the alcohol and/or drug abuse assessment be included to assist in planning and coordination of services.

IV. SCREENING A REFERRAL

Upon receiving a referral from a hospital of a substance exposed infant, screeners in local departments shall use structured decision making to determine what risk factors have been identified in the hospital that place the infant at substantial risk of harm. It is not necessary for injury to have occurred.

In addition to conditions in the infant, conditions or behaviors in the mother or father that may indicate risk of harm include, but are not limited to:

- special medical and/or physical problems in the newborn infant;
- close medical monitoring and/or special equipment or medications needed by the newborn infant;
- no prenatal care or inconsistent prenatal care;
- previous delivery of drug-exposed newborn infant;
- prior CPS history;
- prior removal of other children by the courts;
- no preparations for the care of the infant;
- intellectual limitations that may impair the mother’s ability to nurture or physically care for the child;
- major psychiatric illness or chronic history of depression or anxiety;
- home environment that presents safety or health hazards;
- evidence of financial instability that affects the mother’s ability to nurture or physically care for the child;
- limited or no family support;
- young age, coupled with immaturity;
- parenting skills demonstrated in the health care setting that suggest a lack of responsiveness to the newborn infant’s needs (i.e., little or no response to infant’s crying, poor eye contact, resistance to or difficulties in providing care);
- domestic violence.
VI. REQUIREMENTS OF THE INVESTIGATION

The investigation must include the following:

- Contact with the reporting person to determine whether the mother and/or infant’s toxicology tests were positive for alcohol or illegal drugs; to identify any needed medical treatment for the infant or mother; to assess the mother’s attitude and behavior with the infant; to determine the expected discharge dates of the mother and infant; and to determine whether there are other children in the home.

- Complete a MD CHESSIE check to obtain history of CPS involvement with the mother.

- Interview the parents to determine their willingness and capacity to provide adequate care of the infant and any other children in the home.

- Refer the mother, and if necessary, the father for a substance abuse assessment if not completed in the hospital.

- Contact relatives of the parents to determine their suitability as resources if placement is needed.

- Complete a Safety Assessment for Every Child (SAFE-C) prior to the discharge of the infant from the hospital, or if not possible, within five (5) days of discharge. When a safety plan is developed, the caseworker must take the necessary steps to assure the safety and well-being of the child. If the infant is in need of the protection of the Juvenile Court, follow normal procedures for removal and petitioning the court.

- Staff will follow standard neglect investigation procedures in all cases accepted for investigation, including an assessment of any other children in the home and under the care of the birth mother. Should circumstances warrant, transfer the case to continuing services.

- Alcohol and/or drug use, either during pregnancy or after the birth of an infant, does not in and of itself support a finding of indicated neglect.
DEPARTMENT OF HUMAN RESOURCES
SOCIAL SERVICES ADMINISTRATION
311 WEST SARATOGA STREET
BALTIMORE, MARYLAND 21201

DATE: October 1, 2013

POLICY: SSA# 14-11

TO: Directors, Local Department of Social Services
   Assistant Directors of Services

FROM: Camitra D. White, Executive Director
   Social Services Administration

RE: Substance-Exposed Newborns

PROGRAMS AFFECTED: Child Protective Services, In-Home Services, Out of Home Placement, Consolidated Services, Non-CPS Services

ORIGINATING OFFICE: Office of Child Welfare and Adult Services Programs

ACTION REQUIRED OF: All Local Departments

REQUIRED ACTION: Implementation of Substance-Exposed Newborn Program

ACTION DUE DATE: October 1, 2013

CONTACT PERSONS: Deborah Ramelmeier, Deputy Executive Director
   Child Welfare and Adult Services Programs
   410-767-7506
debbie.ramelmeier@maryland.gov

   Steve Berry, Manager
   In-Home Services
   410-767-7018
   sberry@maryland.gov
PURPOSE:

The purpose of this policy is to provide direction as to the implementation of the Substance-Exposed Newborn Program.

BACKGROUND:

When Congress reauthorized and amended the Child Abuse Prevention and Treatment Act (CAPTA) in 2003 (P.L. 108-36) and in 2010 (P.L. 111-320), certain provisions were added in regard to the reporting of substance-exposed newborns. The revised laws require states to have policies and procedures to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure or affected by a fetal alcohol spectrum disorder (FASD). The laws also include a requirement for health care practitioners involved in the delivery or care of substance-exposed newborns to notify the child protective services (CPS) system of these infants. The laws specifically prohibit the notification to be construed as establishing a definition under federal law of what constitutes child abuse or neglect, or to require prosecution for any illegal action.

The CAPTA provisions also require states to develop procedures for:

- the immediate screening of a report of the birth of a substance-exposed newborn;
- the prompt investigation of such reports;
- the completion of assessments of safety of and risk to the newborn; and
- the development of a plan of safe care for the substance-exposed newborn.

Through a series of policy directives since 2004, DHR/SSA has developed statewide policies and procedures that provide guidance to CPS staff in the local department of social services (LDSS) responding to hospital referrals of newborns affected by prenatal exposure to illegal drugs. In the summer of 2012 DHR developed and proposed legislation with the support and participation of the Maryland chapters of the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the Maryland Hospital Association. Bringing Maryland law into full compliance with federal law, the legislation was passed and signed into law in May by Governor Martin O’Malley. Family Law §5-704.2, Annotated Code of Maryland, requires health care practitioners who deliver or care for infants affected by prenatal exposure to controlled substances or by a FASD to notify a LDSS.

OVERVIEW:

Definitions:

"Controlled drug" means a controlled dangerous substance include in Schedules I through V under Title 5, Subtitle 4 of the Criminal Law Article, Annotated Code of Maryland.

"Fetal Alcohol Spectrum Disorder" (FASD) is an umbrella term for the wide range of effects from prenatal alcohol exposure, including a broad array of physical defects and cognitive, behavioral, emotional, and adaptive functioning deficits.
'Health care practitioner" has the meaning stated in Health Occupations Article, §1-301, Annotated Code of Maryland.

"Newborn" means a child less than 30 days old who is born or who receives care in the state.

"Substance-exposed newborn" means a newborn:

- Who has a positive toxicology screen for a controlled drug as evidenced by any appropriate test after birth;
- Who displays the effects of controlled drug use or symptoms of withdrawal resulting from prenatal controlled drug exposure as determined by medical personnel;
- Who displays the effects of a FASD; or
- Whose mother had a positive toxicology screen for a controlled drug at the time of delivery.

Information to be Reported by Hospitals

The law and regulations require individuals who make a report, usually the hospital social worker, to provide the following information:

- The name, date of birth, and home address of the newborn;
- The names and home addresses of the newborn's parents;
- The nature and extent of the effects of the prenatal alcohol and controlled drug exposure on the newborn;
- The newborn's medical condition and any current or ongoing health care needs, including an extended hospital stay prior to discharge, specific medical procedures, medication, specialized equipment, or the need for more frequent monitoring;
- Whether and when the newborn's mother had prenatal care;
- The nature and extent of the mother's current drug use;
- The nature and extent of the impact of the alcohol and controlled drug use on the mother's ability to provide proper care and attention to the newborn;
- The extent to which the mother is responsive to the newborn's needs and is involved with providing care;
- The nature and extent of any history of mental illness, intimate partner violence; or cognitive limitations; or
- Any other information that leads the reporter to believe that the newborn is at substantial risk of harm.

Screening protocols:

Reports of substance-exposed newborns are accepted as a child protection referral. Historically all local departments were either able to accept referrals of substance exposed newborns as either CPS reports or screened out referrals, based on the nature of the allegations. As of October 1, 2013, all local departments are MANDATED to accept all reports of substance exposed newborns for either a CPS response or a Non-CPS assessment.
LDSS screening staff should:

1- Take full and thorough information from the caller;
2- Hospitals are provided a form to facilitate collection of information;
3- Remind the caller to send a copy of the form to the LDSS within the required 48 hours;
4- Using Structured Decision Making (SDM) properly categorize the concern/allegation;
5- On the Demo tab check Substance Exposed Newborn or FASD which will automatically check the Substance-Exposed Newborn under Risk of Hann on the Maltreatment tab of the SDM;
6- Check any other appropriate maltreatment that is reported on the Maltreatment tab as well;
7- If only items under Risk of Hann are checked the system will categorize the report for a Non-cps response;
8- If other items are checked the system will categorize the report to be screened in for a CPS response;
9- Recommendation override functionality remains the same.

MD CHESSIE Screen Shots

The term "drug exposed" will be changed to "substance-exposed" in MD CHESSIE and Business Object reports. If "substance-exposed newborn" or "FASD" is the only item selected (no other allegation of abuse or neglect), the case MUST go to an assessment track, not a CPS response.
Selections have been added for Substance-Exposed Newborn, Fetal Alcohol Spectrum Disorder, Substance Class and Other Substances.
A 1350 warning message will appear if the Referral Type of Non-CPS is made and Substance-Exposed Newborn and/or Fetal Alcohol Spectrum Disorder is checked on the Demo tab.
The SEN checked on the Demo tab auto-populates to the Maltreatment tab under Risk of Harm.
The Screening Decision tab contains a new radio button labeled "Accept as a Non-CPS: Only Risk of Harm type is marked."
The Screening Decision tab and Final Screening Decision portion of the screen shows a new radio button: "Accept as Non-CPS: Risk of Harm is the only maltreatment type marked. Complete Section 3 labeled Response Time Decision."
CASEWORK PROCESS

Time Frames:

Within 48 hours after receiving the report, staff from the LDSS shall:

- See the newborn in person;
- Consult with a health care practitioner with knowledge of the newborn's condition and the effects of the prenatal alcohol or drug exposure; and
- Begin to interview the newborn's mother and any other individual responsible for care of the newborn and make an appointment to make a home visit.

When a referral of a substance-exposed newborn meets the criteria for child abuse or neglect and is "screened in", a caseworker shall go to the hospital within 48 hours after receiving the report, see the newborn, consult with hospital staff, and begin to interview the mother and any other individual responsible for care of the newborn. As a CPS Investigation all other standard timeframes and procedures apply. If the mother has an open CPS Investigation and a new report is accepted, that new report will go to the active Investigation worker. That worker needs to meet the requirements written above within 48 hours. If the mother has an active case in In-Home Services, a new report of maltreatment will be opened in CPS. All existing policies apply.

When the referral is opened as a non-CPS case, the 30 day assessment period is used to either provide services for a family that can be addressed within 30 days or to evaluate a family's need for ongoing services. A referral to ongoing Consolidated In-Home Services (CIHS) can also be made at any time should safety and/or risk assessments classify the family as in need of CIHS. The case will be closed when the service requested has been provided either by the agency or by referral to a community service.

Assessment Procedure:

The report for a Non-CPS assessment is a collaborative effort that involves the family in all conclusions and recommendations for service provision. Workers shall ensure that parents and children are approached in a non-adversarial manner and allow all family members to participate in the assessment process. Ensuring the safety of the newborn and assessing the risk of maltreatment must always be paramount in all interactions with the family. The tenets and procedures related to Family Centered Practice are to be applied in the work with the family.

The report requires a full family assessment, which includes:

- Complete Safety Assessment for the newborn and ALL children in the household within 7 working days of case acceptance;
- Complete Risk Assessment within 30 days of case acceptance;
- Evaluate child's home environment during the home visit;
- Discuss with child's caregiver and family members their service needs;
• Identify a resource if needed for a substance use assessment and work with the family to set up an appointment;
• Assess the need for additional resources and services and determine whether case should be transferred to CIHS.

If any of the children are "conditionally safe" (per SAFE-C) or the risk assessment indicates moderate-high risk, the case should be transferred to Consolidated In-Home Services (CIHS) for continued service provision.

At any time the assigned worker can petition the court for shelter of any child in the household when the circumstances and safety and risk assessments indicate that it is necessary. The worker can also petition the court if safety concerns appear high and the family refuses to allow access to the child or to participate in the completion of the assessments. Any new allegation of abuse or neglect must be reported to CPS screening.

Completion of Assessment and Case Closure

Within 30 days after a report of a substance-exposed newborn has been accepted for a Non-CPS assessment, the caseworker shall complete the In-Home Services Progress Review form that describes the family situation and recommendation for services.

Services shall be discontinued and the case closed at any time when:

• The family declines to accept services and there are no safety issues regarding the children in the home nor grounds to sustain a Child In Need of Assistance petition;
• The family has been linked to appropriate community resources to stabilize the family and does not need ongoing services from the Department; or
• The issues that brought the family to the Department's attention have been resolved, and there is no current need for services.

All case information will be maintained in MD CHESSIE.

Jurisdictions with Alternative Response (AR) and Investigation Response (IR) tracks

As jurisdictions go 'live' with Alternative Response, reports of Substance Exposed Newborns accepted for a CPS response can be categorized as either AR or IR depending on information provided in the report or known to the LDSS. Policy Directive SSA# 13-13 applies.
Title 07
DEPARTMENT OF HUMAN RESOURCES
Subtitle 02 SOCIAL SERVICES ADMINISTRATION

07.02.08 Substance-Exposed Newborn Safe Care Plan

Authority: Family Law Article, §5-704.2, Annotated Code of Maryland
(Federal Authority: U.S.C. 42 §5106b)

Notice of Proposed Action
[13-290-P]

The Secretary of the Department of Human Resources proposes to adopt new Regulations .01—.06 under a new chapter, COMAR 07.2.08 Substance-Exposed Newborn Safe Care Plan.

Statement of Purpose
The purpose of this action is to require health care practitioners to report newborns affected by prenatal exposure to controlled substances or by a fetal alcohol spectrum disorder (FASD) to the Local Department of Social Services (LDSS). The LDSS will be required to consult with the health care practitioner, interview the mother, visit the infant, and complete safety and risk assessments. If services are needed, the caseworker from the LDSS will develop a plan of safe care and make the appropriate referrals. The action also brings Maryland law into compliance with federal law.

Comparison to Federal Standards
There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

Estimate of Economic Impact
The proposed action has no economic impact.

Economic Impact on Small Businesses
The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities
The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment
Comments may be sent to Andrea Shuck, Regulations Coordinator, Department of Human Resources, 311 W. Saratoga Street, Room 270, Baltimore, MD 21201, or call 410-767-2149, or email to andrea.shuck@maryland.gov, or fax to 410-333-0637. Comments will be accepted through November 4, 2013. A public hearing has not been scheduled.

.1 Purpose and Goals.
A. The purpose of the Substance-Exposed Newborns Program is to address the needs of infants born with and identified as being affected by prenatal exposure to controlled substances or by a fetal alcohol spectrum disorder (FASD) by:
   (1) Requiring health care practitioners who deliver or care for substance-exposed newborns to make a report to a local department of social services;
   (2) Assessing the safety of, and risk to, substance-exposed newborns;
   (3) Developing a plan of safe care for substance-exposed newborns if necessary; and
   (4) Referring the family for appropriate services.
B. The goals of the Substance-Exposed Newborns Program are to:
   (1) Provide for the safe discharge of substance-exposed newborns from the hospital;
(2) Assist the mother, and other family members, in obtaining treatment related to alcohol or drug use or any other appropriate services or resources that may be needed to address child safety; and
(3) Generate accurate reports to assist in the evaluation of this program.

.2 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) “Controlled drug” means a controlled dangerous substance included in Schedule I, Schedule II, Schedule III, Schedule IV, or Schedule V under Criminal Law Article, Title 5, Subtitle 4, Annotated Code of Maryland.
(2) “FASD” means fetal alcohol spectrum disorder, which is an umbrella term for the wide range of effects from prenatal alcohol exposure, including a broad array of physical defects and cognitive, behavioral, emotional, and adaptive functioning deficits.
(3) “Health care practitioner” has the meaning stated in Health Occupations Article, §1-301, Annotated Code of Maryland.
(4) “Local department” means the local department of social services in the county where the mother of the substance-exposed newborn resides.
(5) “Newborn” means a child younger than 30 days old who is born or who receives care in the State.
(6) “Substance-exposed newborn” means a newborn:
(a) Who has a positive toxicology screen for a controlled drug as evidenced by an appropriate test after birth;
(b) Who displays the effects of controlled drug use or symptoms of withdrawal resulting from prenatal controlled drug exposure as determined by medical personnel;
(c) Who displays the effects of FASD; or
(d) Whose mother had a positive toxicology screen for a controlled drug at the time of delivery.

.3 Reports by Health Care Practitioners.
A. Except as provided in §C of this regulation, a health care practitioner involved in the delivery or care of a substance-exposed newborn shall:
(1) Make an oral report to the local department as soon as possible; and
(2) Make a written report to the local department not later than 48 hours after the contact, examination, attention, treatment, or testing that prompted the report.
B. To the extent known, a report made pursuant to this section shall include the following information:
(1) The name, date of birth, and intended home address of the newborn;
(2) The names and home addresses of the newborn’s parents;
(3) The nature and extent of the effects of the prenatal alcohol or controlled drug exposure on the newborn;
(4) The newborn’s medical condition and any current or ongoing health care needs, including an extended hospital stay prior to discharge, specific medical procedures, medication, specialized equipment, or ongoing monitoring;
(5) Whether and when the newborn’s mother had prenatal care;
(6) The nature and extent of the mother’s current drug use;
(7) The extent to which the mother is responsive to the newborn’s needs and is involved with providing care;
(8) The extent of any limitation of the mother’s cognitive skills;
(9) The nature and extent of any history of mental illness; and
(10) Any additional information regarding:
(a) The nature and extent of the impact of the prenatal alcohol or controlled drug exposure on the mother’s ability to provide proper care and attention; and
(b) The nature and extent of the risk of harm to the newborn.
C. A health care practitioner is not required to make a report under this section if the health care practitioner:
(1) Has knowledge that the head of an institution, a designee of the head, or another individual at that institution has made a report regarding the substance-exposed newborn;
(2) Has verified that, at the time of delivery, the mother was using a controlled drug as currently prescribed for the mother by a licensed health care practitioner; or
(3) Has verified that, at the time of delivery, the presence of the controlled drug was consistent with a prescribed medical or drug treatment administered to the mother or the newborn.
D. The provisions of §C of this regulation do not relieve the health care practitioner of the obligation as a mandated reporter to make a report to the local department if the health care practitioner has reason to believe that the substance-exposed newborn has been abused or neglected.

.4 Receiving Reports of Substance-Exposed Newborns.
Within 48 hours after receiving a report of a substance-exposed newborn, the local department shall:
A. See the newborn in person;
B. Consult with a health care practitioner with knowledge of the newborn’s condition and the effects of any prenatal alcohol or controlled drug exposure; and
C. Attempt to interview the newborn’s mother and any other individual responsible for care of the newborn.

.5 Assessment.
A. Promptly after receiving a report, the local department shall assess the safety of, and risk of harm to, the newborn to determine whether any further intervention is necessary.
B. The assessment may include but is not limited to consideration of the following:
   (1) Prior child protective services involvement;
   (2) The mother’s prior delivery of a substance-exposed newborn;
   (3) The nature and extent of mother’s alcohol and controlled drug use and treatment history;
   (4) The mother’s level of cooperation and willingness to address concerns;
   (5) The extent and availability of the newborn’s family or other individuals to assist with caregiving and the provision of other support;
   (6) Evidence of preparations for the newborn’s birth;
   (7) Availability of stable housing with no apparent safety or health hazards; and
   (8) The nature and extent of drug use in the home.
C. If, after the assessment, intervention is necessary, the local department shall:
   (1) Develop a plan of safe care for the newborn;
   (2) Refer the family for appropriate services including alcohol or controlled drug treatment; and
   (3) As necessary, develop a plan to monitor the safety of the newborn and the family’s participation in appropriate services.

.6 Scope.
Reports made under this chapter do not create a presumption that a child has been or will be abused or neglected.

THEODORE DALLAS
Secretary of Human Resources
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<th>NEWBORN’S DRUG OF EXPOSURE</th>
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Referral Information (All sections must be completed by reporter to the extent known)

**NEWBORN’S MEDICAL CONDITION AND CURRENT AND/OR ONGOING HEALTH CONCERNS:**

**SYMPTOMS OF WITHDRAWAL FROM OR EFFECTS OF PRENATAL ALCOHOL OR CONTROLLED DRUG EXPOSURE ON THE NEWBORN:**

**IMPACT OF ALCOHOL OR CONTROLLED DRUG USE ON MOTHER’S ABILITY TO PROVIDE PROPER CARE AND ATTENTION TO NEWBORN:**

**NATURE AND EXTENT OF MOTHER’S CURRENT DRUG USE AND HISTORY OF PREVIOUS TREATMENT:**

**EXTENT TO WHICH MOTHER IS RESPONSIVE TO NEWBORN’S NEEDS AND IS INVOLVED WITH PROVIDING CARE:**

**NATURE AND EXTENT OF PARENTS’ SOCIAL SUPPORT SYSTEM:**

**EXTENT OR HISTORY OF ANY VIOLENCE, MENTAL ILLNESS, OR COGNITIVE LIMITATIONS:**

**NATURE AND EXTENT OF RISK OF HARM TO THE NEWBORN:**

**PARENTS’ LEVEL OF COOPERATION:**

**PREPARATIONS FOR NEWBORN:**

**ANY OTHER AVAILABLE INFORMATION THAT WOULD ASSIST STAFF IN ASSESSING SAFETY AND RISK AND DEVELOPING PLAN OF CARE:**

**INFORMATION ON PREVIOUS INVOLVEMENT WITH THE DEPARTMENT OF SOCIAL SERVICES**

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<th>NAME OF LDSS STAFF PERSON TO WHOM REPORT MADE:</th>
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Click here to enter a date.
Appendix 3: Template for Creating Pathways of Communication

Improving outcomes for children and families affected by substance use disorders requires a coordinated approach to communication, connection, and collaboration across the systems of child welfare, substance use disorder treatment, healthcare systems, and other community agencies. Adopting strategies to coordinate services across a wide range of systems is recommended for substance exposed newborns because children and families affected by substance use disorders need multiple systems involved to ensure their safety and help them thrive. This communication tool was created to support the work detailed in the document *Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)*. SAFERR is a collaborative model to help systems make better informed decisions when determining outcomes for children and families affected by substance use disorders. The work of implementing SAFERR highlights collaboration among child welfare, substance use disorder treatment, court professionals, and other community agencies coming together to develop effective communication protocols that address the major challenge of *Who Needs to Know What and When?*

The SAFERR model provides insights that are applicable to diverse groups and can be utilized for many permutations of collaborative partners. In this permutation, we have utilized the concepts presented in SAFERR to support communication among child welfare, substance use disorder treatment, healthcare systems, and other community agencies necessary to support infants affected by prenatal substance exposure and their families particularly around the collaborative work necessary for the development, implementation, and monitoring of Plans of Safe Care.

Substance exposed newborns and their families are often identified within multiple systems unbeknownst to each of the individual systems serving the family. While the roles, responsibilities, terms, activities, and processes that guide each individual system are likely to differ, all of these systems engage in specific activities throughout the time a family is involved in services.

Developing a coordinated response requires formal and clear patterns of communication across the systems serving the unique needs of this population of children and families. These “communication bridges” are essential to addressing the challenge of *Who Needs to Know What and When* and must be clearly defined within each community and organization. While communicating across systems is an ongoing process, there are three distinct communication points or stages which must be considered:

1) Determining Presence and Immediacy of an Issue;
2) Determining Nature and Extent of the Issue;
3) Development, Implementation and Monitoring of the Plan of Safe Care.

Policymakers, administrators, legal experts, and practitioners must consider each of these communication points and provide the policies, procedures, and specific content needed for staff to share information about families with each other and with family members.

Refer to *Table 1: SAFERR Terms and Processes in Substance Use Disorder Treatment Services, Child Welfare Services, and Health Care Systems* to better understand the roles and responsibilities of child welfare, substance use disorder treatment and the health care systems. Communities may use this table as a template to develop a common language and base of understanding across systems, and to create a unified glossary of terms and processes to be used by all systems in discussing a family’s Plan of Safe Care.

Refer to *Table 2: Pathways of Communication Template* for a visual representation of information flow across the systems of child welfare, substance use disorder treatment, health care systems, and other community agencies. Templates illustrate examples of the variety of information each individual system shares at each of the three distinct communication points. Systems may use this template to develop clearly defined communication protocols and information sharing agreements within their jurisdictions.

For more information or to request training or technical assistance on developing communication and information sharing protocols in your community, please contact us at contact_us@effutures.org.

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1 To access this publication online visit: [https://www.ncsacw.samhsa.gov/files/SAFERR.pdf](https://www.ncsacw.samhsa.gov/files/SAFERR.pdf)
<table>
<thead>
<tr>
<th>Questions to answer:</th>
<th>Substance Use Disorder Treatment Services</th>
<th>Child Welfare Services</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a substance use or child abuse and neglect issue?</td>
<td>Screen</td>
<td>Use of brief screening questions</td>
<td>Brief questions posed to determine whether a report of abuse or neglect will be accepted for in-person response²</td>
</tr>
<tr>
<td>If so, what is the immediacy of the issue?</td>
<td>Immediate Need Triage</td>
<td>Clinical determination of imminent risk</td>
<td>Use of a formal tool to determine imminent harm to a child, whether the child will be removed from or remain in the home</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Questions to answer:</th>
<th>Substance Use Disorder Treatment Services</th>
<th>Child Welfare Services</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the nature of the substance use or child abuse and neglect issue?</td>
<td>Diagnosis</td>
<td>Use of standardized questions in an interview to determine whether a substance use disorder is mild, moderate or severe</td>
<td>Use of an interview protocol and risk assessment tools to determine level of risk to a child and whether services will be voluntary or court involved</td>
</tr>
<tr>
<td>What is the extent of the substance use or child abuse and neglect issue?</td>
<td>Multi-Dimensional Assessment</td>
<td>Use of a standardized set of questions by a staff member trained in substance use disorders, including functioning, needs, and strengths leading to a determination of the level of care required and needed for services</td>
<td>Family assessment of strengths and needs to determine the areas of family functioning requiring interventions for children to be safe in a permanent living situation that contributes to their well-being</td>
</tr>
</tbody>
</table>

² Screening and Assessment for Family Engagement, Retention, and Recovery. To access this publication online visit: [https://www.ncsacw.samhsa.gov/files/SAFERR.pdf](https://www.ncsacw.samhsa.gov/files/SAFERR.pdf)

³ Differential response is an approach that enables child protective services (CPS) to differentiate its response to reports of child abuse and neglect based on several factors, including the level of risk associated with the report, indicators of child safety, and the family's need for services and support. Differential response is an area of CPS reform also referred to as "dual track," "multiple track," or "alternative response." Approaches to differential response vary from state to state. For more information on differential response visit: [https://www.childwelfare.gov/pubPDFs/differential_response.pdf](https://www.childwelfare.gov/pubPDFs/differential_response.pdf)

Appendix 3: Template for Creating Pathways of Communication
### Table 1: SAFERR Terms and Processes in Substance Use Disorder Treatment Services, Child Welfare Services, and Healthcare Systems (Continued)

#### Stage II: Determining Nature and Extent of the Issue, and Treatment and Case Plans (Continued)

<table>
<thead>
<tr>
<th>Questions to answer</th>
<th>Substance Use Disorder Treatment Services</th>
<th>Child Welfare Services</th>
<th>Healthcare System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Plan</td>
<td>Treatment Plan</td>
<td>Treatment Plan</td>
<td>Patient specific treatment plan with specific action steps to be taken by the healthcare professional and the patient including follow up requirements for additional exams and testing.</td>
</tr>
<tr>
<td>Individualized treatment plan with measurable objectives and outcomes</td>
<td>Individualized treatment plan with measurable objectives and outcomes</td>
<td>Individualized treatment plan with measurable objectives and outcomes</td>
<td></td>
</tr>
<tr>
<td>Case Plan</td>
<td>Case Plan Monitoring</td>
<td>Permanency Determination</td>
<td></td>
</tr>
<tr>
<td>Patient specific treatment plan with specific action steps to be taken by the healthcare professional and the patient including follow up requirements for additional exams and testing.</td>
<td>Conducting oversight and tracking of participant’s progress in treatment and recovery</td>
<td>Assessment of the most appropriate form of permanency for the child</td>
<td></td>
</tr>
<tr>
<td>Stage III: Monitoring Change, Transitions, and Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions to answer</th>
<th>Substance Use Disorder Treatment Services</th>
<th>Child Welfare Services</th>
<th>Healthcare System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there demonstrable changes?</td>
<td>Treatment Monitoring</td>
<td>Conducting oversight and tracking of participant’s progress in treatment and recovery</td>
<td>Case Plan Monitoring</td>
</tr>
<tr>
<td>Is the family ready for transition?</td>
<td>Transition Planning</td>
<td>Assessment of on-going recovery plan, support system and other needed services</td>
<td>Permanency Determination</td>
</tr>
<tr>
<td>What happens after discharge or case closure?</td>
<td>Recovery Management</td>
<td>Ongoing self-assessment, and periodic professional assessment, as needed</td>
<td>Family Well-Being</td>
</tr>
<tr>
<td>Did the interventions work?</td>
<td>Outcome Monitoring</td>
<td>Data-driven outcome monitoring of changes in life functioning and substance-use related consequences</td>
<td>Outcome Monitoring</td>
</tr>
</tbody>
</table>
TABLE 2: PATHWAYS OF COMMUNICATION

<table>
<thead>
<tr>
<th>COMMUNICATION BRIDGES—WHO NEEDS TO KNOW WHAT AND WHEN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving outcomes for children and families affected by substance use disorders requires coordinated responses across systems as this population of families are often simultaneously involved with multiple systems. As a result, systems need formal and clear patterns of communication during three distinct communication points or stages:</td>
</tr>
</tbody>
</table>

**Stage I: Determining Presence and Immediacy of an Issue:**
- Is there a substance use or child abuse and neglect issue in the family?
- If so, what is the immediacy of the issue?

**Stage II: Determining Nature and Extent of the Issue:**
- What are the nature and extent of the substance use or child abuse and neglect issue?
- What is the response to the substance use or child abuse and neglect issue (notification vs. report)?

**Stage III: Developing, Implementing and Monitoring Plans of Safe Care:**
- Is the family ready for hospital discharge?
- What happens after discharge?
- Did the Plan of Safe Care work to keep the infant safe and provide needed services to the infant, parent/caregiver and family?

---

4 Substance use disorder treatment professions, child welfare, healthcare systems, and dependency court systems have strict confidentiality rules. Typically, the treatment consent forms, rather than the child welfare forms, need to be used, as they are designed to conform to federal government regulations (federal government regulations 42 CFR, Part II and the Health Insurance Portability and Accountability Act of 1996 [HIPAA] Privacy Rule) that address the key treatment confidentiality requirements for sharing information. They are likely to be more guarded and specific in the types of information that can be shared. Regulation 42 CFR Part 2 states that "no state law may authorize or compel any disclosure prohibited by the federal legislation." However, states may impose additional confidentiality protections.
<table>
<thead>
<tr>
<th>COMMUNICATION STAGES</th>
<th>CHILD WELFARE</th>
<th>HEALTH CARE PROVIDERS (PRENATAL PROVIDER/BIRTHING HOSPITAL/PEDIATRICIAN)</th>
<th>OTHER COMMUNITY AGENCIES</th>
</tr>
</thead>
</table>
| **STAGE I: DETERMINING PRESENCE AND IMMEDIACY OF AN ISSUE** | - Physical and behavioral observations of potential substance use  
- Results of drug tests or other substance use disorder screening tool  
- Knowledge of children in the home and risk or safety factors  
- Services recommended and services initiated | - Results of drug tests or other substance use disorder screening tool for mother or others in the household  
- Services recommended and services initiated for mother and other family/caregivers  
- Medicaid eligibility (if known) | - Potential service needs/gaps  
- Services being provided  
- Medicaid eligibility (if known) |
| **STAGE II: DETERMINING NATURE AND EXTENT OF AN ISSUE** | - Results of substance use disorder assessment including diagnosis, recommendations for level of care, and recommended treatment plan  
- Identified strengths and needs of the family including identified systems of support  
- Treatment compliance updates | - Results of substance use disorder assessment including diagnosis, recommendations for level of care, and recommended treatment plan  
- Identified strengths and needs of the family including identified systems of support  
- Treatment compliance updates | - Potential service needs/gaps  
- Medicaid eligibility (if known)  
- Services being provided |
| **STAGE III: DEVELOPING, IMPLEMENTING AND MONITORING PLANS OF SAFE CARE** | - Treatment compliance (e.g., attendance to individual/group/case management meetings; drug testing attendance and results)  
- Treatment progress (e.g., treatment plan progress; behavioral changes; phase progression)  
- Changes in treatment plan (e.g., diagnosis; level of care; drug testing requirements, service recommendations)  
- Observations of parent-child interaction including any child risk and safety concerns (e.g., unsafe home environment or parent relocation; indicators of substance use)  
- Outcomes monitoring (e.g., sustaining long term recovery, improved functioning) | - Treatment compliance  
- Treatment progress  
- Changes in treatment plan  
- Observations of parent-child interaction including any parent-child bonding concerns and/or parenting education needs  
- Outcomes monitoring | - Observations of parent-child interaction including any parent-child bonding concerns and/or parenting education needs  
- Changes in treatment plan  
- Service recommendations |
### COMMUNICATION STAGES

#### STAGE I: DETERMINING PRESENCE AND IMMEDIACY OF AN ISSUE
- Is there a substance use or child abuse and neglect issue in the family?
- If so, what is the immediacy of the issue?

- Reason for substance use assessment, results of substance use screen and any other indicators of substance use
- Results of investigation/assessment (e.g., whether allegations are substantiated, whether a case is opened)
- Family’s history with child welfare
- Case plan

#### STAGE II: DETERMINING NATURE AND EXTENT OF AN ISSUE
- What are the nature and extent of the substance use or child abuse and neglect issue?
- What is the response to the substance use or child abuse and neglect issue? (notification vs. report)

- Reason for substance use assessment, results from substance use screening tool and any other indicators of substance use
- Results of investigation/assessment (e.g., whether allegations are substantiated, whether a case is opened)
- Child welfare and treatment case plans

#### STAGE III: DEVELOPING, IMPLEMENTING AND MONITORING PLANS OF SAFE CARE
- Is the family ready for hospital discharge?
- What happens after discharge?
- Who is managing/leading the implementation of the POSC?
- Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family?

- Case plan progress and participation
- Changes in permanency goals
- Observations regarding parent-child interaction
- Any other observations and information pertinent to the case
- Visitation plan and changes to visitation plan
- Outcomes monitoring (e.g., recidivism—re-occurrence of child maltreatment, sibling entry into foster care)

### HEALTH CARE PROVIDERS (PRENATAL PROVIDER/ BIRTHING HOSPITAL/ PEDIATRICIAN)

- Reason for substance use assessment, results of substance use screen and any other indicators of substance use
- Results of investigation/assessment (e.g., whether allegations are substantiated, whether a case is opened)
- Case plan

### OTHER COMMUNITY AGENCIES

- Referrals for community support services
- Referrals for developmental assessment
- Referrals for early intervention services

---

**NOTE:** Examples are provided for the purpose of generating discussion and do not constitute a comprehensive list of information to share across systems.
## COMMUNICATION STAGES

### STAGE I: DETERMINING PRESENCE AND IMMEDIACY OF AN ISSUE
- Is there a substance use or child abuse and neglect issue in the family?
- If so, what is the immediacy of the issue?
  - Results of drug screen and/or drug test on parents/caregivers
  - Results of drug testing on infant
  - Mother and/or infants health issues

### STAGE II: DETERMINING NATURE AND EXTENT OF AN ISSUE
- What are the nature and extent of the substance use or child abuse and neglect issue?
- What is the response to the substance use or child abuse and neglect issue? (notification vs. report)
  - Mother and Infant’s health diagnosis
  - Identified developmental needs of infant
  - Observations regarding parent-child interaction

### STAGE III: DEVELOPING, IMPLEMENTING AND MONITORING PLANS OF SAFE CARE
- Is the family ready for hospital discharge?
- What happens after discharge?
- Who is managing/leading the implementation of the POSC?
- Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family?
  - Observations regarding parent-child interaction
  - Recommendations for ongoing health related care

## CHILD WELFARE

- Results of drug screen and/or drug test on parents/caregivers
- Results of drug testing on infant
- Mother and/or infants health issues

## SUBSTANCE USE DISORDER TREATMENT

- Results of drug screen and/or drug test on parents/caregivers
- Mothers immediate health issues
- Parents/Caregivers Medicaid eligibility (if applicable)

## OTHER COMMUNITY AGENCIES

- Results of drug screen and/or drug test on parents/caregivers
- Results of drug testing on infant
- Mother and/or infants health issues
- Parents/caregivers/family/ infant Medicaid eligibility (if applicable)

### COMMUNICATION POINTS/STAGES

- Health care providers (Prenatal Provider/ Birthing Hospital/ Pediatrician)

### COMMUNICATION BRIDGES—WHO NEEDS TO KNOW WHAT AND WHEN? (EXAMPLES)

**NOTE:** Examples are provided for the purpose of generating discussion and do not constitute a comprehensive list of information to share across systems.

- Results of drug screen and/or drug test on parents/caregivers
- Results of drug testing on infant
- Mother and/or infants health issues
- Parents/Caregivers Medicaid eligibility (if applicable)

- Mother and Infant’s health diagnosis
- Identified developmental needs of infant
- Observations regarding parent-child interaction

- Mother’s health diagnosis
- Observations regarding parent-child interaction

- Recommendations for ongoing health related care

- Observations regarding parent-child interaction
- Recommendations for ongoing health related care

- Observations regarding parent-child interaction
- Recommendations for ongoing health related care

- Eligibility/ appropriateness for home visiting services
## Communication Stages

### Stage I: Determining Presence and Immediacy of an Issue
- Is there a substance use or child abuse and neglect issue in the family?
- If so, what is the immediacy of the issue?

<table>
<thead>
<tr>
<th>Child Welfare</th>
<th>Health Care Providers (Prenatal Provider/Birthing Hospital/Pediatrician)</th>
<th>Substance Use Disorder Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Services recommended and services initiated</td>
<td>o Services recommended and services initiated</td>
<td>o Services recommended and services initiated</td>
</tr>
</tbody>
</table>

### Stage II: Determining Nature and Extent of an Issue
- What are the nature and extent of the substance use or child abuse and neglect issue?
- What is the response to the substance use or child abuse and neglect issue? (notification vs. report)

<table>
<thead>
<tr>
<th>Child Welfare</th>
<th>Health Care Providers (Prenatal Provider/Birthing Hospital/Pediatrician)</th>
<th>Substance Use Disorder Treatment</th>
</tr>
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<tr>
<td>o Services recommended and services initiated</td>
<td>o Services recommended and services initiated</td>
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</tr>
</tbody>
</table>

### Stage III: Developing, Implementing and Monitoring Plans of Safe Care
- Is the family ready for hospital discharge?
- What happens after discharge?
- Who is managing/leading the implementation of the POSC?
- Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family?

<table>
<thead>
<tr>
<th>Child Welfare</th>
<th>Health Care Providers (Prenatal Provider/Birthing Hospital/Pediatrician)</th>
<th>Substance Use Disorder Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Services recommended and services initiated</td>
<td>o Services recommended and services initiated</td>
<td>o Services recommended and services initiated</td>
</tr>
<tr>
<td>o Outcomes monitoring (e.g., completion of recommended services, improvements in functioning or stability)</td>
<td>o Outcomes monitoring (e.g., completion of recommended services, improvements in functioning or stability)</td>
<td>o Outcomes monitoring (e.g., completion of recommended services, improvements in functioning or stability)</td>
</tr>
</tbody>
</table>

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Appendix 3: Template for Creating Pathways of Communication
## COMMUNICATION STAGES

### STAGE I: DETERMINING PRESENCE AND IMMEDIACY OF AN ISSUE
- Is there a substance use or child abuse and neglect issue in the family?
- If so, what is the immediacy of the issue?

### STAGE II: DETERMINING NATURE AND EXTENT OF AN ISSUE
- What are the nature and extent of the substance use or child abuse and neglect issue?
- What is the response to the substance use or child abuse and neglect issue? (notification vs. report)

### STAGE III: DEVELOPING, IMPLEMENTING AND MONITORING PLANS OF SAFE CARE
- Is the family ready for hospital discharge?
- What happens after discharge?
- Who is managing/leading the implementation of the POSC?
- Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family?
## Communication Stages

### Stage I: Determining Presence and Immediacy of an Issue
- Is there a substance use or child abuse and neglect issue in the family?
- If so, what is the immediacy of the issue?

### Stage II: Determining Nature and Extent of an Issue
- What are the nature and extent of the substance use or child abuse and neglect issue?
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- What happens after discharge?
- Who is managing/leading the implementation of the POSC?
- Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family?
<table>
<thead>
<tr>
<th>COMMUNICATION STAGES</th>
<th>CHILD WELFARE</th>
<th>SUBSTANCE USE DISORDER TREATMENT</th>
<th>OTHER COMMUNITY AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE I: DETERMINING PRESENCE AND IMMEDIACY OF AN ISSUE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is there a substance use or child abuse and neglect issue in the family?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If so, what is the immediacy of the issue?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAGE II: DETERMINING NATURE AND EXTENT OF AN ISSUE</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>• What are the nature and extent of the substance use or child abuse and neglect issue?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What is the response to the substance use or child abuse and neglect issue? (notification vs. report)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAGE III: DEVELOPING, IMPLEMENTING AND MONITORING PLANS OF SAFE CARE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the family ready for hospital discharge?</td>
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<td>• What happens after discharge?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Who is managing/leading the implementation of the POSC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Communication Stages

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Child Welfare</th>
<th>Health Care Providers (Prenatal Provider/Birthing Hospital/Pediatrician)</th>
<th>Substance Use Disorder Treatment</th>
</tr>
</thead>
</table>
| **Stage I: Determining Presence and Immediacy of an Issue** | • Is there a substance use or child abuse and neglect issue in the family?  
• If so, what is the immediacy of the issue? | | | |
| **Stage II: Determining Nature and Extent of an Issue** | • What are the nature and extent of the substance use or child abuse and neglect issue?  
• What is the response to the substance use or child abuse and neglect issue? (notification vs. report) | | | |
| **Stage III: Developing, Implementing and Monitoring Plans of Safe Care** | • Is the family ready for hospital discharge?  
• What happens after discharge?  
• Who is managing/leading the implementation of the POSC?  
• Did the Plan of Safe Care work to keep the infant safe and provide needed services to the caregiver and family? | | | |
Appendix 4: Sample Prenatal and Birth Screening and Assessment Protocols

The ability to recognize drug or alcohol exposure in infants and substance use disorders among pregnant women and new mothers provides the best opportunity for engaging mothers in treatment and identifying the potential needs of the infant. The screen itself can be conducted through interview and self-report using questionnaires or valid screening instruments at the birth event. There may be additional follow-up assessments and tests that may include a toxicology panel for both newborns and their mothers.

This appendix includes brief summaries of three (3) prenatal and birth screening and assessment protocols from the State of Maine, Massachusetts and Washington as well detailed documents from each State. The protocols represent sample documents that might be illustrative to the field but, are not endorsed by Children and Family Futures.

State of Maine
The Snuggle ME Project: Embracing Drug Affected Babies and their Families in the First Year of Life To Improve Medical Care and Outcomes Maine—Provides recommendations for screening for substance use during pregnancy, care of pregnant women with opioid dependency, and treatment of newborns with prenatal substance exposure. It includes sample hospital policy guidelines and patient education handouts.

Snuggle ME Screening Algorithm—A step-by-step screening flow chart that can be used to guide the process of screening, brief intervention and referral to treatment for pregnant women.

State of Massachusetts
Massachusetts Department of Public Health Guidelines for Community Standard for Maternal/Newborn Screening For Alcohol/Substance Use—Provides guidelines to the screening of pregnant women and their newborns for prenatal exposure to substances.

State of Washington
Substance Use Disorders During Pregnancy; Guidelines for Screening & Management—Includes concrete steps for healthcare professionals in developing and implementing a maternal screening and assessment model.

Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State—Provides guidance to hospitals, health care providers and affiliated professionals about maternal drug screening, laboratory testing and reporting of drug-exposed newborns delivered in Washington State. Includes discussion on signs or indicators when a test should be conducted and how issues of consent are addressed.
http://here.doh.wa.gov/materials/guidelines-drug-exposed-newborns
The Snuggle ME Project:
Embracing Drug Affected Babies and their Families in the First Year of Life
To Improve Medical Care and Outcomes Maine

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A. Screening and substance use in pregnancy
B. Patient Education Tri-fold
C. Patient Education Handbook
* The following recommendations are not intended to replace providers’ clinical judgment or to establish a single protocol. Some clinical problems may not be adequately addressed in this document. As always, clinicians are urged to document management strategies and obtain consultations as indicated.
Quick Reference: Pregnancy Care Recommendations

Antepartum Care - 1\textsuperscript{st} trimester

- Do SBIRT screening (Screening, Brief Intervention, Referral to Treatment)
- Ask if patient is enrolled in a treatment program and obtain appropriate consents for coordination of care.
- Check patient’s record in the Prescription Monitoring Program.
  
- Patient receiving prescriptions for chronic pain should have a drug agreement in place (see Appendix H).
- Add HIV, Hepatitis C, and Sexually Transmitted Infections to routine lab panel.
- Perform Risk screening for tuberculosis (TB).
- Do Dating ultrasound upon entry to care.
- At first prenatal visit, assess need for anti-emetics and antacids for reflux/morning sickness.
- At first prenatal visit, consider bowel regimen of stool softeners, fluids, fiber products and hemorrhoid cream.
- Enroll in text4baby.org for anticipatory guidance during pregnancy and first year of life.
- Consider referral to Public Health Nursing, case management, or social worker.
- Make appropriate referrals such as Maine Families, legal services, child protective services, education and career building support, adoption, domestic violence counseling, WIC, public assistance, food stamps (SNAP), transportation, mental health services.
- Give patient information about maternal drug use/effect on infants.

Antepartum Care - 2\textsuperscript{nd} and 3\textsuperscript{rd} trimester

- Work with patient to develop pain management plan in the second trimester. Patients will most likely need an epidural for adequate pain control in labor.
- Order a 18-20 week ultrasound for anatomic abnormalities and cervical incompetence.
- Give family trifold about newborn care and NAS. See Appendix J Section B.
- Consider monthly ultrasounds starting at 28-32 weeks to monitor fetal growth, fluid, and placental function. Doppler studies are needed when intrauterine growth restriction and/or oligohydramnios is identified.
- Repeat labs (Hep C/HIV/STI panel) at 28 weeks if indicated by continued use of illicit drugs, multiple sexual partners, other high risk behaviors, or social situation.
- Consider anesthesia consultation in the third trimester if IV access is difficult or severe anxiety, or coexisting medical issues could prevent spinal analgesia.
Discuss importance of having trained newborn providers care for infant after delivery. Encourage communication between patient and newborn care provider. Consider prenatal appointment with pediatrician/neonatologist who will care for infant after birth.

If delivering hospital is not able to provide care for infant with NAS, discuss patient preference for transfer of care in last trimester of pregnancy vs. transfer of newborn after delivery if pharmacologic management is required.

Confirm that hospital has buprenorphine available on formulary. If not available, the patient should bring her own medication.

**Anticipatory guidance in 3rd Trimester**

- Give families longer booklet about newborn care. See Appendix J Section C
- Inform families that a Drug Affected Infant (DAB) notification to DHHS will be done at the time of delivery.
- Advise families that recommended length of stay of newborns is 5-7 days with minimal symptoms and that NAS scoring will be done. Infants may need to stay longer if treatment or prolonged monitoring is required.
- Review hospital breastfeeding guidelines with mothers. Women who are stable in treatment on buprenorphine or methadone and do not use illicit drugs can be encouraged to breastfeed. Breastfeeding is not recommended if mothers continue to use marijuana. Mothers and providers should be aware that marijuana can be positive in the urine for up to 2 months. A recommended resource for medication safety during lactation is: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
- Refer for Childbirth education.
- Consider referral to Public Health Nursing if not done previously.
- Perform toxicology testing when clinically indicated. Routine toxicology tests may differ by institution. Testing for methadone, buprenorphine, and/or their metabolites may need to be specially ordered. Alcohol can be measured via serum alcohol level or urine ethanyl glucuronide. Positive toxicology tests should be sent for confirmation.

**Intrapartum Recommendations**

- When possible, contact addiction treatment provider to confirm dose of methadone or buprenorphine and notify of admission. While the patient is admitted to the hospital, an attending provider may legally prescribe buprenorphine and methadone to maintain a patient’s outpatient dose during his/her
hospitalization. Documentation of this Federal regulation is available at:
http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm

- Anticipate that an opioid dependent mother will require higher and more frequent dosing of narcotic pain medications during labor.
- Methadone or buprenorphine do not provide adequate pain relief during labor. These medications should be continued at their normal dose and time during labor and/or a cesarean section.
- **Do not use Nubain or Stadol for pain control during labor in opioid dependent patients. All patients should be asked about substance use history prior to use of these medications. They should be informed that they can cause acute withdrawal.**
- **If Nubain or Stadol is given inadvertently, withdrawal symptoms can be reversed with IV Fentanyl or Morphine.**
- **Neuraxial analgesia (spinal or epidural) may be the most safe and effective way to control pain both for vaginal births and cesarean sections.** Surgical patients delivered with general anesthesia will usually need a PCA with morphine or dilaudid to control post cesarean section pain.
- Patients who are suing illicit substances may require increased doses of pain medication. If a patient discloses illicit substance use at the time of delivery that was not recognized during pregnancy, consider phone consultation with an addiction specialist, treatment center, or Maternal Fetal Medicine physician.
- Consider acute withdrawal in the differential diagnosis of a patient with intractable nausea, vomiting or abdominal pain.
- PICC or central line may be needed when peripheral venous access is too difficult due to history of IV drug use.
- Review newborn testing recommendations with patients privately.

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**Postpartum Checklist**

**Vaginal**

- Patients on chronic opioids are more sensitive to pain than those who are not and pain should be managed appropriately. They may require scheduled doses of NSAIDS and Acetaminophen for mild to moderate pain rather than prn. Short acting opioids can be added as needed.
- Patient’s regular maintenance dose of Methadone or Buprenorphine prior to delivery. The dose should be re-evaluated with the addiction treatment provider after delivery.
Cesarean Sections

- Patients undergoing C-section should also continue their maintenance dose of Buprenorphine or Methadone. Patient controlled IV analgesia and/or duramorph added to the spinal are effective options for the first 24 hours. Oral opioids can be added for break-through pain in addition to the maintenance dose of Methadone or Buprenorphine. Anticipate scheduled dosing of 1.5 times their normal dose every 3 hours.

General Postpartum

- Hospital breastfeeding guidelines should be reviewed with mothers. Women who are stable in treatment on buprenorphine or methadone and do not use illicit drugs can be encouraged to breastfeed. Caution should be advised against the abrupt cessation of breastfeeding, particularly in patients maintained on methadone.
- Each hospital should have a clear policy regarding breastfeeding and marijuana use. Go to: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT for medication and breastfeeding recommendations.
- Breastfeeding is contraindicated in women who are HIV positive or who have herpetic lesions on the breast.
- If infant is on an opioid for treatment of NAS, consider maintaining mother on buprenorphine as opposed to Subuxone because of the potential risk of acute withdrawal in the newborn due to the Naloxone component.
- Skin to skin contact and rooming in should be encouraged.
- Complete drug affected baby (DAB) notification as required by law.
- Work with social workers or nursing staff to complete newborn referral sheet to public health nursing and Child Development Services, in collaboration with the newborn’s primary care provider.
- Notify the addiction treatment provider upon discharge to confirm the patient has a follow up appointment. Give patient a list of medications administered during hospitalization as well as those prescribed at discharge. Be sure to indicate the timing of the last dose. Treatment providers will re-evaluate the patient’s dose postpartum and provide all outpatient prescriptions.
- Some methadone clinics close by early afternoon. Check hours of methadone clinic prior to discharge so that the patient does not miss a dose.
- Be alert for symptoms of overmedication. When a patient appears somnolent, consider decreasing either pain medication or patient’s regular dose of Buprenorphine or Methadone. It is best to consult with the addiction treatment provider prior to adjusting the dose of the medication assisted treatment.
- A postpartum visit should be scheduled, which should include making a reproductive plan, screening for postpartum depression, and connecting patient to a primary care provider for continued follow up.
Chapter 1: Screening for Substance Use during Pregnancy

Why screen for substance abuse during pregnancy:
Perinatal alcohol and drug use is an issue critical to the health of mothers and newborns. Substance abuse is associated with adverse pregnancy outcomes, including preterm birth, placental abruption, intrauterine death, low birth weight, and neonatal withdrawal. Exposure to alcohol and certain drugs is a leading preventable cause of birth defects and developmental disabilities in the United States. Women are most likely to participate in health care while they are pregnant.

Screening for alcohol and drug use early in the course of pregnancy allows for timely referral to substance abuse treatment when needed. Research shows that integrating substance abuse treatment into prenatal care reduces prenatal exposure, improves pregnancy outcomes, and decreases the cost of care for mothers and newborns (Goler et al. 2008, 2012).

Who should be screened?
The American College of Obstetricians and Gynecologists and the American Society for Addiction Medicine recommend universal screening of pregnant women for drug and alcohol use, and the American Academy of Family Physicians recommends periodic screening for all adolescent and adult patients. Women of child bearing age should also be screened pre-conceptually and provided with education about the risks of substance use during pregnancy. Unfortunately, many women who use alcohol and drugs do not seek regular medical care until they are already in mid-pregnancy. (ACOG references 2011 and 2012, ASAM reference, AAFP)

When should screening occur?
The earlier screening and referral for treatment occurs, the greater the opportunity to reduce harm to both mother and fetus.
- Screen at first prenatal visit (ACOG and ASAM)
- Repeat in mid-second trimester (24-28 weeks) (Chasnoff, 4 Ps Plus)

How to screen:
Universal verbal screening for substance abuse allows the health care provider to discuss the risks of alcohol, drug, and tobacco use with every pregnant woman and eliminates provider bias in determining who is screened. Screening all patients using a validated instrument increases the chance that prenatal...
substance abuse will be identified, addressed, and potentially reduced (Chasnoff et al., 2005, Chang et al., 2011)

Screening should be done with women in a private setting. Screening can be performed using interview-based or self-administered questionnaires. A number of instruments have been developed and tested for use with pregnant women. These include the 4Ps Plus, CRAFFT, TACE, and TWEAK (see Appendix B) (Chang et al., 2011; Burns et al., 2010; Chasnoff et al., 2005; Gavin et al., 1987; Humeniuk et al., 2008; Yonkers et al., 2010).

Some clinicians advocate universal urine drug testing for pregnant patients. Urine toxicology is a useful follow up test when a woman screens positive for drug or alcohol use, and to monitor progress during treatment. However, standard urine drug tests lack the ability to detect intermittent use, may not include drugs commonly used in a particular community, do not routinely test for alcohol use, and add significant cost to prenatal care. Mandatory urine testing may be a deterrent to seeking prenatal care for some women. The American College of Obstetricians and Gynecologists recommends against urine toxicology as a screening method for pregnant women (ACOG, 2008, 2012).

A significant correlation exists between depression, a history of trauma and/or current abuse, and substance use during pregnancy. Pregnant women who are at risk for substance abuse should also be screened concurrently for mental health problems and intimate partner violence (Hoorigan 2000, Moylani et al., 2001). Sample validated screening tools for mental health disorders and domestic violence are included in Appendix B.

**Brief Intervention**

Although screening may identify a patient at risk for alcohol or drug use, it does not diagnose drug or alcohol dependence. Following a positive screen, a brief intervention is necessary to explore a woman’s use, her readiness to consider change, what type of treatment is indicated, and what treatment, if any, would be accepted. Because women are generally motivated to seek care because of the pregnancy, the initial intervention should be delivered by a woman’s primary obstetrical provider. This should be done with a woman in a private setting.

Following a positive screen, the provider should express concern that a woman is at risk for alcohol or drug use during her pregnancy. He/she should affirm the mutual goal of a safe and healthy pregnancy for the woman and her newborn; provide accurate information about the risks of prenatal alcohol and drug use; evaluate her readiness to change, and explore options for treatment appropriate to the type of substance(s) used, the presence or absence of
physiologic dependence, her social environment, and her degree of acceptance. **Documentation of the above must be included in the medical record.**

**Motivational Interviewing:**
Techniques are useful in helping assess a woman’s readiness to change. Three key questions are asked:
On a scale of 1-10, how important is it to you to change your substance use? How confident are you that you can make this change? And how willing are you to make this change now? Her response will help guide treatment options. (SAMHSA TIP 43, 35)

**Referral to Treatment:**
If a woman is at risk for drug and/or alcohol use during pregnancy, the obstetrical provider should seek to refer her for further assessment and/or substance abuse treatment. If a woman is not ready to accept treatment, the provider may be able to point out the discrepancy between their mutual goal of a healthy pregnancy and substance use which is potentially harmful.

Women tend to under-report substance use in pregnancy; therefore evaluation by a professional trained in addiction treatment is essential if available. Referrals can be made to Licensed Alcohol and Drug Counselors (LADC), Certified Alcohol and Drug Counselors (CADC) or other professionals trained in addiction treatment. If a woman is physically dependent on drugs or alcohol, a provider trained in addiction medicine should evaluate whether she is appropriate for outpatient treatment or whether she may require admission for medically assisted stabilization (see algorithm, Appendix C).

When admission is not medically necessary, a provider should explore other strategies, including individual counseling, appropriate 12-step programs, the Maine Tobacco helpline, and other out-patient treatment programs. Referrals must fit a woman’s needs, be covered by her health insurance, and accessible to her in terms of transportation and childcare. If possible, her initial treatment appointment should be scheduled by the obstetrical provider while the patient is in your office. When a referral is made, ask the patient to sign a medical release allowing communication between her obstetrical and substance abuse treatment providers.

**Referral to the emergency department is recommended if a pregnant woman is in acute withdrawal and unable to access immediate treatment. Obstetrical providers should not attempt to treat a woman who is withdrawing from drugs in the outpatient setting or prevent withdrawal by prescribing opioids.**
If a woman is unwilling to accept treatment, offer her relevant written information about the risks of perinatal substance use. Increasing the number of prenatal visits have been demonstrated to improve pregnancy outcomes, even when the mother does not enter substance abuse treatment. (El-Mohandes, 2003) Address co-existing psychiatric conditions and social risk factors which make accessing treatment more difficult.

**Pregnant women should be given priority for treatment and should be seen by a treatment provider within 48 hours after requesting care. (SAMHSA TIP 43)**

**Appendix D contains a list of substance abuse treatment programs in the state and a link to the Maine State Substance Abuse Mental Health Services website.**

**Resources related to substance abuse screening and intervention:**

Online continuing medical education is available to improve provider techniques for screening, brief intervention and referral for treatment:

1. **SBIRT:** [http://www.sbirttraining.com/SBIRT-core](http://www.sbirttraining.com/SBIRT-core). This program has been developed through collaboration between the American Society of Addiction Medicine (ASAM) and the National Institute for Drug Abuse (NIDA)
   - On-line, on–demand program
   - Cost: $75
   - AMA PRA Category 1 CME (4 hours)

2. The University of New England College of Osteopathic Medicine is hosting an ongoing, online CME course: Domestic Violence Response Initiative: Screening for Abuse. This course is taught by Daniel Oppenheim, MD and Karen Wentworth, Domestic Violence Community Educator. To register, go to: [http://aicme.com/catalog_class.asp?clid=167](http://aicme.com/catalog_class.asp?clid=167)
   - Cost is $29
   - CEU 1

3. Training in Motivational Interviewing is available through on-line programs: [http://www.motivationalinterview.org/](http://www.motivationalinterview.org/)

4. Links to a few of the SAHMSA TIPS:


GOALS OF TREATMENT PROGRAMS FOR OPIOID-DEPENDENT PREGNANT PATIENTS

Best results are achieved when women are enrolled in a comprehensive program of treatment which includes substance abuse counseling, psychiatric treatment, and social services. (Goler, 2008) Stabilization on opioid maintenance therapy using methadone is the standard of care; however, the use of buprenorphine is also widely accepted. (ACOG 2012, NEJM 2010) A multidisciplinary approach is recommended to improve pregnancy outcomes. By utilizing a team approach, prenatal care is improved, risk for relapses is reduced, and fewer patients will return to using illicit drugs. (Goler 2008, Clark 2011)

The use of buprenorphine monotherapy, previously known as Subutex, now available only in generic, (as opposed to buprenorphine/naloxone-Suboxone®) and is recommended during pregnancy due to the risks to the fetus of acute withdrawal if the buprenorphine/naloxone combination product is misused. The use of buprenorphine monotherapy during pregnancy is a service covered by Mainecare but it requires the prescriber to complete a prior authorization form. The approval generally covers the duration of the pregnancy. Similar to non-pregnancy, the use of buprenorphine doses greater than 16 mg daily during pregnancy requires the prescriber to complete a Mainecare prior authorization form. If the pregnant patient has been in buprenorphine treatment for more than 24 months while insured by Mainecare, the prescriber will also need to complete a prior authorization form. Pregnancy and/or a child under the age of 3 meet the medical necessity criteria for continuing treatment with buprenorphine. Pregnancy and/or child under the age of 12 meet criteria for continuing methadone. Please refer to Mainecare's preferred drug list (PDL) for the most up to date information, http://www.mainecarepdl.org/pafiles

This link will take you to the state website and webinar, PowerPoint and PA documents http://www.maine.gov/dhhs/oms/provider/addiction.html

Drug withdrawal should be prevented during pregnancy. Obstetrical providers should incorporate assessment for withdrawal symptoms at each prenatal visit and communicate with treatment provider if present. Dosage of methadone or buprenorphine should be sufficient to minimize both maternal drug craving and illicit drug use and consequently prevent fetal withdrawal and/or exposure to street drugs. To be most successful, the mother must be engaged and part of the treatment plan.
Providers should facilitate access to appropriate services:

- childbirth education
- child care
- parent skill building classes
- education and career building support and information
- legal services
- child protective services
- adoption counseling
- newborn follow-up with a primary care provider
- domestic violence counseling and services
- infant development follow-up services
- WIC nutrition
- public assistance
- transportation services
- mental health services

The American College of Obstetricians and Gynecologists has recognized methadone as the mode of treatment for maintenance therapy of opioid-dependent pregnant women based on the long standing evidence around safety for mother and fetus. However, more recent studies indicate that buprenorphine may have a shorter neonatal recovery time. It also has the convenience of being a “take home” medication that can be prescribed in the context of outpatient office visits by certified physician prescribers who may be local family physicians. ACOG recommends that if buprenorphine is to be utilized during pregnancy, the woman should be informed about the lack of evidence surrounding the long-term neurodevelopmental effects of exposure to buprenorphine in utero.

Treatment can be provided in a variety of clinical settings. Whether a residential treatment center, clinic, or private physician provides the services; medical screening, substance abuse counseling and full social assessment should be included. Provision of ancillary services improves retention in treatment as well.

**BARRIERS TO TREATMENT**

The major barriers to methadone treatment are the restricted hours of operation at clinics and the distance patients have to travel every day. These issues are particularly problematic for women in school, working, or with small children at home. Access to medication and the ability to realistically comply with a treatment program must be considered in the ultimate decision making regarding medication choice. Due to limitations in the number of providers of buprenorphine and the limited
availability of methadone clinics, patients often cannot choose the medication they prefer. Prior to accepting patients maintained on buprenorphine or methadone, obstetric providers must be sure that newborn providers in their hospitals can properly care for neonates with NAS. When local care is not available, there must be planned transition late in gestation to an institution with providers trained to care for both the opioid-dependent mother and the substance exposed neonate.

PRENATAL CARE OF WOMEN WITH HISTORY OF DRUG USE
At the initial visit, the obstetrical provider should obtain consent consistent with federal and state requirements to facilitate communication with all of the patient’s providers, including the substance abuse treatment provider, counselor or psychiatrist, and other medical providers. In addition to usual prenatal care, smoking cessation/reduction counseling should be offered. HIV testing should be strongly encouraged. Screening for tuberculosis should be performed based on exposure risk.

ULTRASOUND TESTING
Pregnancy dating should be confirmed with early ultrasound as oligomenorrhea and irregular cycles are associated with opioid dependence. All patients should have complete ultrasound examinations for anatomical abnormalities by 18-20 weeks. Neither methadone nor buprenorphine are known to cause anomalies. However, lifestyle variations such as smoking, polysubstance use, diet, chaotic social environment, work or exercise have an impact on fetal growth. Clinicians should consider monthly ultrasounds starting at 28-32 weeks’ gestation based on patient’s individual risk. Doppler flow studies should be added to assess placental function when intrauterine growth restriction or oligohydramnios is suspected. Cocaine, amphetamines and tobacco particularly predispose the fetus to growth restriction and placental disruption. Alcohol exposure may also cause growth restriction. Patients still using illicit drugs, or whose lifestyles, toxicology tests, or physical signs and symptoms are concerning will require more frequent ultrasound surveillance to determine fetal wellbeing. If the patient is relatively stable in treatment and her only other risk factor is tobacco use, monthly ultrasounds are likely not necessary.

It is NOT necessary to schedule frequent fetal testing such as weekly NSTs or biophysical profiles for all patients on opioid maintenance therapy. Non-stress tests should be ordered only for usual obstetrical indications in a stable patient being treated with an opioid agonist. The fetus exposed to methadone or buprenorphine may have a less reactive NST or BPP with the greatest reduction in fetal activity noted at 2 to 3 hours after maternal dosage.

Women should receive adequate psychiatric treatment to address comorbid post traumatic stress disorder (PTSD), depression, anxiety, and eating disorders. Patients on opioid agonists often request
psychotropic medications like benzodiazepines to treat anxiety symptoms, however, the risk and benefits of additive therapy must be carefully considered. Many clinics discourage the use of benzodiazepines concurrently with opioid replacement therapy due to concerns about drug-drug interactions for the mother and increased rate and severity of abstinence symptoms in the newborn (SAMHSA TIP 43, Cleary 2012).

Patients with risk factors for sexually transmitted or blood born infections should have repeat testing for STIs, Hepatitis C and HIV in the third trimester.

**DENTAL ISSUES**

Dental disease should be treated during pregnancy. Patients insured by MaineCare may have no option other than extraction. Definitive treatment (extraction) is preferable to long term treatment for pain, multiple courses of antibiotics, and frequent ER visits. Dentists are often hesitant to treat pregnant patients, and may request guidance from the OB practitioner regarding the safety of antibiotics, analgesia, and anesthesia. A letter from the obstetrical provider may be necessary to assure treatment of these patients.

**MUSCULOSKELETAL PAIN**

Musculoskeletal pain may be the result of previous injury and is frequently exacerbated by pregnancy. MRI is safe in pregnancy if definitive diagnosis is needed. Patients should be referred to physical therapy, chiropractic, osteopathy, sports medicine, massage therapy, or acupuncture for treatment that does not involve narcotics. However, it should be noted that MaineCare does not cover all forms of complementary therapy.

**GASTROINTESTINAL PROBLEMS**

Maintenance therapy with opioids exacerbates the usual gastrointestinal problems of pregnancy. Common problems like “morning sickness” and reflux can become significantly worse for patients treated with methadone or buprenorphine, and may cause missed doses due to vomiting. Anti-emetics and antacids should be prescribed prophylactically. Patients on chronic narcotics generally have constipation. This common complication of pregnancy should be treated using a complete bowel regimen of stool softeners, fluids, fiber products, and hemorrhoid cream. The standard dose of docusate may be doubled for this population.
PAIN CONTROL

Pain control, both in labor and after surgery is a particular challenge for opioid dependent obstetrical patients and is often a source of particular anxiety. When possible, an anesthesia consultation is recommended in the third trimester. The various pharmacologic and nonpharmacologic options to manage pain in labor and their effectiveness should be discussed with the patient prior to labor onset.

TOXICOLOGY TESTING

Toxicology tests obtained without the patients’ consent can be used as information for newborn providers caring for withdrawing neonates only. The decision to perform a urine drug test must be based on medical necessity. Patients can be offered toxicology testing to verify that they are using only their prescribed medications. Toxicology tests may be medically indicated in patients who have:

- 3 visits or less prenatal care
- physical signs of substance abuse or withdrawal
- smell of alcohol and/or chemicals noted
- recent history of substance abuse or entry into treatment
- fetal distress
- placental abruption
- preterm labor
- intrauterine growth restriction (IUGR)
- unexplained, intermittent hypertensive episodes
- stroke or heart attack
- severe mood swings
- multiple medication sources

DRUG TESTING panels for drugs and alcohol vary with the lab used. Different institutions have “toxicology panels” that test for a spectrum of substances which may or may not reflect patterns of use in the local community. Providers should be knowledgeable about the composition of the panel available at their institutions because it may be necessary to order specific tests separately. Testing for methadone and metabolites and buprenorphine metabolites must be added in many institutions. Urine is most commonly tested for illicit drug use. Recent alcohol use can be detected using serum alcohol levels and urine testing for ethanal glucoride detects alcohol use within 72 hours. Results need to be confirmed before they are considered accurate. Unless a clear “chain of evidence” has been established, drug tests performed in the medical context cannot be used in a court of law. Test results are used primarily to
assist in treating the exposed neonate and determining the need for services for the mother. Testing of neonatal meconium is often performed if there is suspicion of prenatal exposure.
Chapter 3: INTRAPARTUM MANAGEMENT

Women with a history of substance abuse often have significant anxiety regarding pain control in labor, or after cesarean section. These concerns must be respected and taken seriously by accepting and supportive providers. Women who lack social support or reliable people to serve in the traditional roles of significant other, friend, or family member may subsequently require more help coping with the stress of labor than a well supported patient. Opioid dependent women usually require significantly more narcotic analgesia than the average woman in labor. Cross-tolerance with other narcotics necessitates more frequent and higher doses of narcotics used for pain control. A common misconception about methadone or buprenorphine therapy is that the dose a patient takes for maintenance will provide pain relief and that a lower dose of labor analgesia will therefore be effective. On the contrary, her usual dose of maintenance therapy should be maintained and the amount needed to achieve effective analgesia will likely be higher. If a patient is in labor or scheduled for cesarean section, she should take her usual daily dose of methadone or buproenorphine at her usual time to avoid withdrawal symptoms and anxiety. While hospitalized the patient should have her usual dose ordered by the attending provider, whether during antepartum admission, an induction of labor that may take days, or a scheduled cesarean section. The patient should be reassured that providing her with adequate pain control is important to achieve a successful and comfortable labor and delivery or cesarean section. An anesthesia consultation prior to or during the third trimester can be very helpful in alleviating the patient’s fears about pain control in labor, during a cesarean section, and postpartum/postoperatively. This provides an opportunity to explain the different modalities that are available and how they work.

Unusual complaints of pain requiring significantly higher doses of pain medication should not be viewed as “drug seeking behaviors” but should be anticipated due to the relative hyperalgesia (more sensitive to pain) associated with chronic narcotic use. **Neuraxial analgesia (spinal or epidural) may be the most effective and safest way to control pain both for vaginal births and cesarean sections,** and patients will be more receptive if they are prepared and educated. Surgical patients delivered with general anesthesia will usually need a PCA with morphine or dilaudid to control post cesarean section pain. Women maintained on methadone or buprenorphine should continue to take their established dose through labor and delivery and into the postpartum period.

Some patients and providers fear that using opioids for pain management will lead to a loss of control and fear re-addiction. Patients can be reassured that the methadone or buprenorphine will block the euphoric effects of opioid analgesia which will still provide pain relief. If nausea and vomiting is a
problem, patients should be pre-medicated with anti-emetics so that they can tolerate oral medications and food. Patients on methadone maintenance who have developed a prolonged Q-T interval should be treated with phenergan rather than zofran. Patients who cannot tolerate oral medication can be treated parenterally. Central lines or PICC lines may be needed in patients with a history of IV drug use with sclerotic veins.

Narcotics with mixed agonist/antagonist properties are **contraindicated** for pain relief in opioid dependent patients, as these drugs may precipitate withdrawal. Examples include: Talwin (pentazocine), Stadol (butorphanol), and nubain (nalbuphine). If inadvertent administration occurs, and the patient has withdrawal symptoms, an opioid agonist should be administered to alleviate withdrawal symptoms. Examples: morphine, fentanyl, Demerol.
Chapter 4: POSTPARTUM MANAGEMENT

Mandatory notification to DHHS and Institutional Policies:
Whenever possible, patients should be advised prior to admission for delivery that a notification will be made to DHHS in compliance with federal and state laws regarding drug affected neonates. Patients, who are late registrants, or those who have had no prenatal care, may need to be informed after delivery. Patients benefit from meeting with the social worker in the antepartum period to alleviate their fears and prepare them for DHHS notification. Patients should also be informed of their institution’s policy on breast feeding and marijuana use earlier in pregnancy, but may need to have protocols explained again after delivery.

It may be helpful to mothers to be educated about NAS scoring – how it works, how it impacts length of stay for their neonate, whether or not they will be able to breastfeed or not, whether they will be able to stay at the hospital or an “off campus” facility. Mothers should be advised that the infant going through NAS may be very difficult to soothe.

Breastfeeding:
New mothers should be encouraged to hold and spend time with their infants as well as breastfeed when appropriate. “Skin to skin contact” and “rooming in” are encouraged. Patients with hepatitis B and C may be encouraged to breastfeed as long as they are not HIV positive. Breastfeeding is not limited by methadone or buprenorphine usage or dosage, as the small amounts that cross into the breast milk may reduce the severity of neonatal withdrawal symptoms. Caution against the abrupt cessation of breast feeding should be advised particularly in women maintained on methadone due to the possibility of rebound NAS that has been reported in the literature. The American Academy of Pediatrics does not support breastfeeding in women who use marijuana. This is due to the retention of the drug in “fatty” breast cells leading to bioaccumulation in breast milk. Patients using marijuana throughout their pregnancy as an anti-emetic should be made aware of this limitation early in gestation, particularly as THC is easily picked up in toxicology screens weeks after use. The following resource may be used to determine breastfeeding compatibility: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Postpartum and pain control:
After a vaginal delivery, acetaminophen and non-steroidal anti-inflammatory agents should be used for mild to moderate pain. Short-acting opioid analgesics can be added on an as needed basis. Opioids for pain control should not be needed following discharge for a routine vaginal delivery, except in special
cases, (i.e. third and fourth degree tears). In cases of cesarean section deliveries, patient controlled IV analgesia or duramorph added to the spinal can assist with pain for the first 24 hours. Oral opioids can be added for break-through pain and can be utilized for the next week or longer in addition to the maintenance medication (methadone or buprenorphine). Upon discharge patients will often need a written letter from their provider that documents what medications they received in the hospital, including dose, date, and time.

Studies have shown that methadone-maintained patients have increased postpartum pain and require up to 70% more oxycodone equivalents after cesarean section deliveries than the average patient. (This is about 1.5 times to 2 times the usual dose of opioid analgesic.) Narcotics that are opioid agonists such as morphine, or fentanyl or dilaudid should be prescribed at more frequent intervals and higher doses, as dictated by patient response. Hydromorphone may need to be substituted for oxycodone for effective control of post-operative pain in this patient population. Patients who become somnolent or appear overmedicated can have dosages adjusted appropriately, but their providers need to be informed of the changes.
APPENDIX A

Screening Tools

Screening instruments specifically validated for use during pregnancy:

4P’s - 4 questions, screens for alcohol and drug use
CRAFFT - valid for use in adolescents, piloted in pregnancy
PHQ9 – depression
Edinburgh-postpartum depression
WAST-domestic violence
PVS-domestic violence

4P’s

The 4 P’s has been tested and validated and effectively identifies pregnant women at highest risk for substance use during pregnancy.

Administration Time: 3 to 5 min.

Parents

Did any of your parents have a problem with alcohol or other drug use?

Partner

Does your partner have a problem with alcohol or other drug use?

Past

In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?

Present

In the past month have you drunk any alcohol or used other drugs?

Scoring: Any “yes” should trigger further questions
Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990

CRAFFT*

C – Have you ever ridden in a car driven by someone (including yourself) that was “high” or had been using alcohol or drugs?
R – Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
A – Do you ever use alcohol or drugs while you are by yourself, alone?
F – Do you ever forget things you did while using alcohol or drugs?
F – Do your family or friends ever tell you that you should cut down on your drinking or drug use?
T – Have you ever gotten into trouble while you were using alcohol or drugs?

Scoring Instructions:

CRAFFT Scoring: Each “yes” response scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment

CRAFFT is available in multiple languages by going to:

http://www.ceasar-boston.org/CRAFFT/selfCRAFFT.php
**Domestic Violence Screening Tools**

**WAST**

1. In general, how would you describe your relationship—a lot of tension, some tension, no tension?
2. Do you and your partner work out arguments with great difficulty, some difficulty, or no difficulty?
3. Do arguments ever result in you feeling down or bad about yourself? often, sometimes, never
4. Do arguments ever result in hitting, kicking, or pushing? often, sometimes, never
5. Do you ever feel frightened by what your partner says or does? often, sometimes, never
6. Has your partner ever abused you physically? often, sometimes, never
7. Has your partner ever abused you emotionally? often, sometimes, never
8. Has your partner ever abused you sexually?

A score of 4 indicates exposure to IPV

**PVS**

1. Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Scoring: Positive response to any question denotes abuse
**Depression Screening**

**PHQ9 Depression**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Feeling bad about yourself - or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Moving or speaking so slowly that other people could have noticed - Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Free copy for download by going to:  [http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire_sample/](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire_sample/)
Edinburgh Postpartum Depression Screening

The Edinburgh Post Natal Depression Scale (EPDS)

(J.L. Cox, J.M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburgh)

The Edinburgh Postnatal Depression Scale (EDPS) was developed in 1987 to help doctors determine whether a mother may be suffering from postpartum depression. The scale has since been validated, and evidence from a number of research studies has confirmed the tool to be both reliable and sensitive in detecting depression. During the postpartum period, 10 to 15% of women develop significant symptoms of depression or anxiety. Unfortunately, many moms are never treated, and although they may be coping, their enjoyment of life and family dynamics may be seriously affected.

Instructions:

Please select the answer which comes closest to how you have felt in the past 7 days – not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things -
   a. As much as I always could
   b. Not quite so much now
   c. Definitely not so much now
   d. Not at all

2. I have looked forward with enjoyment to things -
   a. As much as I ever did
   b. Rather less than I used to
   c. Definitely less than I used to
   d. Hardly at all

3. I have blamed myself unnecessarily when things went wrong -
   a. Yes, most of the time
   b. Yes, some of the time
   c. Not very often
   d. No, never
4. I have been anxious or worried for no good reason -
   a. No, not at all
   b. Hardly ever
   c. Yes, sometimes
   d. Yes, very often

5. I have felt scared or panicky for no good reason -
   a. Yes, quite a lot
   b. Yes, sometimes
   c. No, not much
   d. No, not at all

6. Things have been getting on top of me -
   a. Yes, most of the time I haven’t been able to cope at all
   b. Yes, sometimes I haven’t been coping as well as usual
   c. No, most of the time I have coped quite well
   d. No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping -
   a. Yes, most of the time
   b. Yes, some of the time
   c. Not very often
   d. No, not at all

8. I have felt sad or miserable -
   a. Yes, most of the time
   b. Yes, some of the time
   c. Not very often
   d. No, not at all

9. I have been so unhappy that I have been crying -
   a. Yes, most of the time
   b. Yes, quite often
   c. Only occasionally
   d. No, never

10. The thought of harming myself has occurred to me -
   a. Yes, quite often
   b. Sometimes
   c. Hardly ever
   d. Never
Appendix B

**Policy Title: Guidelines for Intrapartum Testing for Substance Use among Pregnant Women**

**Purpose:**

1. To improve providers’ ability to effectively identify and refer pregnant women for treatment of substance use during pregnancy.
2. To standardize guidelines for testing for prenatal drug exposure.
3. To improve the health and well-being of pregnant women and their fetus/newborn.

Performed by: All healthcare practitioners providing care for pregnant women admitted to labor and delivery.

**Protocol:** A urine drug test will be performed with patient consent on pregnant women admitted to labor and delivery, who meet the following criteria:

1. Known or suspected current substance abuse and/or substance abuse within the last year.
2. Non-adherence to recommended prenatal care (no prenatal care, history of inconsistent prenatal care with 3 visits or less, or entry to prenatal care later than 24 wks).
3. Medical history of Hepatitis B, Hepatitis C, or HIV.
4. Signs of abuse of prescribed substances and/or abuse of any illicit or non-prescribed substance (i.e., physical signs of substance abuse or withdrawal, intoxication (smell of alcohol or chemicals), admission of illicit drug use, inappropriate behavior, frequent and unscheduled evaluations at the office and hospital, multiple Emergency Room presentations with complaints of pain, suicidal ideation and self-harm, and self-mutilation, severe mood swings, multiple medication sources).

**Consider testing women, on a case-by-case basis, who:**

1. Present with preterm labor, fetal distress, IUGR (intrauterine growth restriction), preterm birth, or placental abruption, unexplained onset hypertension (significant change in baseline blood pressure), stroke, heart attack, multiple episodes of nausea and vomiting, anxiety, and/or abdominal pain.
2. Are currently participating in an opiate replacement program depending on the availability of previous drug screening and/or communication with the substance abuse treatment program.
3. Has a child in DHHS custody if a previous history of substance abuse is documented.

**Guidelines:**

1. The healthcare provider will inform the pregnant woman who meets these criteria of the medical indication for a urine drug test and this notification should be documented in the patient’s medical record. The patient will have the ability to decline testing. A social work consult should be considered if this is the case and the newborn’s provider should be notified.

2. A urine drug test should include assays for opiates, oxycodone, methadone, hydrocodone, benzodiazepines, marijuana, cocaine, amphetamines, and buprenorphine. Ethyl Glucuronide should be considered if alcohol intake within 72 hours is suspected. *If a provider is uncertain how to interpret the results of a urine drug screen, he/she should contact the hospital’s laboratory and/or pathologist as needed. When lab results from a urine drug test will not be available until more than 24 hours, the newborn’s provider should be notified to allow a meconium sample for drug testing.*

3. Providers should be aware that a negative urine drug test does not rule out the possibility of drug use during pregnancy. In addition, false positives can occur which must be ruled out by confirmatory testing.

4. If a pregnant woman has a urine drug test that is positive for illicit substances that she did not disclose, a confirmatory test should be sent. If the urine test was not done upon first arrival to the maternity unit, the women’s medical record should be reviewed to see what medications were administered prior to the urine screen.

5. If a woman’s urine drug test is positive, the newborn’s provider should be notified and a social services consult should be ordered.
Appendix C

Policy Title: Drug Screening and Notification of Newborn Drug Exposure

Policy Statement: A meconium toxicology test will be performed on a newborn known or suspected of prenatal drug exposure. A newborn urine toxicology test will be sent if the mother refuses a urine toxicology screen, if the mother meets maternal criteria, or if the provider was unable to obtain a maternal toxicology screen within 8 hours of admission to Labor and Delivery.

**Purpose:**

1. To improve providers’ ability to effectively identify newborns exposed to prescribed and non-prescribed substances that cause withdrawal symptoms.
2. To standardize guidelines for neonatal screening for prenatal drug and alcohol exposure.
3. To improve the health and well being of at-risk newborns.
4. To identify opportunities for early intervention and referral to available resources for families of at-risk newborns.

**Performed by:**

All healthcare practitioners providing care for neonates admitted to the hospital.

**Protocol:** A meconium drug screen will be performed on newborns meeting the following criteria:

1. The newborn manifests signs and symptoms consistent with withdrawal from exposure to drugs in utero.

2. Maternal urine toxicology screen is positive of substances not prescribed or the mother meets criteria for substance use and urine drug screen was not sent.

3. Unexplained intrauterine growth restriction (IUGR) and/or head circumference less than 10th percentile (ACOG 2007).

4. If a mother has been tested for substance use during the admission for delivery of the newborn, a urine drug screen on the baby is not indicated, as the results are not expected to be different than those of the mother. If the mother has not been tested during the admission for delivery of the newborn and meets screening criteria, the newborn provider should consider ordering a urine toxicology screen for prompt identification of recent substance exposure in addition to a meconium testing.
Guidelines:

1. The health care provider or nurse reviews the prenatal record, admission assessment and lab results for an indication of maternal drug use during the prior year, with or without a prescription, or that the mother has 3 or less prenatal visits, entry to care later than 24 weeks, or no prenatal care.

2. The health care provider, nurse or social worker informs the mother of the need to obtain a drug screen on the baby “...according to our policy.” The provider should explain the rationale for the testing, which should include, but not necessarily be limited to, proper medical management of the newborn, as well as identification of the need for and referral to early intervention services based on substance exposure. This notification should be documented in the newborn’s medical record.

3. If a parent refuses the recommended testing on the baby after being notified of the policy for such testing, they should be informed that their refusal will be noted but the test will still be completed. Testing the baby after parental refusal is deemed acceptable given that the testing involves no risk of harm to the baby and the best interests of the baby are being served through proper identification and intervention for factors that will have an impact on the child’s physical and developmental well-being both in the acute care setting and post-discharge.

4. The nurse initiates drug screen order set and obtains first available meconium (urine as needed).

5. Urine and meconium drug screens should test for oxycodone, buprenorphine, methadone, hydrocodone, opiates, benzodiazepines, marijuana, amphetamines and cocaine not necessarily in that order. Every institution will need to explore what drugs are tested for in their drug screening panel and may need to specifically ask for the certain tests. If the healthcare provider is not familiar with interpreting these tests, he/she should contact the hospital’s lab and/or pathologist as needed.

6. The nurse will inform the newborn’s health care provider that a meconium (and urine as needed) has been obtained because of maternal drug use, status of prenatal care, or newborn withdrawal symptoms. A system should be set up on the newborn unit to track results of meconium screening once ordered. If a urine toxicology screen is ordered because a maternal urine screen is not available and the result is positive, a confirmatory urine toxicology screen should be sent if the mother denies using the illicit substance.
7. If the newborn is at risk of narcotic withdrawal or demonstrates withdrawal symptoms, the nurse will initiate the clinical practice guidelines around Neonatal Abstinence Syndrome (NAS) including an objective scoring system such as Finnegan within 2 hours of birth. Of note, the Finnegan Scoring system was developed for use in assessing babies with narcotic withdrawal in the first month of life. If the tool is used at greater than one month of age, consideration must be made for developmental norms, such as decreased amounts of sleep and improving muscle tone over time. It is not been validated for infants exposed to antidepressants or other substances that may cause a withdrawal syndrome in infants.

8. Newborns should be hospitalized for at least 5 days after birth to observe for withdrawal symptoms and determine if further treatment is necessary. While observing the infant in the hospital, symptomatic care should be provided including rooming in as much as possible, swaddling, holding, skin to skin contact with parents, decreased stimulation (light, noise, tactile), and the use of pacifiers as desired. Also consider increasing the caloric density of breast milk or formula if the infant requires pharmacologic treatment for NAS. If the infant needs pharmacologic treatment, refer to hospital treatment guidelines.

9. The nurse will report NAS scores to the newborn’s health care provider.

10. The newborn’s health care provider will report the results to the mother and review the treatment plan if intervention is necessary.

11. When either maternal or neonatal factors are present to indicate a need to test for substance use/exposure, a social services or clinical counselor consult should be ordered. A social worker or clinical counselor will complete a psychosocial assessment of the family and provide recommendations to the medical team for safe discharge planning. This may include notification by the social worker (or health care provider in the absence of a social worker) to the Department of Health and Human Services (DHHS) regarding the baby having been affected by one or more drugs during the pregnancy according to Maine State Law Infants Born Affected by Substance Abuse or After Prenatal Exposure to Drugs (2003) Department of Health and Welfare, Title 22, Chapter 1071, Section 4004B and 4011B. Additional intervention by the social worker may be offered and will be based on an assessment of the parent’s present stage of change. If there are any signs of child abuse and neglect, a report should be made to DHHS.
12. Referrals to Child Development Services (CDS), Public Health Nursing (PHN), and to the newborn’s primary care provider should be initiated to inform them of infant’s medical care in hospital and need for future services. A referral should also be considered to the Maine Families network.
### Appendix D: Finnegan Scoring Tool

#### NEONATAL ABSTINENCE SCORING SYSTEM

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>SIGNS AND SYMPTOMS</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Continuous High Pitched (or other) Cry</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuous High Pitched (or other) Cry</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleeps &lt;1 Hour After Feeding</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleeps &lt;2 Hours After Feeding</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Sleeps &lt;3 Hours After Feeding</td>
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<td></td>
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<tr>
<td></td>
<td>Hyperactive Moro Reflex</td>
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<td></td>
</tr>
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<td></td>
<td>Markedly Hyperactive Moro Reflex</td>
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<td></td>
<td>Mild Tremors Disturbed</td>
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<tr>
<td></td>
<td>Moderate-Severe Tremors Disturbed</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild Tremors Undisturbed</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate-Severe Tremors Undisturbed</td>
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<td></td>
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<tr>
<td></td>
<td>Increased Muscle Tone</td>
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<td></td>
<td>Excoriation (Specific Area)</td>
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<tr>
<td></td>
<td>Myoclonic Jerks</td>
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<tr>
<td></td>
<td>Generalized Convulsions</td>
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<td></td>
<td>Sweating</td>
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<tr>
<td></td>
<td>Fever 100.4°-101°F (38°-38.3°C)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Fever &gt; 101°F (38.3°C)</td>
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<td></td>
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<tr>
<td></td>
<td>Frequent Yawning (&gt;3-4 times/interval)</td>
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<td></td>
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<tr>
<td></td>
<td>Mottling</td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>Nasal Stuffiness</td>
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<td>Sneezing (&gt;3-4 times/interval)</td>
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<tr>
<td></td>
<td>Nasal Firing</td>
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<td>Respiratory Rate &gt;60/min</td>
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<td>Respiratory Rate &gt; 60/min with Retractions</td>
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<td>Regurgitation</td>
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<td>Projectile Vomiting</td>
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<tr>
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<td>Loose Stools</td>
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<tr>
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<td>Watery Stools</td>
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</table>

**TOTAL SCORE**

**INITIALS OF SCORER**
## Appendix E:

### Drug Affected Infant Referral

<table>
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<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Referent (person sending report):</td>
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<tr>
<td>Hospital:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Requesting Confidentiality?</td>
<td></td>
</tr>
<tr>
<td>Child:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Mainecare#:</td>
<td></td>
</tr>
<tr>
<td>Birth Weight:</td>
<td></td>
</tr>
<tr>
<td>Gestational Age:</td>
<td></td>
</tr>
<tr>
<td>Mother:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Siblings:</td>
<td></td>
</tr>
<tr>
<td>1)</td>
<td>DOB/Age:</td>
</tr>
<tr>
<td>2)</td>
<td>DOB/Age:</td>
</tr>
<tr>
<td>3)</td>
<td>DOB/Age:</td>
</tr>
<tr>
<td>Father:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
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<tr>
<td>Fax to: Infant’s Primary Care Provider:</td>
<td></td>
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</tbody>
</table>
Fax Number:

PHN: fax number: (207) 561-4467

DAB: email to intakereports.dhhs@maine.gov, phone 1-800-452-1999

CDS: call 1-877-770-8883 (this form not adapted fully yet for fax use for CDS due to confidentiality issues)

**Prenatal Care** *(To be completed in Obstetric Care Providers Office)*

Provider Name:

Address:

Phone:

Mother’s prenatal care (please indicate whether none, less than 3 visits, late care, routine care, etc):

Pregnancy complications (if yes, describe):

Medications/drugs taken by mother during the pregnancy (please list medications/drugs and indicate whether each was prescribed or illicit):

Did the mother self-disclose her drug use?

Did the mother have a urine drug screen?

If positive, was confirmatory testing completed?

Enrolled in narcotic treatment program?

Provider Name:

Address:

Phone:

**Newborn Care** *(To be completed hospital by nursing or newborn physician or social worker prior to discharge)*

Which substances affected the infant? (Please list all that apply and indicate whether prescribed or illicit):

Was the infant drug screened? (if yes, please indicate what method of screening was employed):
Is the infant experiencing withdrawal symptoms? (if yes, describe):

If the baby has Neonatal Abstinence Syndrome, are the Finnegan Scores:
Mild (less than 8)  Moderate (8-12)  Severe (12 or higher)

What care is the infant now receiving? *(Observation only, medication, other – describe)*:

What specialized care will the parents need to provide to the infant after discharge? (medication, specialty formula, etc. Please describe):

Is the mother breastfeeding?
Lactation Support in Hospital?
Lactation support needed at home?

**Family Assessment** *(To be completed by Hospital Social Worker or Nursing Staff)*

What observations have been made of the parent’s interactions with the infant?
What are the current living arrangements?

What preparations have the parents made for the infant’s care? (does the family have diapers, crib, car seat, clothing, formula if needed, etc).

What Services have been offered and accepted by the parents and when will those services begin?

What additional supports are available to the infant and parents *(family, church, community based services)*?

Domestic Violence Issues *(if yes, describe; please indicate whether current or past and details)*:

Mental Health Issues *(if yes, describe)*:
In treatment?

Provider Name:

Address:

Phone:

Household member substance abuse *(if yes, describe)*:

Treatment Location:

Provider Name:

Address:

Phone:

Service Providers:

Provider Name:

Address:

Phone:

Relative resources:

Relative Name:

Relationship:

Address:

Phone:

Native American heritage (ICWA):

If yes, please indicate tribal affiliation:

Primary Language:

Was an interpreter used in the hospital?
APPENDIX F

Maine Office of Substance Abuse
11 State House Station
41 Anthony Avenue, Augusta Maine 04333-0011
Phone: 1-800-499-0027 or (207) 287-8900
All TTY users call Maine Relay 711
Email: osa.ircosa@maine.gov
Online: http://www.maineosa.org

Maine Office of Substance Abuse Programs & Service Directory
This online searchable directory is the most up-to-date listing of Maine agencies and programs
http://www.maineosa.org/help/directory.htm

SAMHSA Buprenorphine Physician & Treatment Program Locator (by State)
The Locator is an on-line resource designed to assist States, medical and addiction treatment communities, potential patients, and/or their families in finding information on locating physicians and treatment programs authorized to treat opioid addiction with buprenorphine (Suboxone® and Subutex®)
http://buprenorphine.samhsa.gov/bwns_locator/

The Women’s Project
Southern Maine: 1-800-611-1588
Northern Maine: 1-800-611-1779

2-1-1 Maine
A comprehensive statewide directory of over 8,000 health and human services available in Maine
Dial 211

24-Hour Statewide Crisis Hotline
If you are concerned about yourself or about somebody else, call the crisis hotline. This will connect you to your closest crisis center.
1-888-568-1112
APPENDIX G

Treatment Definitions:

Below is a listing of Substance Abuse treatment options and definitions. It is important to remember that this is a simply a guideline for reference and you are not responsible for determining what level of treatment your patient needs.

Co-Occurring (Integrated) Treatment:

Many individuals who have been diagnosed with a substance abuse disorder also have co-occurring mental health conditions and/or diagnoses. Agencies that provide co-occurring or integrated treatment provide treatment that addresses both issues at the same time and following the same track, not treating them as separate diagnoses.

DSAT (Differential Substance Abuse Treatment):

DSAT is a treatment program designed to reduce substance abuse and related criminal behaviour within the Maine offender population. This treatment is an evidenced based practice that addresses the different needs of men and women in substance abuse treatment, but also the individual level of substance use severity. This model can be used in institutional and/or community outpatient services.

Detoxification "Detox":

A "detox" may be a hospital based or outpatient program that helps stabilize people who are experiencing withdrawal from alcohol or other drugs. These programs provide evaluation, observation, medical monitoring, and addiction treatment in a short term inpatient setting.

Detoxification Management:

This service includes a call center and coordination of services provided by Aroostook Mental Health Center (AMHC) for individuals looking for a "detox" program in the northern Maine region. This service includes a central access point where individuals call and AMHC helps to access a "detox" bed in various hospitals in the Region III area (Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties.)

Emergency Shelter:

This service provides food, lodging, and clothing for individuals who abuse alcohol and other drugs, with the purpose of helping people enter alcohol and drug treatment. Shelter services are provided at least 12 hours per day, with some shelter services providing 24 hour care. Services include referrals for
detoxification, arrangements for needed health care services, transportation, and help with coordinating care.

**Extended Care:**
Extended Care provides a residential treatment program for more than 180 days to individuals with extensive substance abuse or co-occurring substance abuse and mental health conditions. This service includes a structured environment where substance abuse treatment is provided along with life skills training, relapse prevention, and the development of a social network that supports recovery.

**Halfway House:**
Halfway house is a residential program that provides less intense treatment services to support recovery from substance abuse. It is designed to improve the individual’s ability to structure and organize daily living and recovery. Services include assessment, group/individual/family counseling, life skills, employment preparation, transportation between programs and coordination of services.

**Intensive Outpatient Services:**
These services are located at an agency office and provide intensive and structured substance abuse treatment, three to four days a week. The programs usually last three or four weeks and may be conducted during the daytime or in the evening.

**Outpatient Services:**
These services are located at an agency office and provide individual, group, and family sessions, usually for an hour or ninety minutes once a week.

**Medication Assisted Treatment for Addiction:**

**Opioid Treatment Program (OTP)** - Under medical supervision for maintenance or detoxification, OTP clinics administer opioid agonist medication (such as methadone), monitor dosages, and provide counseling to people with a dependence on heroin or prescription opioid medications.

**Other:** Some other forms of Medication Assisted Treatment used for detoxification and/or long term treatment include, but is not limited to, Suboxone, Buprenorphine, Subutex, Vivitrol, and Antabuse which are prescribed medications by a physician in an inpatient or outpatient setting.
**Residential Rehabilitation:**
Residential rehabilitation services are designed to treat persons who have significant social and psychological problems. The goals of treatment are to promote abstinence from substance use and enhance participant’s lifestyles, attitudes, and values. For placement in this level of service an individual would have multiple challenges, which may include substance related disorders, criminal activity, mental health problems, and impaired functioning.

**Residential Rehabilitation – Adolescent:**
Residential rehabilitation services as described above that are designed to treat adolescents who have significant social and psychological problems.

**Residential Rehabilitation 1:**
Residential rehabilitation services as described above that are designed to treat persons (specifically women and their children) who have significant social and psychological problems.
Controlled Substances Contract

Controlled Substances are regulated by law and my Doctor needs a special license to prescribe them. These medicines are controlled because they have a risk of addiction and drug abuse.

This contract lists the conditions for my use of controlled substances.

1. I will only use controlled substances that are prescribed by my doctor, named below. If another person prescribes a controlled substance for me, I will let my doctor know immediately.

2. I will use the medication only as prescribed. I will not sell, share or trade my medication.

3. I will not use any illegal substances or controlled substances that were not prescribed to me.

4. I will fill my prescriptions for controlled substances only at one pharmacy, named below. I will let my doctor know immediately if I change pharmacies.

5. I will keep my medications in a safe place. I know that lost or stolen prescriptions will not be replaced.

6. I will call for refills at least 24 hours before my medication runs out. Refill requests made on Friday will not be completed until the following Monday. Refills will not be issued after hours or on weekends or holidays. If I feel I need a change in my dose of controlled substance, I will discuss this with my provider before making a change in the dose. Otherwise no early refills will be granted. If I use up my controlled substance before I am due for a refill, I will have to do without this medication until I am due for a refill.

7. I agree to provide a urine sample for drug testing at any time.

8. I agree to bring my controlled substance pills in for a pill count at any time at the request of my doctor.
9. I understand that breaking this contract will result in stopping my controlled substance prescription.

10. Additionally, there may be other reasons my controlled substance prescription may be discontinued, such as 1) chronic pain, which may require referral to a pain clinic, 2) the treatment is not working, 3) missing appointments or other inappropriate behavior, 4) my doctor determines that the source of my pain is not obstetrical or gynecologic.

Patient Signature/Date____________________________________________________________

Patient Name/DOB_______________________________________________________________

Doctor Signature/Date____________________________________________________________

Pharmacy______________________________________________________________________
Patient Name: ________________________________ DOB: __________

1. I understand that I have been diagnosed with opioid dependence. I have elected to enter MDFMR’s outpatient buprenorphine treatment program.

2. I understand that buprenorphine is a narcotic medication and that buprenorphine, like all narcotics, may make me drowsy. If I have this side effect, I should not drive, operate equipment, or perform any duty or task that requires complete mental or physical alertness.

3. I understand that not everyone is appropriate for treatment with buprenorphine. If, at any point within treatment, my provider thinks that methadone is a more appropriate treatment option for me, I will be referred to a methadone clinic. In these cases, I understand that MDFMR is not obligated to provide any further buprenorphine prescriptions and that MDFMR has no control over the availability of treatment at methadone clinics.

4. I agree to take my buprenorphine only as prescribed. I will not increase my dose or frequency of use under any circumstances. The only person who can adjust my buprenorphine dose is my provider. If I take more buprenorphine than I am prescribed, I understand that my prescription will not be refilled early and may not be refilled at all.

5. I understand that any lost, misplaced, or stolen buprenorphine prescriptions or medication will not be replaced or refilled early even if I have a police report.

6. I understand that I need to meet regularly with my provider to assess my progress. Depending upon my individual needs, these visits may be up to daily. I understand that, even if I am stable in recovery, I need to schedule an office visit at least once a month. It is my responsibility to schedule these appointments.

7. I understand that my buprenorphine may not be refilled if I am not able to attend my appointments as scheduled.
8. I understand that frequent cancellations and/or no shows for office visits will be considered a violation of this contract.

9. I will abstain from the use of medications and/or substances not prescribed to me (both legal and illegal) during my treatment for opioid dependence. I will also abstain from alcohol, and other sedatives, anxiolytics, or tranquilizers, which may have an addictive effect, as well as any and all paraphernalia.

10. I understand that the misuse of buprenorphine on its own or in combination with other substances particularly benzodiazepines and alcohol may result in drug overdose and/or death.

11. I understand that it is my responsibility to be sure that MDFMR can reach me. I understand that MDFMR must have at least two ways to contact me by phone including by voicemail. I must return voicemail messages within 24 hours. If my phone numbers change, I must notify MDFMR within 24 hours.

12. If I use more than one last name (i.e., a maiden and married name), I will provide a list of these names to MDFMR.

13. I understand that if prescriptions for narcotics and/or other controlled substances are needed, these medications should only be prescribed by MDFMR. If I am in treatment with another specialist, I will notify MDFMR of any new medications or changes to my current medication regimen within 48 hours.

14. If I need to seek emergency care and I think that I have been prescribed, and/or provided with, a narcotic medication or other controlled substance, I must notify MDFMR within 24 hours.

15. I understand that substance abuse counseling is a mandatory component of MDFMR’s buprenorphine treatment program. My provider will help me identify the best counseling option. I understand that the frequency and/or type of counseling may depend upon my recovery progress. My provider may require me to attend more intensive treatment at any time. I understand that failure to comply with these recommendations is grounds for dismissal.

16. I understand that I must sign a release for MDFMR to speak with my substance abuse counselor.
17. I understand that I am expected to keep a record of my substance abuse counseling and that I need to present this to my provider at every office visit.

18. I understand that, if I do not complete my counseling requirements, I will likely no longer be able to receive care at MDFMR’s buprenorphine treatment program.

19. I understand that I am expected to leave a urine drug screen at every visit. I will only supply my own urine and I agree not to tamper with my urine in any way. If I am unable to leave a urine sample, I understand that I may be asked to leave a catheterized specimen prior to receiving my medication.

20. I understand that the collection of my urine drug screen may be observed by a member of the MDFMR clinical staff at any time.

21. I agree to random urine and/or blood tests to assess my compliance with my prescribed medications, including buprenorphine.

22. I also agree to random requests for medication verification through pill/film counts.

23. I understand that I will be asked to present for a random urine drug screen and/or pill/film count within 24 hours. I understand that failure to comply with this request will be considered a violation of this contract.

24. I understand that if my provider determines that the medication has lost its effectiveness in increasing my function, I will promptly taper off the medication.

25. I understand the eventual goal is to taper my buprenorphine while in outpatient treatment.

26. I understand that I must behave appropriately at all times. Abusive and/or threatening behavior, physical or verbal, will not be tolerated and are grounds for immediate dismissal. Illegal activities including, but not limited to, prescription alterations and/or selling prescribed medications are also grounds for immediate dismissal. I understand that MDFMR will also notify the appropriate authorities as indicated.
27. I understand and agree to the release of all information regarding my use or misuse of medication, whether legal or illegal, by MDFMR to any pharmacy, other physician, or medical treatment facility to which my provider deems medically necessary.

28. I understand that, like all health care providers, MDFMR’s providers are mandated reporters of suspected abuse, neglect or exploitation of certain groups of people including children. Maine also has a specific law mandating the referral of all drug affected infants to DHHS.

29. I understand that it is not the responsibility of MDFMR or MaineGeneral Medical Center to supply any of my medications, and I am solely responsible for them.

30. I understand that buprenorphine is pregnancy category C. It is my responsibility to notify my provider if I think I might be pregnant, if I am trying to get pregnant or if I am not always using contraception when I am sexually active. Under these circumstances, buprenorphine may or may not be the right medication for me.

31. I am aware that failure to comply with any of the rules in this contract is grounds for my dismissal from the program without further medications or a rapid taper off of the medication (at a rate at or above 25% per day).

I have read, understand, and have been afforded answers to any and all questions that I have asked. By signing this contract, I agree to all the conditions of this contract.

________________________________________  ____________________________
Patient name (Print)                                      Date

________________________________________  ____________________________
Patient Signature                                       Date

________________________________________  ____________________________
Provider Signature                                      Date
Appendix I

References


ACOG Committee Opinion No. 294, May 2004 At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice


ACNM, 2004 Position statement: Addiction in pregnancy


Appendix J: Patient Education Resources

A. Screening and Substance Use during Pregnancy

B. Caregiver for NAS baby Tri-fold

Your Baby and Neonatal Narcotic Abstinence Syndrome

Your baby is at risk for Neonatal Narcotic Abstinence Syndrome (NAS). NAS is a group of signs and symptoms of withdrawal that a baby can have when a mother has taken certain medications during her pregnancy. These medications include methadone, Subutex, Oxycontin, Vicodin, and Codeine.

Many babies exposed to these drugs will have to spend more time in the hospital than other newborn babies. The exact length of time that your baby will stay is not known. It will depend on if your baby has withdrawal, how severe the withdrawal is, and how long it takes to wean the medications to doses safe for discharge. It is common for babies to be in the hospital for two weeks. Please remember: all babies are different. Withdrawal happens in different ways.

If your baby is healthy at birth, he or she will go to the newborn nursery. Withdrawal from medications can take five to seven days. The nurses will watch your baby closely beginning at birth. They will give him or her a “score” every three hours. The nurses use a special form to check withdrawal symptoms in newborns.

If your baby’s score or clinical condition shows withdrawal, your baby will be moved to another unit. Nurses and doctors there will keep watching your baby. If needed, they will give medication to lessen your baby’s withdrawal symptoms.

During withdrawal, your baby may:
- Be irritable or difficult to comfort
- Feed poorly, spit, vomit, have diarrhea
- Have more jaundice (yellow skin)
- Have a hard time sleeping
- Suck very strongly or with no coordination
- Be jittery
- Have higher risk of seizures
- Have frequent hiccoughs and/or sneezing
• Have mild fever
• Sweat
• Have diaper rash

**You can help comfort your baby by:**

• Holding
• Skin-to-skin contact (kangaroo care)
• Rocking gently
• Swaddling
• Offering a pacifier
• Not waking him or her between feedings
• Allowing less light and noise in the room

If these do not help your baby, medications may be considered. These may be Phenobarbital and Morphine. Your baby’s doctor will review the symptoms and how strong they are, then choose what is best for your baby.

**We encourage breastfeeding if:**

• Your urine toxicology testing is negative when you are admitted to the hospital
• You are HIV negative

You and your baby’s doctor should review all drugs and doses you are taking before beginning or continuing breastfeeding.

**Resources:**

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

[www.samhsa.gov](http://www.samhsa.gov)
Substance Abuse and Mental Health Services Administration

[www.ibreastfeeding.com](http://www.ibreastfeeding.com)
[www.drugabuse.gov](http://www.drugabuse.gov)
National Institute on Drug Abuse

Public Health Nursing in Maine
Statewide Central Referral
(During pregnancy and for newborns)
1-877-763-0438
Care for You and Your Baby:

NAS

This guide is a gift for you and your baby to help you learn about the care given to your baby.
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INTRODUCTION

Congratulations on the birth or upcoming birth of your baby!

The early moments with your baby can be both exciting and overwhelming. This book will review what to expect with a new baby who may be having symptoms of withdrawal. This guide can also help others who may care for your baby, including relatives and day care providers.

We all have the goal – to help you and your baby through the withdrawal process to plan for discharge home as soon as possible.

How do I use this book?

This guide has three parts:
Part One: What to expect Before You Deliver
Part Two: Care in the Hospital
Part Three: Transition to Home.

We suggest you read it from the beginning. The back of the book has a list of symptoms with some suggestions that may help. There is also a glossary of words which may be helpful during your hospitalization.

PART ONE

What to expect before you deliver:

The days and weeks before the birth of your baby are very exciting, but can be very stressful. Many people have a fear of the unknown. We hope this guide will help answer many of your questions and leave you feeling prepared. All questions are encouraged so write down and ask your care providers questions.

We understand you may feel emotional right now, but the goal is a healthy delivery and a safe start for you and your newborn

Neonatal Abstinence Syndrome (NAS) is a term to refer to the symptoms babies may have when withdrawing from contact with narcotics. Heroin, morphine, codeine, oxycodone Oxycontin or percocet, hydrocodone (Vicodin), meperidine, (Demerol) or fentanyl, are just a few of the drugs that may cause
NAS to occur in a baby. Withdrawal also may occur if the mother has been on methadone or buprenorphine (Subtex)treatment during pregnancy.

How can I help?

- All pregnant women are asked questions to help their healthcare professional help you have a healthy baby. Be honest with the people who take care of you and your baby. Tell them about your symptoms and cravings.
- Follow the plan of care as recommended.
- For the health and safety of your baby, continue to take the medications that have been prescribed for you by your care provider. They may have been given to you for conditions like depression, anxiety, or drug dependence. These medications can cause NAS in your newborn baby, but it is far worse for you and your baby if you are not treated. Your baby needs a healthy mom.

I seem to be very emotional. Is this normal?

- Being emotional is normal as you prepare for the birth of your baby.
- It will help to have a support network that includes friends and family as well as trained counselors in this time of change.
- If you think you need more help, please tell your care provider or call
- There are many resources available to help including your primary care physician. Other resources include:

  **Office of Substance Abuse Information and Resource Center:**
  1-800-499-0027 (in Maine only)
  Or 207-287-8900

  **Public Health Nursing**
  1-877-763-0438

  **Division of Community Based Care Services** Bureau of Behavioral Health (New Hampshire)
  105 Pleasant Street
  Concord, NH 03301
  Phone: 603-271-5000
  1-800-852-3345, x5000 (statewide)

  **Emergency Mental Health**
(New Hampshire)
Hotline: 1-800-852-3388 (statewide)
Fax: 603-271-5058

- If you are using illegal drugs or alcohol, we encourage you to get help right away.
- Contact the hospital you plan to deliver at for tours, classes, and other info.

**Signs and symptoms of NAS**
Your baby may have signs of withdrawal, which we call Neonatal Abstinence Syndrome (NAS). Caring for any baby with NAS can take extra time and patience.

**Will my baby be born with NAS and will NAS affect my baby?**
- It is hard to tell before a baby is born how he or she will be affected by drugs. After birth, there are things that can help your nurses or doctors determine if your baby has signs of NAS.

**How soon will we see signs of NAS?**
- Most babies who have NAS will show signs 24 to 72 hours, or as late as five to seven days after birth.
- This depends on the
  - dose of subutex, methadone or other opiates
  - Exposure to prescribed medications, including some psychiatric medications
  - Exposure to other drugs – such as opiates (heroin), amphetamines, marijuana, and tobacco-particularly in the days just before the birth
- The type of childbirth (vaginal or c-section)
- Your baby’s gestational age

**What signs will we see?**
The potential signs of NAS include:
- High-pitched cry
- Tremors/jitters
- Stuffy nose
- Hard time feeding and sucking
- Poor weight gain
- Increased breathing rate
• Irritability or fussiness and difficult with comforting
• Trouble sleeping
• Sneezing
• Tight muscles (arms & legs seem stiff)
• Vomiting, diarrhea
• Skin irritation
• Hyperactive reflexes (very big response to being startled)

What do the doctors look for to be certain my baby has NAS?
Your baby must have several of the signs previously listed to be diagnosed with NAS. Some of the signs may also be seen in babies who have other problems so your baby will be closely checked to confirm NAS.

How long can the signs and symptoms of NAS last?
Many babies need treatment even after they have gone home.

PART TWO:

Care in the hospital:

What will happen after my baby is born?
• Your baby will be watched closely after the delivery. If your baby was exposed to medication or other drugs before birth, he or she will be watched in the hospital for a minimum of 5 to 7 days.

When will my baby show signs of NAS?
• Most babies will show signs of NAS in the first 24-72 hours. It is possible to see symptoms start as late as 5-7 days.
• Your baby’s doctor will decide how long your baby needs to be observed in the hospital.

Does my baby need any special care?
• After birth, your baby will usually go with you to the mother/baby unit.
• We will care for you and your baby in the same way as we care for any other new mom and baby.
• You will be encouraged to care for your baby in the hospital as much as possible.
• Please look at your hospital’s guide for information on the basic care of yourself and your newborn.

Will my baby be tested for drugs?
• Most babies who have risk factors for NAS will have their urine and first bowel movements (called meconium) sent to the lab for testing.

Other things to expect:
• While you are in the hospital, someone from social work department, case management, or nursing will come and talk to you to help in the transition home.
• A Drug affected baby report is submitted in order for you and your baby to receive support services. The Drug Affected baby services are here to help you and your baby, they are not here to take your baby away. We also refer your baby to child development services. This report is a mandated by the federal government.

Feedings and weight gain:

Why do you need to watch my baby?
We will watch to see how your baby is feeding. We will keep close daily checks on his or her weight.

How will my baby’s weight be different from a baby who has not been exposed to drugs?
Most babies will lose 6% to 8% of their birth weight after birth. We expect these babies to be back to their birth weight in two weeks. Babies with NAS may lose more than this and have a hard time putting the weight back on.

Why do babies with NAS have a hard time putting weight back on?
• Babies with NAS are very active and use a lot of energy.
• Some babies with NAS may have a hard time feeding.
• Many babies with NAS need to be on special formulas with higher calories.

Can I breastfeed my baby?
• While breastfeeding is an excellent way for a mother to feed and bond with a baby, the decision to support breastfeeding must be made on a case-by-case basis.
• Talk to your baby’s health care provider to decide if it is safe for you to breastfeed.
  o Be open and honest with your baby’s health care provider.

Is there anything about the stools I need to watch?
• Babies who are withdrawing can have very loose or water stools.
• Babies with NAS are more prone to diaper rash, and may need special cream.
• Watch the diaper area closely. Please let the baby’s caregiver know if you see redness at a diaper change.

Is there anything else my baby will be watched for?
Your baby will be watched for signs of withdrawal. We do this with the NAS scoring system described in the next section.

NAS scoring:
How will my baby be checked for signs of withdrawal?
• The nurses taking care of your baby will use the Finnegan scoring system to check your baby for signs of withdrawal. All the nurses have been trained in the use of the Finnegan scoring system.

What is the Finnegan Score?
• This score rates your baby’s symptoms of withdrawal over a specific time period.
• You will see differences in the scores for your baby over the time period. This is because every baby has differences during the adjustment period after birth.
• We use the scores as one way to decide on the plan of care.

What score would show my baby has NAS?
• Many babies have one or two of the symptoms on the Finnegan scoring sheet. Most babies would not have more than three or four symptoms. Scores that are near eight tell us that your baby is having withdrawal symptoms and may need medication.
• If the score for your baby is eight or above, two or more times, the doctor is called. Your baby may need medicine and may need to go to a special nursery or pediatric unit to be watched more closely or for special treatment.
**Medications:**
Our goal with medications and treatment is to keep your baby comfortable during the withdrawal process.

**How much medication will my baby be given?**
The dose given will depend on:
- Your baby’s Finnegan scores
- Your baby’s weight
- Your baby’s response to treatment

**How will the doctors know my baby is getting enough?**
- The baby’s dose will be adjusted according to his or her symptoms.
- A health care provider will check your baby each day and the Finnegan scores will be taken every two to four hours.
- The medicine can be adjusted as needed. Weaning will start when your baby shows minimal signs of withdrawal.
- Each baby responds differently to being weaned off the medicine. A plan will be made each day for your baby.

**How long will my baby have to stay in the hospital?**
- If your baby is on medicine, he or she may need to stay in the hospital for two to three weeks, sometimes longer.

**Providing Supportive Care for your Baby**

**Can I spend time with my baby?**
Yes, we encourage you to spend time with your baby and learn about your baby and how to care for him or her. Please understand that babies with NAS are very sensitive to the sounds, lights, and activity around them.

**Suggestions:**
- We encourage skin to skin care as much as possible. This can help
  - to settle your baby
  - lowers his or her breathing and heart rate.
  - you bond with your baby.
Safe Sleep:
Anytime your baby is put to sleep, it is always safest to place them on their back. Babies should sleep in a crib near their parents but should not sleep in the bed, couch, or chair with their parents. Remember if you are sleepy put your baby down.

PART THREE:

Transition to home:
Will my baby still have signs of withdrawal when he or she goes home?
Most infants have an amazing ability to recover from early problems. This includes babies with NAS.
- Once at home, your baby may have mild signs of withdrawal for several weeks or months. The symptoms slowly become less severe.

Is my baby fussy because of NAS?
- There are many things that all newborns have in common, such as a fussy time. Most babies have a fussy time in the evening.
- The loving care you provide is the most important influence on your baby’s future.

Are there special things I need to do to care for my baby?
- Babies with NAS have all of the same needs as babies who were not exposed but they also have specific care needs. We highlight needs specific to babies with NAS, but please refer to the information given to you at your hospital for general care issues.

Establishing a routine:
Is getting my baby into a routine a good thing?
- NAS babies need a good routine.
- You may already know what your baby likes. Please ask your baby’s nurse about any routines the baby may already have.
- Most parents of small children have busy lives, full of appointments and errands. Try to work these activities around your baby’s schedule. Well-rested babies eat better and are usually happy, alert and ready to learn about their world.
What should I know about feeding my baby?

Feeding times may be difficult in the beginning
Looking for cues of hunger, which include sucking on hands, munching, increased movements, and crying may not indicate true hunger with your newborn.

- He/She may appear to act hungry but is not able to eat because of uncoordinated sucking and swallowing
- Cues such as pulling away from the bottle or breast while feeding your baby may appear to indicate your baby getting tired. Before stopping a feeding try to burp or gently encouraging him/her to finish the feeding.

How often should my baby eat?

- Bottle fed babies eat about every two and a half to four hours, while breastfed babies may eat every one and a half to three hours (good guide is: eight to 12 times in 24 hours)
- Babies will take more at some feedings than at others so ask the nurse what your baby has been taking.
- If your baby seems to spit up often, try smaller frequent feedings.
- As your baby grows, he or she will take larger feedings less often.

Is there anything special I should do when feeding my baby?

- Providing optimal nutrition is a challenge
  - feeding behavior may be impaired
  - decreased intake
  - even an adequate intake may not promote weight gain
- Providing high calorie formula may be needed
- Babies like to be in a comfortable position while eating
  - Always hold babies while they are eating
  - Some babies like to be swaddled or held closely.
  - Others like their arms free.
- Some like to be reclined
- Others more upright.
- Your baby will let you know what he or she likes best.
Sleep:

How long should my baby sleep?

• Most babies with NAS will go home from the hospital when they are one to six weeks old. At this age, infants usually sleep 16 to 20 hours a day.

• Falling asleep and staying asleep are important things for your baby to know how to do. Setting a routine for daytime naps and nighttime sleeping is an important developmental step for your baby.

• It may be 6-9 months for NAS babies to develop a good sleep routine.

How can I help my baby sleep better?

• Low lighting
• Care can be coordinated with feeding times.
• A pacifier might provide some soothing sucking while falling asleep.
• Place your baby on his back to sleep
• For your baby’s safety, bed sharing with parents or siblings is not recommended.
• You can help your baby set a sleep routine by providing a place that is consistently safe and quiet.
• A bedtime routine
  o can be as simple as reading a story or singing a lullaby.
  o Then, place your baby down-always on the back-when he or she is still drowsy.
• Remember to keep nighttime feedings a time for “business only.”
• Babies with NAS may be active or have jerky movements.
• Babies usually only need one more layer than you have on.
• Using music to soothe the baby
  o play soft music for about 20 minutes
    ▪ try a tape or CD player instead of a wind-up
    ▪ this gives the baby time to fall into a deep sleep before the music stops.

Awake time:

What should I do when my baby is awake?

Sometimes between naps, your baby will cry and other times your baby will be awake and alert. This is a time when you can interact with your baby, and offer some beginning play activities.
• Babies need to be in different positions during the day to learn about their world, and develop muscle control. Try things like holding the baby facing you or facing out, on your shoulder or on your hip, or secured in a swing or seat. Many babies like swings and vibrating seats but some babies with NAS may find them too stimulating.

• “Tummy time” is very important. Although your baby should always sleep on his or her back, when awake he or she should spend 10 to 20 minutes on the tummy on a firm surface (a blanket on the floor is best) while you are watching. This will strengthen the back and shoulder muscles, and your baby will learn to move around.

• Cuddle up with a book or a song. Rhythmic, soft music can be soothing for both of you, especially when your baby is restless or tired. Reading to your baby has the same effect.

**Daily Schedule:**

**How should I touch my baby?**

Babies with NAS can be very sensitive to touch. However, touch is one of the ways all babies learn and become more aware of their bodies.

Gentle, slow massage is a wonderful, soothing way to interact with your baby and to give loving care. If you make time for massage as part of your regular routine, such as at bath time, your baby will begin to look forward to and enjoy this activity.

**Crying:**

**Why does my baby cry?**

Crying is your baby’s way of talking to you. Some babies cry more than others.

What should I check when my baby cries?

• Check the diaper to see if it needs to be changed.
• See if the baby needs another burp or is hungry.
• Try swaddling the baby in a blanket so he or she feels more secure.
• Look around for things that could be bothering your baby.
  o Is he or she too warm or cool?
  o Are there sights and sounds from the television or music that are too stimulating rather than soothing?
  o Is light shining in your baby’s eyes?
  o Has your baby been in the same position for a long time?
  o Has it been a busy day, and your baby needs to go to sleep?
What if I can’t stop my baby from crying?
If your baby seems to be crying more than you would expect, please call your baby’s health care provider. This could be a sign that something is wrong. Your health care provider may be able to suggest some other helpful techniques or resources. Do not let yourself get too upset by the crying before you ask for help. Remember to never shake a baby.

The Period of PURPLE Crying:
Is a new way to help parents understand this time in their baby’s life, which is a normal part of every infant’s development. It is confusing and concerning to be told your baby “has colic” because it sounds like it is an illness or a condition that is abnormal. When the baby is given colic medicine it reinforces the idea that there is something wrong with the baby when in fact the baby is going through a very normal developmental phase. That is why we prefer to refer to this time as the Period of Purple Crying. No, it is not because the baby turns purple when he/she cries but provides a meaningful and memorable way to describe what parents and their babies are going through.

The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months. There are other common characteristics of this phase, or period, which are better described by the acronym PURPLE. All babies go through this Period it is just that during this time some can cry a lot, some far less, but they all do go through it. You will receive a period of Purple Crying DVD upon discharge.

Other resources:
If you find that you need more help please ask. You are not alone. Staff from the visiting nurses may visit you at home and check on your baby from time to time. This will be arranged before your baby leaves the hospital. If you are concerned or worried about your baby’s health, contact your baby’s health care provider.

Other resources that offer help include:
Maine Association of Alcoholism and Drug Abuse Counselors (MAADAC)
maadac2001@yahoo.com
(207) 548-2877 (fax)

Maine Association of Substance Abuse Programs (MASAP)
www.masap.org

Maine Alliance for Addiction Recovery (MAAR) - www.masap.org/site/recovery.asp
(207) 621-8118
**BEHAVIOR CALMING SUGGESTIONS**

**Difficult or poor feeding**
- Your baby may need more time to feed than others
- Feed your baby with the same nipple type as was used in the hospital
- Feed small amounts more often. You may need to use a special formula to make sure the baby is taking in enough calories.
- Feed in a quiet, calm place with little noise and interruptions.
- Swaddle baby to keep arms and hands close to midline and reduce extra movement.
- Be alert to your baby’s cues. They may include searching or pulling away from nipple or needing to pause to swallow or burp.

**Sneezing, stuffy, nose**
- Call your pediatrician, especially if your baby is working to breathe.
- Keep your baby’s nose and mouth clean.
- Do not overdress or wrap your baby too tight.
- Keep your baby in a position where the head is above the heart, well supported and supervised.
- Do not let your baby sleep on his or her tummy.
- Ask your baby’s doctor about saline drops.
Spitting up

• Feed your baby slowly. Let your baby rest between feeds.
• Feed your baby less but more often.
• Burp your baby often.
• After feeding, keep your baby upright in your arms for 20 minutes to help with digestion.

Trembling

• Keep your baby in a warm quiet room.
• Swaddle your baby snugly.
• When positioning your baby, move slowly and carefully to not startle him or her.
• Gently and slowly, massage your baby’s arms and legs.

GLOSSARY

Department of Health and Human Services: a system of health and human services where access to services is easier, care is coordinated and costs are contained. Virtually every citizen in Maine encounters the Department of Health and Human Services in one way or another.

Finnegan score: a rating system developed by Dr. Loretta Finnegan for babies withdrawing from opiates.

Gestational Age: The age of the baby in weeks, starting from the beginning of the pregnancy to the date of birth.

Meconium: the first stool passed by the baby. It is often black and sticky like tar.

Neonatologist: a pediatrician trained specifically in caring for high-risk newborns.

Visiting Nurse Association (VNA): nurses who can make home visits to check weights and babies
Screen for Substance Use
First Prenatal Visit/Intake:
Tools: 4P+ or CRAFFT
Women should be screened privately
• Assess and address psychiatric co-morbidities (PHQ-9)
• Assess social risk factors: Domestic violence/homelessness (PVS or WAST)

Positive Screen for Substance Abuse
Willingness to Accept Treatment

Signs of acute withdrawal
YES
Go to Emergency Department
Referral to residential or intensive outpatient treatment
Or
Step down to office-based buprenorphine or methadone program
And
Weekly counseling by substance abuse counselor
And
Sign consents to coordinate substance abuse treatment plans with OB Provider

NO
Probable Physiologic Dependence
Unclear or Unlikely Physiologic Dependence

Denies Need for Treatment
• Provide information about perinatal risks
• Assess/address psychiatric co-morbidities
• Assess/address social risks including domestic violence and homelessness
• Close interval follow-up appointments including motivational interviewing

Refer to Counselor Trained in Addiction Treatment

Negative Screen
Re-screen at 24 to 28 Weeks

Brief intervention (should be done privately)

*Withdrawal Symptoms May Include:
Maternal
* Dilated Pupils
* Anxiety
* Hypertension, Tachycardia
* Muscle spasms, tremors
* Sweating chills, flushing
* GI Distress: Vomiting, Diarrhea

Fetal
* Fetal Distress
* Fetal Tachycardia
* Late decelerations (EFM)
As a health care professional, you have an important role in identifying substance-exposed newborns. These guidelines have been developed to assist health care professionals:

- Improve their ability to effectively identify substance-exposed newborns;
- Implement standardized guidelines for maternal screening in Massachusetts; and
- Improve the health and well-being of women and their at-risk newborns.

**Purpose:**
These guidelines provide a community standard and consensus approach to the screening of pregnant women and their newborns for exposure to drugs during pregnancy (Note: the term drugs/substance includes alcohol). Providers need to determine the risk of fetal exposure and be able to determine the risk to the newborn after delivery.

**Background:**
Infants exposed in utero to substances of abuse are known to be at risk for a variety of problems, including medical conditions, growth issues, developmental delays, and child abuse and neglect. Additionally, the federal law, Individuals with Disabilities Education Act, (IDEA) Part C, which addresses children age 0-3 years, includes prenatal drug and alcohol exposure as a risk factor for adverse developmental outcomes, and therefore qualifies these children for evaluation and developmental services, as needed.

Identifying pregnancies complicated by substance use has implications for maternal, fetal, and newborn health. Testing for substances in pregnancy is a complex issue with medical, social, ethical, and legal implications. For these purposes, *screening* refers to a more global assessment for alcohol and/or substance use by eliciting exposure through history-taking and dialogue with the mother, while *testing* refers to an actual laboratory tool that identifies the drug in a body substance (e.g., serum, urine, meconium).

---

These guidelines address the utility of both screening and testing, recognizing that there is controversy on which patients are tested, and whether subgroups of women are being profiled; protection of adult patients’ rights to informed consent and privacy; and protection of vulnerable infants from the harm of prenatal exposure to substances. It is also recognized that an individual may be using and/or abusing a drug or alcohol, however, the screening and/or testing results may be negative.

**Massachusetts Department of Public Health (the Department) recommends:**

- Screening all pregnant women through interviews using a standard tool (see Appendix A) at the beginning of pregnancy, as well as at 28 weeks and at the time the woman presents for delivery.

- Performing a toxicology panel based on screening results and other defined criteria (see Appendix B).

The Department also recommends that each hospital work with their legal counsel, risk management, nursing, social service, and medical staff to develop a well-defined policy for identifying intra-partum women and newborns with substance use/abuse or exposure. In addition to screening pregnant women, the policy should include specific evidence-based criteria for testing a woman and her newborn, timing of tests, test types, and consent issues. The justification and process for newborn testing will be specific to the written policy of each institution. All health care providers should be informed of the policy and educated in its use. Additional training may be required to assist health care professionals in developing approaches that motivate and guide women to make informed choices regarding testing.

**Recommended Standard Approach:**

Because of the potentially serious consequences of failing to recognize drug or alcohol exposure in infants and abuse in affected families who do not disclose this condition and fail to receive treatment and other supportive services, the Department recommends the following:

**Screen Pregnant Women and Postpartum Women for Substance Use**

- Identify individuals at risk for alcohol and/or substance use
- Screen through interview and self-report (questionnaires/screening instruments)
- Follow-up with assessments, which may include laboratory testing

**Criteria for Screening**

All women should be screened for drug and alcohol use/abuse using a recommended standard tool (see Appendix A #1, Substance Use Risk Profile Pregnancy Tool for Labor and Delivery). Screening should begin with the first prenatal visit to allow for early identification and education, repeated at 28 weeks, and when the mother is admitted to Labor and Delivery. Use of the 5 P’s Screening Tool (Parents, Peers, Partner, Past, Present) is recommended for prenatal and postpartum visits and can be incorporated into the SBIRT (Screening, Brief Intervention, Referral and Treatment) (see Appendix A #2).
Women who answer no to all questions on the Screening Tool are deemed to be at low risk of alcohol or substance use/abuse. Those who answer yes to one question are deemed to be at moderate risk, and those who answer yes to two or more questions are deemed to be at high risk.

Screening:
- Increases the identification of substance users
- Allows for early intervention
- Improves provider skills and comfort addressing the issues
- Provides opportunity for education
- Enhances public awareness and may prevent future use/abuse

Laboratory Testing for Substance Use/Newborn Exposure
Universal testing of women and newborns for substance use/exposure using biological specimens is NOT recommended according to the AAP, ACOG Guidelines for Perinatal Care, 2012. Testing should be based on defined and evidence-based criteria.

Some risk indicators are more predictive of substance use than others. If positive risk indicators are identified at any time during pregnancy or postpartum, rule out other identifiable causes, then test or complete an assessment as appropriate.

Criteria for Testing Women (by urine screen) include:
- Minimal or no prenatal care
- Unusual 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 in the past 5 years and/or currently on Medication Assisted Therapy (MAT). (Participation in MAT does not always equal sobriety).

Other Risk Factors to consider that may be associated with substance use include, but are not limited to:
- History of physical abuse or neglect
- Intimate partner violence
- Mental illness
- Previous child with Fetal Alcohol Effects or Syndrome or alcohol related birth defects
- Previous child with Neonatal Abstinence Syndrome
- Fetal Distress
- Unexplained Placenta Abruptio
- Unexplained Intrauterine Growth Restriction (IUGR)
**Consent for Testing**

Policies should allow testing (without consent) of unconscious or intoxicated patients, or patients with signs and symptoms of complications of intoxication (e.g., seizure).

Hospital policies may require the written consent of pregnant or postpartum women for drug testing. If only verbal consent for testing is obtained, hospitals should be aware that this may not be adequate for reimbursement by some insurers.

If written consent for testing is required, the hospital policy should clarify who is responsible for obtaining the consent for testing (e.g., RN, MD).

Hospital policies should define what actions should be taken if a mother refuses to consent to testing. Considerations may include actions such as:

- Notification to the physician and the hospital social worker requesting further discussion with and evaluation of the mother
- Automatically test the newborn without parental consent
- Notification to the Department of Children and Families (DCF) by a hospital social worker, RN or MD

If laboratory testing is performed staff should:

- Inform the patient of the reason for performing the test and the procedures involved
- Document the patient’s consent
- Review test results with the patient
- Document the patient’s response

**Criteria for Testing Newborns for Substance Exposure**

A newborn may be presumed substance exposed if the mother is on Medication Assisted Therapy (MAT) and/or has a positive drug test on admission to Labor and Delivery. This does not preclude doing a separate test of the newborn (urine/meconium) if medically indicated, or if there are concerns for substance use during the pregnancy. Please note that that a 51A Report is required to be filed if an infant has positive urine/meconium test results.

Newborn drug testing is done for the purposes of determining appropriate medical treatment for the infant and ensuring a safe and appropriate discharge plan. Clinical judgment should be used to determine whether testing newborns, including those born to women on Medication Assisted Therapy (MAT), is necessary. (See Appendix B – Newborn Toxicology, and Appendix D-DCF Guideline under exception). It may be helpful to test the newborn if there is a suspected history of substance abuse, or the mother is not compliant with her treatment program. These tests may include confirming the presence of substances in urine and/or meconium.

Neonatal signs of opioid dependence (marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, and diaphoresis (Finnegan, 1986)) may be delayed for as long as 10–14 days depending on the half-life of the substance in question, however, signs are most likely to present in the first four days of life. This time frame may also be confounded by in utero exposure to other medications or substances, including benzodiazepines and selective serotonin reuptake inhibitors (SSRIs).
**Reporting**

- Physicians, nurses and social workers are all mandated reporters for any concerns related to abuse or neglect of children.

- Hospitals should have a written policy for reporting positive tests and other concerns to the Department of Children and Families (DCF). Policies may include provisions to encourage collaborative work in the best interest of the infant and the infant’s family while maintaining communication between the hospital and DCF staff.

- The Hospital policy should include an action plan on how to evaluate and address positive initial testing in a mother and/or newborn.

- The Hospital policy should include provisions to ensure that the hospital social worker is notified for further evaluation and reporting, as needed.

Mandated reporters, such as physicians, nurses, social workers (see definitions under: Massachusetts General Laws, Chapter, Chapter 119, Section 21 below), must report positive tests at delivery. (Note: M.G.L. Chapter 119, Section 51A, states in part, a mandated reporter who, in his [her] professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from physical dependence upon an addictive drug at birth, shall immediately communicate with the Department orally and, within 48 hours, shall file a written report with the Department detailing the suspected abuse or neglect.)

Please see reference web links to applicable laws at M.G.L. Chapter 119, Section 51A and Section 21, below:

[http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section51A](http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section51A)

[http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section21](http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section21)

**Trauma Informed Care**

Many women seeking health services have a history of physical and/or sexual abuse and other types of trauma-induced experiences. These experiences often lead to mental health and physical disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as encounters with the criminal justice system.

Trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate. These services and programs are supportive and reduce re-traumatization of the trauma survivor.

**Trauma-informed services:**
- Incorporate knowledge about trauma in all aspects of service delivery
- Are designed to be comforting and engaging
- Minimize re-victimization
Release of information from Methadone Clinic providers

Confidentiality

Substance abuse treatment information is protected by federal law under 42 Code of Federal Regulations, Part 2 (42 CFR 2). This federal law prohibits disclosure of information unless it is expressly permitted by the written consent of the person to whom it pertains. The only exception is for child abuse/neglect reporting. This exception allows for the initial report only if the provider is the reporter, but does not allow for open access beyond the initial report (first contact only) – including the remainder of screening, investigation, or during initial assessments. Once the report has been received, a signed release of information will be needed to talk with a substance abuse treatment provider.

This signed release must meet the 42 CFR 2 requirements. The Bureau of Substance Abuse Services (BSAS) is piloting a policy to ensure proper consents for sharing information are consistent and 42 CFR, Part 2 compliant. The attached Legal Action Template (Appendix C) can be used to ensure that agencies (including hospitals) have clients sign a release that is 42 CFR Part 2 compliant. Communicating with the methadone provider will provide the best information for the care of the patient. It is essential to obtain a last dose letter from the methadone clinic when the patient is admitted and also to provide a last dose letter to the clinic when the patient is discharged for continuity of care.

Department of Children and Families (DCF) (see Appendix D)

DCF Practice Guideline: Screening Related to Substance Exposed Newborns - This protocol will allow infants born positive to Methadone, Subutex and other appropriate prescribed medications under certain circumstances to be screened out.

A mandated reporter must file a 51A Report with DCF for all infants who experience neonatal withdrawal as well as all infants born to mothers on opioid maintenance medications (see Appendix D).

If a mandated reporter is a member of the staff of a medical or other public or private institution, school or facility, the mandated reporter may instead notify the person or designated agent in charge of such institution, school or facility who shall become responsible for notifying the department in the manner required by this section. (see web link to Massachusetts General Laws Chapter 119, Section 51A above).

Disclaimer

These guidelines are not an exclusive course of management. Variations that incorporate individual circumstances or institutional preferences may be appropriate.
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and
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C. Sample Consent Forms ................................................................. p. 11
D. Department of Children and Families Policy ................................. p. 12
APPENDIX A

A1. Substance Use Risk Profile Pregnancy Tool for Labor and Delivery*

Ask the following questions to all women admitted to Labor and Delivery:

1. Have you smoked marijuana in the last 3-5 years?
2. In the 3 months before you knew you were pregnant, approximately how many beers, how much wine, or how much liquor did you drink?
3. Have you ever felt that you needed to cut down on your drug or alcohol use?
4. Have you ever taken prescription medication for non-medical use?

*Adapted from the Substance Use Risk Profile-Pregnancy scale published in the October 2010 issue of Obstetrics & Gynecology.

A2. 5 P’s Screen for Alcohol/Substance Use: Prenatal and Postpartum visits**

PARENTS: Did any of your parents have a problem with alcohol or drug use?     Yes     No

PEERS: Do any of your friends have a problem with alcohol or drug use?     Yes     No

PARTNER: Does your partner have a problem with alcohol or drug use?     Yes     No

PAST: In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?     Yes     No

PRESENT: In the past month, did you drink any alcohol or use other drugs?     Yes     No

1. How many days per month do you drink? ________
2. How many drinks on any given day? ________
3. How often did you have 4 or more drinks per day in the last month? ________

**Adapted from the Institute for Health and Recovery 5 P’s

Questions may also be more specific, for example:

1. What kind of alcohol (beer, wine, liquor)/drugs (heroin, cocaine, prescription drugs, methamphetamine, marijuana) do you use?
2. During the month before you were pregnant, how many times a week did you drink____ (alcohol)/ use____ (drugs)?
3. How many bottles/cans/shots/glasses of ________ (alcohol) /how much ____ (name the drug) did you use each time you drank/used drugs during the month before you were pregnant?
APPENDIX B

B 1. Maternal Urine Toxicology

Urine toxicology determines the presence or absence of a drug in a urine specimen. It detects drugs that have been used within the previous 48-72 hours. It may be useful as a follow-up to a positive interview screen. See criteria for testing mother (page 3 above). The toxicology results are to be used for medical purposes only and not for any legal or employment purposes.

Each facility should have an established urine toxicology panel, plus the ability to add tests as needed. An example is a basic urine panel: cocaine, TCH, amphetamines, benzodiazepines, opiates. Depending on the assay used for testing, drug cut off values can measure pharmacologic use or levels of abuse. Hospital staff should be familiar with what drugs are identified in the urine toxicology at their hospital and what are the cut off values. For example, Buprenorphine (Subutex, Suboxone), methadone and Oxycontin are not routinely included in the “opiate” portion of all urine toxic screens.

Due to the significant ramifications of a positive test for both mothers and newborns, it is essential that all positive screening tests be confirmed by GC/MS testing before reporting a positive test.

B 2. Newborn Toxicology

See details regarding newborn testing below. A detailed, professionally obtained history can be more helpful than toxicology screening of the newborn to accurately screen for substance abuse.

Urine:
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, and alcohol is nearly impossible to detect in newborn urine.

If possible, collect the newborn’s first void for testing as the urine will contain the highest concentration of substances. Failure to collect the first urine decreases the likelihood of a positive test.

Newborn urine reflects substance exposure during the preceding one to three days, however, cocaine metabolites may be present for four to five days.

Marijuana may be detected in newborn urine for weeks, depending on maternal usage.

Meconium:
Meconium in term infants reflects substance exposure during the second half of gestation; preterm infants may not be good candidates for meconium testing. Note, a meconium screen may reveal intrapartum medications given to a mother to control pain. 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)
SAMPLE NOTICE PROHIBITING REDISCLOSURE

PROHIBITION ON REDISCLOSURE
OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, __________________________________________ authorize

(Name of patient)

(Name or general designation of alcohol/drug program making disclosure)
to disclose to

(Name of person or organization to which disclosure is to be made)

the following information:

(Nature and amount of information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this consent is to:

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under
the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient
Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act
of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written
consent unless otherwise provided for in the regulations. I also understand that I may
revoke this consent at any time except to the extent that action has been taken in
reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure
for purposes of treatment, payment, or health care operations, if permitted by state law.
I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form. Dated: ________________________________

Signature of patient __________________________ Signature of person signing form if not patient

Describe authority to sign on behalf of patient ____________________________________________

Prepared by the Legal Action Center
Appendix D

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Department of Children and Families
600 Washington Street
Boston, MA 02111

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

ÂNGELO MCCLAIN
Commissioner

TO: Mandated Reporters, Community Partners and Other Stakeholders
RE: Change in DCF Screening Policy Related to Substance Exposed Newborns (SENs)
DATE: December 14, 2012

The Massachusetts Department of Children and Families (DCF) would like to inform you about a change in policy related to screening of reports involving Substance Exposed Newborns (SENs). This change is being implemented to better protect the vulnerable SEN population, while recognizing the need for medication assisted treatment during pregnancy for women who are dependent upon opioids or who have other medically diagnosed conditions requiring medication.

The change in DCF policy DOES NOT change the responsibility for mandated reporters to report a situation involving a SEN.

Summary of Policy Changes
Effective January 2, 2013, DCF may screen out a 51A report involving a Substance Exposed Newborn (SEN) if the only reported condition is maternal use of methadone, buprenorphine (Subutex), buprenorphine with naloxone (Suboxone) or another appropriately prescribed and used medication (such as psychotropic and narcotic prescription medications) as substance abuse or medical treatment resulting in a SEN, when:

- the only substance affecting the newborn was one of the three (3) drugs described above or other appropriately prescribed and used medication;

- DCF is able to verify with medical or other qualified providers that mother used the medication as part of substance abuse or medical treatment as authorized; and

- there are no other concerns of child abuse and/or neglect as determined by any available information, including a review of DCF’s historical records.
DCF will continue to screen in and complete a response to all other 51A reports involving a SEN.
The Department, in partnership with the DPH Bureau of Substance Abuse Services (BSAS), has established a communication protocol with substance abuse treatment providers for verifying a mother’s treatment history and progress. Opioid treatment providers are being asked to work with mothers prior to delivery to obtain a signed release allowing DCF to speak with providers during the screening process. As required by the updated policy, without appropriate treatment verification, a 51A will be screened in.

DCF will also contact other medication prescribers during screening to verify that mother is using the medication appropriately, as prescribed and there are no other concerns regarding child abuse and/or neglect.

What does this mean for Mandated Reporters?
Mandated reporters should continue to report any situations involving a SEN to DCF. If possible, mandated reporters should include in the 51A report: the name and contact information for the mother’s medication assisted treatment provider and the prescriber(s) of other medications that may appear in the report of a urine or meconium screen.

For Further Information
Please contact Kim Bishop-Stevens, DCF Substance Abuse Manager, at 617-748-2049.
Substance Use Disorders During Pregnancy: Guidelines for Screening & Management

Revised Edition 2016

- SCREEN and ASSESS
- BRIEF INTERVENTION
- REFERRAL to TREATMENT
- MANAGEMENT

Includes Quick Reference Guide!

Washington State Department of Health

Healthy Communities Washington
Partners promoting healthy people in healthy places
www.doh.wa.gov/healthycommunities
Adapted from *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*, published by the National Center for Education in Maternal and Child Health, 1997.
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Substance use disorders during pregnancy have been identified as critical to the health of mothers and babies from all socioeconomic groups. Substance use contributes to obstetric and pediatric complications, including Fetal Alcohol Spectrum Disorders, prematurity, abruptio placenta, stillbirth, and low birth weight.

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

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

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

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

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

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

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

In addition, many addicted women are homeless, low income, and victims of interpersonal violence. Frequently there is history of child abuse/neglect and/or sexual assault. Unintended pregnancy rates are higher in this population making it difficult to intervene prior to pregnancy.
Treatment for substance use disorders during pregnancy can be more effective than at other times in a woman’s life. Providers play a key role in influencing the health behaviors of pregnant women in their care. Pregnant women often describe their healthcare providers as the best source of information and generally follow their advice.

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

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

Quick Reference Guide

Ask-Screen (see algorithm, page 5)

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

Assess-Intervene

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

Advise – Everyone, even women who deny use/abuse

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

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

- Offer help based on her readiness to change. “We both have the same goals, healthy pregnancy and baby.” Ask what she will do and agree on a plan.
- Praise all efforts to change.
- Refer for specialty assessment: addiction, mental illness based on level of addiction.
- Refer to addiction treatment for stabilization and treatment: Washington State Recovery Helpline 1-866-789-1511. Find more information about treatment options and models on page 33.
- Make other referrals as appropriate (see referral resource information, page 36).
- Obtain consent/release for coordination with substance abuse and mental health treatment providers.
- Provide overdose education and information on where to obtain Naloxone kits if using opioids.
**Manage pregnancy medical issues** *(more information on page 18)*

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

**Manage Intrapartum**

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

**Post-partum**

- Encourage continuation in a therapeutic drug treatment program; coordinate with programs.
- Encourage and provide appropriate contraceptive method: consider LARC as first line option and consider starting before discharge.
- Close follow up for pain management.
- Coordinate with treatment – may need dose adjustment.
- Consider more frequent postpartum visits.
- Support breastfeeding as appropriate. Breastfeeding is typically recommended in methadone maintenance but is contraindicated if the woman is HIV positive or using illegal drugs or marijuana.
- Breastfeeding women with a positive history of drug use during pregnancy should be tested periodically while breastfeeding.
- Coordinate with social services for a safe discharge plan.
- See page 23 for referral resources to consider.
Screening and Brief Intervention Algorithm

Screen for substance abuse @
First Prenatal Visit/Intake:
Tools: 4P+ or CRAFFT
Women should be screened privately
- Assess and address psychiatric co-morbidities (PHQ-9)
- Assess social risk factors: domestic violence/homelessness (PVS or WAST)

Brief intervention (should be done privately)

Positive screen for substance abuse
- Willingness to accept treatment
  - Signs of acute withdrawal*
    - Yes
      - Go to emergency department
    - No
      - Probable physiologic dependence
    - Unclear or unlikely physiologic dependence
      - Refer to counselor trained in addiction treatment

Negative screen
- Re-screen at 24 to 28 weeks

Positive screen for substance abuse
- Denies need for treatment
  - Provide information about perinatal risks
  - Assess/address psychiatric co-morbidities
  - Assess/address social risks including domestic violence and homelessness
  - Close interval follow-up appointments including motivational interviewing

Consider in-patient stabilization or referral to experienced outpatient addiction provider:
- Alcohol (detox required if physically dependent)
- Opiates/benzodiazepines (management may vary based on level and type of use)
- Amphetamines (residential treatment recommended)

Referral to residential or intensive outpatient treatment
- OR
- Step down to office-based buprenorphine or methadone program
- AND
- Weekly counseling by substance abuse counselor
- AND
- Sign consent to coordinate substance abuse treatment plans with OB Provider

* Withdrawal symptoms may include:

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

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

Fetal
- Fetal distress
- Fetal tachycardia
- Late decelerations (EFM)
The American College of Obstetrics and Gynecology recommends that all pregnant and non-pregnant women should be routinely asked about use of tobacco, alcohol, marijuana and other drugs, as well as non-medical use of prescription medications. The purpose of this Washington State Department of Health document is to:

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

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

**Definitions (DSMS now uses the term Substance Use Disorders)**

**Use** refers to any use of alcohol or drugs.

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

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

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

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

Addiction is characterized by:
- Inability to consistently abstain
- Impairment in behavioral control
- Craving or increased hunger for drugs or rewarding experiences
• Diminished recognition of significant problems with one’s behaviors and interpersonal relationships
• Dysfunctional emotional response
www.asam.org/research-treatment/definition-of-addiction

**Nonmedical, Misuse, and Abuse of Prescription Medication:**

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

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

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

**Neonatal Abstinence Syndrome (NAS):**

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

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

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

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

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

- Includes collecting objective and subjective information
- May include screening and lab testing
- Should be timely and culturally appropriate
- May result in a diagnosis and plan for intervention
It is the responsibility of every practice to make sure that all pregnant and postpartum women are screened for substance use. Physicians, nurses, and others involved in prenatal care play an important role in the reduction of substance use during pregnancy. For clients who require intervention for substance use, a team approach is recommended, including the primary provider, clinic nurse, social worker, public health nurse, chemical dependency treatment provider, and the client herself.

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

Steps to Implementing Screen and Intervention Model

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

Benefits of Universal Screening, Interviews and Observation

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

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

Studies examining brief interventions for smoking and alcohol use among pregnant women, and for illicit drug use in the general population, have shown small but statistically significant results of the effectiveness of such interventions.14
Urine Toxicology Not for Universal Screening

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

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

Screening Tools

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

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

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

How to Screen

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

This approach decreases subjectivity, discomfort and bias. Ideally, pregnant women should be screened at each encounter, and minimally, once each trimester. Include inquiries into substance use problems in family members. Know how to respond to both positive and negative responses to screening tools (see Page 11). As trust develops, the client who is using is more likely to disclose that use. When use is disclosed, remember that screening tools identify risk but are not diagnostic. Know how to respond, including discussing risks of use, benefits of stopping, and resources for further evaluation.
Recent addiction research has identified physical, sexual, and emotional abuse as frequent precursors to substance use in women; therefore, pregnant women should also be screened for risk of domestic violence. In addition to brief structured screening tools, asking about foster care during childhood or history of foster care for the woman’s own children may lead to discussion of the potential for substance use.

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

Create a Respectful Environment

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

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

ASSESS: Intervene

When a Woman Denies Use

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

When a Woman Admits Use

Many women are able to abstain during pregnancy, so the woman who admits to current use of significant amounts is likely to have severe addiction and may be using substances to help her cope with psychosocial stressors in her life. The woman may feel safe enough to share with the medical provider about her use but may not be ready to take the next step of a comprehensive assessment and treatment. Review use patterns, share score on the screener and talk about the effects. Assess readiness to change and her ability to change.
The Stages of Change model developed by Prochaska and DiClemente (1992) is one approach to understanding the steps to changing drug or alcohol use during pregnancy.

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

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

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

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

**Resistant:** “Don’t tell me what to do.”

*Provider Response:* Work with the resistance. Avoid confrontation and try to solicit the women’s view of her situation. Ask her what concerns her about her use and ask permission to share what you know, and then ask her opinion of the information. Accept that the process of change is a gradual one and it may require several conversations before she feels safe about discussing her real fears. This often leads to a reduced level of resistance and allows for a more open dialogue. Try to accept her autonomy but make it clear that you would like to help her quit or reduce her use if she is willing.

**Reluctant:** “I don’t want to change; there are reasons.”

*Provider Response:* Empathize with the real or possible results of changing (for example, her partner may leave). It is possible to give strong medical advice to change and still be empathetic to possible negative outcomes to changing. Guide her problem solving.

**Resigned:** “I can’t change; I’ve tried.”

*Provider Response:* Instill hope, explore barriers to change.

**Rationalizing:** “I don’t use that much.”
**Provider Response:** Decrease discussion. Listen, rather than responding to the rationalization. Respond to her by empathizing and reframing her comments to address the conflict between wanting a healthy baby and not knowing whether “using” is really causing harm.

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

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

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

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

**Action.** The woman has stopped using drugs or alcohol.

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

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

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

**ADVISE**

**Educational Messages for Clients**

Assume that all women have some knowledge of the effects of drugs, alcohol, and cigarettes on pregnancy. Ask what the woman knows, affirm what she knows, and ask to share information which can fill in missing pieces or clarify misconceptions. This respectful approach can lay the groundwork for further discussion now and at later visits. It provides an opportunity to educate the client and her partner about the adverse effects of tobacco, drugs, and alcohol, and the benefits of stopping use at any time during pregnancy or postpartum. It’s important to educate about modifiable
factors affected by recovery, such as more stable early life environment and decreased ongoing exposure. These messages can be reinforced through pre-pregnancy, pregnancy, and postpartum discussions not only by the primary obstetric provider, but by the community childbirth educator, outreach worker, community health nurse, and other health care staff.

ASSIST AND ARRANGE

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

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

Referral to Treatment

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

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

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

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

- Discuss the possible strategies for her to stop; for example, individual counseling, 12-step programs, and other treatment programs. Studies have shown that people given choices are more successful in treatment.
- Utilize an advocate or special outreach services if available – Safe Babies Safe Moms, Parent Child Assistance Program, Maternity Support Services, Nurse Family Partnership (see Appendix E, Page 34).
- Tailor resources according to client needs and health insurance coverage.
- If immediate chemical dependency treatment or other support is not available, the primary provider or designated staff might meet with the woman weekly or biweekly to express concern and to acknowledge the seriousness of the situation.
• Maintain communication with the chemical dependency treatment provider to monitor progress.
• Establish rules and goals, such as reducing use, with the woman and her significant others. See the section below on Harm Reduction.
• For tobacco users, provide the American College of Obstetricians and Gynecologists brief intervention (see Page 27) and refer women to the Washington State Quitline (see Page 37).
• If the behavioral approach is not successful, consider 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.16

MANAGEMENT

Laboratory Testing

Urine toxicology determines the presence or absence of a specific substance in a urine specimen. It may be useful as a follow up to a positive interview screen. It should not be used in place of written or verbal screening because it cannot diagnose a drug use-disorder or its severity.16 Urine testing needs verbal informed consent at a minimum and clear discussion about how data will be used. Due to the many limitations of biologic testing, it is more likely that fetal exposure will be identified through a structured interview.15

Benefits of Lab Testing

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

Limitations of Lab Testing

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

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

High Risk Factors

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

Risk Factors Requiring Further Assessment Before Urine Toxicology Testing

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

Signs and Symptoms of Substance Use Disorder

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

<table>
<thead>
<tr>
<th>Behavior Patterns</th>
<th>Physical Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>Markedly dilated or constricted pupils</td>
</tr>
<tr>
<td>Inebriation</td>
<td>Rapid eye movements</td>
</tr>
<tr>
<td>Euphoria</td>
<td>Tremors</td>
</tr>
<tr>
<td>Agitation</td>
<td>Track marks or abscesses or injection sites</td>
</tr>
<tr>
<td>Aggressiveness/violent behavior</td>
<td>Inflamed or eroded nasal mucosa, nose bleeds</td>
</tr>
<tr>
<td>Paranoia</td>
<td>Increased pulse and blood pressure</td>
</tr>
<tr>
<td>Increased physical activity</td>
<td>Increased body temperature</td>
</tr>
<tr>
<td>Anxiety, nervousness, panic</td>
<td>Hair loss</td>
</tr>
<tr>
<td>Disorientation</td>
<td>Hallucinations, panic, anxiety</td>
</tr>
<tr>
<td>Depression</td>
<td>Nystagmus</td>
</tr>
<tr>
<td>Irritability</td>
<td>Gum or periodontal disease, including broken teeth, severe decay, infections</td>
</tr>
<tr>
<td>Prescription drug seeking behavior</td>
<td>Skin conditions: abscesses, dry or itchy, acne type sores</td>
</tr>
<tr>
<td>Suicidal ideations or attempt</td>
<td>Weight loss-low BMI, malnutrition</td>
</tr>
<tr>
<td>Memory loss</td>
<td>Psychosis</td>
</tr>
<tr>
<td>Erratic behavior</td>
<td></td>
</tr>
</tbody>
</table>
Laboratory

- MCV over 95
- Elevated MCH, GGT, SGOT, Bilirubin, Triglycerides
- Anemia
- Positive urine toxicology for drugs
- STI testing (retest in third trimester if at risk)
- HepC

Medical History

- Frequent hospitalizations
- Gunshot or knife wound
- Unusual infections (cellulitis, endocarditis, atypical pneumonias, HIV)
- Cirrhosis
- Hepatitis
- Pancreatitis
- Frequent falls, unexplained bruises
- Chronic mental illness

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

Consent Issues for Drug Testing

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

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

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

Harm Reduction – Decrease Use

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

Harm Reduction Strategies

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

Pregnancy Management Issues

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

Gender Responsive Treatment Principles

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

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

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

Intrapartum

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

Adequate pain management should be available to all laboring mothers who desire it. A substance use disorder history should not be considered a contraindication to the normal use of pain medications in labor. Take into consideration the woman’s substance use disorder history and recovery status. Maximize and schedule non-opioid analgesia and anticipate that opioid-dependent women will need additional opioids at an increased dose for the same duration.
Epidural anesthesia can be used as per hospital routine and is a proven effective pain management strategy for laboring women. Buprenorphine and methadone used for maintenance will not produce any analgesia. That dose may be split during labor and immediately postpartum for safety.

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

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

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

**Postpartum**

- Encourage continuation in a therapeutic drug treatment program.
- Encourage and provide appropriate contraceptive method: birth control pills, patches or ring, implant, Depo-Provera, intrauterine device, sterilization, emergency contraceptive pills, condoms, others. Provide before-hospital discharge if appropriate or feasible.
- Support breastfeeding as appropriate and should be recommended if stable in treatment and no current illicit use. Breastfeeding is not contraindicated and is typically recommended in buprenorphine or in methadone maintenance. It is contraindicated if the woman is HIV positive or using illegal drugs. Transferred amounts of methadone or buprenorphine are insufficient to prevent symptoms of neonatal abstinence syndrome. Neonatal abstinence syndrome can occur after abrupt discontinuation of methadone.19
- Breastfeeding women with a positive history of drug abuse during pregnancy should be tested periodically while breastfeeding.
- AAP 2012 Breastfeeding and the Use of Human Milk references marijuana, along with other substances, as potential concern for long-term neurodevelopment and thus use of street drugs, including marijuana, are contraindicated while breastfeeding. It is a clinical decision as to whether or not a woman who continues to use marijuana should continue to breastfeed.
With this approach, the provider can assess how much the woman is using. http://pediatrics.aappublications.org/content/129/3/e827.full

In the July 2015 Committee Opinion, ACOG cites the insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding and, in the absence of such data, marijuana should be discouraged. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Marijuana-Use-During-Pregnancy-and-Lactation


Relapse – From SAMSHA’s Keys for Clinicians: Addressing Specific Needs of Women

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

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

History of Substance Dependence

- Active Use
  - Stimulants
    - Consider q2-4w growth US
    - Consider regular NST/BPP as approaching term
  - Opiates
    - Consider q4w growth US
    - Consider regular NST/BPP as approaching term
  - Sedatives including alcohol
    - Consider extra 3rd tri growth US

- Abstinence/Treatment
  - Prior opiates/sedatives (Current pregnancy)
    - Monitoring as usual
  - Prior stimulants (Current pregnancy)
    - Consider increased screening for placental insufficiency

*Adapted from presentation by Abigail Plawman, MD. Author, 2013. Advanced Practice Acute & Primary Care Conference, Seattle, WA
Pregnant women who need treatment for substance use disorders often have different issues than men and non-pregnant women. Pregnancy further complicates treatment needs. Issues to consider include:

**Psychosocial Issues**

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

**Medical Issues**

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

**Potential Referrals**

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

- Additional specialized medical care, such as HIV management
- Childbirth preparation class
- Transportation to services
- Public assistance, medical assistance, food stamps
- WIC Nutrition Program
- First Steps Services, including Maternity Support Services and Infant Case Management
- Child care (day care, foster care)
- Peer directed prenatal and postpartum support groups
- Parent skill-building services
- Home management skill-building services
- Education and career building support
- Safe and sober housing access
- Legal services
- Child Protective Services
- Adoption counseling
- Pediatric follow-up for special care infant
- Mental health services
- Chemical Using Pregnant Women intensive inpatient care programs
- Domestic violence counseling and services
- Infant development follow up with occupational or physical therapy
- Pregnant and Parenting Women Residential Chemical Dependency Treatment
- Parent Child Assistance Program
- Safe Babies Safe Moms
- Nurse Family Partnership
Appendix A: Screening Tools for Drugs and Alcohol

Screening Tools for Alcohol Use

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

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

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

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

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

http://www.samhsa.gov/sbirt

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

Oregon tools
http://sbirtoregon.org/screening.php
<table>
<thead>
<tr>
<th>Tool</th>
<th>Description/Time it takes to complete</th>
<th>Sensitivity</th>
<th>Screens for</th>
<th>Validation</th>
<th>Training Available</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT-C</td>
<td>3 questions/ approximately 1-2 mins <a href="http://www.integration.samhsa.gov/images/res/tool_auditc.pdf">http://www.integration.samhsa.gov/images/res/tool_auditc.pdf</a></td>
<td>67%-95% Sensitive 85% specificity Positive predictive value 92%-100%</td>
<td>EtOH use</td>
<td>For prenatal patients Sensitivity varies widely in different studies</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td>CRAFFT</td>
<td>Validated for use in patients aged 15-24 6 questions/ approximately 2-3 mins <a href="http://ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf">http://ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf</a></td>
<td>76% sensitivity 94% specificity</td>
<td>EtOH and drug use</td>
<td>Recently for prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td>4P’s Plus</td>
<td>5 questions with follow-up if positive; 2-5 mins Parents, partners, past, present, pregnancy <a href="http://aia.berkeley.edu/media/pdf/chasnoff_4ps.pdf">http://aia.berkeley.edu/media/pdf/chasnoff_4ps.pdf</a></td>
<td>87% sensitivity 76% specificity</td>
<td>All substance</td>
<td>For prenatal patients</td>
<td>Yes</td>
<td>Requires permission for use</td>
</tr>
<tr>
<td>Substance Use Risk Profile Pregnancy Scale</td>
<td>3 questions/ approximately 2 mins <a href="http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/SubstanceUseRiskProfile.pdf">http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/SubstanceUseRiskProfile.pdf</a></td>
<td>91% sensitivity 67% specific</td>
<td>EtOH and THC</td>
<td>Recently developed Specifically for prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td>T-ACE</td>
<td>4 questions/ approximately 1-2 mins <a href="http://www.mirecc.va.gov/visn22/T-ACE_alcohol_screen.pdf">http://www.mirecc.va.gov/visn22/T-ACE_alcohol_screen.pdf</a></td>
<td>69%-88% sensitivity 1%-89% specificity</td>
<td>EtOH only – for heavy use</td>
<td>For prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td>TICS</td>
<td>2 questions/ &lt;1 min <a href="http://www.mirecc.va.gov/visn22/TICS.pdf">http://www.mirecc.va.gov/visn22/TICS.pdf</a></td>
<td>80% sensitivity 80% specificity Negative predictive value 92.7%</td>
<td>EtOH and drug use</td>
<td>Easy to implement in primary care setting</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td>Screening Tool</td>
<td>Description</td>
<td>Sensitivity</td>
<td>Specificity</td>
<td>Recommended Use</td>
<td>Cost</td>
<td>Access Method</td>
</tr>
<tr>
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</tr>
<tr>
<td>TWEAK</td>
<td>5 questions/ approximately 1-2 mins</td>
<td>71%-91%</td>
<td>73%-83%</td>
<td>For prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td>SBIRT</td>
<td>Screening, brief intervention, referral to treatment: 1-3 questions</td>
<td>AMA, SAMHA recommends based on evidence</td>
<td>ETOH and drugs</td>
<td>Primary care and specialty care Easy to implement; Medicaid covers</td>
<td>Webinar</td>
<td>Free</td>
</tr>
<tr>
<td><a href="http://www.integration.samhsa.gov/clinical-practice/sbirt#why">http://www.integration.samhsa.gov/clinical-practice/sbirt#why</a>? Select validated screen: SAMSHA recommends AUDIT, ASSIST or DAST-10</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>DAST-10</td>
<td>10 items/approximately 3-5 mins/self report</td>
<td>41%-95%</td>
<td>68%-99%</td>
<td>Adults and adolescents in primary care. Not validated for prenatal patients.</td>
<td>No</td>
<td>Free</td>
</tr>
</tbody>
</table>

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

*Adapted from Goodman, DJ and Wolff, KB. 2013. Screening for Substance Abuse in Women’s Health: A Public Health Imperative. *Journal of Midwifery and Women’s Health.* 50, 278-287.*
ASK – 1 minute

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

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

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

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

ADVISE – 1 minute

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

ASSESS – 1 minute

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

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

ASSIST – 3 minutes +

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

ARRANGE – 1 minute +

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

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

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

See Readiness Ruler on next page.

<table>
<thead>
<tr>
<th>BNI STEPS</th>
<th>DIALOGUE/PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Raise subject and ask permission</td>
<td>➤ Hello, I am ________. Would you mind taking a few minutes to talk with me confidentially about your use of [X]? <strong>&lt;&lt;PAUSE and LISTEN&gt;&gt;</strong></td>
</tr>
<tr>
<td></td>
<td>➤ Before we start, could you tell me a little about yourself and your goals…What’s important to you?</td>
</tr>
<tr>
<td>2. Provide feedback</td>
<td>➤ 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].</td>
</tr>
<tr>
<td>• Review screen</td>
<td>➤ What connection (if any) do you see between your use of [X] and this ED visit?</td>
</tr>
<tr>
<td>• Make connection (no arguing)</td>
<td>➤ If pt sees connection, reiterate; If pt does not see connection: make one using medical info</td>
</tr>
<tr>
<td>• For alcohol… Show NIAAA guidelines &amp; norms</td>
<td>➤ 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.</td>
</tr>
</tbody>
</table>
| 3. Enhance motivation                  | Ask pros and cons
|   • Explore Pros and Cons             | ➤ Help me to understand what you enjoy about [X]? **<<PAUSE AND LISTEN>>** |
|   • Use reflective listening          | ➤ Now tell me what you enjoy less about [X] or regret about your use of [X]
|                                           | **<<PAUSE AND LISTEN>>**
|                                           | On the one hand you said...
|                                           | **<<RESTATE PROS>>**
|                                           | On the other hand you said…
|                                           | **<<RESTATE CONS>>**
|   • Readiness to change               | ➤ 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]? |
|   • Reinforce positives               | ➤ Ask: Why did you choose that number and not a lower one like a 1 or a 2? Other reasons for change? |
|   • Develop discrepancy between ideal and present self | ➤ Ask: How does this fit with where you see yourself in the future? |
| 4. Negotiate & advise                 | What’s the next step?
|   • Negotiate goal                    | ➤ What do you think you can do to stay healthy and safe? |
|   • Benefits of change                | ➤ If you make these changes what do you think might happen? |
|   • Reinforce resilience/resources    | ➤ What have you succeeded in changing in the past? How? Could you use these methods to help you with the challenges of changing? |
|   • Summarize                         | ➤ This is what I’ve heard you say… Here’s an action plan I would like you to fill out, reinforcing your new goals. This is really an agreement between you and yourself |
|   • Provide handouts                  | ➤ Provide agreement and information sheet |
|   • Suggest PC f/u                    | ➤ Suggest Primary Care f/u to support plan |
|                                        | ➤ Thank patient for his/her time |
Readiness Ruler

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not ready</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Very ready</td>
<td></td>
</tr>
</tbody>
</table>

Appendix C: Screening Tools for Depression and Intimate Partner Violence

**Depression**

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

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

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

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

**ACOG District II Perinatal Depression Screening Toolkit**  
[http://mail.ny.acog.org/website/DepressionToolKit.pdf](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

**Intimate Partner Violence**

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

**Health Cares About Intimate Partner Violence**  
Information about IPV, screening, how to screen, links to resources, advocacy tools, and how to order educational materials:  
[www.healthcaresaboutipv.org](http://www.healthcaresaboutipv.org)

**National Health Resource Center on Domestic Violence**  
Fact sheets, free patient and provider materials, training videos, and technical assistance:  

For Washington State information and resources refer to **Intimate Partner Violence and Pregnancy Screening, Resources and Referrals** provider guide for Washington State at  
### Appendix D: Interpreting Urine Toxicology Screens – UNC Health Care

**General Information**
- Before ordering a urine toxicology screen, review the patient’s medication record to ensure it is accurate and up-to-date
- Sensitivities, cross-sensitivities, false positives, and false negatives may vary based on assay; contact the laboratory for specific information
- False positives and negatives are possible on initial urine screens but can be ruled out on confirmation screens
- Contact the laboratory if results of urine toxicology screen are abnormal, or not as expected
- Currently, assays are unable to determine a reliable relationship between dose and urine concentration

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

Toxicology Laboratory: 966-6338 or 966-2361

Downloaded online October 1, 2014.
Adapted February 2016.
Appendix E: Resources

Statewide Resources

Chemical Dependency Assessment and Treatment

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

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

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

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

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

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

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

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

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

**Safe Babies Safe Moms**

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

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

For information at the local level, contact the following:

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

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

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

**Parent Child Assistance Program**

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


Parent Child Assistance Program services include:

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

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

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

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

<table>
<thead>
<tr>
<th>County</th>
<th>Clinical Director</th>
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<tbody>
<tr>
<td>Clallam</td>
<td>First Step Family Support Center</td>
</tr>
<tr>
<td></td>
<td>Christina Miko</td>
</tr>
<tr>
<td></td>
<td>360-457-8355</td>
</tr>
<tr>
<td>Clark</td>
<td>Community Services Northwest</td>
</tr>
<tr>
<td></td>
<td>Amy Morrison</td>
</tr>
<tr>
<td></td>
<td>360-448-2121</td>
</tr>
<tr>
<td>Cowlitz</td>
<td>Family Health Center</td>
</tr>
<tr>
<td></td>
<td>Tabatha O’Brien</td>
</tr>
<tr>
<td></td>
<td>360-425-960</td>
</tr>
<tr>
<td>Grant</td>
<td>Grant County Prevention and Recovery Center</td>
</tr>
<tr>
<td></td>
<td>Wendy Hanover</td>
</tr>
<tr>
<td></td>
<td>509-765-5402, ext. 5486</td>
</tr>
<tr>
<td>Grays Harbor/Pacific</td>
<td>Children’s Advocacy Center of Grays Harbor</td>
</tr>
<tr>
<td></td>
<td>Margaret Cabell</td>
</tr>
<tr>
<td></td>
<td>360-249-0005, ext. 14</td>
</tr>
<tr>
<td>King</td>
<td>Evergreen Recovery Centers</td>
</tr>
<tr>
<td></td>
<td>Charlene Takeuchi</td>
</tr>
<tr>
<td></td>
<td>206-323-1300, ext. 2237</td>
</tr>
<tr>
<td>Kitsap</td>
<td>Agape Unlimited</td>
</tr>
<tr>
<td></td>
<td>Mary Allison Brown</td>
</tr>
<tr>
<td></td>
<td>360-377-0370</td>
</tr>
<tr>
<td>Pierce</td>
<td>Evergreen Recovery Centers</td>
</tr>
<tr>
<td></td>
<td>Shermoin Claray</td>
</tr>
<tr>
<td></td>
<td>253-475-0623</td>
</tr>
<tr>
<td>Skagit</td>
<td>Brigid Collins Family Support Center</td>
</tr>
<tr>
<td></td>
<td>Elizabeth Morgan</td>
</tr>
<tr>
<td></td>
<td>360-866-6669, ext. 323</td>
</tr>
<tr>
<td>Spokane</td>
<td>New Horizons Care Centers</td>
</tr>
<tr>
<td></td>
<td>Denise Joy</td>
</tr>
<tr>
<td></td>
<td>509-838-6092</td>
</tr>
<tr>
<td>Yakima</td>
<td>Triumph Treatment Services</td>
</tr>
<tr>
<td></td>
<td>Lashaunda Harris</td>
</tr>
<tr>
<td></td>
<td>509-248-1800</td>
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</tbody>
</table>
Other Related Washington State Resources for Pregnant Women

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

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

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

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

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

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

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

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

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

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

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

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

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

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

StopOverdose.org
Website for prevention of Opioid overdoses through Naloxone:
http://stopoverdose.org/faq.htm
StopOverDose overdose education site:
http://stopoverdose.org/index.htm
Tobacco Quitline – 1-800-784-8669
For assistance quitting tobacco use.
www.doh.wa.gov/YouandYourFamily/illnessanddisease/tobacco-related/quittingtobacco.aspx

Washington Law Help
www.washingtonlawhelp.org

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

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

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

Websites – National

American College of Nurse Midwives
www.midwife.org

American Society of Addiction Medicine
www.asam.org

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

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

Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, SAMHSA: TIP Protocol 40

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

KAP Keys for Clinicians Substance Abuse Treatment: Addressing the Specific Needs of Women, TIP 51

Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, SAMHSA: TIP 43

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

National institute on Drug Abuse – Commonly Abused Drugs
http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts
National Organization on Fetal Alcohol Syndrome
http://www.nofas.org/

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

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

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

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

Websites – Washington State

Department of Health
www.doh.wa.gov

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

Interagency Guideline on Prescribing Opioids for Pain
developed by Agency Medical Directors Group 2015

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

Pediatric Interim Care Center
www.picc.net

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

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

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

Washington State Fetal Alcohol Spectrum Disorders
www.fasdwa.org

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

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

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

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

Spanish Health Educational Resources

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

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

Drinking and your pregnancy

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

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

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

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

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

US Department of Agriculture Food and Nutrition Service
Substance Use Prevention Screening, Education, and Referral Resource Guide for Local WIC Agencies
A USDA handbook addressing WIC's role in preventing substance use disorder, predictors, screening methods and tools and resources, updated September 2013.

www.mainedartmouth.org/pdf/OConnorAltoOutpatientTreatmentManualOpioidDependentPregnant_V2.pdf

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

National Institute of Drug Abuse
Screening for Drug Use in General Medical Settings: Quick Reference Guide

Additional Tools: Screening, Assessment, and Drug Testing

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

Detoxification Services

Assists clients in withdrawing from drugs, including alcohol.

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

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

Outpatient Treatment Services

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

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

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

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

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

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

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

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

Substance Abuse During Pregnancy: Guidelines for Screening
Appendix G: Department of Social and Health Services Children’s Administration Prenatal Substance Abuse Policy

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

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

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

How Do I Make A Report?

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

Children’s Administration offers several ways to report abuse:

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

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


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

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

- The name, address, and age of the child and parent(s), stepparents, guardians, or other persons having custody of the child.
- The nature and extent of alleged:
  - Injury or injuries
  - Neglect
  - Sexual abuse
  - Any evidence of previous injuries
Any other information that may be helpful in establishing the cause of the child’s death, injury or injuries, and the identity of the alleged perpetrator(s).

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

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

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

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

What Happens After A Report Is Made?

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

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

Child Protective Services interventions include the following:

- Determining the nature and extent of abuse and neglect.
- Evaluating the child’s condition, including danger to the child, the need for medical attention, etc.
- Identifying the problems leading to or contributing to abuse or neglect.
- Evaluating parental or caretaker responses to the identified problems and the condition of the child and willingness to cooperate to protect the child.
- Taking appropriate action to protect the child.
- Assessing factors which greatly increase the likelihood of future abuse or neglect and the family strengths which serve to protect the child.
If a child is of Indian ancestry social services staff must follow requirements of the Federal Indian Child Welfare Act (ICWA), state laws, and the RCW.

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

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

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

**What Services May Be Provided?**

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

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

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

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

When Children’s Administration receives information about a pregnant woman who is not parenting other children and is allegedly abusing substances, intake staff documents this information and available information about risk and protective factors in an “Information Only” referral. This referral is then forwarded to First Steps Services.
When Children’s Administration receives information about a substance-exposed but not substance-affected newborn, intake staff will ask about available information, including information about safety threats and protective factors to determine if there is an allegation of child abuse or neglect or safety threat(s). If there are no allegations of child abuse or neglect or safety threats, Children’s Administration does not have the authority to conduct a Child Protective Services investigation and the referral is documented as “Information Only.” If a decision is made not to respond, and you disagree, you may discuss your concerns with the Intake Supervisor. When a case is not appropriate for Child Protective Services, you may consult with the local Children’s Administration office for suggestions or guidance in dealing with the family.

CA Practices and Procedures – Prenatal Substance Abuse Policy Definitions

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

A Substance-Affected Newborn is one who has withdrawal symptoms resulting from prenatal substance exposure and/or demonstrates physical or behavioral signs that can be attributed to prenatal exposure to substances and is identified by a medical practitioner as affected.
Appendix H: Medical and Public Health Statements Addressing Prosecution and Punishment of Pregnant Women

American Medical Association

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

American Academy of Pediatrics

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

American College of Obstetricians and Gynecologists

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

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

American Public Health Association

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

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

[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).

The threat of criminal prosecution prevents many women from seeking prenatal care and early intervention for their alcohol or drug dependence, undermines the relationship between health and social service workers and their clients, and dissuades women from providing accurate and essential information to health care providers. The consequence is increased risk to the health and development of their children and themselves.” Association of Maternal and Child Health Programs Law and Policy Committee, Statement Submitted to the Senate Finance Committee Concerning Victims of Drug Abuse: Resolution on Prosecution (1990).
Appendix I: A Guide for Medical Professionals about Tobacco, Marijuana, and E-Cigarettes in Pregnant & Breastfeeding Women

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

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

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

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

Current research and information during pregnancy and breastfeeding

Marijuana

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

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

Hookah smoking:* A hookah is an eastern tobacco pipe or water pipe

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

Breastfeeding and smoking

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

Nicotine

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

Secondhand smoke

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

- **Washington State Tobacco Quitline**: 1-800-QUIT-NOW (1-800-784-8669) or 1 855-DEJELO-YA for help with tobacco and marijuana.


Provider resources

- The PHS publication, *Treating Tobacco Use and Dependence: A Clinical Practice Guideline, 2008 Update* describes the 5 A’s intervention in detail and provides a chapter about special populations, including pregnant women (Fiore 2008).

- **Smoking Cessation During Pregnancy: Guidelines for Intervention**
  A handbook designed for healthcare professionals, includes information on using motivational interviewing techniques and the 5 As, tips for dealing with relapse, developing quit plans, pharmacotherapy information and additional resources.

- **Substance Use Prevention Screening, Education, and Referral Resource Guide for Local WIC Agencies**
  A USDA handbook addressing WIC’s role in preventing substance use disorders, patterns and predictors, screening methods and tools and resources.
Bibliography


Lester BM, et al (2004). Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*. [www.harmreductionjournal.com/content/1/1/5](http://www.harmreductionjournal.com/content/1/1/5)


Footnotes

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


16 American College of Obstetricians and Gynecologists, 2011 Committee Opinion 503 Tobacco Use and Women’s Health.


19 Hari Cheryl Sachs and COMMITTEE ON DRUGS The Transfer of Drugs and Therapeutics Into Human Breast Milk: An update on Selected Topics. Pediatrics 2013;132:e796; originally published online August 26, 2013.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD / TTY 711).
Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State

July 2015
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EXECUTIVE SUMMARY

This document provides guidance to hospitals, 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.

In 2003, Congress enacted the Keeping Children and Family Safe Act which requires each state, as a condition of receiving federal funds under the Child Abuse Prevention and Treatment Act, to develop policies and procedures “to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.” This law requires health care providers who deliver or care for such infants, to notify Child Protective Services.

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.
Introduction

The purpose of this document is to provide consistent guidance to health care professionals and hospitals about maternal screening and testing and reporting drug-exposed newborns born in Washington State hospitals. This guidance also applies to newborns born elsewhere (home, clinic, or another hospital) and admitted to your hospital, and then determined to be drug exposed or affected.

Screening refers to methods used to identify risk of substance abuse during pregnancy and postpartum, including self-report, interview and observation. Testing is the process of laboratory testing to determine the presence of a substance in a specimen.

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
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 confirmed (as opposed to screen) drug toxicology; her newborn is presumed to be drug exposed. If a screen only positive toxicology (without confirmation testing), has been done on the mother, a newborn toxicology may be indicated.

Hospital Policy
Each hospital should work with risk management attorneys, nursing, social service, and medical staff to develop a defined policy for identifying intrapartum and postpartum 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 pregnant 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
Washington referral resource information can be found at the DSHS Behavioral Health and Service Integration Administration website: https://www.dshs.wa.gov/bhsia/substance-use-treatment-services

Table 1

Newborn Risk Indicators

It is not necessary to test a newborn with signs of drug withdrawal whose mother has a positive confirmed 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 associated with maternal drug use may include: (American College Obstetricians and Gynecologists, 2005)

- 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 infant
- Signs of neonatal narcotic abstinence syndrome include: marked irritability, tremors, increased wakefulness, hyperactive deep tendon reflexes, exaggerated Moro reflex, seizures, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis (American Academy of Pediatrics, 2012; 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. In a recent study, lower gestational age was associated with lower risk of withdrawal. The decrease in severity of signs in the preterm infant may relate to developmental immaturity of the CNS, differences in total drug exposure or lower fat deposits of the drug (AAP, 2012). Immature organ systems may also modify test results. In addition, scoring tools for withdrawal were developed in term or late preterm infants.

Table 2

Maternal Risk Indicators

Maternal characteristics that suggest a need for biochemical testing of the newborn include: (AAP, 2012)

- No prenatal care
- Admitted history of drug use
- Previous unexplained fetal demise
- Precipitous labor
- Abruptio placentae
- Hypertensive episodes
- Severe mood swings
- Cerebrovascular accidents
- Myocardial infarction
- Repeated spontaneous abortions
- Cannabinoid hyperemesis syndrome (intractable nausea (unresponsive to treatment) relieved by frequent hot bathing/showers.

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 conditions: abscesses, dry or itchy, acne type sores

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.

According to the June 2015 American College of Obstetricians and Gynecologists Committee
Opinion, Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetrics and
Gynecologic Practice, when a legal or medical obligation exists for obstetrician-gynecologists to test
patients for substance use disorder, there is an ethical responsibility to notify patients of this test and
make a reasonable effort to obtain informed consent. ¹

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 most useful when the history and clinical
  presentation strongly suggest neonatal withdrawal but the material urine screening is negative.
  (AAP, Pediatrics 2012). 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.
• **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. (Vinner, Therapeutic Drug Monitoring 2003) Hair has a high false
  positive rate because of passive exposure to minute quantities of illicit substances in the
  environment.

¹ American College of Obstetricians and Gynecologists. 2015, Alcohol Abuse and Other Substance Use Disorders:
Ethical Issues in Obstetric and Gynecologic Practice, ACOG Committee Opinion, Number 633
Umbilical cord segments reflect substance exposure during the second half of gestation. Drugs given to the mother during labor will appear in cord tissue toxicology. Recent testing of umbilical cord tissue by using drug class-specific immunoassays was shown to be in concordance with testing of paired meconium specimens for detection of amphetamines, opiates, cocaine and cannabinoids (AAP, 2012). Currently testing for buprenorphine (Subutex), and designer stimulants (“bath salts”) is available. Detection of alcohol at high levels is also possible with cord tissue testing. The ease of collection and turn around time for results, make this confirmation test ideal for neonatal drug testing. Cost of analysis per specimen approximates the cost of meconium. More information is available at www.usdtl.com.

Table 4
Management of a Newborn with a Positive Drug Toxicology

- Confirm any positive test with gas chromatography/mass spectroscopy particularly if opiates are found.
- Consider the fact that intrapartum drugs prescribed to control labor pain can be detected in meconium and umbilical cord tissue.
- 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.

Legal substances such as alcohol and marijuana have strong potential to cause harm. Adverse effects due to maternal alcohol use are well known. Marijuana use by adults is now legal in Washington State. There are health risks to infants of mothers who use medical or recreational marijuana. The main psychoactive component in marijuana (THC) passes from mother to child during pregnancy and through breast milk. Emerging research also suggests there is an association between marijuana and decreased fetal growth, development and executive functioning and mood disorders in children. (Goodman) THC stays in the body of mothers and babies for a long time, babies can test positive for THC weeks after being exposed. (Garry) Babies exposed to THC can have problems with feeding. (Miller)

Reporting to Children’s Administration
Hospitals should contact their local Department of Social and Health Services Children’s Administration office and request an in-service on mandatory reporting and other Children’s Protective Services processes. The hospital’s risk management staff should attend the in-service. After the in-service, parties may have a better idea of points needing clarification. Starting at the local level is important for developing key relationships and ensuring smooth and consistent
procedures. See Page 14 for Department of Social and Health Services Children’s Administration Prenatal Substance Abuse Policy.

Parental substance use doesn’t necessarily result in child harm or neglect. If a mandated reporter has reasonable cause to believe that a child has suffered child abuse/neglect they are mandated to report. We also agreed to add the following language: If you believe that a parent’s substance use/abuse is causing child abuse or neglect, consult CPS. This includes the use of marijuana and alcohol.

The DSHS guide for reporting allegations of child abuse and neglect can be found online at http://www.dshs.wa.gov/pdf/publications/22-163.pdf.

Child Protective Services: Guidance for Mandatory Reporters can be found online at http://www.dshs.wa.gov/pdf/ca/MandatedReporterTraining.pdf.

You can find your local Children’s Administration office by entering your zip code at the following website, https://fortress.wa.gov/dshs/f2ws03apps/caofficespub/offices/general/OfficePick.asp or by following this link, Local Children's Administration Office locator.

**DSHS Substance Abuse during Pregnancy - Intake Screening**

Intake must take the following actions regarding reports of substance abuse during pregnancy.

**A.** Document a pregnant woman's alleged abuse of substance(s) (not medically prescribed by the woman's medical practitioner) in an intake as “Information Only.”

**B.** Document available information on the following risk and protective factors:

1. Current substance abuse (specific substance(s) used, frequency, intensity, duration and amount of use).
2. History of substance abuse (e.g., periods of abstinence).
3. History of or refusal to enter substance abuse treatment.
4. Results of prior substance abuse treatment.
5. Current prenatal care and name of physician or obstetric care provider.
6. History or current presence of domestic violence.
7. Previous history of serious mental health disorder and/or postpartum mood disorder.
8. Environmental factors, including exposure to toxic chemicals (i.e. drug manufacturing).
9. Support available to the pregnant woman.

Information from a-i above will be documented in the Narrative section - Caregiver Characteristics. This information may be used to assess safety of the child.

**C.** On all "Screened Out" intakes on a pregnant woman allegedly abusing substances, intake staff will identify whether the woman is receiving Medicaid.

1. If the woman is not on Medicaid, intake will email a copy of the intake to ESA at CSDFirstSteps@dshs.wa.gov.

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2 American College of Obstetricians and Gynecologists. 2015. *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG Committee Opinion, Number 633
2. If the woman is on Medicaid, intake staff will send a copy of the intake by email, mail or fax to the First Steps provider whenever possible. If there are multiple First Steps providers serving one community, intake staff will send to ESA HQ at CSDFirstSteps@dshs.wa.gov.

D. When the referrer is an ESA HQ or First Steps provider, intake staff will not need to send an intake.

E. Upon receipt of an intake involving an Indian child, CA intake will send intakes to the Tribe for the Tribe’s information. Refer to ICW Manual Section 05.05.

F. Follow the intake procedures (outlined in section 2220 Practices and Procedures Guide) when there is a pregnant woman who is parenting a child and there is an allegation of child abuse or neglect (CA/N).

**DSHS Intake numbers:**
Toll free number for region 3 (old regions 5 and 6) is **Toll Free Intake**: 1-888-713-6115.
Region 1 intake (old regions 1 and 2) is **Toll Free Intake**: 1-800-557-9671. Central intake covers new region 2 (old 4 and 5).
Appendix A

References and Resources:


Lester BM, et al. 2004. Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*; [http://www.harmreductionjournal.com/content/1/1/5](http://www.harmreductionjournal.com/content/1/1/5).


Additional Resources


Washington State Department of Health, Access, Systems and Coordination Phone: 360-236-3582)

Washington State Department of Social and Health Services Children’s Administration website – video and materials for mandatory reporters: http://www1.dshs.wa.gov/ca/general/index.asp


Washington State Hospital Association (Phone: 206-216-2531)

Neonatal Advances – Enhancing the Care of Drug-Exposed Infants http://neoadvances.com/

Appendix B

Guidelines for Obtaining Consent from Parents
For Infant Drug Testing

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:
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,

XXXXX
Enclosure
### Neonatal Abstinence Scoring System

**Morphine Sulfate**

<table>
<thead>
<tr>
<th>System</th>
<th>Signs and Symptoms</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Central Nervous System</td>
<td>Crying: Excessive high pitched</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Crying: continuous high pitched</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sleeps &lt; 1 hour</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sleeps &lt; 2 hours after feeding</td>
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<td></td>
<td>Sleeps &lt; 3 hours after feeding</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Hyperactive Moro reflex</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Markedly hyperactive Moro reflex</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Mild tremors: Undisturbed</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Moderate-severe tremors: Undisturbed</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Mild tremors: Disturbed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Moderate-severe tremors: Disturbed</td>
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</tr>
<tr>
<td></td>
<td>Increased muscle tone</td>
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</tr>
<tr>
<td></td>
<td>Excoriation (specify area)</td>
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<tr>
<td></td>
<td>Myoclonic Jerks</td>
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</tr>
<tr>
<td></td>
<td>Generalized convulsions</td>
<td>5</td>
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<td>Metabolic, Vasomotor,</td>
<td>Sweating</td>
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</tr>
<tr>
<td>and Respiratory</td>
<td>Fever 37.2-38.3°C (99-101°F)</td>
<td>1</td>
</tr>
<tr>
<td>Disturbances</td>
<td>Fever &gt; 101°F (&gt;38.4°C)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Frequent yawning (&gt;3)*</td>
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</tr>
<tr>
<td></td>
<td>Mottling</td>
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<tr>
<td></td>
<td>Nasal Stuffiness</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sneezing (&gt;3) *</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nasal flaring</td>
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<tr>
<td></td>
<td>Respiratory rate (&gt;60/min.)</td>
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<td>Respiratory rate (&gt;60/min. with retractions)</td>
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<tr>
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<td>Poor feeding</td>
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<tr>
<td></td>
<td>Regurgitation+</td>
<td>2</td>
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<tr>
<td></td>
<td>Projectile vomiting+</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Loose stools</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Watery stools</td>
<td>3</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
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<tr>
<td>Initials of Scorer</td>
<td></td>
<td></td>
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</tbody>
</table>

*As they have occurred in the entire scoring period (i.e., within the previous 2 or 4 hours, whatever the scoring interval).
+ More than or equal to 2 times during or after feeding.

Appendix E

Children's Administration

Prenatal Substance Abuse Policy

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

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

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

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

Children’s Administration offers several ways to report abuse:

Daytime: Contact local Children's Administration CPS office. A local CPS office can be located on the following link:
https://fortress.wa.gov/dshs/f2ws03apps/caofficespub/offices/general/OfficePick.asp

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

Additional information about reporting abuse and neglect of children can be located at:

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:

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

2. The nature and extent of alleged
   - Injury or injuries
   - Neglect
   - Sexual Abuse

3. Any evidence of previous injuries.
4. 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 DSHS at intake or during the course of a CPS 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.
- Did the mother participate in prenatal care.
- Extended family and family strengths which can help the parent(s) to care for and protect children and their family.
- Parent(s) 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 CPS 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, CA intake staff determines whether the situation described meets the legal definition of child abuse or neglect. In order for CPS 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.

CPS 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 (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 CA receives information that does not meet the definition of child abuse or neglect and CA does not have the authority to investigate, intake staff documents this information in the systems database as an “Information Only” referral.

When CA 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 CA receives information about a substance exposed but not substance-affected newborn, intake 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, CA does not have the authority to conduct a CPS 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 CPS, you may consult with the local Children’s Administration office for suggestions or guidance in dealing with the family.

CA Practices and Procedures – Prenatal Substance Abuse Policy – Definitions

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

A Substance-Affected Newborn is one who has withdrawal symptoms resulting from prenatal substance exposure and/or demonstrates physical or behavioral signs that CAN BE attributed to prenatal exposure to substances and is identified by a medical practitioner as affected.
The Child Abuse Prevention and Treatment Act (CAPTA) requires that grants to States are provided to implement a State plan that ensures enforcement of a State law that includes provisions for infants affected by substance use. Implementation of the State’s plan should be developed and monitored by a State-level authority, which works across agencies and providers to develop a strategic, multi-year response to the problems of prenatal substance exposure. Details on the charge to the State-level team, suggested membership, data collection and monitoring considerations and the specific tasks to be accomplished by the team are outlined in this appendix.
Charge to the Governor’s Council—A Governor’s interagency council could be charged with developing a comprehensive State Plan for implementation of Plans of Safe Care to focus on reducing prenatal substance exposure and responding effectively to the needs of infants who are affected by prenatal substance exposure, their mothers with substance use disorders and their families/caregivers. The charge of such an entity is to develop, coordinate and support the child- and family-focused service delivery system, emphasizing prevention, early intervention, and an array of community-based treatment services. The Governor’s Council would be tasked with evaluating the State’s existing legislation, policies and procedures that govern the State-wide implementation of the CAPTA provisions and determining if changes are needed in State laws or regulations. The Council would also issue guidance to local jurisdictions that are charged with developing an effective response, and implementing, monitoring and reporting on Plans of Safe Care for infants and their families/caregivers.

Membership of the Governor’s Council—Previously existing councils at the State level such as Children’s Cabinets or Early Childhood Councils could be tasked with this role if given adequate emphasis and greater priority to the issues of responding to prenatal exposure and its effects. The Council could include:

- Departments of Health, including Public Health and Maternal and Child Health (including Home Visiting Division)
- Substance Use Disorder prevention and treatment,
- Children’s and Adult Mental Health
- Social Services (Child Abuse Prevention and Protection Services)
- Early Intervention (Individuals with Disabilities Education Act (IDEA) Part C)
- Developmental Disabilities
- Administrative Office of the Courts
- State Department of Education
- Department of Budget and Finance
- Medicaid Director, as well as representatives from the State Hospital Association
- State branches of the American College of Obstetricians and Gynecologists (ACOG)
- State branches of the American Academy of Pediatrics (AAP)
- The Insurance Commissioner's office who has oversight of private health insurers in the State

Tasks of the Governor’s Council—At a minimum the plan should review current State statutes and policy manuals to be focused on implementation of needed practice and policy changes, data-driven decision making and could include the following tasks at the various points of intervention:

Prevention of Infants with Prenatal Substance Exposure

- Strategies for raising awareness about the risks associated with alcohol, tobacco and other substance use during pregnancy. Specific strategies are developed to engage young women of childbearing age, including the adolescent and foster care population.
- Strategies that focus on changing the culture regarding substance use during pregnancy so that women and families are supported to make healthy decisions and to receive appropriate intervention and treatment when needed.
Screening, Assessment and Intervention during Pregnancy, at Birth and Childhood

- Implementing universal screening for substance use during pregnancy using an evidence-based reliable tool.
- Medicaid and private insurer requirements for coverage of screening during pregnancy and the minimum insurance benefit and payment rates (e.g., determining factors such as screening during prenatal care as a billable item in the Medicaid plan and at what rate and who can bill for that service) for treatment in accordance with Federal parity legislation and the Affordable Care Act.
- Demonstrate that policies and protocols for the notification to Child Protective Services (CPS) of an infant with prenatal substance exposure to CPS are developed with hospitals and medical providers responsible for the delivery of such infants.
- A lead agency (e.g., a substance use disorder treatment agency or the public health authority) is designated to ensure that multi-disciplinary and comprehensive assessments with the pregnant woman are conducted. However, the Medicaid agency, for example, may be charged with monitoring implementation of the assessments by determining that claims for routine prenatal care include billing codes for substance use disorder screening and assessments.
- A lead agency must also be designated that has the responsibility to ensure that a Plan of Safe Care is implemented for infants identified with prenatal exposure, their mothers and families. While signs and symptoms of neurological effects of prenatal exposure would not be evident during pregnancy or in some cases at birth, the intent of designating which agency is responsible is to ensure that a plan is developed and that follow up with the family occurs to reduce longer-term effects and to foster the child’s development.
- A continuum of services for pregnant, post-partum and parenting women that acknowledges women’s treatment needs for evidence-based, family-centered and trauma-informed services and addresses barriers to accessing services for pregnant and parenting women. Steps to ensure that continuum include determining gaps in the availability of these services and the development of strategic plans to create such a continuum in States and communities.
- Practice protocols for women in treatment, particularly those receiving medication-assisted treatment, to ensure effective communication between substance use disorder treatment agencies and physicians providing medications.
- Policy and procedures to ensure home visiting or other programs that provide follow-up to high risk infants include this population in their services and that all such infants receive those follow-up services, regardless of their placement following discharge from the hospital (e.g., with mother and family or an out-of-home care placement).
- A policy for automatic referral to and assessment of need by IDEA Part C providers for infants born affected by substance use disorders as specified by CAPTA for substantiated child welfare cases under the age of 3; exposed to and affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder (FASD).
- The provision of evidence-based training to personnel across multiple domains, agencies, and disciplines to educate them on issues related to prenatal alcohol exposure and the diagnosis of fetal alcohol syndrome and the broad spectrum of associated disorders that fall within FASD. Criteria for diagnosing individuals who were exposed to alcohol and have neurodevelopmental deficits without any physical indicators of exposure have been presented in the DSM5 and should be communicated to health care providers.
Data Collection and Monitoring

- Identifying and resolving barriers to data collection and information sharing across agencies and systems.
- Establishing state-wide performance measures and benchmarks with annual monitoring of the numbers, including the data points sufficient to monitor Plan of Safe Care implementation:
  - the prevalence of substance use during pregnancy;
  - pregnant women who screen positive for substance use;
  - the number of treatment admissions for pregnant women;
  - infants born with prenatal substance exposure;
  - notifications to child welfare of infants with prenatal exposure;
  - the number of infants and families with implemented Plans of Safe Care;
  - average hospital stays and costs for infants and mothers;
  - infants with prenatal exposure who remain at home and those placed in custody of the State;
  - the number of families receiving home visiting interventions or other on-going supportive services, including those covered by Plans of Safe Care; and,
  - referrals to and receipt of early intervention services through IDEA Part C.
- Assessment of data from hospitals and CPS on the needs of children and families to make appropriate policy updates.
- State policies on the appropriate follow-up time frames for collecting the data needed to monitor child and family benchmarks based upon an agreed-upon set of outcomes and indicators.
- Methods for evaluating costs of the continuum of care involved with Plans of Safe Care, including cost avoidance, in hospitals, child welfare, special education and other agencies.
Appendix 6: The Community Level Plan of Safe Care for an Infant and Family/Caregiver

At the local government level, a multi-disciplinary approach is needed that draws on professional expertise across agencies and includes an initial response and triage process that assesses risk and protective factors but does not presume child abuse or neglect. The charge to the local community implementation team, suggested membership and tasks to be accomplished at the various intervention points are specified in this appendix.
Charge to the Community Team—A Community’s interagency team is charged with implementing the Governor’s Interagency Council’s decisions by developing a comprehensive practice protocol to focus on reducing prenatal substance exposure and responding effectively to infants who are affected by prenatal substance exposure, to their mothers with substance use disorders and to their families. The charge of such an entity is to develop specific practice and communication protocols that coordinate the child- and family-focused service delivery system, emphasizing prevention, early intervention, and an array of community-based treatment and support services for infants, children, and their families.

Membership of the Community Team—This team would include, at a minimum, representatives from the Departments of Health, including Public Health and Maternal and Child Health and Home Visiting Services, Substance Use Disorder Prevention and Treatment, Mental Health, Social Services (Child Abuse Prevention and Protection Services), Early Intervention Services, Developmental Disabilities, Juvenile/Dependency Courts, Office of Education as well as representatives from the Local Hospital Association, local representatives of the American College of Obstetricians and Gynecologists (ACOG) and local representatives of the American Academy of Pediatrics (AAP). These representatives should have decision-making authority to approve or provide needed services to children and families.

Tasks of the Community Team—At a minimum the Community Team would establish community goals that:

- Implement an interagency memoranda of agreement that codifies agency roles and responsibilities in reducing prenatal exposure and responding to its effects;
- Focus on changing the culture regarding substance use during pregnancy so that women and families are supported to make healthy decisions and to receive appropriate intervention and treatment when needed;
- Implement a continuum of care that ensures infants, mothers and families/caregivers can remain safely together with any needed community supports focused on their well-being;
- Ensure appropriate placement for infants who cannot stay in the custody of their birth mother with preference for kin providers when possible;
- Ensure coordination and avoid duplication of services for infants, mothers and families;
- Identify resources, barriers to care and gaps in services including availability of appropriate resources and the effects of current eligibility criteria; and,
- Identify and address information and data sharing barriers including aggregating, monitoring and changing practice and policies based on the data.

Practice Protocol Specific Tasks Include:

- Developing efficient methods for health care providers to identify and notify specific personnel in the Child Protective Services (CPS) agency in accordance with provisions in the Child Abuse Prevention and Treatment Act (CAPTA) or the prevailing State’s law that implements the CAPTA requirements.
- Ensuring a prompt assessment of families for whom notifications are received by CPS to determine if there are immediate safety concerns and risk of future harm to the infant.
- Determining which infants require a Plan of Safe Care. Options may include those with positive results on the universal screening tool during prenatal care and repeating that measure in the month prior to the expected due date and at birth. A Plan of Safe Care
should be triggered by positive results on the screen or a positive toxicological screen 30 days prior to birth or at birth, or enrollment of an infant under the age of one year in the substantiated child abuse and neglect caseload who may have not been detected at birth as experiencing prenatal substance exposure.

- Establishing a procedure that assures families are included in the “assessment track” in communities with differential response or methods to assess for immediate safety concerns with the preference for maintaining the infant, mother and family bond.

- Developing methods for the assessments to be conducted by and coordinated with relevant agencies and service providers. This coordination may take the form of a family team meeting in which multiple disciplines work with the family to ensure a comprehensive assessment of strengths and needs of the infant’s and mother’s physical, social-emotional health and safety needs.

- Determining whether the community’s existing safety and risk assessment and intervention protocols are appropriate and sufficient for this group of families and enhancing those assessment tools and procedures as needed.

- Making determinations on how to support infants and families for whom medication-assisted treatment is being used in accordance with the mother’s treatment plan.

- Determining the process for and content of an individual Plan of Safe Care which addresses the needs of the infant and family/caregivers identified by the multidisciplinary, comprehensive assessments.

- Ensuring other caregivers receive medical information, training and support to appropriately care for infants with prenatal exposure prior to discharge from the hospital when such infants will not be released to the care of his/her mother and family.

- Determining the appropriate timing for the development of the Plan of Safe Care with a preference that plans are developed with families prior to the infant’s birth so that the family is supported and there is communication among health providers, substance use disorder treatment agencies, child welfare and other community supportive agencies.

- Ensuring Plans of Safe Care are consistent with the individual family support plans that are required for all children accepted by early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA).

- Developing the process for ensuring that families who are determined to have insufficient protective capacity to ensure the safety of the baby with prenatal substance exposure receive prompt investigation services by CPS.

- Implementing policies that ensure the infant’s safety plan includes a safety and risk assessment of the home environment, community and family support, mother’s recovery status and ongoing treatment needs (including her need and receipt of medication assisted treatment) as well as other health care needs in appropriate medical homes, and infants’ health, developmental, well-being and safety needs.