SBIRT TOOLKIT

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

Addressing perinatal substance use and implementing evidence-based practices to identify, reduce, and prevent problematic use.

Kansas Department of Health and Environment

KANSAS MATERNAL & CHILD HEALTH

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SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TOOLKIT

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SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TOOLKIT

INFORMATION ON IMPLEMENTATION

KANSAS MATERNAL & CHILD HEALTH

KANSAS MATERNAL & CHILD HEALTH

INFORMATION ON IMPLEMENTING SCREENING FOR SUBSTANCE USE DISORDERS IN PERINATAL WOMEN

INTRODUCTION

Mental health and substance use disorders affect people from all walks of life and all age groups. While common, recurrent, and often serious, these illnesses are also treatable, and many people do recover. Additionally, these conditions are often co-occurring. Nearly 50% of people who have one disorder have the other. Research suggests this may be the result of common risk factors contributing to both disorders; substance use may be a form of self-medicating for mental health disorders and brain chemistry can change due to substance use, making mental health disorders more likely. The mental health illnesses which most commonly co-occur with substance use are depression, bipolar disorder, and anxiety disorders.[1] Because of the complex interplay between the two it is important assessment and treatment be comprehensive.

It is also important to understand how these disorders present individually, though there may be similarities. Mental health disorders involve changes in thinking, mood, and behavior. These disorders can affect how we relate to others and make choices. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] Addiction is encompassed within the framework of substance use disorders, but may refer to more severe symptoms. Addiction is a primary, chronic disease of brain reward and often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[3]

The risks associated with untreated mental health disorders and substance use disorders can be progressive and devastating. This is especially true for the perinatal population as the effects are twofold: both mother and child may experience health and social complications. Estimates

1. Nation Institute on Drug Abuse. Common Comorbidities with Substance Use Disorders. Retrieved from https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness
2. Substance Abuse and Mental Health Services Administration. Mental Health and Substance Use Disorders. Retrieved from https://www.samhsa.gov/find-help/disorders
3. American Society of Addiction Medicine. Public Policy Statement: Short Definition of Addiction. Retrieved from https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_short_4-11.pdf?sfvrsn=6e36cc2_0

suggest that about 5 percent of pregnant women use one or more addictive substances.[4] Only 17 percent of pregnant women have spoken to their doctors about alcohol use, yet 9% report using alcohol and three percent report binge drinking (more than three drinks in one sitting). Additionally, six percent of pregnant women aged 15 to 44 years and 18% of pregnant women aged 15 to 17 years reported using recreational drugs during pregnancy.[5]

This toolkit will specifically address substance use in perinatal populations and how providers can assist in the identification and treatment of these disorders. While this toolkit explicitly addresses substance use in the perinatal period it is important to remember the interplay between substance use and mental health when providing services. These conditions are often cooccurring and should be treated in tandem for successful and ongoing recovery. This toolkit outlines one model for addressing substance use in perinatal populations, specifically through the integration of screening into perinatal healthcare.

Please note, for the purposes of this work the term "perinatal" is being defined in the broadest sense, referring to the entire pregnancy through one year postpartum.

BACKGROUND

This background section outlines the negative impacts and risks associated with substance use during pregnancy. Providers play a critical role in identifying, treating, and supporting women who struggle with substance use during the perinatal period. Understanding the risk factors for substance use during pregnancy and the postpartum period is integral to providing a full circle of care for every woman. This full circle includes addressing substance use throughout the perinatal period; this can be accomplished through universal screening for substance use and implementing policies to support patients following screenings. Through screening and brief interventions, providers may uncover risk factors for substance use disorders such as domestic violence, symptoms of mental health disorders, and general misunderstanding about the effects of substance use during pregnancy.

The use of alcohol and recreational drugs in pregnancy creates significant barriers to receiving high-quality prenatal, intrapartum, and postpartum care. These barriers include but are not limited to: inadequate screening for substance use by prenatal care providers; fear of seeking

4. National Institute on Drug Abuse. Substance Use in Women: Substance Use While Pregnant and Breastfeeding. Retrieved from https://www.drugabuse.gov/publications/substance-use-in-women/substance-use-while-pregnant-breastfeeding
5. SAMHSA-HRSA Center for Integrated Solutions. Substance Use Disorder and Pregnancy. Retrieved from https://www.integration.samhsa.gov/about-us/integration-edge/substance-use-disorder-and-pregnancy

care due to societal stigma and legal ramifications; high baseline anxiety and poor coping skills; difficulty establishing trusting relationships with providers; underlying psychiatric disorders; lack of transportation and child care; intimate partner violence; and incarceration.

According to the National Institute on Drug Abuse (NIDA), research shows that use of tobacco, alcohol, or recreational drugs or misuse of prescription drugs by pregnant women can have severe health consequences for infants. This is because many substances pass easily through the placenta, so substances that a pregnant woman takes also reach the fetus. Recent research shows that smoking tobacco or marijuana, taking prescription pain relievers, or using illegal drugs during pregnancy is associated with double or even triple the risk of stillbirth.[6]

Pregnancies complicated by substance use are also at risk of miscarriage, preterm delivery, intrauterine growth restriction, placental abruption, fetal intraventricular hemorrhage, intrauterine fetal demise, neonatal abstinence syndrome (NAS), and other infant developmental effects. An accurate accounting of total costs related to substance use in pregnancy would need to include those related to antepartum hospitalizations for drug intoxication, withdrawal, and associated complications; correctional services expenditures related to incarceration and associated legal costs; care of infants born prematurely or with other medical complications related to substance exposure; funding of child protective services investigations and interventions; and the essentially impossible-to-quantify cost of human suffering of women and their children, families, and communities.[7]

EXAMPLES OF RISK OF SUBSTANCE USE DURING THE PRENATAL PERIOD INCLUDE:

- Smoking during pregnancy has been linked to increased risk for slowed fetal growth and low birth weight, stillbirth, pre-term birth, infant mortality, Sudden Infant Death Syndrome (SIDS), and respiratory problems.
- Using alcohol during pregnancy can cause miscarriage, stillbirth, and a range of lifelong disorders for the child known as Fetal Alcohol Spectrum Disorders (FASDs). FASDs can lead to physical, cognitive, and behavioral problems—for example, facial abnormalities; attention problems and hyperactive behavior; learning disabilities; poor reasoning and judgment skills; and problems with the heart, kidney, or bones.

6. National Institutes of Health. Tobacco, Drug Use in Pregnancy Can Double Risk of Stillbirth. Retrieved from https://www.nih.gov/news-events/news-releases/tobacco-drug-use-pregnancy-can-double-risk-stillbirth
7. Gopman, Sarah. Prenatal and Postpartum Care of Women with Substance Use Disorders. Obstetrics and Gynecology Clinics of North America. Vol. 21, Issue 2, Pages 213-228.

- The use of recreational drugs, such as cocaine, heroin, and marijuana, during pregnancy can have a variety of adverse effects on children ranging from low birth weight to developmental problems related to behavior and cognition, such as impaired attention, problems with language development and learning, and behavior problems.
- The use of some types of prescription drugs during pregnancy may also have an impact on the child. Prenatal exposure to opioids may result in physiological dependency, causing withdrawal symptoms—a condition called Neonatal Abstinence Syndrome (NAS), which can require prolonged hospitalization of the infant and medication to treat.

The full extent of the consequences of substance use in pregnancy are not known because many individual, family, and environmental factors such as nutritional status, extent of prenatal care, and socio-economic conditions make it difficult to determine the direct impact of prenatal substance use on the child. Therefore, abstinence is the best prevention.[8]

Universal screening of all perinatal women for substance use disorders is part of the complete circle of care provided by health and social service providers. It also serves as an opportunity for early intervention and reinforces the importance abstinence from drug and alcohol use in the perinatal period. The World Health Organization recommends that all prenatal women should be screened as soon as possible and at all subsequent appointments throughout their pregnancy and postpartum period.[9] In addition to working as a preventative measure, universal screening throughout the perinatal period may also increase a woman's likelihood of disclosing use due to an increased belief in the support and compassion of her provider. Furthermore, the postpartum period is a high-risk time for relapse; therefore, it is critical providers understand their client's past and current relationship with drugs and alcohol.

While medical providers are the most visible frontline support for perinatal women, Public Health providers across Maternal and Child Health programs can, and should have a role in screening, providing education, and referring perinatal women to substance use treatment services. With the support of local partners, appropriate training, and resources, screening can be done in public health settings as well as medical settings. This Toolkit provides a first step toward implementing universal screening for perinatal substance use. Algorithms, policy templates, and provider resources have been identified or developed as part of this Toolkit.

8. National Institute on Drug Abuse. Principles of Substance Abuse Prevention for Early Childhood. Chapter 2: Risk and Pro¬tective Factor. Retrieved from https://www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/chapter-2-risk-protective-factors
9. World Health Organization. Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf;jsessionid=5B485510AE251879B47E18BEF1FF41E3?sequence=1

> *Please reference the 'Recommendation and Opinion Statements' section under Provider Resources or the 'Reference and Resource Guide for Providers' for more information on best practices for screening and a host of useful information for integrating screening into practice.*

INTRODUCTION TO SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and recreational drugs. This section will address SBIRT in the context of substance use; however, while developed for the identification and reduction in problematic use of drugs and alcohol, the use of SBIRT can be extended to any health risk behavior (e.g. mental health, tobacco use, unsafe sexual practice, violent or suicidal ideations, etc....). mental health settings and interventions as well. SBIRT is an approach to the delivery of early intervention and treatment to people, including perinatal women, with substance use disorders and those at risk of developing these disorders. The SBIRT process can be implemented in a wide variety of settings by clinical and social service entities to ensure pregnant and postpartum women have access and opportunities to seek support and treatment. The following sections will outline the main components of SBIRT including information on specific screening tools, who is qualified to screen, who should be screened, and when it should take place. This conversation is specific to and tailored for the perinatal population and their care providers.

Of note, KanCare reimbursement requirements for SBIRT includes completion of the training credentialing processes outlined by the State. Practitioners must complete a training program approved by the Kansas Department for Aging and Disability Services (KDADS) with a proficiency test score of 80% or greater. Following completion, providers must submit documentation of training completion and proof of licensure as a provider in an approved service area. Providers must submit the same documentation to KMAP for both managed care and fee-for-service patients. Facilities shall maintain documentation of training completion and professional licensure for each practitioner performing SBIRT services in the facility. Organizations may only bill for SBIRT when the provider providing the SBIRT service has completed the training and is certified based on these requirements. Brief intervention and motivational interviewing training are also helpful but not required.

> *For more information please reference KDADS Standards Policy BHS/MCO 503 found at the following link: https://www.kdads.ks.gov/docs/default-source/CSP/bhs- documents/policies_regulations/bhs-mco-503---process-for-approval-to-provide-screening-brief- intervention-and-referral-for-treatment-services-to-medicaid-eligible-patients.pdf*

Screening

Screening is used to identify women at risk of substance misuse. Universal screening tools validated for various populations, including perinatal women, help ensure that consistent and equitable screening processes occur. Screening quickly assesses the severity and risk of substance use and helps to identify the appropriate level of treatment needed. It is recommended a brief pre-screen be used universally. Following a positive score (potential risk indicated) on the pre-screen, a full screen be administered. More information about screening tools is outlined below.

Recommended screening tools

There are several tools that can be used for alcohol and substance use screening with varying functionality and administration instructions. It is recommended screening tools be evidence-based, validated for the intended population, and be used with adequate systems of care for following up on a positive screening in place.

The Kansas Department of Health and Environment, Bureau of Family Health is recommending the use of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) for full screens. This screening tool covers alcohol, tobacco, illegal drugs, and misuse of prescription medications. The ASSIST, available in over 10 languages, was designed to be administered in primary health care settings across a variety of cultures but is useful for any human service worker including Registered Nurses, Social Workers, Obstetricians, and Midwives, to name a few. The ASSIST was designed to be administered by a health worker to a patient using paper and pencil and takes about 5-10 minutes to administer.[10] The ASSIST is also on the Kansas Department for Aging and Disability Services' (KDADS) approved screening tools list for KanCare reimbursement.

10. World Health Organization (WHO). ASSIST Project- Alcohol, Smoking, and Substance Involvement Screening Test. Retrieved from https://www.who.int/substance_abuse/activities/assist/en/

The ASSIST is an 8-question interview with an accompanying patient response card. The interview covers both lifetime use and use within the last 3 months including questions asking if anyone has expressed concern about the patient's use or if the patient has tried and failed to control their use. The screening tool is designed to capture an involvement score for each discrete substance a patient discloses using and includes a Feedback Report Card which details specific health risks associated with specific substances. The interview also covers the patient's past and present use of substances by injection and provides specific guidance on the health considerations related to this behavior. For honest and accurate responses, providers should ask questions in a non-judgmental and empathetic tone while demonstrating sensitivity and adequately contextualizing the purpose of the screen. Providers should explain limits of confidentiality and any mandated reporting requirements to the patient before administering the screen.

> *The ASSIST, and other validated and reimbursable screening tools, can be found in the 'Screening Tools' section of this toolkit. Also, additional information for implementing this tool into practice and providing subsequent intervention can be found in this toolkit under Integration Resources in 'Resource and Reference Guide for Providers'*

> *For more information about the KDADS policy as it related to SBIRT, including training and reimbursement, visit: https://www.kdads.ks.gov/provider-home/training-registration-and- surveys/medicaid-mental-health-service-provider-training/trainings/sbirt-information*

Who should screen

Universal maternal substance use screening in prenatal, postnatal, and pediatric settings should occur. Settings may include, but are not limited to, health care providers (e.g., primary care physicians, obstetricians, midwives, and pediatric specialists), Public Health centers, behavioral and mental health clinics, community social service organizations, and early childhood programs. Both, the provider and the patient, benefit when adequate systems of care are in place surrounding the implementation of screening protocols. Examples of these protocols include policies for a routine screening schedule and a referral network for consultation and further assessment, diagnosis, and treatment services. The resources within this toolkit can help guide the development of agency protocols surrounding implementation.

Who to screen

Alcohol and other substance use during pregnancy can lead to serious long-lasting consequences for women and infants including miscarriage, stillbirth, fetal alcohol spectrum disorders (FASD), and neonatal abstinence syndrome (NAS). While the risks of substance use during pregnancy are often known among providers, few women of childbearing age are screened for risk

of substance use behaviors. Identifying risks of substance use before and during pregnancy is a critical first step to preventing use and reducing harm through treatment and services.[11]

Moreover, it is impossible to precisely and accurately predict substance use from looking at an individual. Universal screening reduces the possibility for implicit bias, accounts for the possibility of relapse associated with high stress life events, and helps providers identify the need to facilitate a brief intervention.

When to screen

It is recommended that local organizations develop protocols identifying key opportunities for screening based on services provided by other partners within the community's system of care. The American College of Obstetricians and Gynecologists (ACOG) recommends all women seeking obstetric-gynecologic care should be screened for alcohol use at least yearly and within the first trimester of pregnancy[11] and also that universal screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.[12] Based on organizational policies, it may be practical to integrate substance use screening into existing workflows for perinatal depression and anxiety screening.

> *For more information on integrating screening into practice refer to the 'SBIRT Integration Plan' and 'SUD Screening Office Procedures and Policy Template' in Templates for Local Use.*

Brief Intervention

Brief intervention is an evidence-based practice which involves a short conversation between provider and patient designed to educate and motivate behavior change. Brief interventions should occur immediately following a moderate or high-risk positive screen. These conversations allow providers to identify risky behaviors to patients and increase their awareness about the consequences of substance use. Using motivational interviewing techniques, providers can help encourage perinatal women to make a change toward a lifestyle that is healthiest for their circumstances. Pregnant women should be informed about the health risks of alcohol use while

11. Substance Abuse and Mental Health Service Administration (SAMHSA) – Health and Resources Services Administration (HRSA) Center for Integrated Health Solutions. Substance Use Order and Pregnancy. Retrieved from https://www.integration.samhsa.gov/about-us/integration-edge/substance-use-disorder-and-pregnancy
12. American College of Obstetricians and Gynecologists. At-risk drinking and alcohol dependence: obstetric and gyneco-logic implications. Committee Opinion No. 496. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/At-Risk-Drinking-and-Alcohol-Dependence-Obstetric-and-Gynecologic-Implications?IsMobileSet=false

other perinatal women should be educated on healthy lifestyle choices surrounding alcohol. All women should receive education about eliminating tobacco and recreational drug use. For women seeking help, there is frequently a fear of judgment. Many are afraid they will be arrested, forced to have an abortion, asked to leave a prenatal care program, and reported to child protective services. It is essential that advice be provided without judgment or blame.

The ASSIST was developed to seamlessly link to a 3-15 minute brief intervention for patients presenting with moderate risk. This guidance can be found in Integration Resources, 'Resource and Reference Guide for Providers' section of this toolkit.

Referral to Treatment

Following a positive screening for high risk of substance use, a referral for further assessment needs to be made by the screening provider. Ideally this will be done through a warm hand-off. The handoff from the screening provider to the specialty treatment provider should include up-to-date information regarding the woman's care, treatment and service, condition, and any recent or anticipated life changes. The exchange should be interactive and allow for discussion between providers. The Joint Commission requires that staff use a record and read-back process before acting on a verbal order or verbal report of a critical test result. Verbal communication includes a face-to-face conversation or a telephone call. Face-to-face exchange of information is generally the preferred form of verbal communication, because it allows direct interaction among those present.[13]

Please note, in the context of this document and in alignment with Kansas MCH programing, a warm hand-off refers to a hand-off of care (or referral) from one provider to another ensuring the circle of care loop has been closed. This may mean using IRIS, introducing the patient to the referring specialist in-person, or following up with both provider and patient following a referral. The use of "referral", "hand-off", or "warm referral" should all be understood the same way as a warm hand-off.

A positive screen does not necessarily indicate the need for substance use treatment nor should it be used as a diagnostic tool. A positive screen does indicate that there is a need for further assessment by a specialty provider. In Kansas, only Licensed Addiction Counselors can serve as Drug and Alcohol Evaluation Providers. These providers complete substance use assessments and referral services for individuals presenting with a current or past pattern of drug or alcohol

13. American College of Obstetricians and Gyne¬cologists. Communication strategies for patient handoffs. Committee Opinion No. 517. Retrieved from https://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Patient%20Safety%20and%20Quality%20Improvement/co517.pdf?dmc=1&ts=20131030T1556376525

use. The provider completes an assessment to gather and analyze information regarding the patient's current substance use behavior as well as the patient's social, medical, and treatment history with the purpose of obtaining sufficient information for problem identification, and if appropriate, substance use related referral to treatment. To schedule an assessment or to find a Drug and Alcohol Evaluation Provider in a specific area, contact a local treatment program or Beacon Health Options (1-866-645-8216, option 2).

There are several substance use disorder treatment services available in Kansas based on the patient's medical necessity. Drug and Alcohol Evaluation Providers will coordinate care based on the outcome of the assessment. Possible treatment services could include:

- Acute Detoxification - Provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. In this modality of treatment, 24-hour observation, monitoring and counseling services are available.
- Case Management - Assists individuals to become self-sufficient through an array of services which assess, plan, implement, coordinate, monitor and evaluate the options and services to meet an individual's needs, using communication and available resources to promote quality, cost effective outcomes.
- Inpatient Treatment - Delivered in an acute care inpatient setting. This modality of care is appropriate for those individuals whose acute biomedical, emotional, behavioral and cognitive problems are so severe they require primary medical and nursing care. This program encompasses a planned regimen of 24-hour medically directed evaluation and treatment services. Although treatment is specific to substance abuse problems, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed.
- Intensive Outpatient Treatment - Provided any time during the day or week and provides essential education and counseling services while allowing the individual to apply their newly acquired skills outside of treatment. The program has the capacity to arrange for referral to any auxiliary service and has active affiliations with other modalities of care. Programs may provide overnight housing for individuals who have problems related to transportation or family environment but who do not need the supervision or 24-hour access afforded by a residential program.
- Outpatient Treatment - Delivered in a wide variety of nonresidential settings which are designed to help individuals achieve changes in their substance abuse behaviors. Treatment shall address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the treatment goals.
- Peer Mentoring (Support) - Provided by people who are in long-term recovery and have been trained in providing recovery support. The purpose of providing this service is to help

build recovery capacity for persons new to recovery by connecting them to naturally occurring resources in the community, assisting in the reduction of barriers to fully engaging in recovery, and providing support in skill development for maintaining a recovery lifestyle.

Kansas also has eight Designated Women's Substance Abuse Treatment Programs, six of which allow children to reside at their facility while their mother is participating in residential treatment. Designated Women's programs provide specialized services to meet the needs of women and their children, as well as give priority admission to pregnant women, women with dependent children, and women using drugs intravenously. Pregnant women are given priority status by federal mandate for admission to treatment. All pregnant women must be offered an assessment within 24-hours of initial contact, and admitted into treatment within 48 hours, as clinically indicated. Women with dependent children, including those who are attempting to regain custody, are given priority status by state mandate for admission to treatment. It is important for the screening provider to include this relevant information to the Drug and Alcohol Evaluation Provider when making the referral for further assessment. The Drug and Alcohol Evaluation Provider will coordinate treatment services taking into consideration these specialty treatment options and ensure the state and federal regulations are followed.

> *A comprehensive list of all available substance use disorder treatment services can be found on KDADS' website: https://www.kdads.ks.gov/commissions/behavioral-health/services-and-programs/substanceuse-disorder-treatment-services*

It is imperative that a pregnant woman be under a doctor's care to detox from alcohol and/or drugs during pregnancy, both for her safety and the safety of her unborn child. Detox methods ultimately depend on the substance that has been used, the level of abuse, and the mother's health and psychiatric history. Pregnant women – particularly those addicted to alcohol – should seek treatment in an inpatient setting due to the risk of miscarriage during detox. Those addicted to sedatives and opioids should also consider an inpatient setting with 24-hour medical care.[14]

Special treatment considerations should be made for pregnant women with an opioid use disorder. Medication-Assisted Treatment (MAT) combines behavioral therapy and medications to treat such disorders. Common medications to treat opioid addiction include methadone,

14. Communication strategies for patient handoffs. Committee Opinion No. 517. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012; 119:408-11.

naltrexone, and buprenorphine. Consultation with a substance use provider before initiating these treatments is highly recommended. Confidentiality is extremely important regarding the communication of medical information. Consent to disclose any medical information must be expressly given by the patient. According to 42 CFR Part 2, consent can be revoked to one or more parties at any time when requested by the patient.

> *Additional information and resources on practicing SBIRT can be found under Provider Resources, 'Related Videos and Websites'.*

EFFECTIVENESS OF SBIRT DURING PREGNANCY

The following findings show the effectiveness of SBIRT during pregnancy. Evidence suggests that simply asking about alcohol and other substance use may result in behavior change and asking in detail may increase women's awareness of their actual levels of consumption and may lead to modified behavior. Substance use is common in women of childbearing age. In 2012, more than 50% reported current use of alcohol, 20% used tobacco products, and approximately 13% used other drugs.[15] Most women stop or cut back the use of harmful substances during pregnancy, however, some women do not.

It has been shown that a brief intervention reduces the number of drinks consumed and the number of heavy drinking days during the postpartum period. Pregnant women with higher levels of alcohol use may reduce consumption after a brief intervention that includes their partner. Pregnant adolescents with a substance use disorder have been shown to reduce substance use after one standardized brief intervention session.[16] Often the effectiveness of SBIRT during the perinatal period hinges on the quality of transitions in care.

The postpartum period is a high-risk time for relapse, perhaps in part because use is no longer inhibited by maternal concerns about exposure to the fetus but also likely related to increased stress levels caused by sleep deprivation, hormonal changes, and the demands of parenting. Postpartum depression, which occurs more frequently among women with substance use disorders, may be another risk factor for relapse. Close follow-up, including an early postpartum clinic visit at 1 to 2 weeks after delivery, is recommended. At this visit, a formal assessment for

15. McHugh RK, Wigderson S, Greenfield SF. Obstetrics and Gynecology Clinics of North America. Epidemiology of substance use in reproductive-age women. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4068964/
16. Giesel School of Medicine at Dartmouth. Screening, Brief Intervention and Referral to Treatment in Maternity Care. Retrieved from http://sbirtnh.org/wp-content/uploads/2014/09/Goodman-2016_SBIRT-in-Maternity-Care_NHSummit-1.pdf

postpartum depression, such as the Edinburgh Postnatal Depression Scale, can be administered, and clinicians should ask directly about possible substance use relapse.[17]

> *For a comprehensive look at mental health disorders specific to the perinatal population visit the companion Mental Health Integration toolkit at: http://www.kdheks.gov/c- f/mental_health_integration.htm*

In addition to following the SBIRT process, similar communications as practiced during the referral to treatment phase should also be used across a woman's continuum of care. This impacts perinatal providers as women transition from obstetrics to primary care. Access to primary care is important for all women and perhaps more crucial for women with physical and mental health issues related to past substance use. Encouraging women to seek appropriate primary care, whether by continuing visits with the current provider or transitioning to another non-obstetric provider, is an important message after delivery, pregnancy loss, or termination. Pregnancy often serves as an entry point to health care for women and the opportunity to engage women in comprehensive, ongoing care should not be lost. For obstetric providers who do not provide comprehensive primary care, developing a referral relationship with a clinician who can do so and who is able to demonstrate respect and compassion for women affected by substance abuse can facilitate a smooth transition of care.[18]

It is also important to continue screening during the postpartum period. In addition to maternal substance use and its impact on their child at infancy, exposure to alcohol, tobacco, and other drugs during the prenatal period can affect children throughout their lifetime. Examples include[19]:

- Substances used by a mother can be passed to a nursing infant through breast milk;
- When parents smoke in the home, it can also expose children to secondhand smoke. This puts them at risk for health and behavioral problems, as well as increases the child's likelihood of smoking when they grow older;

17. Gopman, Sarah. Prenatal and Postpartum Care of Women with Substance Use Disorders. Obstetrics and Gynecology Clinics of North America. Retrieved from https://www.clinicalkey.com/#!/content/playContent/1-s2.0S0889854514000114?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0889854514000114%3Fshowall%3Dtrue&referrer=https:%2F%2Fwww.ncbi.nlm.nih.gov%2F
18. Gopman, Sarah. Prenatal and Postpartum Care of Women with Substance Use Disorders. Obstetrics and Gynecology Clinics of North America. Vol. 21, Issue 2, Pages 213-228.
19. National Institute on Drug Abuse. Principles of Substance Abuse Prevention for Early Childhood. Chapter 2: Risk and Protective Factor. Retrieved from https://www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/chapter-2-risk-protective-factors

- Parental substance use can also impact the family environment by giving rise to family conflict and potentially harmful parenting behaviors. This could increase risk for child abuse, neglect, and involvement with the child welfare system, and;
- Poor family functioning can increase the risk for multiple problem behaviors in children and adolescents, including risk for substance use and dependence.

SBIRT is an innovative and evidence-based method for addressing substance use and beyond. By utilizing patient-centered change talk and a non-judgmental positionality, patients have agency in their care. Additionally, the continuum of care is built into the process and encourages cooperative relationships between the screening providers and referred specialty providers. While the efficacy and cost-effectiveness of SBIRT are widely reported, it remains under implemented. Reasons for this include discomfort addressing the topic, limited time with the patient, and lack of knowledge and training. Through this toolkit and its associated resources, providers can take the first step in overcoming these barriers to provide preventative and comprehensive care to perinatal patients. The final section of this document will provide details on the resources developed specifically for this toolkit.

DESCRIPTION OF ALGORITHMS

An SBIRT workflow has been developed to offer appropriate responses during each stage of the SBIRT process. This workflow can be used when implementing SBIRT into practice. Additionally, a crisis algorithm was developed for use when a woman is currently at risk of causing harm to herself or others; an algorithm for administering and scoring the ASSIST has been created; and a workflow for navigating referral access points was created to guide providers in best practices when making referrals to treatment.

These algorithms are meant to guide an organization wanting to incorporate perinatal substance use screening into practice. It is important that each agency or community develop individualized procedures and/or protocol for responding to various situations using the unique resources available within the community. With the implementation of alcohol and drug use screening, staff should receive educational training on the chosen screening tool, SBIRT, and any additional enhancement of these trainings (e.g., motivational interviewing).It is intended that these algorithms, as well as other resources included in this SBIRT Toolkit, will be helpful to organizations and communities as they work to advance the behavioral health care of the families served.

PROVIDER CONSULTATION

Through the combined efforts of state and local partners, a provider consultation line has been developed to address questions healthcare and social service providers may have when providing care for a woman experiencing, or at risk of experiencing, perinatal behavioral health symptoms. General questions related to screening, brief interventions, and referrals to treatment for the perinatal population can also be directed here. Calls will be fielded by a clinician licensed in both Addiction Counseling and mental health with specialty training in perinatal mental health. A psychiatrist will be available to assist with any questions specific to prescribing best practices.

As of March 2020, the consultation line is active. Providers are encouraged to call the line for a preliminary introduction to the resource prior to calling with patient cases.

Contact the consultation line at: (833)765-2004
Operates Monday-Friday, 8:00 AM- 5:00 PM

The provider consultation line will be funded by Kansas Connecting Communities, a Health Resources and Services Administration (HRSA) Screening and Treatment for Maternal Depression and Related Behavioral Disorders program that is administered by the Kansas Department of Health and Environment (KDHE). Providers utilizing consultation line service will be asked to enroll as a Kansas Connecting Community provider to aid in KDHE meeting HRSA grant requirements.

INTEGRATION PLAN OVERVIEW

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SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) INTEGRATION PLAN OVERVIEW

INTRODUCTION

This SBIRT Integration Plan and associated toolkit has been created through the work of many state and local partners with a shared interest in providing coordinated and comprehensive services to women before, during, and after pregnancy. Information contained in the toolkit is based on sound research and recommendations from the U.S., Preventive Services Task Force* (USPSTF), American College of Obstetricians and Gynecologists (ACOG), National Institute on Drug Abuse (NIDA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Screening, referral, and crisis intervention algorithms have been adapted from those developed by the Minnesota Department of Health and used in the Kansas Maternal and Child Health Mental Health Integrated Toolkit. The plan and toolkit have been developed for use by Kansas Maternal and Child Health (MCH) service providers.

The aim of this toolkit is to improve identification, clinical care, and coordination for perinatal women using substances. The toolkit provides guidance on implementing SBIRT, including algorithms, policy templates, training recommendations, and resources for both providers and patients. Through successful implementation, outcomes in maternal and infant health will improve.

PLAN STEPS

1. All organizational staff are strongly encouraged to participate in an SBIRT training course. The Kansas approved training was developed by the University of Missouri-Kansas City (UMKC) SBIRT Training Project and is called *SBIRT for Health and Behavioral Health Professionals*. Completion of this training and submission of the required documentation (outlined in the accompanying "Information on Implementing Screening for SBIRT" document found in the toolkit) will allow the provider to be reimbursed by KanCare for the SBIRT services they provide. Brief Intervention and motivational interviewing training is also helpful but not required.

> *For more information about the SBIRT for Health and Behavioral Health Professionals training course, visit: http://healtheknowledge.org/course/index.php?categoryid=50*

> *For more information about State requirements, including policies and the steps to become a Medicaid approved SBIRT practitioner, visit: https://www.kdads.ks.gov/provider-home/training-registration-and-surveys/medicaid-mental-health-service-provider-training/trainings/sbirt-information*

2. Prepare for implementation across MCH services by utilizing the accompanying "Information on Implementing Screening for SBIRT" document found in the toolkit.

3. Develop agency policies and procedures focused on SBIRT, specifically addressing screening, brief intervention, referral, treatment options, and follow-up procedures within the agency and broader community to support and sustain a comprehensive approach. A template for creating local policy on SBIRT implementation is provided in this toolkit for use if not already developed. Policy must assure an adequate system of care is in place to best meet patient needs and should include the following standardized components:

    a. **Educational resources and information on available substance use disorder services provided universally to every pregnant and postpartum woman served.** Identify key opportunities (i.e. enrollment, a particular appointment or visit) that are a routine part of care, to engage a patient in discussion about perinatal substance use and to provide educational materials. Options for educational resources on this topic are available in the associated toolkit under "Patient Education Resources", as well as those identified locally. Additionally, a template for creating a local substance use resource directory is provided in the associated toolkit. This template is available for use if a similar resource has not already been developed locally. Information should include: resource name and location, contact information (including 24-hour hotline or after-hours numbers if available), hours of service, level/type of services provided, and payment source options (i.e. insurance types accepted, sliding-fee scale, etc.).

b. **Every pregnant and postpartum woman served is screened for substance use disorders.** Identify the standardized screening tool to be used, timing of use, and which staff will administer the screen. Research based recommendations are included in the accompanying "Information on Implementing Screening for SBIRT" document.

c. **Following every positive screen, a brief intervention, referral to services, and follow-up is provided.** Algorithms for ideal work flow related to screening, scoring, referral, and follow-up are provided in the associated toolkit and should be adapted to match local policy.

ALGORITHMS AND WORKFLOWS

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ALGORITHMS

1. ASSIST Screening Algorithm 23
2. SBIRT Workflow 24
3. Navigating Referral Access Points Workflow 25
4. Crisis Intervention Following Screening Workflow 26

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ALCOHOL, SMOKING, AND SUBSTANCE INVOLVEMENT SCREENING TEST (ASSIST) ALGORITHM

Administration Directions:

1. *Reference the "ASSIST" in the "Screening Tools" section of the toolkit for Q1-Q8.*
2. *Give patient the response card which outlines substances and responses*
3. *Explain confidentiality issues and any mandated reporting requirements, if not already done.*
4. *Administer screen through interview; Q2-Q7 should be asked for each substance indicated in Q1.*
5. *Track & calculate score. Scores indicated in parentheses below.*

Scoring Abbreviation Key

Once or twice=O/T
Monthly=MO
Weekly=WK
Daily or almost daily=D

If at any point during this workflow the patient presents in crisis, please initiate procedures found on the crisis algorithm

Q1: **Lifetime use**

YES → Q2: **Use in the last 3 months**

NO → **NO**

YES
(O/T=2 MO=3 WK=4 D=6)

Q3/Q4/Q5: **Usage patterns in the last 3 months**
Q3: (O/T=3 MO=4 WK=5 D=6)
Q4: (O/T=4 MO=5 WK=6)
Q5: (O/T=5 MO=6 WK=7 D=8)

Q6/Q7: **Lifetime concern & attempts to cut down or quit**
(Never=0)
(Yes, not in past 3 MO=3)
(Yes, in the past 3 MO=6)

Q8: **Lifetime Use by Injection**
(No associated score)

NO, never → Ask about pattern to determine their risk level and the best course of intervention

YES, not in past 3 MO → Ask about pattern to determine their risk level and the best course of intervention

YES, in past 3 MO → Ask about pattern to determine their risk level and the best course of intervention

Ask about pattern to determine their risk level and the best course of intervention

>1/week **or** ≥ 3 days in a row
Further assessment and more intensive treatment indicated

≤ 1/week **or** <3 days in a row
Provide Brief Intervention including "risks associated with injecting" card

SCORE CALCULATIONS

The type of intervention is determined by the patient's specific substance involvement score.

Based on responses, add scores for Q2-Q7 for each substance indicated in Q1

LOWER Risk
Alcohol 0-10; Other Substances 0-3

At low risk of health and other problems related to current pattern of use.

Provide positive reinforcement and follow up at upcoming appointments.

MODERATE Risk
Alcohol 11-26; Other Substances 4-26

At moderate risk of health and other problems related to current pattern of substance use.

Provide Brief Intervention (see SBIRT algorithm) and follow up at upcoming appointments.

HIGH Risk
All substances 27+

At high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of current pattern of use.

Provide Brief Intervention (see SBIRT algorithm) and Referral to Treatment (see Navigating Referral Access Points workflow). Follow up with patient to make sure they accessed and received care.

**Please reference ASSIST Manual, linked in Reference Guide for Providers, for scoring exceptions.*

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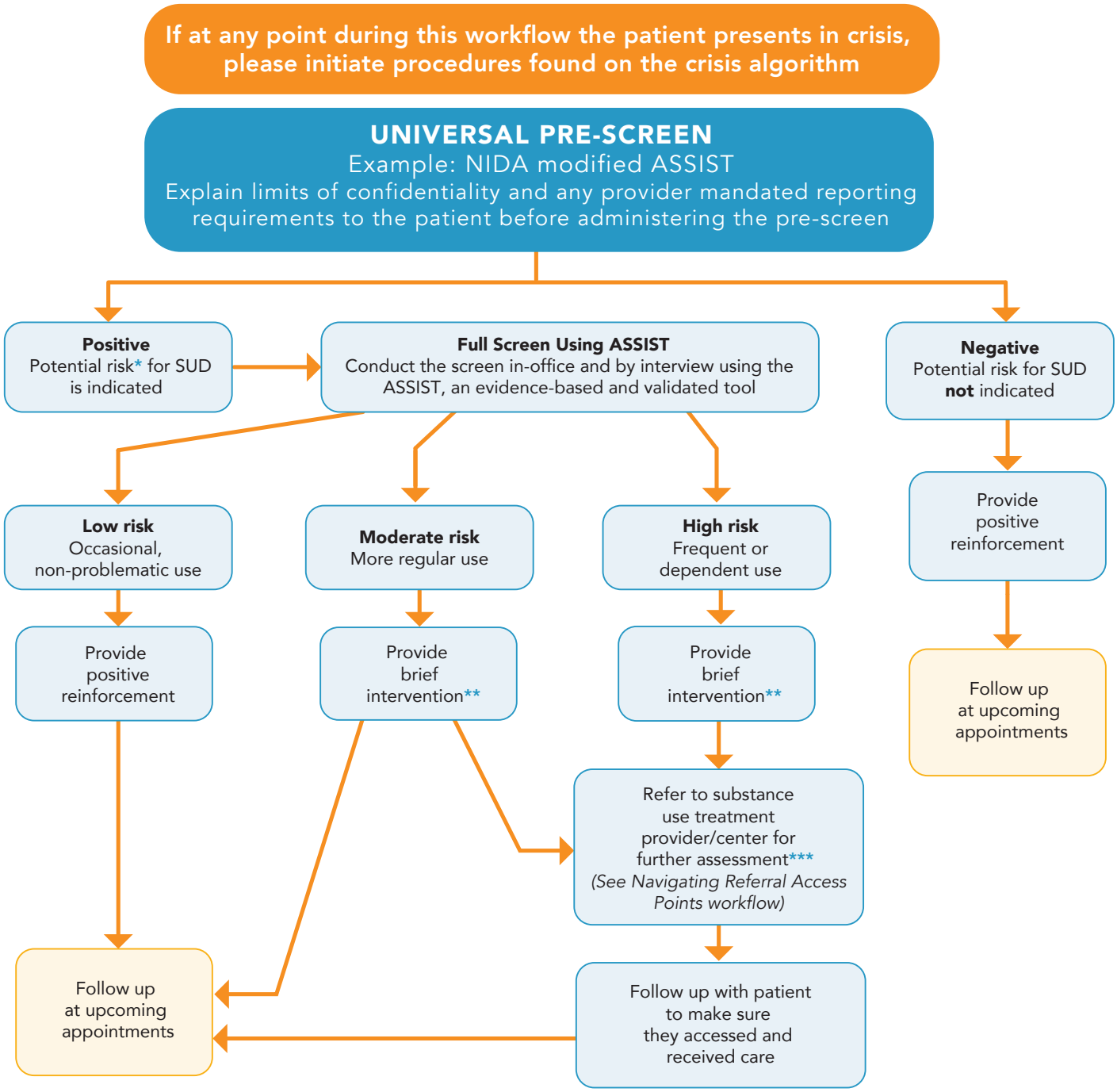
SBIRT WORKFLOW



* *Risk is associated with health, legal, financial, and personal consequences. Low risk suggests potential patterns for increased risk. Moderate risk refers to those who have already experienced consequences related to their substance use. High risk refers to those at risk for developing a substance use dependence or addiction. See ASSIST algorithm for specific scoring guidance.*

** Brief intervention — *3 to 15 minute intervals used to educate the patient to increase her awareness on how substance use can affect their health and what resources may be available to them in their community.*

*** Patient handoff/referral — *the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians during transitions of care across the continuum. It includes an opportunity to ask questions, clarify, and confirm the information being transmitted.*

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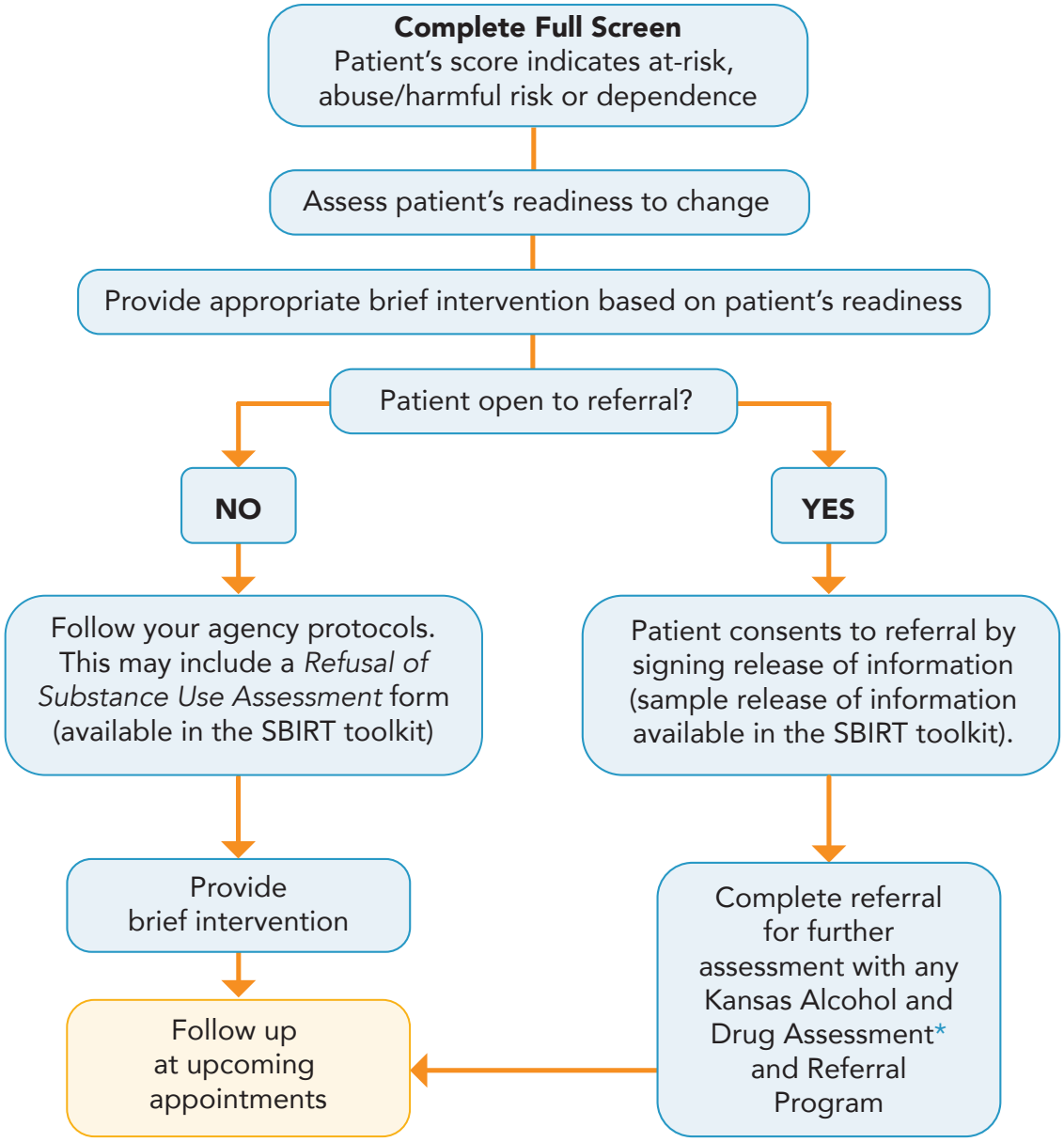
NAVIGATING REFERRAL ACCESS POINTS

If at any point during this workflow the patient presents in crisis, please initiate procedures found on the crisis algorithm



* Assessment: The purpose of the assessment is for a Licensed Addictions Counselor to obtain information for problem identification and treatment services Contact the local program (**bit.ly/KDADS_SUTreatmentServices**) directly, or call Beacon Health Options at **1-866-645-8216**

- Patients should be made aware of State reporting requirements associated with substance use and the perinatal period. For more information go to: **www.dcf.ks.gov/services/pps/documents/guidetoreportingabuseandneglect.pdf**
- Confidentiality related to substance use disorders and treatment are protected under **42 CFR Part 2**. To ensure compliance when referring patients, use a federally compliant release of information form (available in SBIRT toolkit).

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CRISIS INTERVENTION FOLLOWING SCREENING

FURTHER ASSESS

positive response to #10

- Is patient having active thoughts of harming self or others?
- Does patient have a plan for causing harm to self or others?

Arrange for emergency services (per plan as developed by local agency; may include the following, but should be adapted to a plan/procedure that fits your community and ensures an adequate system of care; edit below to reflect local plan)

- Discuss need for emergency services
- Identify emergency service options per local *mental health resources directory* and local policy and procedure
- Assess if patient is willing to accept services

Active thoughts or plan of self-harm or harm to others

NO

Arrange for same day or next day appointment (per plan as developed by local agency; may include the following, but should be adapted to a plan/procedure that fits your community and ensures an adequate system of care; edit below to reflect local plan)

- Ask patient to verbally contract for safety
- Discuss need for immediate appointment and follow-through
- Assess if patient is currently seeing a mental health provider or if requires a new referral
- Provide patient with local mental health resources directory and identify available services/providers
- Schedule same day or next day appointment with mental health provider
- Refer to OB/GYN or primary care provider for follow-up
- Assure patient has support person available to her and emergency plan in place in the event feelings/thoughts worsen
- Document event/intervention (including patient's denial of current thoughts or plan)
- Fax EPDS and documentation to providers

YES

Willing to accept emergency services?

YES

If patient accepts emergency services/treatment:

- Assess if patient has support person available to transport to emergency service location
- Verbally contract for safety
- Arrange for transportation

NO

If patient refuses emergency services/treatment:

- Have patient sign *refusal of transport for evaluation* form
- Call for transport to facility (e.g., hospital ER) by law enforcement officer as per local protocol for mental health evaluation non-compliance

- Stay with patient until arrangements are made for patient safety
- Collaborate with patient for care of child/ren (if applicable)
  –Consider friends, relatives, neighbors
  –Local emergency shelter or law enforcement if no other options
- Document to complete the intervention, including:
  –patient condition
  –Contacts made
  –Arrangements made
  –Time of events
  *Send copy of documentation to applicable providers
- Contact care provider (primary care, OB/GYN, and/or mental health provider) to inform of situation

***Contact supervisor at any point in this process (per agency policy)**

FOLLOW UP

Debrief with supervisor

Contact patient next day:

- Provide support
- Obtain updated status
- Plan for ongoing follow-up visits (by self or partnering program staff, as applicable based on available resources)
  –Make warm referral if necessary to refer

On follow-up visit with patient:

- Continue to evaluate mental health status
- Discuss experience
- Determine plan for mental health follow-up
- Help problem solve issues with accessing appropriate care
- Get signed consent from patient for follow-up communication with OB/GYN, primary care, or mental health provider
- Stay focused on purpose of keeping baby and mom safe

Keep in touch with assigned therapist/provider:

- Minimum of monthly contact until mother is stable as determined by therapist/mental health provider

Adapted for use by Kansas Maternal and Child Health programs by the Kansas Department of Health and Environment, Bureau of Family Health, with review, recommendations, and endorsement by the Maternal Depression Screening Workgroup. Credit is given to the Minnesota Department of Health for their work to create the Crisis Intervention Alorithm. www.health.state.mn.us/divs/cfh/topic/pmad/content/document/pdf/crisisalg.pdf

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INTEGRATION RESOURCES

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RESOURCE AND REFERENCE GUIDE FOR PROVIDERS

Screening tools

- ASSIST
  https://www.who.int/substance_abuse/activities/assist/en/
- NIDA Quick Screen
  http://bit.ly/NIDAQuickScreen
- AUDIT – C
  http://bit.ly/SAMSA_AuditC
- AUDIT
  http://bit.ly/Audit_Interview
- DAST – 10
  http://bit.ly/DAST_10

National resources

- SAMHSA – HRSA SBIRT Training and Other Resources
  http://bit.ly/SAMSA_SBIRT_Training
- National Directory of Drug and Alcohol Abuse Treatment Facilities 2019:
  http://bit.ly/TreatmentDirectory

Kansas resources

Training

- SBIRT tools, resources, patient education materials, and access to trainings and videos
  www.SBIRT.care
- KDADS Approved SBIRT training
  http://www.healtheknowledge.org/

Policy

- KDADS Standard Policy 503
  http://bit.ly/KDADS_Policy503
- KDADS Standard Policy 504
  http://bit.ly/KDADS_Policy504
- Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2)
  http://bit.ly/SUD_Confidentiality
- Medicaid approved screening tools
  http://bit.ly/MedicaidScreening

Treatment

- SAMHSA Treatment Facility Locator Map:
  https://findtreatment.samhsa.gov/locator
- Behavioral Health Association of Kansas: Member Service Locations (scroll to bottom of page)
  https://www.bhakansas.com/
- Beacon Health Options Kansas Engagement Center administers inpatient and outpatient substance use disorder treatment services for eligible populations.
  https://kansas.beaconhealthoptions.com/contact/
- Community Support Medication Program:
  http://bit.ly/KDADS_CSMP
- Kansas Designated Women's Substance Use Disorder Treatment:
  http://bit.ly/SUDTreatment_Women
- Methadone Maintenance Treatment:
  http://bit.ly/MethadoneMaintenanceTmt
- Substance Use Treatment Services, including information about the services provided in Kansas:
  http://bit.ly/SUD_TmtServices
- For questions, concerns, or more information about Licensed Addition Practitioners in Kansas:
  https://ksbsrb.ks.gov/professions/addiction-counselors

Provider resources

Recommendation and opinion statements

- ABM Clinical Protocol: Guidelines for Breastfeeding and Substance Use of Substance Use Disorder
  http://bit.ly/SUandBreastfeeding

- AJOG, Special Report: The Role of Screening, Brief Intervention, and Referral to Treatment in the Perinatal Period
  https://www.ajog.org/article/S0002-9378(16)30383-0/pdf
- SAMHSA TIP (Treatment Improvement Protocol) 24: A Guide to Substance Abuse Services for Primary Care Clinicians:
  http://bit.ly/TmtImprovmentProtocol
- SAMHSA Quick Guide for Clinicians Based on TIP 24:
  http://bit.ly/SAMSA_QuickGuide
- Substance Abuse and Mental Health Services Administration (SAMHSA) – Substance Use Disorder and Pregnancy:
  http://bit.ly/SUD_Pregnancy
- U.S. Prevention Services Task Force, Drug Use, Illicit: Screening:
  http://bit.ly/PrevTaskForce_Screening
- ACOG: At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications:
  http://bit.ly/ACOG_AlcoholDependence
- ACOG: Opioid Use and Opioid Use Disorder in Pregnancy:
  http://bit.ly/ACOG_OpioidUse
- ACOG: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in OBGYN Practice:
  http://bit.ly/ACOG_SUD_Ethics
- ACOG: Methamphetamine Abuse in Women of Reproductive Age:
  http://bit.ly/ACOG_Meth_Pregnancy
- ACOG: Motivational Interviewing:
  http://bit.ly/Motivational_Interviewing
- ACOG: Substance Abuse Reporting and Pregnancy: The Role of the OBGYN:
  http://bit.ly/SubAbusePregnancy_Reporting
- ACOG: Health Disparities in Rural Women:
  http://bit.ly/HealthDisparities_RuralWomen
- ACOG: Consultations:
  http://bit.ly/ACOG_Consultations
- ACOG: Smoking Cessation During Pregnancy:
  http://bit.ly/ACOG_SmokingCessation
- ACOG: Group Prenatal Care:
  http://bit.ly/GroupPrenatalCare
- ACOG: Communication Strategies for Patient Handoffs:
  http://bit.ly/HandoffCommunication

- ACOG: Team Based Care:
  http://bit.ly/Team-BasedCare
- ACOG: Marijuana Use During Pregnancy and Lactation:
  http://bit.ly/MarijuanaUse_Pregnancy
- ACOG: Optimizing Postpartum Care:
  http://bit.ly/Opt_PostpartumCare
- American Academy of Addiction Psychiatry:
  http://bit.ly/AAAP_SubUsePregnancy
- American Society of Addiction Medicine:
  http://bit.ly/ASAM_SubUsePregnancy
- World Health Organization:
  http://bit.ly/WHO_SUDPregnancy

Support and treatment

- Brief Negotiated Interview Algorithm (English/Spanish)
  http://bit.ly/BNI_Algorithim
- World Health Organization, ASSIST Primary Care Manual
  http://bit.ly/ASSIST_PCManual
- World Health Organization, ASSIST Linked Brief Intervention
  http://bit.ly/ASSIST_BI
- Mid-America ATTC Perinatal Provider Toolkit
  http://bit.ly/ATTCToolkit
- SBIRT Implementation Playbook for Perinatal Providers
  http://bit.ly/SBIRTPerinatalPlaybook
- Commonly Abused Drugs:
  http://bit.ly/CommonlyAbusedDrugs
- Commonly Abused Prescription Drugs
  http://bit.ly/AbusedRx
- SBIRT Provider Card
  http://www.sbirt.care/tools.aspx
- SBIRT Index card
  http://bit.ly/SBIRT_IndexCard
- SBIRT Poster
  http://bit.ly/SBIRT_AskEvery1Poster

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SCREENING TOOLS

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1. ASSIST (Full Screen, Including Response Card and Risks of Injecting Card) 35
2. ASSIST Fact Sheet 47
3. NIDA Quick Screen (Pre-Screen) 49
4. AUDIT-C (Pre-Screen, Alcohol) 51
5. AUDIT (Full Screen, Alcohol) 53

A. WHO - ASSIST V3.0

INTERVIEWER ID		COUNTRY		CLINIC	
PATIENT ID		DATE			

INTRODUCTION ***(Please read to patient)***

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT

Question 1
(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative: "Not even when you were in school?"	*If "No" to all items, stop interview.* *If "Yes" to any of these items, ask Question 2 for each substance ever used.*

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? ***(NON-MEDICAL USE ONLY)***	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING	INTERVENTION GUIDELINES
Once weekly or less or **Fewer than 3 days in a row**	**Brief Intervention including "risks associated with injecting" card**
More than once per week or **3 or more days in a row**	**Further assessment and more intensive treatment***

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name_____ **Test Date** _____

Specific Substance Involvement Scores

Substance	Score	Risk Level
a. Tobacco products		0-3 Low 4-26 Moderate 27+ High
b. Alcoholic Beverages		0-10 Low 11-26 Moderate 27+ High
c. Cannabis		0-3 Low 4-26 Moderate 27+ High
d. Cocaine		0-3 Low 4-26 Moderate 27+ High
e. Amphetamine type stimulants		0-3 Low 4-26 Moderate 27+ High
f. Inhalants		0-3 Low 4-26 Moderate 27+ High
g. Sedatives or Sleeping Pills		0-3 Low 4-26 Moderate 27+ High
h. Hallucinogens		0-3 Low 4-26 Moderate 27+ High
i. Opioids		0-3 Low 4-26 Moderate 27+ High
j. Other - specify		0-3 Low 4-26 Moderate 27+ High

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.

Moderate: You are at risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

a. tobacco	Your risk of experiencing these harms is:..... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular tobacco smoking is associated with:**
	Premature aging, wrinkling of the skin
	Respiratory infections and asthma
	High blood pressure, diabetes
	Respiratory infections, allergies and asthma in children of smokers
	Miscarriage, premature labour and low birth weight babies for pregnant women
	Kidney disease
	Chronic obstructive airways disease
	Heart disease, stroke, vascular disease
	Cancers

b. alcohol	Your risk of experiencing these harms is:..... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular excessive alcohol use is associated with:**
	Hangovers, aggressive and violent behaviour, accidents and injury
	Reduced sexual performance, premature ageing
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
	Anxiety and depression, relationship difficulties, financial and work problems
	Difficulty remembering things and solving problems
	Deformities and brain damage in babies of pregnant women
	Stroke, permanent brain injury, muscle and nerve damage
	Liver disease, pancreas disease
	Cancers, suicide

c. cannabis	Your risk of experiencing these harms is:..... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cannabis is associated with:**
	Problems with attention and motivation
	Anxiety, paranoia, panic, depression
	Decreased memory and problem solving ability
	High blood pressure
	Asthma, bronchitis
	Psychosis in those with a personal or family history of schizophrenia
	Heart disease and chronic obstructive airways disease
	Cancers

d. cocaine	Your risk of experiencing these harms is:…. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cocaine is associated with:**
	Difficulty sleeping, heart racing, headaches, weight loss
	Numbness, tingling, clammy skin, skin scratching or picking
	Accidents and injury, financial problems
	Irrational thoughts
	Mood swings - anxiety, depression, mania
	Aggression and paranoia
	Intense craving, stress from the lifestyle
	Psychosis after repeated use of high doses
	Sudden death from heart problems

e. amphetamine type stimulants	Your risk of experiencing these harms is:……. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of amphetamine type stimulants is associated with:**
	Difficulty sleeping, loss of appetite and weight loss, dehydration
	jaw clenching, headaches, muscle pain
	Mood swings –anxiety, depression, agitation, mania, panic, paranoia
	Tremors, irregular heartbeat, shortness of breath
	Aggressive and violent behaviour
	Psychosis after repeated use of high doses
	Permanent damage to brain cells
	Liver damage, brain haemorrhage, sudden death (ecstasy) in rare situations

f. inhalants	Your risk of experiencing these harms is:…….. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of inhalants is associated with:**
	Dizziness and hallucinations, drowsiness, disorientation, blurred vision
	Flu like symptoms, sinusitis, nosebleeds
	Indigestion, stomach ulcers
	Accidents and injury
	Memory loss, confusion, depression, aggression
	Coordination difficulties, slowed reactions, hypoxia
	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)
	Death from heart failure

g. sedatives	Your risk of experiencing these harms is: Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of sedatives is associated with:**
	Drowsiness, dizziness and confusion
	Difficulty concentrating and remembering things
	Nausea, headaches, unsteady gait
	Sleeping problems
	Anxiety and depression
	Tolerance and dependence after a short period of use.
	Severe withdrawal symptoms
	Overdose and death if used with alcohol, opioids or other depressant drugs.

h. hallucinogens	Your risk of experiencing these harms is:..... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of hallucinogens is associated with:**
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory
	Difficulty sleeping
	Nausea and vomiting
	Increased heart rate and blood pressure
	Mood swings
	Anxiety, panic, paranoia
	Flash-backs
	Increase the effects of mental illnesses such as schizophrenia

i. opioids	Your risk of experiencing these harms is: Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of opioids is associated with:**
	Itching, nausea and vomiting
	Drowsiness
	Constipation, tooth decay
	Difficulty concentrating and remembering things
	Reduced sexual desire and sexual performance
	Relationship difficulties
	Financial and work problems, violations of law
	Tolerance and dependence, withdrawal symptoms
	Overdose and death from respiratory failure

D. RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- **The substance**

  - If you inject any drug you are more likely to become dependent.
  - If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - If you inject heroin or other sedatives you are more likely to overdose.

- **The injecting behaviour**

  - If you inject you may damage your skin and veins and get infections.
  - You may cause scars, bruises, swelling, abscesses and ulcers.
  - Your veins might collapse.
  - If you inject into the neck you can cause a stroke.

- **Sharing of injecting equipment**

  - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

❖ **It is safer not to inject**

❖ **If you do inject:**

- ✓ always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
- ✓ always use a new needle and syringe
- ✓ don't share equipment with other people
- ✓ clean the preparation area
- ✓ clean your hands
- ✓ clean the injecting site
- ✓ use a different injecting site each time
- ✓ inject slowly
- ✓ put your used needle and syringe in a hard container and dispose of it safely

❖ **If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.**

- ✓ avoid injecting and smoking
- ✓ avoid using on a daily basis

❖ **If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.**

- ✓ avoid using other drugs, especially sedatives or alcohol, on the same day
- ✓ use a small amount and always have a trial "taste" of a new batch
- ✓ have someone with you when you are using
- ✓ avoid injecting in places where no-one can get to you if you do overdose
- ✓ know the telephone numbers of the ambulance service

E. TRANSLATION AND ADAPTATION TO LOCAL LANGUAGES AND CULTURE: A RESOURCE FOR CLINICIANS AND RESEARCHERS

The ASSIST instrument, instructions, drug cards, response scales and resource manuals may need to be translated into local languages for use in particular countries or regions. Translation from English should be as direct as possible to maintain the integrity of the tools and documents. However, in some cultural settings and linguistic groups, aspects of the ASSIST and it's companion documents may not be able to be translated literally and there may be socio-cultural factors that will need to be taken into account in addition to semantic meaning. In particular, substance names may require adaptation to conform to local conditions, and it is also worth noting that the definition of a standard drink may vary from country to country.

Translation should be undertaken by a bi-lingual translator, preferably a health professional with experience in interviewing. For the ASSIST instrument itself, translations should be reviewed by a bi-lingual expert panel to ensure that the instrument is not ambiguous. Back translation into English should then be carried out by another independent translator whose main language is English to ensure that no meaning has been lost in the translation. This strict translation procedure is critical for the ASSIST instrument to ensure that comparable information is obtained wherever the ASSIST is used across the world.

Translation of this manual and companion documents may also be undertaken if required. These do not need to undergo the full procedure described above, but should include an expert bi-lingual panel.

Before attempting to translate the ASSIST and related documents into other languages, interested individuals should consult with the WHO about the procedures to be followed and the availability of other translations. Write to the Department of Mental Health and Substance Dependence, World Health Organisation, 1211 Geneva 27, Switzerland.

THE WHO ASSIST PROJECT

INTRODUCTION

There is substantial evidence for the benefits of Screening and Brief Intervention (SBI) for alcohol problems in primary health care settings, as a cost effective way of reducing alcohol consumption and associated problems. However, given the prevalence and consequences of drug use throughout the world, there is a need for an inexpensive international screening test for substances other than alcohol or tobacco.

The WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed in 1997 by the World Health Organization and specialist addiction researchers in response to the overwhelming public health burden associated with psychoactive substance use worldwide. The ASSIST has undergone significant testing (see below) to ensure that it is feasible, reliable, valid, flexible, comprehensive and cross-culturally relevant, and able to be linked to brief interventions.

The ASSIST was developed principally for use in primary health care settings where harmful substance use among patients may go undetected, or become worse. Many health care professionals can identify dependence ("addiction") in patients, but may not be able to identify substance use that is not dependent, but still causing harms. The ASSIST is an interviewer-administered pencil and paper questionnaire and screens for all levels of problem or risky substance use. A risk score is provided for each substance, and scores are grouped into low, moderate or high risk. The risk score determines the level of intervention (treatment as usual, brief intervention or referral to specialist treatment).

The revised version of the ASSIST (V3.0) consists of eight questions or items, covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (including ecstasy), inhalants, sedatives, hallucinogens, opioids and 'other drugs', that can be answered by most patients in around 10 minutes. The resulting scores are recorded on a custom-designed feedback report card and are used to provide feedback to patients about their substance use and associated risks as part of a brief intervention.

PHASE I

Phase I of this project commenced in 1997 and involved the development of a culturally neutral 12-item preliminary screening instrument for psychoactive substance use (ASSIST V1.0). With logistic and financial support from the WHO, the Phase I feasibility and test-retest reliability study was conducted at nine different participating sites around the world in Australia, Brazil, India, Ireland, Israel, the United Kingdom, the USA (Coordinating Centre), the West Bank and Gaza Strip, and Zimbabwe, chosen for their ability to provide access to culturally diverse samples of individuals with different substance use patterns.

The ASSIST V1.0 incorporated all major substance groups. Alcohol and tobacco products were incorporated into the questionnaire to make screening for the other substances more acceptable, given that both these substances are commonly investigated in primary care settings. The 12 items selected by consensus for initial evaluation provided ample coverage of the content domains considered most relevant to screening: life-time and recent substance use, dependence symptoms, substance-related problems and injecting drug use.

The findings of this study showed that the ASSIST was feasible and reliable. On average, *K*-levels ranged from .58 to .90 for the question stems, while the average ranges for substance class were between .61 for sedatives to .78 for opioids. Qualitative interview data from both the interviewers and respondents were also examined. Questions that were found to be difficult to administer or understand were reviewed in light of their corresponding *K*-values. These findings resulted in revisions to the ASSIST instrument including shortening the questionnaire from 12 to 8 items, and changing the content of some of the questions.

The revised version of the ASSIST V2.0 consisted of eight questions covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (including ecstasy), inhalants, sedatives, hallucinogens, opioids and 'other drugs', that could be answered by most subjects in around 10 minutes.

PHASE II

Phase II of the project was conducted between 2000 and 2002 and was devoted to validation of the ASSIST and the development of appropriate brief intervention and referral procedures. This was conducted at seven sites in different parts of the world chosen for their ability to provide access to culturally diverse samples of individuals with different substance use patterns; Australia (Coordinating Centre), Brazil, India, Thailand, United Kingdom, the USA and Zimbabwe. A test is said to be valid when it actually measures the desired parameters intended. The outcomes from a range of standardized screening procedures, diagnostic interviews and questionnaires were compared with those of the ASSIST V2.0. Some subjects also were administered a brief intervention.

Quantitative analysis of the data demonstrated that the ASSIST V2.0 showed significant concurrent, construct, predictive and discriminative validity. The ASSIST scores were significantly comparable with other measures of substance use and the ASSIST was able to discriminate between low, moderate and high risk use. In addition, a pilot test of the effectiveness of a brief intervention demonstrated that ASSIST scores significantly decreased over a three month period. Modifications to ASSIST coding and scoring also were implemented resulting in the ASSIST V3.0.

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Management of Substance Abuse

THE WHO ASSIST PROJECT

PHASE III

Commencing in 2003 and completed in 2007, Phase III consisted of a randomized controlled trial investigating the effectiveness of a brief intervention linked to ASSIST scores for risky cannabis, cocaine, amphetamine-type stimulant or opioid use.

The proposed trial examined how primary health care patients who screen positive for non-dependent problematic drug use on the ASSIST V3.0 for cannabis, amphetamine-type stimulants, cocaine or opioids, respond to a 5-15 minute brief intervention. The brief intervention is based on the FRAMES model and Motivational Interviewing, and has nine main steps including the delivery of personalized feedback through the use of a purpose-designed ASSIST Feedback Report Card (see resources below). The brief intervention is bolstered with take-home self-help information. Subjects were re-administered the ASSIST three months later and were also asked to describe how they were influenced by the brief intervention. The findings were compared with control subjects who did not receive a brief intervention.

The Phase III project was implemented in Australia (Coordinating Centre), Brazil, India, and the USA.

ASSIST RESOURCES

The following draft resources and materials have been developed as part of the WHO-ASSIST study and will undergo dissemination similar to that of the Alcohol Use Disorders Identification Test (AUDIT) materials:

ASSIST ADMINISTRATION

ASSIST V3.0. The Alcohol Smoking and Substance Involvement Screening Test V3.0 questionnaire consisting of eight questions covering 10 main substance groups. There is a table at the end of the questionnaire that health care professionals can use to record patients' ASSIST score for each drug and determine the appropriate intervention.

RESPONSE CARD FOR PATIENTS. A one page card that assists the patient to answer the questions, comprising the 10 main substance groups and examples of each, as well as a description of the time frames used throughout the questionnaire.

BRIEF INTERVENTION MATERIALS

FEEDBACK REPORT CARD FOR PATIENTS. A 4-page card that can be printed (double-sided) on a folded A3 sheet to be completed with the patient's ASSIST scores upon completion of the ASSIST interview. This card allows the provision of personalized feedback and advice to patients as part of the brief intervention. Interviewers can enquire as to whether the patient is interested in knowing the results of the questionnaire just completed which also serves to minimise resistance to the brief intervention. Patients are given the Feedback Report Card to take home.

RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS. A one page card to assist in giving feedback and information to patients who have injected drugs in the last 3 months. Patients are given the Risks of Injecting Card to take home.

RESOURCE MANUALS

THE ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (ASSIST): GUIDELINES FOR USE IN PRIMARY CARE. Draft V1.1. A manual for health professionals which provides the rationale for screening for psychoactive substance use, both in primary care and in other contexts. It covers the acute and chronic effects of using specific substances and risks associated with drug use. The manual provides a history covering the stages behind the development of the ASSIST (feasibility, reliability, validity), the ASSIST questionnaire, guidelines for administration of the ASSIST, and scoring and interpretation of ASSIST scores.

BRIEF INTERVENTION FOR SUBSTANCE USE: A MANUAL FOR USE IN PRIMARY CARE. Draft V1.1. A companion manual to 'The ASSIST: Guidelines for use in Primary Care' to help health professionals to manage persons whose substance use is risky. This manual includes an introduction to brief interventions within the context of primary care by screening and determining the level of risk according to the ASSIST. Management of all risk levels will be discussed, including those associated with injecting, but the main focus of the manual will be management of those for whom a brief intervention would be most appropriate. Motivational interviewing techniques, stages of change and behavioural strategies for change are described.

SELF-HELP STRATEGIES FOR CUTTING DOWN OR STOPPING SUBSTANCE USE. Draft V1.1. This manual is for patients to take home with them to bolster the brief intervention. It will help the patient decide whether or not they want to cut down on their use and provide them with useful and practical strategies. The manual is written in language that is easy to understand, and is pictorial in nature. It also contains material in the appendices that will help patients to weigh-up and keep track of their substance use over time.

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NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/ activities/assist_v3_english.pdf).*

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Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take.
Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

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Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:

12 oz. beer 5 oz. wine 1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

(For the Provider)

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a zone of use, which can be circled on the bottom left corner.

Score	Zone	Explanation	Action
0-3	I – Low Risk	Patient NOT at risk for health or social complications based on alcohol use	Positive Health Message – describe low risk levels
4-9	II – Risky	Alcohol use likely leads to new health problems or makes existing ones worse	Brief intervention to reduce use
10-13	III – Harmful	Patient has experienced repeated negative consequences & continues to use despite persistent problems	Brief Intervention to reduce or abstain (Brief Treatment if available) and specific follow-up appointment
14+	IV – Severe	Patient is experiencing multiple signs of substance use disorder, needs further assessment by substance use disorder specialist	Brief Intervention to accept referral to specialist treatment for assessment

Positive Health Message: An opportunity to educate patients about low-risk consumption levels and the risks of excessive alcohol use.

Brief Intervention (BI) to Reduce Use: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior. Brief interventions are typically 5-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief intervention to reduce or abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their drinking, or patients with likely dependence who cannot or will not obtain specialized treatment, should receive more numerous and intensive BI's with follow up. The recommended behavior change is to cut back to low-risk drinking levels or abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

BI to Accept Referral: A proactive process that facilitates access to specialized care for individuals. These patients are referred to substance use disorder treatment experts for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

***** Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

TEMPLATES FOR LOCAL USE

KANSAS
MATERNAL &
CHILD HEALTH

1. Release of Information 57
2. Consent for Communication with Medical Providers 59
3. Refusal of Transport for Evaluation 61
4. Substance Use Directory for Patients 63
5. SUD Screening Office Procedures 65
6. Memorandum of Understanding 71

Authorization for Release of Information

***Please have patient initial all highlighted lines**

First Name:_____

Last Name:_____

Date of Birth:_____

Authorize _____ to: _____ Disclose To _____Receive From

(Name of organization)

Provider/Agency/Individual:_____

The following identifying information from my records:

_____ Scheduling and attendance of services

_____ Assessment

_____ Treatment progress

The purpose and need for such disclosure is:

_____ To communicate regarding care coordination and patient engagement/progress in care

I understand that my records (including alcohol, drug abuse, or mental status information) may be protected by Federal Regulations. This consent to disclose information may be revoked by me at any time except to the extent that action has been taken in reliance thereon. This consent (unless expressly revoked earlier) expires upon: One Year Past Date of Discharge or (specify date, event, or condition upon which it will expire)

Date/Condition of Expiration: (If left blank, release will expire 1 year from date of discharge)

_____

Signature of Patient:_____Date:_____

Signature of Witness:_____Date:_____

Signature of Parent, Guardian, or Legal Representative:

_____ Date:_____

(Signature) (Nature of Relationship)

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATED THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN $500, IN THE CASE OF A FIRST OFFENSE, AND NOT MORE THAN $5,000, IN THE CASE OF EACH SUBSEQUENT OFFENSE. Drug Abuse Office and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42USC 4582), Federal Register, Vol. 40, No. 127 - Tuesday, July 1, 1975.

09/2019

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CONSENT FOR COMMUNICATION WITH MEDICAL PROVIDERS FOLLOWING SUBSTANCE USE SCREENING AND REFERRAL

PLEASE READ THE BELOW INFORMATION CAREFULLY BEFORE SIGNING!

Consent for release of medical information

I, _____ (print name of patient), give permission for my health provider _____ (print provider's name), to share any and all pertinent information regarding my treatment and care, with _____(Agency Name and Service/Program) who referred me for care following a substance use, to ensure they are informed of my treatment and care process.

Patient Signature: _____ Date: ____/____/____

Your consent is effective for a period of one year from the date of your signature on this release.

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REFUSAL OF SUBSTANCE USE ASSESSMENT
FOLLOWING UNIVERSAL SUBSTANCE USE SCREENING

PLEASE READ THE BELOW INFORMATION CAREFULLY BEFORE SIGNING!

Because it is sometimes impossible to recognize actual or potential risks associated with perinatal behavioral health disorders outside of a professional setting, we (staff) are recommending that you receive further assessment from a specialty provider.

You have the right to refuse this recommendation, however your safety, and the safety of your baby, could be at risk by continuing any substance usage OR by detoxing without receiving care from a qualified provider.

By signing below, you are acknowledging that you have been informed, and that you understand, the potential harm to your health, and the health of your baby, that may result from your refusal of the recommended care, and you release our personnel from all liability resulting from this refusal.

☐ **I refuse: REFERRAL FOR A SUBSTANCE USE ASSESSMENT PER STAFF RECOMMENDATION, AND I HAVE BEEN INFORMED OF LOCAL PROGRAM PROTOCOL WITH MY REFUSAL TO SEEK IMMEDIATE CARE.**

Patient's Printed Name _____DOB_____ Phone #_____

Signature_____

Support signature, if applicable_____

Staff Signature_____ Staff Printed Name_____

Witness Signature, if applicable_____

Date and Time_____

For office use only:

1. Suicidal/homicidal? Yes No
   If yes, did mother verbalize a plan of self-harm or harm to others? Yes No

2. Drug(s) intoxicated on:
   - ○ Alcohol ○ Methamphetamine ○ Cocaine/Crack ○ Opiates
   - ○ Marijuana ○ Bath Salts ○ Potpourri ○ Other:_____

3. Behaviors:
   - ○ Cooperative ○ Anxious/Restless ○ Aggressive ○ Other:_____
   - ○ Oriented ○ Cursing ○ Complaining

4. Verbalizes understanding of recommended evaluation and consequences of refusal to seek immediate care?
   Yes No

5. Narrative: Describe reasonable alternatives to treatment that were offered; the circumstances of the concern; specific consequences of refusal; and, names of family or witnesses present:
   _____
   _____
   _____
   _____

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[Insert Community or County Name] Substance Use Treatment Resources

Agency / Address / Contact Number	Payment Sources Accepted	Regular Hours of Operation	Diagnostic and Treatment Services	Counseling Services	Support Groups	Discounted or sliding fee scale available	*After Hour Emergency Services
[Insert Name of Community Mental Health Center] [Insert Address] [Insert Contact Number]							
[Insert Name of Agency/Organization/ Substance Use Treatment Center] [Insert Address] [Insert Contact Number]							
[Insert Name of Agency/Organization/ Substance Use Treatment Center [Insert Address] [Insert Contact Number]							
[Insert Name of Agency/ Organization/Private Practice] [Insert Address] [Insert Contact Number]							
[Insert Name of Agency/ Organization/Private Practice] [Insert Address] [Insert Contact Number]							
[Insert Name of Hospital/ Emergency Service] [Insert Address] [Insert Contact Number]							
[Insert Name of Hospital/Emergency Service] [Insert Address] [Insert Contact Number]							

RESOURCES

National Suicide Prevention Lifeline Center for Kansas
1-800-273-TALK (8255) or 785-841-2345

Crisis Text Line
(text KANSAS to 741741)

Substance use assessment and treatment options in Kansas

Beacon Health Options of Kansas
1(888) 800-6791

Perinatal Behavioral Health Consultation Line
1-800-????

Licensed Addiction Practitioners in Kansas

Kansas Behavioral Science Regulatory Board
ksbsrb.ks.gov/professions/addiction-counselors

Wichita State University – Community Engagement Institute
Peer Support Group Database
supportgroupsinkansas.org

Screening for Substance Use Disorders Model Policy Template for Maternal and Child Health Services

THIS IS A SUGGESTED SUBSTANCE USE DISORDER SCREENING POLICY FOR USE WITHIN AN ORGANIZATION. PLEASE REVIEW AND ADAPT LOCALLY.

IT IS SUGGESTED THIS DOCUMENT ALSO BE ACCOMPANIED BY STAFF TRAINING. TRAINING RESOURCES ARE INCLUDED IN THE ACCOMPANYING SBIRT INTEGRATION TOOLKIT.

MODEL POLICY SUPPLEMENTAL MATERIALS ARE INCLUDED IN THE SBIRT INTEGRATION TOOLKIT AND MAY BE ADDED TO THE POLICY AS ATTACHMENTS. SUCH MATERIALS INCLUDE: *SBIRT Integration Plan Overview; Integration Plan Overview; Information on Implementing Screening for Substance Use Disorders in Perinatal Women; SBIRT Integration – Resource/Reference Guide for Providers*; *ASSIST Screening Tool* (algorithm); *Crisis Intervention following Screening for Substance Use Disorders* (algorithm); *Consent for Communication with Medical Providers; and Refusal of Substance Use Assessment following a high-risk screen*.

Document Number:	Enter Policy Number.
Document Name:	Enter Policy Name
Effective Date:	Select effective date.
Document Status:	

[*INSERT AGENCY NAME*]

PERINATAL SUBSTANCE USE SCREENING POLICY

I. PURPOSE

The purpose of this policy is to establish guidelines for implementing perinatal substance use screening in Maternal and Child Health (MCH) programs, assuring it is done in a universal fashion, along with provision of patient education on Substance Use Disorders (SUDs), and standardized referral and follow-up procedures with all moderate and high-risk screens.

Agencies are expected to do the following:

- Provide staff with adequate training opportunities.
- Prepare for implementation by utilizing tools and resources within the Kansas Department of Health (KDHE) Bureau of Family Health (BFH) provided SBIRT Integration Toolkit.
- Provide educational resources on SUDs and information on available behavioral health services to every pregnant and postpartum (through one year post-delivery) woman served.
- Universally screen every pregnant and postpartum (through one year post-delivery) woman served for SUDs.
- Provide a brief intervention for every moderate and high-risk screen in a standardized fashion.
- Refer and follow up on every high-risk screen in a standardized fashion.
- Work with providers and agencies across the community to establish and assure an *adequate system of care* is in place.

II. DEFINITIONS

Perinatal is being defined in the broadest sense for the purpose of this policy and its related work. It is inclusive of the entire pregnancy through one year postpartum.

Postpartum is being defined in the broadest sense for the purpose of this policy and its related work. It is inclusive of one year following childbirth.

Adequate System of Care means having systems and clinical staff in place to ensure that patients are screened and, if they screen positive, are appropriately diagnosed and treated with evidence-based care or referred to a setting that can provide the necessary care.

SBIRT (Screening, Brief Intervention, and Referral to Treatment): SBIRT is an approach to the delivery

of early intervention and treatment to people with substance use disorders and those at risk for developing these disorders.

III. PROCEDURES

A. Preparation for Implementation

1. *[Identify the evidence-based screening tool to be used. May use the following sample language:]*

   The ASSIST is recommended for use for the perinatal population and is the identified screening tool to be used to assure standardized screening.

2. *[Identify staff authorized to administer the screening tool. May use the following sample language:]*

   In order for services to be billable by KanCare, the following guidelines are in place:

   - Provider must be licensed and in good standing in the state of Kansas as a:
     - Physician, physician's assistant, nurse practitioner, psychiatrist, nurse, dentist, or certified health educator, or
     - Psychologist, social worker, professional counselor, marriage and family therapist or addiction counselor
   - In order to be able to be reimbursed for these procedures, the individual who has gone through the training must be providing the service.

   - Provide the appropriate professional licensure and training documentation to the appropriate entities (See Information on *Implementing Screening for Substance Use Disorders in Perinatal Women* in the SBIRT toolkit).

   - SBIRT services must be provided in approved service areas:
     - Primary medical care practices
     - Acute medical care facilities
     - Rural health clinics
     - Critical access hospitals
     - Federally Qualified Health Centers (FQHCs)
     - Licensed SUD treatment centers
     - Indian health centers
     - Community Mental Health Centers (CMHCs)

   - Documentation: Providers shall maintain documentation in the patient's health record. At minimum, documentation shall include the date/time (beginning and

ending), the results of the full screen, brief intervention and any appropriate referrals. The person performing the screening and/or intervention should be clearly noted.

3. *[Assure an adequate system of care is in place within the community. Work with providers and agencies to establish what services are available and to identify each provider/agency's unique role in establishing this adequate system of care. May use the following sample language, but should be customized to local system of care:]*

   Representatives from the following provider practices/agencies agree to work together, each providing their identified unique role, in assuring an adequate system of care for women screened for SUDs:

   a) [Insert Agency Name] – Role: education; screen; referral; follow-up (i.e. home visitation service providers, BaM facilitators, etc.).

   b) [Insert Provider/Clinic Name] - Role: prenatal care/primary care provider – accepts referrals from positive screens; provides further assessment and possible diagnosis/treatment or referral to substance use treatment specialist for further evaluation, diagnosis, and treatment.

   c) [Insert Provider/Clinic Name] - Role: Substance use addiction/specialist – accepts referrals for high-risk screens; consults with prenatal care/primary care providers seeking further evaluation of patient; completes substance use assessments; can diagnose and provider treatment services.

   d) [Insert Provider/Clinic Name] – Role: behavioral health clinician/specialist – available on-call for crisis situations.

4. *[Provide staff training to assure competence and confidence in providing patient education, administering the screening tool, and handling all screens. May use the following sample language:]*

   All staff administering the ASSIST will complete the required SBIRT training within the first six months of employment. Training dates and locations can be found at:

   http://www.sbirt.care/.

   In-house training consists of an overview of the ASSIST Screening Tool, including scoring and established workflows. Other training resources can be found in the SBIRT Toolkit.

B. Implementation

1. **Educational resources** about perinatal SUDs, methods of coping with the illness, and treatment resources, are provided universally to every pregnant and postpartum woman served.

[Should identify key educational resources to be used and timing of provision to assure universal approach. May use the following sample language:]

a) Resources – must include, but are not limited to, resources outlined within SBIRT toolkit. The resource in *Templates for Local Use* entitled *Substance Use Resource Directory* can be extremely helpful with providing patients with information.

b) Timing of resource delivery assures every perinatal woman receives education on this topic.

2. **The Substance Use Screen is administered <u>at least once to every pregnant woman and every postpartum woman served upon initial contact</u>**. Repeat screening is administered according to the following outlined schedule

   [*May use the following sample language, but should be customized to role within local system of care:]*

   a) Prenatal:

      i. At the first prenatal visit

      ii. Any follow-up visits, when the patient's score indicates moderate or high risk during the initial screen

   b) First prenatal visit Postpartum:

      i. First postpartum visit, targeted during first two weeks post hospital discharge

      ii. Any follow-up visits during 6-8 week postpartum period

      iii. Every 3 months throughout remainder of first year postpartum

   c) Rescreen anytime there is concern about the patient's ability to function, as observed by the MCH service provider or as voiced by patient or the patient's family/support person.

   d) Annually:

      i. The American College of Obstetricians and Gynecologists recommends all women seeking obstetric-gynecological care should be screened at least yearly.

3. **Referral and follow-up on positive screens** is provided as outlined in the attached algorithms in the SBIRT toolkit.

   **Be sure algorithms reflect any adaptations made locally per provider agreements within the established system of care, and the local Substance Use Resources Directory includes the appropriately identified resources including emergency services available]*

   In addition to steps identified in the algorithms, the following are called out in policy in the event of current thoughts or plan of self-harm or harm to others:

[*May use the following sample language, but should be customized to local system of care:]*

a) Contact on-call [insert name of mental health center/agency] clinician at [insert emergency contact number] to respond to crisis situation and complete a mental health screen per agency agreement [MOA encouraged; include MOA as an attachment to this policy]

b) Notify supervisor as soon as opportunity arises to do so or as any guidance is needed during the process

c) If patient refuses transport for evaluation, have patient sign Refusal of Transport for Substance Use Assessment form. Call 911 and follow mandated reporter criteria.

d) Contact [insert name of mental health center/agency] clinician who completed the screen and with the patient the next business day to obtain any treatment recommendations. Follow-up visits will be provided on a weekly basis by [insert name of agency/staff position responsible for follow-up] until the patient is determined to be stable by treating mental health provider.

e) Document all patient contact and share with involved providers of care, as authorized per signed *Consent for Communication with Care Providers.*

The editable Word version of the memorandum is available in the Templates for local use portion of toolkit

Memorandum of Understanding

Memorandum of Understanding

Between

[Organization 1]

and

[Organization 2]

This Memorandum of Understanding (MOU) sets forth the terms and understanding between the [Organization 1] and [Organization 2], to provide coordinated efforts to ensure quality treatment and/or referral services for perinatal women experiencing risky substance use behaviors.

Background
This partnership is meant to ensure collaboration and needed community supports for [Organization 1's] perinatal patients who are at risk of experiencing risky substance use behaviors. This collaboration works to meet the unique needs of new and expectant mothers to provide treatment, resources, and referral recommendations to patients volunteering to participate. This collaboration builds needed supports for perinatal women experiencing risky substance use behaviors, and positively impacts children by assisting in improving the health and well being of families.

Purpose
This MOU will assure mutual agreement of the purpose of the activity.

The above goals will be accomplished by undertaking the following activities:
[Organization 1] seeks to refer perinatal women experiencing risky substance use behaviors to [Organization 2] for further assessment. This is voluntary based on the patient's interest.
[Organization 2] representative will be trained in perinatal substance use treatment best practices.
[Organization 2] will provide outreach to the patient, complete a substance use assessment, and assist in connecting the patient to treatment and/or necessary resources and supports.

Funding
There is no commitment of funds associated with this MOU.

The editable Word version of the memorandum is available in the Templates for local use portion of toolkit

Duration
This MOU is at-will and may be modified by mutual consent of authorized officials from [Organization 1] and [Organization 2]. This MOU shall become effective upon signature by the authorized officials from the partners and will remain in effect until modified or terminated by any one of the partners by mutual consent. In the absence of mutual agreement by the authorized officials from partners, this MOU shall end on [end date].

Contact Information
Partner:
Contact / Position:
Contact / Position:
Address:
Telephone:
Fax:
Email:

Partner:
Contact / Position:
Address:
Telephone:
Fax:
Email:

_____Date:
(Partner signature)
(Organization 1)

_____Date:
(Partner signature)
(Organization 2)

RESOURCES FOR PROVIDERS

A. Provider Training
1. UMKC–SBIRT Slide Deck with Notes 75
*Full slide deck (108 pages) available in **Provider Resources/Provider Training** portion of digital toolkit*
2. UMKC–SBIRT Online Course Flyer 77
B. Recommendation and Opinion Statements
1. ACOG–At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications 79
2. AJOG–The Role of Screening, Brief Intervention, and Referral to Treatment in the Perinatal Period 85
3. ACOG–Opioid Use and Opioid Use Disorders in Pregnancy 95
4. USPSTF Screening in Primary Care Settings 109
5. Substance Use and Depression in Home Visiting Clients: Home Visitor Perspectives on Addressing Clients' Needs 123
6. USPSTF–Screening for Illicit Drug Use: Systematic Review Excerpt 145
Full Report (40 pages) available in Provider Resources/Recommendation and Opinion Statements portion of digital toolkit
7. USPSTF Recommendation-Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse 149
8. US Surgeon General Advisory: Marijuana Use and the Developing Brain 161
9. AMB Clinical Protocol: Guidelines for Breastfeeding and Substance Use Disorder . . 167
10. KDADS Standard Policy: BHS/503 175
11. KDADS Standard Policy: BHS/504 179
12. SAMHSA Issue Brief-Preventing the Use of Marijuana: Focus on Women and Pregnancy. 185
Full Resource Guide (76 pages) available in Provider Resources/Recommendation and Opinion Statements portion of digital toolkit
C. Provider Handouts
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2. NIDA–Commonly Abused Rx Drugs 187
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UMKC School of Nursing and Health Studies

Screening and Brief Intervention for Substance Use: A Health Imperative

Developed by

Heather Gotham, PhD, Licensed Clinical Psychologist

UMKC | SBIRT
Screening, Brief Intervention, and Referral to Treatment for Substance Use

Full slide deck (108 pages) available in
Provider Resources/Provider Training
portion of toolkit

INCREASE YOUR IMPACT

Learn how Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol and drug use can improve patient care.

The Kansas Department for Aging and Disability Services (KDADS) has approved this free, four-hour online course as one of the options for securing a certificate to allow for billing Medicaid when conducting SBIRT interventions.

Register today for a FREE online course at sbirt.care

About the Course

SBIRT for Health and Behavioral Health Professionals: How to Talk to Patients about Substance Use is a 4-hour, self-paced, online course. Learners will take part in an interactive orientation on SBIRT (screening, brief intervention, and referral to treatment for substance use), applying their learning through interactive games, case scenarios, and quizzes to develop their knowledge, skills, and abilities in using SBIRT as an intervention with patients.

Continuing Education

This course offers 4 contact hours of FREE continuing education for nursing, social work, and counseling professionals (CNE, NASW, CHES, NAADAC, and NBCC).

The University of Missouri-Kansas City School of Nursing & Health Studies is a designated provider of continuing education contact hours in health education by the National Commission for Health Education Credentialing, Inc.

The University of Missouri-Kansas City School of Nursing & Health Studies is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This program is approved by the National Association of Social Workers (Approval #886475666-3147) for 4 continuing education contact hours.

This course was developed by the University of Missouri-Kansas City (UMKC) SBIRT Project located at the UMKC School of Nursing and Health Studies, with funding by grant TI025355 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

Visit sbirt.care today!

Why Learn SBIRT?

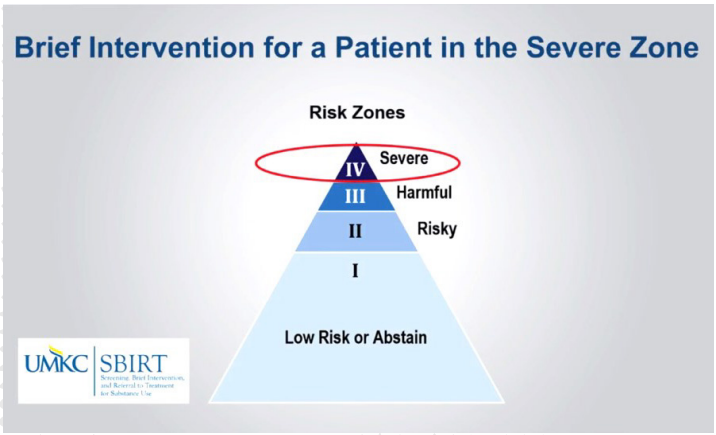
- Standardized alcohol and drug screening helps you identify patients at risk for health and mental health problems.
- A 5- to 15-minute brief intervention helps patients reduce their alcohol use and related consequences.
- A brief intervention with a warm handoff helps you motivate patients to accept a referral to addiction treatment if needed.

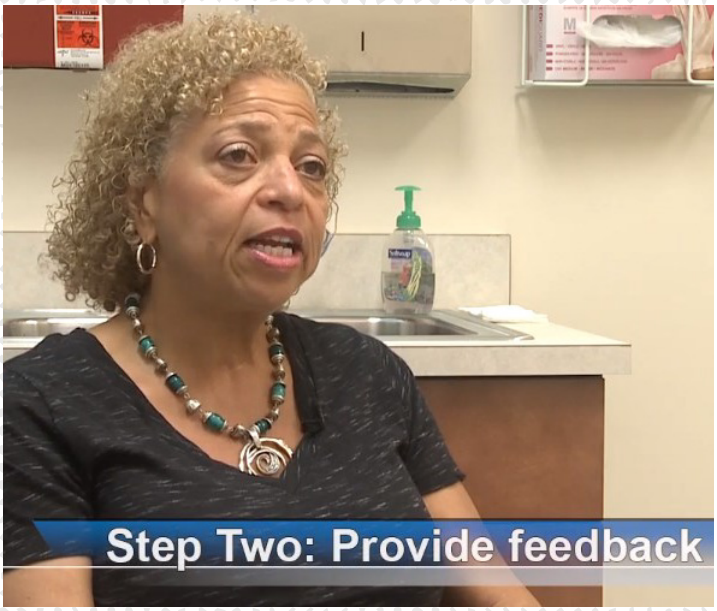
UMKC | SBIRT
Screening, Brief Intervention, and Referral to Treatment for Substance Use

For more information, contact Project Director Debbie Richardson, PhD, at richardsondl@umkc.edu.

Companion Video Series:
SBIRT for Health and Behavioral Health Professionals: How to Talk to Patients about Substance Use

The SBIRT for Health and Behavioral Health Professionals online course features a 4-part video series that demonstrates health and behavioral health professionals using SBIRT with clients. The videos feature brief interventions for patients in the Risky, Harmful, and Severe (Referral to Treatment) Zones and a clinician case study about the importance of universal screening for alcohol and drug use. The videos are embedded throughout the course, but can also be accessed for free on Vimeo: https://vimeo.com/album/3507664





Access these videos for FREE at https://vimeo.com/album/3507664

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 496 • August 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Reaffirmed 2019

At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications

ABSTRACT: Compared with men, at-risk alcohol use by women has a disproportionate effect on their health and lives, including reproductive function and pregnancy outcomes. Obstetrician–gynecologists have a key role in screening and providing brief intervention, patient education, and treatment referral for their patients who drink alcohol at risk levels. For women who are not physically addicted to alcohol, tools such as brief intervention and motivational interviewing can be used effectively by the clinician and incorporated into an office visit. For pregnant women and those at risk of pregnancy, it is important for the obstetrician–gynecologist to give compelling and clear advice to avoid alcohol use, provide assistance for achieving abstinence, or provide effective contraception to women who require help. Health care providers should advise women that low-level consumption of alcohol in early pregnancy is not an indication for pregnancy termination.

The National Institute on Alcohol Abuse and Alcoholism defines *at-risk alcohol use* for healthy women as more than three drinks per occasion or more than seven drinks per week and any amount of drinking for women who are pregnant or at risk of pregnancy. *Binge drinking* is defined as more than three drinks per occasion. Almost 50% of binge drinking occurs among otherwise moderate drinkers (1). *Moderate drinking* is defined as one drink per day (2). When evaluating a patient's drinking habits, it is important to verify the description of "a drink" to determine the actual amount of alcohol consumed (Box 1).

National surveys indicate that American Indian and Alaska Native women (13.7%) were the most likely race to have an alcohol use disorder. This is compared with white non-Hispanic women (5.6%), black non-Hispanic women (3.5%), and Hispanic or Latino women (3.8%) (3). In 2009, 25.6% of individuals aged 18–24 years reported binge drinking (4). Of those individuals, the majority were white non-Hispanic, college graduates who had an average household income greater than $50,000 per year (4). Among women aged 18–34 years who binge drink, approximately one third (31.4%) report drinking eight or more drinks per occasion (5). In 2008, 61% of full-time college students were current drinkers and 40.5% reported binge drinking (3). Binge drinking is associated with a sudden peak in the level of alcohol in the blood, resulting in unsafe behavior and the risk of more reproductive and organ damage than sustained high levels of alcohol consumption (6).

For many people, alcohol use can be a pleasant experience as a method of relaxation and social connection. It also offers some beneficial cardiovascular effects (7). However, women are particularly vulnerable to the physical and psychosocial health risks of at-risk alcohol use. Alcohol-related mortality represents the third leading cause of preventable death for women in the United States (8). As indicated in Box 2, at-risk alcohol use results in multiple adverse health effects. Of note, data indicate that women who drink between two and five drinks

Box 1. What Is a Drink?

One standard drink is equal to 15 mL of pure ethanol

- Beer or wine cooler – 12 oz
- Table wine – 5 oz (25-oz bottle = 5 drinks)
- Malt liquor – 8–9 oz (12-oz can = 1.5 drink)
- 80-Proof spirits – 1.5 oz (a mixed drink may contain 1–3 or more drinks)

per day have up to a 41% increased incidence of breast cancer, and the risk increases linearly with consumption throughout this range (9, 10).

Box 2. At-Risk Alcohol Use: Secondary Consequences Affecting Women

Increased medical and physical risks

- Unplanned pregnancy
- Sexually transmitted diseases*
- Altered fertility [†,‡]
- Menstrual disorders[§]
- Injuries
- Seizures[§]
- Malnutrition[§,‖]
- Cardiomyopathies[¶]
- Cancer of the breast, liver, rectum, mouth, throat, and esophagus[§,#,**]

Increased risk of psychosocial problems

- Loss of primary relationships
- Sexual assault
- Loss of income
- Child neglect or abuse and loss of child custody
- Domestic violence
- Driving under the influence
- Altered judgement
- Bartering sex for drugs
- Depression and suicide

*Nicoletti A. The STD/alcohol connection. J Pediatr Adolesc Gynecol 2010;23:53–4.

†Rossi BV, Berry KF, Hornstein MD, Cramer DW, Ehrlich S, Missmer SA. Effect of alcohol consumption on in vitro fertilization. Obstet Gynecol 2011;117:136–42.

‡Grodstein F, Goldman MB, Cramer DW. Infertility in women and moderate alcohol use. Am J Public Health 1994;84:1429–32.

§Corrao G, Bagnardi V, Zambon A, La Vecchia C. A meta-analysis of alcohol consumption and the risk of 15 diseases. Prev Med 2004;38:613–9.

‖National Institute on Alcohol Abuse and Alcoholism. Alcohol and nutrition. Alcohol Alert No. 22 PH 346. Bethesda (MD): NIAAA; 1993. Available at: http://pubs.niaaa.nih.gov/publications/aa22.htm. Retrieved April 18, 2011.

¶Urbano-Marquez A, Estruch R, Fernandez-Sola J, Nicolas JM, Pare JC, Rubin E. The greater risk of alcoholic cardiomyopathy and myopathy in women compared with men. JAMA 1995;274:149–54.

#Ferrari P, Jenab M, Norat T, Moskal A, Slimani N, Olsen A, et al. Lifetime and baseline alcohol intake and risk of colon and rectal cancers in the European prospective investigation into cancer and nutrition (EPIC). Int J Cancer 2007;121:2065–72.

**Kuper H, Tzonou A, Kaklamani E, Hsieh CC, Lagiou P, Adami HO, et al. Tobacco smoking, alcohol consumption and their interaction in the causation of hepatocellular carcinoma. Int J Cancer 2000;85:498–502.

Obstetrician–gynecologists have important opportunities for at-risk alcohol use intervention in three key areas: 1) identifying women who drink at risk levels, 2) encouraging healthy behaviors through brief intervention and education, and 3) referring patients who are alcohol dependent for professional treatment.

Identification of At-Risk Drinking

The U.S. Preventive Services Task Force recommends that all adult patients in a primary care setting be screened for alcohol misuse and provided counseling for identified risky or harmful drinking. Referral for specialist treatment may be appropriate for those with alcohol abuse or dependence (11). All women seeking obstetric–gynecologic care should be screened for alcohol use at least yearly and within the first trimester of pregnancy. It should be noted that women who drink at risk levels are less likely to maintain routine annual visits, and screening should be considered for episodic visits if not completed within the past 12 months. Screening can be accomplished using a variety of simple validated tools, like TACE with additional questions about the quantity and frequency of alcohol use, within the context of the routine visit (Box 3). Although the CAGE mnemonic screening tool has been taught in most medical schools and residency programs, it has not proved to be sensitive for women and minorities (12). Using a validated screening tool decreases false-positive and false-negative responses. Women may fear disclosure of their alcohol use will result in the loss of employment, their children, or their relationships. Therefore, it is crucial that the clinician assure the patient before screening that the information disclosed is privileged and confidential. Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties or the loss of custody of her children (13).

Women who develop alcohol or substance use dependence are often more likely than men to deny that they have a problem and to minimize the problems associated with their use. However, when they do seek help for the problem, it often is from their primary care providers (14). Importantly, most women who use alcohol at risk levels have no signs on physical examination. A detailed medical history obtained by a trusted clinician remains the most sensitive means of detecting alcohol abuse (15).

Encouraging Healthy Behaviors and Early Intervention Strategies

Many women may be surprised to learn that their drinking exceeds a safe level of alcohol consumption. They may live or associate with others who drink similar amounts of alcohol and consider their alcohol use as "normal." Offering compassionate education, exploring practical strategies to reduce use, and requesting a follow-up appointment is a successful strategy for many women

Box 3. Alcohol Use Screening Tools

TACE

- **T** – Tolerance
  How many drinks does it take to make you feel high?
  (More than 2 drinks = 2 points)
- **A** – Annoyed
  Have people annoyed you by criticizing your drinking?
  (Yes = 1 point)
- **C** – Cut down
  Have you ever felt you ought to cut down on your drinking?
  (Yes = 1 point)
- **E** – Eye-opener
  Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
  (Yes = 1 point)

A total score of 2 points or more indicates a positive screening for at-risk drinking

Alcohol Quantity and Drinking Frequency Questions

- In a typical week, how many drinks do you have that contain alcohol?
  (Positive for at-risk drinking if more than 7 drinks)
- In the past 90 days, how many times have you had more than 3 drinks on any one occasion?
  (Positive for at-risk drinking if more than one time)

Data from Sokol RJ, Martier SS, Ager JW. The T-ACE questions: practical prenatal detection of risk-drinking. Am J Obstet Gynecol 1989;160:863–8; discussion 868–70 *and* National Institute on Alcohol Abuse and Alcoholism. Helping patients who drink too much: a clinician's guide. Updated 2005 edition. Bethesda (MD): NIAAA; 2005. Available at: http://pubs.niaaa.nih.gov/publications/practitioner/CliniciansGuide2005/Guide_Slideshow.htm. Retrieved April 18, 2011.

who are not physically or psychologically dependent on alcohol. There are effective alcohol educational materials available for patients that are free or offered at a very low cost (see Resources).

Brief, motivation-enhancing interventions are associated with a sustained reduction in alcohol consumption (16–18). Following is an example of a brief intervention:

> "You indicated that you are drinking five or six drinks one evening a week and that you often do not feel drunk when you drink that amount. This is considered at-risk drinking. What do you think about that?"
>
> (Wait for her response.)
>
> "As your obstetrician–gynecologist, I am concerned that your menstrual irregularities or other clinical findings may be associated with your drinking. This level of drinking also puts you at risk of unplanned pregnancy and injuries. Are you willing to try and reduce your drinking? I can offer you resources to help."
>
> (Wait for her response.)
>
> "Getting pregnant at this time could be very harmful for you and your baby. I want you to consider using a more effective contraception method while you are working on reducing your alcohol intake."
>
> (Wait for her response.)

At the conclusion of the brief intervention, it is important to assist the patient in setting a goal (eg, "I will not have more than three drinks at the Friday happy hour"), record the goal, and let her know that there will be a follow-up discussion at the next visit. If she does not consistently meet her goal, restate the advice to quit or cut back on drinking, review her plan, and encourage her to seek additional support. A failed attempt is a motivating moment toward seeking help.

Referral

Women who continue to drink or use alcohol at risk levels and women who exhibit signs of alcohol dependence require referral to a substance abuse specialist. This referral is best made while the patient is in the clinician's office so that she is involved in making the appointment with the encouragement of her health care provider. Local substance abuse treatment programs can be found through the Substance Abuse and Mental Health Services Administration treatment locater (19). If the patient refuses treatment, the health care provider should respect her decision, make a short-term follow-up appointment with her, and assure her that she will be welcomed back in the clinician's office. It may take a number of offers before the patient is ready to accept a treatment referral. The patient's trust in her medical provider may be key in taking the step toward treatment.

Alcohol Use and Pregnancy and Breastfeeding

Alcohol is a teratogen. Fetal alcohol syndrome is the most severe result of prenatal drinking. Fetal alcohol syndrome is associated with central nervous system abnormalities, growth defects, and facial dysmorphia. However, for every child born with fetal alcohol syndrome, many more are born with neurobehavioral defects caused by prenatal alcohol exposure. Alcohol-related birth defects include growth deformities, facial abnormalities, central nervous system impairment, behavioral disorders, and impaired intellectual development. Alcohol can affect a fetus at any

stage of pregnancy, and the cognitive defects and behavioral problems that result from prenatal alcohol exposure are lifelong. In early pregnancy during organogenesis and perhaps before the patient's recognition of pregnancy, the fetus may be particularly vulnerable to maternal binge or heavy alcohol use. Alcohol-related birth defects are completely preventable (20). Even moderate alcohol consumption during pregnancy may alter psychomotor development, contribute to cognitive defects, and produce emotional and behavioral problems in children, although patient denial and underreporting make it difficult to quantify these effects (21). There is evidence of varying susceptibility to alcohol's effect on the developing fetus. Although alcohol consumption may have negative consequences for any pregnant woman, the effects of alcohol may be more potent in mothers who are older, in poor health, or who also smoke or use drugs (22).

The U.S. Surgeon General advises that pregnant women should not drink any alcohol. Women who have already consumed alcohol during a current pregnancy should stop in order to minimize further risk, and those who are considering becoming pregnant should abstain from drinking alcohol. Recognizing that nearly one half of all births in the United States are unintended, women of childbearing age should discuss with their clinicians steps to reduce the possibility of prenatal alcohol exposure (20). Health care providers should advise women that low-level consumption of alcohol in early pregnancy is not an indication for pregnancy termination.

A recent study indicated that the highest prevalence of late-pregnancy alcohol use was reported by women who were white non-Hispanic, college graduates, and aged 35 years or older (23). However, these same women were those who reported the least screening and counseling for alcohol use by their health care providers. There is strong evidence that brief behavioral counseling interventions with women who engage in at-risk drinking reduce the incidence of alcohol-exposed pregnancy (24, 25). Pregnant women are generally motivated to change their drinking behavior, and alcohol dependence is relatively rare (24). In one multicenter project, nearly 70% of women who were drinking at risky levels and not using effective contraception reduced their risk of alcohol-exposed pregnancy 6 months after a brief intervention because they stopped or reduced their drinking below risky levels or they started using effective contraception (26). Randomized studies report significant reductions in alcohol use and improved newborn outcomes after interventions with women who are already pregnant. Women who are alcohol dependent need intense specialized counseling and medical support during the process of withdrawal. They should be given priority access to withdrawal management and treatment (24). If a woman continues to use alcohol during pregnancy, harm reduction strategies should be encouraged (24). Postpartum, many women who were abstinent during pregnancy rapidly resume at-risk levels of alcohol use and should be monitored at the postpartum and follow-up visits (27). It is important to educate the at-risk patient about pregnancy prevention and offer and provide effective, long-term reversible contraception until at-risk alcohol use has been curtailed.

Contrary to cultural folklore, alcohol consumption does not enhance lactational performance. There is consistent evidence showing that when lactating mothers consume alcohol, there is reduced milk consumption by the infant (28). Alcohol consumption during lactation is associated with altered postnatal growth, sleep patterns, and psychomotor patterns of the offspring (29). After breastfeeding is well established, a mother should be encouraged by her health care provider to wait 3–4 hours after a single drink before breastfeeding her infant. By doing so, the infant's exposure to alcohol would be negligible (30).

Coding for Screening and Assessment and Brief Intervention

There are two *Current Procedural Terminology* codes to report for alcohol abuse structured screening and brief intervention services. Report *Current Procedural Terminology* codes 99408 (alcohol abuse structured screening and brief intervention services; 15 to 30 minutes) and 99409 (greater than 30 minutes) for screening and brief intervention services for patients without Medicare. These codes are only reportable for structured screening using a validated screening tool, such as TACE, and brief intervention. They are not reportable when physicians ask patients about their alcohol use as part of a comprehensive medical history. The services under these new codes may be conducted as part of a periodic, scheduled, preventive care office visit or in an acute setting.

Resources

American College of Obstetricians and Gynecologists. Alcohol, tobacco, and other substance use and abuse. *Guidelines for Adolescent Health Care* [CD-ROM]. 2nd ed. Washington, DC: ACOG; 2011.

National Institute on Alcohol Abuse and Alcoholism (NIAAA), has free brochures on women and alcohol as well as pregnancy and drinking available in English, Spanish and for American Indians. They also have videotaped screening and brief intervention interviews to guide physician–patient interaction.

National Institute on Alcohol Abuse and Alcoholism. Helping patients who drink too much: a clinician's guide and related professional support resources. Available at: http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx. Retrieved April 18, 2011

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The role of screening, brief intervention, and referral to treatment in the perinatal period

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Substance use during pregnancy is at least as common as many of the medical conditions screened for and managed during pregnancy. While harmful and costly, it is often ignored or managed poorly. Screening, brief intervention, and referral to treatment is an evidence-based approach to manage substance use. In September 2012, the US Centers for Disease Control and Prevention convened an Expert Meeting on Perinatal Illicit Drug Abuse to help address key issues around drug use in pregnancy in the United States. This article reflects the formal conclusions of the expert panel that discussed the use of screening, brief intervention, and referral to treatment during pregnancy. Screening for substance use during pregnancy should be universal. It allows stratification of women into zones of risk given their pattern of use. Low-risk women should receive brief advice, those classified as moderate risk should receive a brief intervention, whereas those who are high risk need referral to specialty care. A brief intervention is a patient-centered form of counseling using the principles of motivational interviewing. Screening, brief intervention, and referral to treatment has the potential to reduce the burden of substance use in pregnancy and should be integrated into prenatal care.

Key words: alcohol, brief intervention, opioid use, pregnancy, referral to treatment, screening, substance use disorders, tobacco

Introduction

Substance use is common in women of childbearing age. Prior to pregnancy, approximately 55% of women drink alcoholic beverages, 23% smoke cigarettes, and 10% use either illicit drugs or prescription drugs without a prescription.[1] Although most women are able to quit or cut back harmful substances during pregnancy, many are unwilling or unable to stop. National survey data indicate that during pregnancy, 10% of women drink alcohol (4% binge, ie, had ≥5 alcoholic drinks on the same occasion on at least 1 day in the past 30 days), 15% smoke cigarettes,[1] and 5% use an illicit substance. This makes substance use as or more common than many conditions routinely screened for and assessed during prenatal care (PNC), such as cystic fibrosis, gestational diabetes, anemia, postpartum depression, or preeclampsia. Moreover, substance use during pregnancy is both costly and harmful. Substance use during pregnancy is associated with poor pregnancy outcomes, including preterm birth, low birthweight, birth defects, developmental delays, and miscarriage.[2] Long-term effects on the mother and infant include medical, legal, familial, and social problems, some of which are lifelong and costly.[3,4]

The perinatal provider, therefore, has an important medical and ethical role in screening for substance use, counseling women on the importance of avoiding harmful substances, supporting their behavioral change, and referring women with addiction to specialized treatment when needed.[5,6] This process, known as screening, brief intervention (BI), and referral to treatment (SBIRT), represents a public health approach to the delivery of early intervention and treatment services for persons with substance use disorders (SUD)[7] (Table 1). Its use in emergency, general primary care, and obstetric settings for alcohol and tobacco has been recommended by the US Preventive Services Task Force[8,9] as well as by professional societies such as the American Congress of Obstetricians and Gynecologists (ACOG).[5]

Unfortunately, a number of barriers has limited the public health impact of SBIRT, particularly during pregnancy. First, although universal screening for substance use is recommended during pregnancy,[5] many women are not screened[11] or not screened with

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TABLE 1
Components of screening, brief intervention, and referral to treatment

Component	Goal	Approach
Screening	Assess substance use and its severity	Patient-/computer-administered instrument or direct provider questions (Table 4)
Brief intervention	Increase intrinsic motivation to affect behavioral change (ie, reduce or abstain from use)	1–5 Patient-centered counseling sessions lasting <15 min using principles of motivational interviewing (Table 2)
Referral to treatment	Provide those identified as needing more treatment access to specialty care	Warm handoff to specialized treatment (eg, provider-to-provider telephone call), which requires practitioner familiarity with community resources and systems of care

Wright. SBIRT in pregnancy. Am J Obstet Gynecol 2016.

evidence-based screening tools.[12] Providers are often overwhelmed by the number of disease states for which they are expected to screen and/or feel inadequately trained to screen for substance use.[12] Clinicians may also question the clinical utility of screening and the likelihood that women will reduce substance use or attain abstinence; conversely, they may be under the impression that they do not have patients who use substances in their practices or may not want to "play police" due to mandatory reporting requirements in some states.[14] In addition, providers may be at a loss of what to do if they encounter a patient with a SUD or unsure how to help the patient if unaware of community resources for treatment. Finally, inadequate reimbursement for evaluation and management services is a disincentive to provide preventative care even in the case of pregnant women.[15]

Second, failure to disclose substance use (or incomplete disclosure) is also common, and further complicates efforts to identify at-risk women.[16-20] Pregnant women also have reasons to withhold information about their use of substances in pregnancy. Some states have mandatory reporting requirements with the possibility of incarceration in a minority of states. This may not only create a disincentive for disclosure, but possibly for treatment-seeking itself.[21] Women may also be concerned about prejudicial treatment and stigma from their physicians who should be their advocates, while pregnant youth may fear disclosure to family members and the possible consequences of such disclosure.

Third, SBIRT research and practice has traditionally focused on the more commonly used substances such as alcohol and tobacco, with relatively less focus on illicit drugs.[22] This gap has become particularly apparent and troubling as rates of prescription drug misuse in pregnancy have risen steadily in recent years, leading to almost 3-fold increases in the incidence of neonatal abstinence syndrome from 2000 through 2009.[4] This increase has prompted calls for urgent action to help limit prescription opioid use and misuse during pregnancy.

In response to these calls, the US Centers for Disease Control and Prevention (CDC) convened an Expert Meeting on Perinatal Illicit Drug Abuse in Atlanta, GA, in September 2012. The expert panel participants were chosen based on their experience and past work specifically related to the use of the SBIRT approach in pregnant women. About 40 clinicians, scientists, and public health professionals representing academia (Johns Hopkins University, Harvard Medical School, Yale University, University of North Carolina, University of Maryland, University of Hawaii, and Wayne State University), professional organizations (ACOG and American Academy of Pediatrics [AAP]), states (Massachusetts, Washington, Georgia, and Indiana) and federal agencies (CDC, National Institutes of Health [NIH], Substance Abuse and Mental Health Services Administration [SAMHSA], Human Resources and Services Administration, and the Food and Drug Administration) were present at the meeting. This article represents the formal conclusions from that meeting, presented below within each of the 3 major elements of SBIRT for drug use in the perinatal period.

Screening

Screening for substance use should be universal, as SUDs occur in every socioeconomic class, and racial and ethnic group. Moreover, screening based on risk factors such as late entry to PNC or prior poor birth outcome potentially leads to missed cases and can exacerbate stigma and stereotyping.[10] Universal screening is recommended by many professional organizations, including ACOG,[5] AAP,[23] American Medical Association (AMA),[24] and CDC.[6] Screening should be done at the first prenatal visit, and repeated at least every trimester for individuals who screen positive for past use (Table 2). In addition, screening for tobacco use, at-risk drinking, illicit drug use, and prescription drug misuse should occur on an annual basis as a part of routine well-woman care. Women should be asked at medical exams if they are planning to get pregnant in the next year, so that adequate contraception and preconception care can be provided. Conclusions regarding screening are summarized in Table 3.

Most of the studies looking at screening have focused on using instruments, such as TWEAK, T-ACE, 4P's, or AUDIT-C (Table 4). These instruments have the advantage of being validated and most are fairly sensitive. Also, preliminary screening can be done by anyone in the practice, with follow-up by the provider. Barriers to implementing instrument-based screening include patient discomfort and lack of literacy,

staff resistance due to time pressures, and organizational issues such as lack of administrative support.[31] Integration into practice flow can be eased by incorporation into electronic medical record systems or by using a computer-based approached, which may diffuse the discomfort women feel in disclosing a behavior about which they are embarrassed, but this has not been compared to clinician-administered screening in pregnant women.[32] All positive screens require follow-up by the provider.

To counteract some of the institutional barriers to instrument-based screening, some experts encourage simply asking 3 open-ended questions regarding use of tobacco, alcohol, and other drugs (NIDA Quick Screen)[30]: "In the past year how many times have you drunk >4 alcoholic drinks per day? Used tobacco? Taken illegal drugs or prescription drugs for nonmedical reasons?" Among the expert panel, the consensus was that these questions are likely sensitive with fairly good specificity. Women are also more likely to report lifetime use or use before pregnancy than they are to disclose use during pregnancy because of the risks and stigma involved.

Regardless of which method is used and how the screening is delivered, it is essential that conversations around substance use be nonjudgmental. Prefacing screening with statements such as "I ask all my patients about substance use" can help normalize the enquiry and increase patient comfort with disclosure. The process of screening is only the first step in a conversation with the patient that may lead to treatment referral or provision of other treatment resources.

Urine drug testing is a common practice for many obstetricians and family practice physicians. It does have the advantage of detecting use in cases where the woman does not disclose her use and may help in diagnosing neonatal abstinence syndrome. Toxicology testing is a useful adjunct for individuals in SUD treatment[33] and has utility at the time of delivery[6] in case of complications of pregnancy, where knowing the substance used informs management decisions. Toxicology testing of pregnant women also has a number of limitations and negative consequences and should therefore never be done without the woman's knowledge or consent. For example, it greatly increases the risk of legal or child welfare involvement, particularly in states with mandated reporting requirements that include mention of drug use during pregnancy. This places physicians in a difficult ethical position, and raises the likelihood that women will fail to disclose potential health risks or avoid recommended medical care.[21] Further, the reporting of drug use during pregnancy to child welfare—made more likely or even mandated as a result of positive toxicology—is strongly biased against racial and ethnic minorities,[10] even following concerted efforts to prevent such bias.[34] A positive toxicology test also shows evidence of use, but does not provide any information about the nature or extent of that use; similarly, a negative test does not rule out substance use, which is often sporadic.[35] Additionally, the consequences of false-positive results can be devastating to the woman and her family.

Finally, the use of toxicological testing for illicit drugs encourages a focus on substances such as cocaine, opiates, and marijuana that is not justified by their prevalence or the risk that they pose. Other substances such as tobacco and alcohol pose as much or more risk[36] and are far more prevalent[1]; similarly, other risk factors such as inadequate PNC, depression, or violence exposure present significant unique risks that should be acknowledged—and that are not amenable to toxicology testing. If drug testing is used, a discussion of all substances and medications taken is mandatory as it will allow the clinician to order the correct test(s). Many substances including synthetic opioids such as oxycodone, fentanyl, buprenorphine, and some benzodiazepines[37] are not routinely captured by standard urine tests, and, if suspected, must be ordered

TABLE 2
Components of brief interview (modified[41])

Raise subject	• "Thank you for answering my questions—is it ok with you if we talk about your answers?" • "Can you tell me more about your past/current drinking or drug use? What does a typical week look like?"
Provide feedback	• "Sometimes patients who give similar answers are continuing to use drugs or alcohol during their pregnancy." • "I recommend all my pregnant patients not to use any alcohol or drugs, because of risk to you and to your baby."
Enhance motivation	• "What do you like and what are you concerned about when it comes to your substance use?" • "On a scale of 0—10, how ready are you to avoid drinking/using altogether? Why that number and not a ____ (lower number)?"
Negotiate plan	• Summarize conversation. Then: "What steps do you think you can take to reach your goal of having a healthy pregnancy and baby?" • "Can we schedule a date to check in about this next time?"

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TABLE 3
Key screening conclusions by expert group

- Screening for substance use should be done on all pregnant women at first prenatal visit and subsequently throughout pregnancy on those women at higher risk;
- Screening can be done either by using validated instrument with follow-up by provider or by asking standardized questions during interview;
- Screening should be nonjudgmental and questions should be open-ended;
- Urine toxicology testing should not be used in place of substance use screening questions.

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TABLE 4
Examples of screening instruments for use in pregnancy

Instrument	Substance	Validated in pregnancy	Subjects identified
CAGE[13]	Alcohol	No	At-risk drinking
Cut down			
Annoyed			
Guilt			
Eye opener			
T-ACE[25]	Alcohol	Yes	At-risk drinking
Takes			
Annoyed			
Cut down			
Eye opener			
TWEAK[26]	Alcohol	Yes	At-risk drinking
Tolerance			
Worry			
Eye opener			
Amnesia			
Cut down			
4Ps[a28]	Any substance	Yes	Any affirmative answer is considered positive screen
Past			
Present			
Parents			
Partner			
Substance Use Profile-Pregnancy[29]	Alcohol Illicit drugs	Yes	Any drinking or illicit drugs

[a] Modifications of 4Ps screener are available; eg, 5Ps (adding smoking) and 4Ps Plus,[27] which is copyrighted and requires yearly fee to use.

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separately. In addition, regular urine drug screens do not pick up alcohol use, and tests for alcohol metabolites, such as ethyl glucuronide and ethyl sulfate, are not routine, nor well studied in pregnant women. For these reasons, the expert panel did not endorse using urine drug testing as a primary means to screen women for drug use during pregnancy.

Clinicians who do use urine drug testing should ensure that all positive drug tests are followed by confirmatory testing by mass spectrometry. The health care provider should be aware of the potential for false-positive and false-negative results of urine toxicology for drug use, the typical urine drug metabolite detection times, and the legal and social consequences of a positive test result. It is incumbent on the health care provider, as part of the procedure in obtaining consent before testing, to provide information about the nature and purpose of the test to the patient and how the results will guide management.[35]

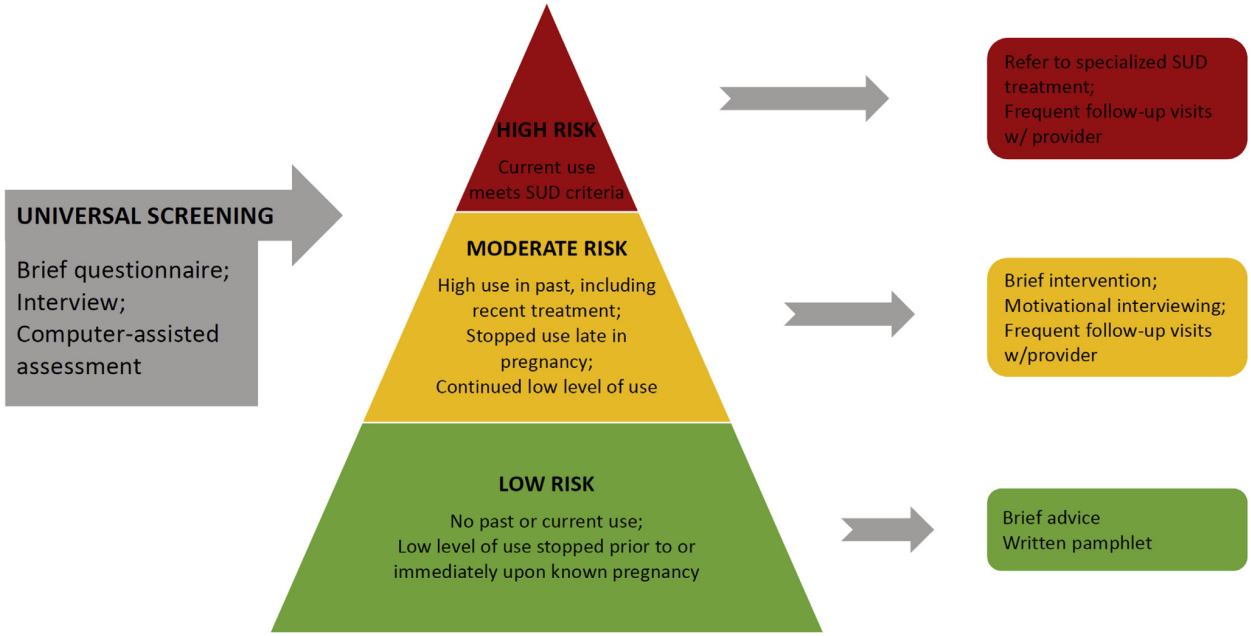
The overarching purpose of screening for substance use is to stratify women into zones of risk given their pattern of use. Based on the consensus of the group and available literature on drug use in pregnancy, we developed the risk pyramid shown in Figure 1. The majority of women will fall into the low-risk zone (ie, no past use of tobacco, alcohol, or other drugs, or low levels of substance use that stopped prior to or immediately following knowledge of pregnancy) and will need only brief advice/reinforcement. Moderate-risk women are those who have used high quantities of (any) substances in the past (including those who have been recently treated for SUDs), those who stopped during pregnancy, and those with sporadic, low-level use during pregnancy. Per the consensus of the group, these are the women who benefit most from BI. Only about 4-5% of women will fall into the high-risk zone of continued use of illicit drugs during pregnancy.[1] Women in the high-risk zone meet criteria for SUD. While these women can benefit from BI, most need referral to specialized addiction treatment. Figure 2 illustrates the flow of SBIRT in clinical practice.

Brief intervention

Women who did not use substances prior to pregnancy or those who used at low levels in the past and report cessation of all substance use (often due to pregnancy) are considered to be in the low-risk group. For this group, brief advice can be given. The simplest form of such intervention is reinforcement to remain abstinent (eg, "That's great you do not use drugs or alcohol, as drug use has been shown to cause many complications in pregnancy and problems with your baby, and there is no safe amount of alcohol use in pregnancy").[38] Providing written handouts to all women can reach those who are afraid to disclose use, but who may be at risk and need treatment.

Individuals who screen positive for any substance use in pregnancy and fall into the moderate-risk group should receive a BI. This type of intervention is a patient-centered form of counseling using the principles of motivational interviewing (MI) to effect behavioral change. MI was first described by Miller and Rollnick[39] in 1990 and has been adapted to various interventions in health care settings.[40] The purpose of MI is not to cure the patient, but to instill in her a desire to change by pointing out

FIGURE 1
Risk pyramid for assessment of substance use during pregnancy



SUD, substance use disorder.

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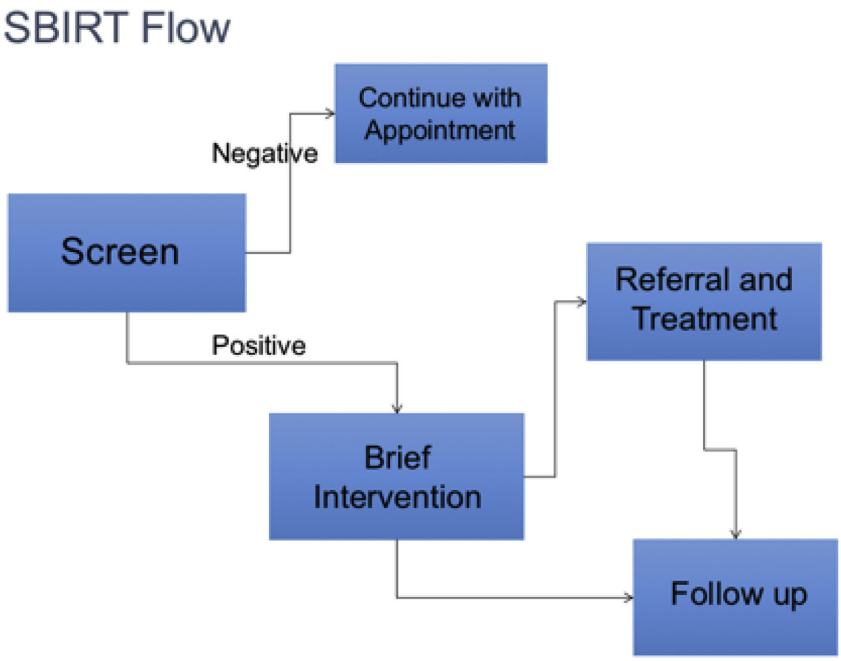
discrepancies between her current behavior and her future goals. This is facilitated in pregnancy because the overwhelming majority of women desire a healthy pregnancy and healthy baby. Principles of MI include using an empathetic counseling style, asking open-ended questions, developing rapport and trust, expressing empathy, and rolling with resistance. MI must be nonjudgmental and works best if the patient adopts the motivation and develops a plan to change her behavior.[39]

For the provider, the 3 tasks of an effective BI are to: (1) provide feedback of personal responsibility (eg, "As your doctor, I recommend you stop using cocaine for your health and the health of your baby, but it's your decision on what you want to do."); (2) listen and understand a patient's motivation for using ≥1 substances (eg, "I hear that you use drugs to deal with the stress of your life at home"); and (3) explore other options to address patient's motivation for substance use (eg, "Are there other ways you deal with stress in a more healthy way?"). Yet, the provider's objective is not to warn the patient as strong warning statements are often met with resistance from the patient. For example, stating: "Your baby could have a birth defect if you continue to drink alcohol" can be countered with: "I drank in my last pregnancy and that baby is fine." Resistance is a sign that the provider has pushed too hard. Rolling with resistance is a technique to redirect the conversation to a less threatening area. For example: "I'm not saying that your baby will definitely have a birth defect, but as your doctor, I'm concerned that your baby may be affected by your drinking. Babies who are exposed to alcohol in the womb can have lifelong medical and psychological problems."

Being judgmental, shaming, and/or using sarcasm are not effective ways of motivating people to implement behavioral changes. Finding a "hook" or reason for which the patient would like to change their harmful behavior is more effective (eg, "How would your life be better if you didn't use opioids?"). One technique used often to discover this hook is to ask open-ended questions (eg, "What do you like about…?" or "What don't you like about…?") followed by summary statements (eg, "I hear that you smoke cigarettes to calm you down, but you don't like how much they cost and how they make you smell [ie, reflecting the patient's own words], and you're worried about the effects they could have your baby. It sounds like having a healthy baby is very important to you." Examples of language that can be used in a BI are illustrated in Table 2.

The BI can be followed with an oral or written "contract" in which the patient states what she plans on doing to reach readiness, abstinence, or interim goals toward eliminating substance use and the provider arranges for follow-up visits. This way, the patient remains responsible for her treatment and outcome, not the provider. Given that BIs are for patients with moderate-risk substance use, closer follow-up (generally every 2 weeks) is recommended. Patients who are unable to make any behavioral change or whose

FIGURE 2
Flow chart of screening, brief intervention, and referral to treatment (SBIRT) in practice



Flow chart of screening, brief intervention, and referral to treatment (SBIRT) in practice.
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use increases during pregnancy should be referred for specialized addiction treatment. To help physicians implement SBIRT systems, the Oregon Health and Science University, with funding from SAMHSA, developed an online portal[41] that provides many excellent online resources including pocket cards and sample language that can be downloaded.

Referral to treatment

Only a minority of patients will screen into the high-risk category and require specialty treatment for substance use. These women are likely to meet criteria for having a SUD. It is not the responsibility of the obstetric provider to deliver specialty treatment, however his/her knowledge of appropriate referral resources is essential. Provision of addiction treatment in the same location as the PNC may be preferable as there is increased compliance with the behavioral health component and evidence of improved birth outcomes such as decreased rates of preterm labor and low birthweight following implementation of these services.[42] If such clinics are not available, good contacts for local specialty treatment services include state and local health departments, insurance-preferred provider listings, as well as national World Wide Web sites such as the SAMHSA treatment locator (www.findtreatment.samhsa.gov). The referral should be made via a "warm handoff," that is, via direct communication between the PNC clinic and the SUD treatment site. Communication is key for the continued care of the pregnant patient in specialty substance use treatment. All patients should sign Health Insurance Portability and Accountability Act waivers such that clinical information can be shared. The PNC provider can utilize BIs to support the SUD treatment progress during PNC, as there are some studies that show increased effect with increased dosages (better treatment outcomes with more MI sessions).[43]

Barriers to SBIRT implementation in obstetric practice

Reimbursement for the components of SBIRT exists through private insurers (*Current Procedural Terminology* codes 99408 and 99409) and Medicaid (H0049 and H0050). Payment for these codes do have relative value units assigned to them, but not all payers will pay and there may be limitations on the number of SBIRT-related visits that qualify and are approved for reimbursement. In addition, they may not be reimbursed outside of the global obstetrics reimbursement schedule. For reimbursement, screening/assessment instruments such as AUDIT and DAST should be used (SAMHSA http://www.samhsa.gov/sbirt/coding-reimbursement). Of note, SBIRT can be done by ancillary staff under the direction of the physician and added on to other E/M procedure codes. If the specific SBIRT code is not covered by insurance, generally a billable provider can use a corresponding E/M code for time-based counseling if the provider is the one providing the counseling. Generally, one would use the *International Statistical Classification of Diseases, 10th Revision* code for alcohol or specific SUD to obtain reimbursement.

Requirements of reporting pregnant women with SUD vary by state. The federal Child Abuse Prevention and Treatment Act requires states to have policies and procedures in place to notify child protective services agencies of substance-exposed newborns and to establish a plan of safe care for newborns identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.[44,45] Individual state statutes vary in what constitutes a substance-exposed newborn, when reporting should occur, and what constitutes a plan of safe care for the newborn. Specifics of each state statutes were not discussed during the expert meeting and are beyond the scope of this article, but it is imperative that physicians caring for substance-using pregnant women know

their individual state's requirements.[44] In practice, these policies, while important to ensure the safety of newborns/infants, often result in women being afraid to obtain PNC in fear that they may be reported to child welfare agencies and lose custody of their infant. Counseling patients that obtaining PNC and treatment for SUD improves their chances of maintaining custody can provide an important incentive for women to stay in treatment.

Many areas of the country, especially rural counties, lack treatment centers for SUD and especially services for women.[46] Transportation to urban areas for treatment, which often necessitates the woman being separated from her other children, represents a large barrier to treatment. Having more primary care providers certified in providing medication-assisted treatment with buprenorphine as well as expanding training in addiction medicine could help offset this treatment need, as could greater access to telemedicine and telepsychiatry.

Women who are accessing the health care system in any capacity (including treatment for SUD) should have their reproductive health care needs met at that time to help prevent substance-exposed pregnancies.[47] Substance use during pregnancy does not occur in isolation. It is often combined with a multitude of adverse life circumstances, such as poverty, interpersonal violence, psychiatric comorbidity, and lack of access to adequate health care.[48] Women often enter medical care only when they are pregnant, and thus, it is important to address contraception during PNC, so that additional pregnancies are not substance exposed. Barriers to both obtaining and using contraception that can effectively prevent pregnancy should be addressed. The postpartum period is a vulnerable time for relapse back to substance use.[49,50] Continuing access to treatment and support services beyond the traditional 6-week postpartum period can help prevent relapse.[51,52] Identifying risk factors for relapse and employing prevention techniques, such as dietary counseling, psychosocial care, and medical-assisted treatment, can improve future pregnancy outcomes.[48] These services are ideally provided in a medical home environment, as the woman and infant remain at risk for the remainder of their lives, her from relapse to her substance use disorder, which endangers not only her health, but the health and safety of her entire family. Communication between the obstetric provider and the pediatric provider is imperative so that the infant can be provided with early interventions to identify and treat medical and behavioral problems, which can be lifelong and costly if not treated early.

Comment

This article provides an overview of SBIRT for illicit drug use in the perinatal period. SBIRT is an important health intervention that should be integrated into PNC so as to reduce the burden of both undiagnosed and untreated substance use in pregnancy. Identifying women with substance use and SUD during pregnancy allows providers to identify women at risk for having a substance-exposed newborn and tailor counseling and intervention to the women at risk. Pregnancy is the ultimate teachable moment, when motivation for behavioral change is high.

There are several studies showing the efficacy for SBIRT in pregnant women especially as it relates to alcohol use and tobacco use, arguably the most harmful substances used during this period. Several studies, including randomized controlled trials examining the effect of BIs for alcohol use by Chang et al[53,54] and O'Connor and Whaley,[55] have shown that screening with and without BI can be efficacious in decreasing drinking during pregnancy and improving pregnancy outcomes. Montag et al[56,57] showed that screening with and without BI decreased alcohol-exposed pregnancies among Native American and Alaskan Native women. Recent pilot studies have looked at using computer-based screening and BI with good initial acceptability and success in terms of abstinence prevalence and healthy pregnancy outcomes.[58,59] For smoking cessation, several trials have shown the efficacy of BI during pregnancy with higher quit rates than for non-BI comparison groups.[60] Ferreira-Borges[61] showed a 33% quit rate in the MI group vs 8% in the control (non-MI) group.

In addition, a recent systematic literature review looking at the efficacy of BIs for illicit drug use in pregnancy found limited, but promising results in randomized clinical trials.[22] SBIRT programs have been shown to improve pregnancy outcomes, including the incidence of low birthweight, preterm labor, and neonatal intensive care unit admissions, as well as the number of infants exposed to maternal substance use with and without strong mechanisms for referral to specialized addiction treatment in place. The Center for Substance Abuse Prevention has now implemented >147 projects with a BI component targeting pregnant and postpartum women and their children/infants,[62] and there are now several successful models for prevention and treatment of substance use in these subpopulations (eg, AR-Cares,[63] Choices,[64] SafePort,[65] Early Start,[42] and the Mom/Kid Trial[66]). These trials have demonstrated efficacy and, in the case of Early Start[42] at least, cost-effectiveness.[67]

Limitations of SBIRT include a strong need to identify the optimal screening instrument, as well as a menu of best models and implementation strategies for addressing substance use during the perinatal period. These should rely less on busy clinicians and employ broader public health approaches to the problem. Promising techniques rely on ancillary staff and/or computer-based screening[58] paired with systematic approaches to BI and a referral to treatment system that offers continuity of care for pregnant and postpartum women.

A limitation of this article is the delay between the expert meeting and the submission of this article. One priority identified at the expert meeting in September 2012 was a systematic review of BI for illicit drug use in pregnancy. It was believed that this systematic review should occur before an article on SBIRT could be submitted, thus this article was put on hold, and in fact the systematic review of BI informed the content and development of this article. This review

was published in October 2014[22] and 2 of the authors on the review are also authors on this article (S.J.O. and A.A.C.). The authors have been in constant communication since the meeting in 2012 and have used current literature to update the recommendations developed at the meeting, thus believe that the recommendations expressed here remain valid. Additional delays between the publication of the systematic review in October 2014 and the initial submission of this article in February 2016 were due in part to the somewhat lengthy back-and-forth clearance process with both the NIH and the CDC.

Conclusion

Pregnancy is a state of individual biological and social transformation. From a public health perspective, it is a window of opportunity for addressing substance use, including SUDs, as all pregnant women manifest interest in and care for the health of their baby-to-be. Therefore, most women can be helped to quit or cut back on substance use.

Given how common substance use is as well as the evidence supporting BIs in reducing such use during the perinatal period, the expert group concluded that universal screening, ideally at PNC intake, is key to addressing substance use in pregnancy; of note, universal screening is recommended by ACOG,[5] the AAP,[23] and the AMA.[24] Screening will determine an individual's risk stratification: low-risk women should receive brief advice, those with moderate risk should receive a BI, whereas those who are high risk need referral to specialty care. Patients who are unable to make any behavioral change or whose use increases during pregnancy should be referred for specialized addiction treatment. Irrespective of risk stratification and where they are during the SBIRT process, it is imperative that pregnant and postpartum women who use $\geq$1 substances be treated with respect and compassion by their providers. ■

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

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Committee on Obstetric Practice
American Society of Addiction Medicine

The Society of Maternal–Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.

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Opioid Use and Opioid Use Disorder in Pregnancy

ABSTRACT: Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. To combat the opioid epidemic, all health care providers need to take an active role. Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Therefore, it is essential that screening be universal. Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Patients who use opioids during pregnancy represent a diverse group, and it is important to recognize and differentiate between opioid use in the context of medical care, opioid misuse, and untreated opioid use disorder. Multidisciplinary long-term follow-up should include medical, developmental, and social support. Infants born to women who used opioids during pregnancy should be monitored for neonatal abstinence syndrome by a pediatric care provider. Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
- Routine screening should rely on validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).
- For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (eg, exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments.

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- For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes. More research is needed to assess the safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal.
- Infants born to women who used opioids during pregnancy should be monitored by a pediatric care provider for neonatal abstinence syndrome, a drug withdrawal syndrome that opioid-exposed neonates may experience shortly after birth.
- Given the unique needs of pregnant women with an opioid use disorder, health care providers will need to consider modifying some elements of prenatal care (such as expanded sexually transmitted infection [STI] testing, additional ultrasound examinations to assess fetal weight if there is concern for fetal growth abnormalities, and consultations with various types of health care providers) in order to meet the clinical needs of the patient's particular situation.
- Before prescribing opioids for their patients, obstetrician–gynecologists and other health care providers should ensure that opioids are appropriately indicated; discuss the risks and benefits of opioid use and review treatment goals; and take a thorough history of substance use and review the Prescription Drug Monitoring Program to determine whether patients have received prior opioid prescriptions.
- Breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.
- Access to adequate postpartum psychosocial support services, including substance use disorder treatment and relapse prevention programs, should be made available.
- Contraceptive counseling and access to contraceptive services should be a routine part of substance use disorder treatment among women of reproductive age to minimize the risk of unplanned pregnancy.

Background

Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. In 2012, U.S. health care providers wrote more than 259 million prescriptions for opioids, twice as many as in 1998 (1). Rates of admission to substance use disorder treatment programs for misuse of prescription opioids more than quadrupled between 2002 and 2012 (2, 3), and rates of death associated with opioid analgesics rose nearly 400% between 2000 and 2014 (4). Along with the increase in misuse of prescription opioids, there has been a sharp rise in rates of heroin use. Overdose deaths that involve heroin increased more than 300% in less than 5 years, from just above 3,000 in 2010 to more than 10,500 in 2014 (5).

In 2007, 22.8% of women who were enrolled in Medicaid programs in 46 states filled an opioid prescription during pregnancy (6). In a study looking at hospital discharge diagnostic codes, antepartum maternal opioid use increased nearly fivefold from 2000 to 2009 (7). The rising prevalence of opioid use in pregnancy has led to a sharp increase in neonatal abstinence syndrome from 1.5 cases per 1,000 hospital births in 1999 to 6.0 per 1,000 hospital births in 2013, with an associated $1.5 billion in related annual hospital charges. States with the highest rates of opioid prescribing also have the highest rates of neonatal abstinence syndrome (8). In addition, maternal mortality reviews in several states have identified substance use as a major risk factor for pregnancy-associated deaths (9, 10).

Defining Opioid Use Disorder

Opioid use disorder is a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences. Opioid use disorder is a chronic, treatable disease that can be managed successfully by combining medications with behavioral therapy and recovery support (5), which enables those with opioid use disorder to regain control of their health and their lives. Short-term treatment programs aimed at abstinence are associated with high relapse rates (11) and generally do not facilitate patients' stable long-term recovery (5). This underscores the importance of availability and access to ongoing care in opioid treatment programs.

A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, as well as use resulting in social problems and a failure to fulfill obligations at work, school, or home (12). The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), replaced the terms opioid abuse and opioid dependence with the term opioid use disorder. The DSM-5 outlines 11 main symptoms of opioid use disorder and defines the severity of the disorder based on the number of recurring symptoms experienced within a 12-month period. Severity is classified as mild (two to three symptoms), moderate (four to five symptoms), and severe (six or more symptoms) (13). The abuse and dependence terminology do not correlate precisely to the new categories of mild, moderate, and severe opioid use disorder. Although this diagnostic terminology has changed, much of the prior research, recommendations, and regulatory requirements in this field rely on the

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previous terminology, such as abuse and dependence; therefore, those terms are still used when referencing those sources.

Role of the Obstetrician–Gynecologist and Other Obstetric Care Providers

Patients who use opioids during pregnancy represent a diverse group, and it is important to recognize and differentiate between opioid use in the context of medical care (for chronic pain or for addiction), opioid misuse, and untreated opioid use disorder. To combat the opioid epidemic, all health care providers need to take an active role. Appropriate prescribing of opioid medications is vitally important. Before prescribing opioids for their patients, obstetrician–gynecologists and other health care providers should do the following:

- Ensure that opioids are appropriately indicated. For women, including pregnant women, with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy. For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (eg, exercise, physical therapy, behavioral approaches) and nonopioid pharmacologic treatments.
- Discuss the risks and benefits of opioid use and review treatment goals with the patient at the outset. This discussion should include the risk of becoming physiologically dependent on opioids and, in the case of pregnant women, the possibility of an infant developing neonatal abstinence syndrome (NAS) (see Neonatal Abstinence Syndrome). However, health care providers should not hesitate to prescribe opioids based on a concern for neonatal abstinence syndrome alone.
- Take a thorough history of substance use and review the Prescription Drug Monitoring Program, currently operational in 49 states and the District of Columbia. The Prescription Drug Monitoring Program is a valuable resource to determine whether patients have received prior opioid prescriptions or other high-risk medications such as benzodiazepines, and should be consulted when patients request opioid pain medication or when opioid misuse is suspected. This resource (available at www.pdmpassist.org/content/state-profiles) can guide safe prescribing and help identify patients who suffer from opioid misuse or opioid use disorder and who would benefit from treatment. Several states now require that health care providers use Prescription Drug Monitoring Programs before prescribing certain controlled substances.
- Before initiating opioid therapy for chronic pain for reproductive-aged women, clinicians should discuss family planning and how long-term opioid use might affect care during a future pregnancy.
- Finally, a cautious approach to prescribing opioids should be balanced with the need to address pain in the pregnant woman. Pregnancy should not be a reason to avoid treating acute pain because of concern for opioid misuse or NAS.

Obstetric care providers need to be knowledgeable about the medical, social, and legal consequences that can accompany opioid use by pregnant women. Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Identifying patients with substance use disorders using validated screening tools, offering brief interventions (such as engaging a patient in a short conversation, providing feedback and advice), and referring for specialized care, as needed, are essential elements of care (14) (Box 1). Additionally, it is important to advocate for this often-marginalized group of patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women with opioid use disorder who seek prenatal care are not criminalized. Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed (15). In states that mandate reporting, policy makers, legislators, and physicians should work together to

Box 1. SBIRT: Screening, Brief Intervention, and Referral to Treatment ⇦

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use and dependence on alcohol and other substances. The SBIRT model was impelled by an Institute of Medicine (now known as the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) recommendation that called for community-based screening for health risk behaviors, including substance use.

Screening—A health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting.

Brief Intervention—A health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

Referral to Treatment—A health care professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

Data from SAMHSA-HRSA Center for Integrated Health Solutions. SBIRT: Screening, Brief Intervention, and Referral to Treatment. Available at: http://www.integration.samhsa.gov/clinical-practice/SBIRT. Retrieved March 20, 2017.

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retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions (16).

Physiology and Pharmacology of Opioid Use

Opioids diminish the intensity of pain signals and are generally prescribed for the treatment of pain, although cough and diarrhea are other indications for their use. Opioids have the additional effect of causing a sense of euphoria, which can lead to their misuse (17). Opioid use disorder may develop with repetitive use of any opioid, particularly in individuals with an underlying genetic vulnerability. Heroin is a rapidly acting opioid that may be injected, smoked, or nasally inhaled (18). Heroin has a short half-life, and to avoid opioid withdrawal symptoms, a physically dependent heroin user will need to take multiple doses daily. Prescribed opioids such as codeine, fentanyl, morphine, methadone, oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene, and buprenorphine all have the potential for misuse. These products may be swallowed, injected, nasally inhaled, smoked, chewed, or used as suppositories (19). The onset and intensity of effect will vary based on how the drug was taken and the formulation; however, all have the potential for causing respiratory depression, overdose, and death. The risk of respiratory depression, overdose, and death is greater for full opioid agonists (such as fentanyl) than for partial agonists (such as buprenorphine). Injection of opioids also carries the risk of cellulitis and abscess formation at the injection site, sepsis, endocarditis, osteomyelitis, hepatitis B, hepatitis C, and HIV infection. Sharing of snorting implements also has been identified as a risk factor for hepatitis C and other virus transmission in a group of pregnant women with hepatitis C (20).

Regular, long-term use of any opioid leads to predictable physiological dependence, which results in symptoms of withdrawal upon discontinuation of the drug. Typical symptoms of opioid withdrawal include generalized pain, muscle pain, nausea, diarrhea, sweating, rhinorrhea, tearing, dilated pupils, tremor, gooseflesh, restlessness, and anxiety. With short-acting opioids, such as heroin, withdrawal symptoms may develop within 4–6 hours of use, peak at 1–3 days, and gradually subside over a period of 5–7 days. For long-acting opioids, such as methadone, withdrawal symptoms usually begin within 24–36 hours of use and may last for several weeks. Unlike alcohol withdrawal, opioid withdrawal is rarely associated with severe morbidity and can be readily treated.

Effects of Opioid Use on Pregnancy and Pregnancy Outcome

The safety of opioids during early pregnancy has been evaluated in a number of observational studies. Earlier reports have not shown an increase in risks of birth defects after prenatal exposure to oxycodone, propoxyphene, or meperidine (21, 22). An association between first-trimester use of codeine and congenital abnormalities has been found in some studies (23–25) but not in others (26, 27). The authors of one retrospective study observed an increased risk of several birth defects with the use of prescribed opioids by women in the month before pregnancy or during the first trimester (25). Another recent observational study found a possible association between use of opioids in the first trimester and neural tube defects, although not with codeine use specifically (28). However, methodological problems with these studies exist, with potential for recall bias and confounding. The observed birth defects remain rare and represent a minute increase in absolute risk. A recent meta-analysis that compared methadone and buprenorphine found no difference between the groups with respect to congenital malformations. In addition, the incidence of anomalies reported were similar to what would be expected in the general population (29). Overall, concern about a potential small increased risk of birth defects associated with opioid agonist pharmacotherapy during pregnancy should be weighed against the clear risks associated with the ongoing misuse of opioids by a pregnant woman.

During pregnancy, chronic untreated addiction to heroin is associated with lack of prenatal care, increased risk of fetal growth restriction, abruptio placentae, fetal death, preterm labor, and intrauterine passage of meconium (30). Additionally, untreated addiction is associated with engagement in high-risk activities, such as prostitution, trading sex for drugs, and criminal activities. Such behaviors expose women to STIs, violence, and legal consequences, including loss of child custody, criminal proceedings, or incarceration.

Pregnant women with opioid use disorder often suffer from co-occurring mental health conditions, particularly depression, history of trauma, posttraumatic stress disorder, and anxiety. More than 30% of pregnant women enrolled in a substance use treatment program screened positive for moderate to severe depression, and more than 40% reported symptoms of postpartum depression (31). In addition, they are at increased risk of use of other substances, including tobacco, marijuana, and cocaine (32). These women also often suffer from poor nutrition, and many have disrupted support systems leading to social service needs. Identifying these problems during pregnancy with referral for specialized multidisciplinary care is important to achieve optimal care for these women.

Screening for Opioid Use and Opioid Use Disorder in Pregnancy

Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.

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Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome can lead to missed cases, and may add to stereotyping and stigma (33). Therefore, it is essential that screening be universal. Before pregnancy and in early pregnancy, all women should be routinely asked about their use of alcohol and drugs, including prescription opioids and other medications used for nonmedical reasons. To begin the conversation, the patient should be informed that these questions are asked of all pregnant women to ensure they receive the care they require. Maintaining a caring and nonjudgmental approach, as well as screening when the patient is alone, are important and will yield the most inclusive disclosure. Obstetric care providers should protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by laws regarding disclosure of substance use disorder (available at www.guttmacher.org/state-policy/explore/substance-abuse-during-pregnancy). Physicians should be aware that reporting mandates vary widely and should be familiar with the legal requirements within their state or community (15). Routine screening should rely on validated screening tools, such as questionnaires including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger) (Box 2) (34–36). These tools have been well studied and demonstrate high sensitivity for detecting substance use and misuse. They can be used in direct interview format by physicians as well as nonphysicians and can be streamlined into clinical practice by using computer-based approaches (33).

Urine drug testing has also been used to detect or confirm suspected substance use, but should be performed only with the patient's consent and in compliance with state laws. Pregnant women should be informed of the potential ramifications of a positive test result, including any mandatory reporting requirements (15, 16). Routine urine drug screening is controversial for several reasons. A positive drug test result is not in itself diagnostic of opioid use disorder or its severity. Urine drug testing only assesses for current or recent substance use; therefore, a negative test does not rule out sporadic substance use. Also, urine toxicology testing may not detect many substances, including synthetic opioids, some benzodiazepines, and designer drugs. False-positive test results can occur with immune-assay testing and legal consequences can be devastating to the patient and her family. Health care providers should be aware of their laboratory's test characteristics and request that confirmatory testing with mass spectrometry and liquid or gas chromatography be performed as appropriate. Some centers have implemented universal urine toxicology screening for pregnant patients, with one study finding improved rates of detection of maternal substance use compared with standard methods (37). However, this

Box 2. Clinical Screening Tools for Prenatal Substance Use and Abuse ⇦

4 Ps*

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 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.

NIDA Quick Screen†

Screen Your Patients

Step 1. Ask patient about past year drug use—the NIDA Quick Screen

Step 2. Begin the NIDA-Modified ASSIST

Step 3. Determine risk level

Conduct a Brief Intervention

Step 4. Advise, Assess, Assist and Arrange

CRAFFT—Substance Abuse Screen for Adolescents and Young Adults‡

C Have you ever ridden in a CAR driven by someone (including yourself) who 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 or 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 in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.

*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.

†National Institute on Drug Abuse. Resource guide: screening for drug use in general medical settings. Available at: https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen. Retrieved March 8, 2017.

‡Center for Adolescent Substance Abuse Research, Children's Hospital Boston. The CRAFFT screening interview. Boston (MA): CeSAR; 2009. Available at: http://www.ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf. Retrieved April 28, 2017.

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study did not use validated verbal screening tools in the comparison group, which limits the usefulness of these results. Additional research is needed to better understand the effects of universal urine screening on maternal and neonatal outcomes. For these reasons, validated verbal screening tools such as those discussed previously are the preferred method for initial screening. History-taking and verbal screening tools provide the opportunity for the prenatal care provider to offer a brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), to educate patients and use principles of motivational interviewing to bring about a desire to change high risk behaviors, when appropriate (33). More severe substance use disorders warrant a referral to specialized treatment.

Obstetric care providers should be knowledgeable about local resources for substance use treatment. Enlisting the help of social service agencies to facilitate patient referral and communicating with substance use treatment health care providers optimize patient care.

Treatment

Opioid Agonist Pharmacotherapy

Since the 1970s, opioid agonist pharmacotherapy (also referred to as medication-assisted treatment), with methadone in combination with counseling and behavioral therapy, has been the standard treatment of heroin addiction during pregnancy (30). In later years, pharmacotherapy with either methadone or buprenorphine has been used for treatment of opioid use disorder (30, 38) in pregnant women.

The rationale for opioid agonist pharmacotherapy during pregnancy is multifold. Opioid agonist pharmacotherapy prevents opioid withdrawal symptoms and is shown to prevent complications of nonmedical opioid use by reducing relapse risk and its associated consequences. It also improves adherence to prenatal care and addiction treatment programs. Opioid agonist pharmacotherapy in combination with prenatal care has been demonstrated to reduce the risk of obstetric complications (30, 39). Neonatal abstinence syndrome is an expected and treatable condition that can follow prenatal exposure to opioid agonists and requires collaboration with the pediatric care team for care of the infant.

Health care providers of addiction treatment should be familiar with the federal regulations regarding Confidentiality of Alcohol and Drug Abuse Patient Records. These regulations require specific elements (42 CFR Part 2) for written consent to disclose patient information (40). A list of local treatment programs for opioid use disorder can be found at the Substance Abuse and Mental Health Services Administration's website (http://dpt2.samhsa.gov/treatment/directory.aspx) (41).

Methadone

Methadone is dispensed on a daily basis by a registered opioid treatment program and should be part of comprehensive treatment, including addiction counseling, family therapy, nutritional education, and other medical and psychosocial services as indicated for pregnant women with opioid use disorder. Maternal methadone dosages are managed by addiction treatment specialists within registered opioid treatment programs, and communication between the obstetric team and the opioid treatment program facilitates good care. The methadone dosage may need to be adjusted throughout the pregnancy to avoid withdrawal symptoms, which include drug cravings, abdominal cramps, nausea, insomnia, irritability, and anxiety. Methadone has significant pharmacokinetic interactions with many other medications, such as antiretroviral agents, and can prolong the QTc interval in a dose-related fashion, which should be considered before new medications are introduced.

If a woman has been treated with a stable methadone dose before pregnancy, pharmacokinetic and physiologic changes that occur during pregnancy may require dose adjustments, especially in the third trimester (42). Because of metabolic changes in pregnancy, a single daily dosage may not control withdrawal symptoms over a 24-hour period. Rapid metabolism often develops during pregnancy, especially in the third trimester and in these cases, split dosages may be optimal (43). Not all women require dose increases during pregnancy, and dosage adjustments should be made on a clinical basis.

If a woman begins treatment with methadone while pregnant, her dosage should be titrated until she is asymptomatic in accordance with safe induction protocols. An inadequate maternal methadone dosage may result in mild to moderate opioid withdrawal signs and symptoms that may cause fetal stress and maternal drug cravings (43), which increase the likelihood of relapse and treatment discontinuation.

Several studies have examined the extent to which the maternal methadone dosage is related to the severity of neonatal abstinence syndrome. A systematic literature review and meta-analysis concluded that the incidence and duration of neonatal abstinence syndrome do not differ based on the maternal dosage of methadone treatment (44); therefore, attempts to minimize the methadone dose are not indicated as low doses are not consistently associated with milder or shorter NAS symptoms. Interestingly, some studies find lower rates of NAS when split dosing regimens of methadone are used (43).

In most situations, pregnant women initiate methadone induction in a licensed outpatient opioid treatment program. Some obstetric services initiate opioid agonist therapy with methadone or buprenorphine in an inpatient setting. Although this may allow closer monitoring of medication response, it is not always necessary or available. In cases when a pregnant woman initiates methadone treatment as an inpatient, an arrangement should be made before discharge for next-day admission to an opioid treatment program so that there are no missed days. Patients started on buprenorphine as an inpatient

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may receive a prescription until their appointment with a licensed buprenorphine prescriber. Identification of the ongoing buprenorphine provider and scheduling of an appointment should be done before discharge.

With the exception of buprenorphine, it is currently illegal for a physician to write a prescription for any other opioids, including methadone, for the treatment of opioid use disorder outside of a licensed opioid treatment program (where medications are dispensed) (45). Buprenorphine is the only opioid agonist currently approved for the treatment of opioid use disorder by prescription in an office-based setting (46). However, methadone and buprenorphine may be dispensed in a hospital setting by physicians without waivers. Prescribers should be familiar with federal regulations (available at www.gpo.gov/fdsys/pkg/CFR-2016-title21-vol9/xml/CFR-2016-title21-vol9-sec1306-07.xml) and state regulations regarding prescribing of medications for the treatment of opioid use disorder.

Buprenorphine

Recent evidence supports the use of buprenorphine for opioid use disorder treatment during pregnancy. Buprenorphine acts on the same mu-opioid receptors as heroin and morphine (47), but functions as a partial rather than full agonist, making overdose less likely (48). Other advantages of buprenorphine over methadone include fewer drug interactions, the ability to be treated on an outpatient basis without the need for daily visits to an opioid treatment program, and evidence of less need for dosage adjustments throughout pregnancy. In addition, several trials demonstrate evidence of less-severe neonatal abstinence syndrome (49). The disadvantages, compared with methadone, include rare reports of hepatic dysfunction, the lack of long-term data on infant and child effects, potentially more risks associated with induction because of the risk of precipitated withdrawal, and an increased risk of diversion (ie, sharing or sale) of prescribed buprenorphine (50).

Buprenorphine is available as a monoproduct or in a combined formulation with naloxone, an opioid antagonist, used to reduce diversion because buprenorphine combined with naloxone causes severe withdrawal symptoms when injected. However, naloxone is not orally active, so withdrawal symptoms do not occur when used sublingually as directed (47). The buprenorphine monoproduct has been recommended during pregnancy to avoid any potential prenatal exposure to naloxone, especially if injected (50). However, recent studies that evaluated the use of the combination product buprenorphine with naloxone found no adverse effects, and outcomes were similar when compared with buprenorphine alone (51, 52). The use of the combination product during pregnancy will likely expand as more safety data are accumulated.

The buprenorphine monoproduct has a higher potential for misuse, such as intravenous injection and diversion, and a higher street value when compared with the combination product. Thus, all patients should be monitored for the risk of diversion of their medication, especially if the monoproduct is prescribed. Unlike methadone, which may be administered only through tightly controlled programs, buprenorphine may be prescribed for the treatment of opioid use disorder by trained and U.S. Drug Enforcement Administration-approved health care providers in a medical office setting, which potentially increases the availability of treatment and decreases the stigma (47). The Substance Abuse and Mental Health Services Administration publishes a directory of health care providers registered to prescribe buprenorphine (www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator). There are currently more than 37,000 health care providers from a variety of specialties who are trained and able to prescribe buprenorphine in the United States (53).

Patients considered for treatment with buprenorphine instead of methadone need to be able to self-administer the drug safely and maintain adherence to their treatment regimen. Compared with opioid treatment programs, the less stringent structure of office-based treatment with buprenorphine may make it inappropriate for some patients who require more intensive structure and supervision (54).

If the pregnant woman is already receiving therapy with methadone, she should not transition to buprenorphine because of the significant risk of precipitated withdrawal. There is not a similar risk of withdrawal when transitioning from buprenorphine to methadone. The potential risk of unrecognized, adverse long-term outcomes with buprenorphine use, which is inherent with use of any relatively new medications during pregnancy, should always be taken into consideration. The U.S. Food and Drug Administration has recently approved a long-acting buprenorphine implant that provides low-to-moderate doses of buprenorphine for up to 6 months for treatment of opioid use disorder in patients stable on the sublingual form. To date, there are no data on the use of the implant in pregnant women.

Medically Supervised Withdrawal

For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates (55–57), ranging from 59% to more than 90% (58), and poorer outcomes. Relapse poses grave risks, including communicable disease transmission, accidental overdose because of loss of tolerance, obstetric complications, and lack of prenatal care. If a woman does not accept treatment with an opioid agonist, or treatment is unavailable, medically supervised withdrawal can be considered under the care of a physician experienced

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in perinatal addiction treatment and with informed consent; however, to be successful, it often requires prolonged inpatient care and intensive outpatient behavioral health follow up. In some areas, access to opioid agonist pharmacotherapy is limited, and efforts should be made to improve availability of local resources. Early case reports raised concern that withdrawal from opioids during pregnancy could lead to fetal stress and fetal death (59, 60). More recent studies find no clear evidence of an association between a medically supervised withdrawal and fetal death or preterm delivery, but long-term follow up data of these women are lacking (61–63), particularly in terms of relapse rates. More research is needed to assess safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal.

Naltrexone

Naltrexone is a nonselective opioid receptor antagonist that in therapeutic doses blocks the euphoric effects of opioids and has been used to help nonpregnant patients with opioid use disorder in their effort to maintain abstinence. Although the oral form demonstrates poor adherence, the more recently approved injectable long-acting form is more effective than placebo in maintaining abstinence (64). To date, information regarding its use in pregnancy is limited to small case series and case reports, with normal birth outcomes reported (58). However, significant concerns exist regarding unknown fetal effects, as well as risk of relapse and treatment dropout with subsequent return to opioid use and risk of overdose (64). Research on naltrexone treatment during gestation poses ethical and logistic challenges but is needed to inform the use of this treatment in pregnant patients. A recent survey among pregnant women enrolled in a comprehensive substance use treatment program demonstrated a strong interest in considering antagonist treatment during pregnancy (65). The decision whether or not to continue naltrexone treatment for a woman already using naltrexone before pregnancy should involve a careful discussion with the patient that compares the limited safety data versus the potential risk of relapse with treatment discontinuation.

Naloxone

Naloxone is a short-acting opioid antagonist that can rapidly reverse the effects of opioids and can be life-saving in the setting of opioid overdose. Although induced withdrawal may possibly contribute to fetal stress, naloxone should be used in pregnant women in the case of maternal overdose in order to save the woman's life.

Naloxone can be administered intravenously or subcutaneously by health care or emergency medical professionals. Additionally, an autoinjectable form and prepackaged nasal spray can be administered by family members or other bystanders when overdose is suspected (66). Patients at risk of overdose, such as those with long-term use or high doses of opioids, may benefit from having a naloxone kit available at all times. Many states authorize prescribing naloxone to a third party, such as a family member or caregiver, who may be able to assist in an overdose (www.drugabuse.gov/related-topics/naloxone; www.prescribetoprevent.org).

Antepartum, Intrapartum, and Postpartum Care

Antepartum Care

Elements of prenatal care for women with opioid use or use disorder will depend on each patient's situation and comorbid conditions. Several issues to consider include the following:

- Testing for STIs and other infectious agents such as HIV, hepatitis B and C, chlamydial infection, gonorrhea, syphilis, and tuberculosis should be considered. Repeat testing in the third trimester may be indicated if the woman is considered at increased risk. Hepatitis B vaccination is recommended for pregnant women who are HBsAg negative but at high risk of hepatitis B infection.
- Screening for depression and other behavioral health conditions should be conducted.
- In addition to an ultrasound examination for fetal assessment in mid-second trimester, consideration should be given to first-trimester ultrasonography for best determination of the estimated due date and an interval ultrasonographic assessment of fetal weight later in pregnancy if there is concern for fetal growth abnormalities.
- Consultations with anesthesia, addiction medicine specialists, pain management specialists, pediatrics, maternal–fetal medicine, behavioral health, nutrition, and social services should be conducted as needed.
- Because breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications (see Postpartum Care), obstetrician–gynecologists and other obstetric care providers should provide anticipatory breastfeeding guidance during the antepartum period (67).
- Close communication between the obstetric care provider and pediatric team before delivery is necessary for optimal management of the neonate. Neonatal consultation, if available, can be considered prenatally to discuss postdelivery care of the infant.
- Use of other substances, particularly tobacco use, is common in women with opioid use disorder. Screening for and discussion about this and other substances is important, and cessation services should be offered.

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Intrapartum Care

Women taking methadone or buprenorphine who are in labor should have their maintenance opioid agonist dose continued and should receive additional pain relief (68, 69). Epidural or spinal anesthesia should be offered, when appropriate, for management of pain in labor or for delivery. Opioid agonist–antagonist drugs such as butorphanol, nalbuphine, and pentazocine should be avoided because they can precipitate acute withdrawal in patients taking an opioid agonist. Some patients who are physiologically dependent on opioids may not disclose their substance use and health care providers may, therefore, not be aware of their opioid use. Because of this, some units have opted to remove these medications from their formularies because of inadvertent precipitation of withdrawal. Buprenorphine should not be administered to a patient who takes methadone. Pediatric staff should be notified of all infants exposed to opioids to ensure appropriate screening for neonatal abstinence syndrome.

In general, patients taking methadone or buprenorphine will require higher doses of opioids to achieve analgesia than other patients because they are tolerant to their maintenance treatment dose. One study showed that after cesarean delivery, women who took buprenorphine required 47% more opioid analgesic than women who did not take buprenorphine, but adequate pain relief was achieved with short-acting opioids and antiinflammatory medication (70). Injectable nonsteroidal antiinflammatory agents, such as ketorolac, also are highly effective in postpartum and postcesarean delivery pain control. Daily doses of methadone or buprenorphine should be maintained during a woman's labor and postpartum hospital stay to prevent withdrawal, and patients should be advised of this plan in advance in order to reduce anxiety. Dividing the usual daily treatment dose of buprenorphine or methadone into three or four doses every 6–8 hours may provide partial pain relief; however, additional analgesia will be required (68). The pain management of intrapartum and postpartum patients on opioid agonist therapies can be challenging because of their increased drug tolerance and hypersensitivity to pain. When resources are available, a consultation with an anesthesiologist can be beneficial in pregnant women with substance use disorder or chronic opioid use to formulate a pain management plan tailored to the individual patient. A multimodal pain control approach with neuraxial analgesia and nonsteroidal antiinflammatory drugs and acetaminophen typically is needed to provide effective intrapartum and postpartum pain relief (69, 71).

Postpartum Care

Breastfeeding is beneficial in women taking methadone or buprenorphine and has been associated with decreased severity of neonatal abstinence syndrome symptoms, less need for pharmacotherapy, and a shorter hospital stay for the infant (72). In addition, breastfeeding contributes to attachment between a woman and her infant, facilitates skin-to-skin care, and provides immunity to the infant. Breastfeeding should be encouraged in women who are stable on their opioid agonist, who are not using illicit drugs, and who have no other contraindications, such as HIV infection (73, 74). Women should be counseled about the need to suspend breastfeeding in the event of a relapse. The American Academy of Pediatrics recommends breastfeeding for women taking methadone and buprenorphine regardless of maternal dose, as transfer of these medications into breast milk is minimal (75). In nursing women, the ultra-rapid conversion of codeine to morphine can result in high and unsafe levels of morphine in blood and breast milk. The U.S. Food and Drug Administration has strengthened the label warning to state that breastfeeding is not recommended while using medicines containing codeine or tramadol because of the potential for serious adverse effects in the infant due to opioid overdose (76). However, if a codeine-containing medication is considered the preferred choice, the risk and benefits of this drug and the reasoning behind the FDA warning should be discussed with each family.

Although most pregnant women who take methadone will experience dosage increases during pregnancy, and a need for dosage reduction might be expected postpartum, one study demonstrated little need for immediate postpartum methadone dosage reduction (77). Significant dose reductions postpartum should not be done routinely but should be titrated to signs and symptoms of sedation, particularly at the peak of the dose (2–6 hours). Most women taking buprenorphine will not experience large dosage adjustments during their pregnancies and most may continue the same dosages after delivery (77). Other medications that can produce sedation (eg, benzodiazepines, zolpidem, antihistamines) should be used with caution, as they may add to the risk of maternal respiratory depression (78).

Women with substance use disorder should continue their opioid agonist pharmacotherapy postpartum. The postpartum period represents a time of increased vulnerabilities, and women with opioid use disorder relapse far more often in the postpartum period compared with during pregnancy (79). Triggers for relapse may include loss of insurance and access to treatment, demands of caring for the new baby, sleep deprivation, and threat of loss of child custody. Psychiatric disorders such as depression, anxiety, bipolar disorder, and posttraumatic stress disorder are prevalent among women with opioid use disorder. Screening for postpartum depression should be routine, and assessing for other comorbid mental health conditions should be considered if there is a prior history or if concern exists (78, 80). Substance use and overdose are increasingly found to be major contributing factors to pregnancy-associated deaths in the United States (9, 10). Access to adequate postpartum psychosocial support services, including substance use disorder treatment and relapse prevention programs, should be

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made available (81). In addition, postpartum women with opioid use disorder should receive overdose training and preferably, coprescribing of naloxone for overdose prevention (82).

Unintended pregnancy rates among women with substance use disorders are approximately 80%, considerably higher than in the general population. Use of reliable contraception is also lower among this group of women when compared with a nondrug-using comparison population (83). Therefore, discussion of a full range of contraceptive options should begin prenatally with these patients. In particular, obstetric care providers should counsel women about the option of immediate postpartum long-acting reversible contraception, which has few contraindications and is highly effective and convenient (84).

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome is a drug withdrawal syndrome that may result from chronic maternal opioid use during pregnancy and is an expected and treatable condition seen in 30–80% of infants born to women taking opioid agonist therapies (43, 85). Neonatal abstinence syndrome is characterized by disturbances in gastrointestinal, autonomic, and central nervous systems, leading to a range of symptoms including irritability, high-pitched cry, poor sleep, and uncoordinated sucking reflexes that lead to poor feeding. In infants exposed to methadone, symptoms of withdrawal may begin anytime in the first 2 weeks of life, but usually appear within 72 hours of birth and may last several days to weeks (30). Infants exposed to buprenorphine who develop neonatal abstinence syndrome generally develop symptoms within 12–48 hours of birth that peak at 72–96 hours and resolve by 7 days (50). Recent evidence indicates that other substances such as nicotine, selective serotonin reuptake inhibitors, and benzodiazepines may increase the incidence and severity of neonatal abstinence syndrome (72). Use of validated screening assessments such as the Finnegan Scale to diagnose neonatal abstinence syndrome and protocols that standardize treatment using methadone or morphine have been associated with improved outcomes for these infants (72). Each nursery should develop an evidence-based written policy to assess and treat an infant with neonatal abstinence syndrome, and women should be informed of key components of these policies (eg, any delayed discharge of the infant or reporting requirements). Families should be encouraged to visit and care for their infants and women should be supported in their effort to breast feed their infants, if appropriate. Several perinatal collaborative quality initiatives have developed valuable resources for health care providers and patients to optimize the diagnosis and treatment of neonatal abstinence syndrome and promote collaboration between obstetric and neonatal care providers (www.opqc.net/patients-providers/%20NAS; https://public.vtoxford.org/quality-education/nas-universal-training-program/) (86).

Long-Term Infant Outcome

Long-term outcomes of infants with in utero opioid exposure have been evaluated in several observational studies. A major challenge in assessing these outcomes is isolating the effects of opioid agonists from other confounding factors such as use of other substances (tobacco, alcohol, nonmedical drugs) and exposure to environmental and other medical risk factors (eg, low socioeconomic status, poor prenatal care) (87). For the most part, studies have not found significant differences in cognitive development between children up to 5 years of age exposed to methadone in utero and control groups matched for age, race, and socioeconomic status, although scores were often lower in both groups compared with population data (88). Preventive interventions that focus on supporting the woman and other caregivers in the early and ongoing parenting years, enriching the early experiences of children and improving the quality of the home environment are likely to be beneficial (89).

Conclusion

Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes. Contraceptive counseling and access to contraceptive services should be a routine part of substance use disorder treatment among women of reproductive age to minimize the risk of unplanned pregnancy. Pregnancy in women with opioid use disorder should be co-managed by the obstetric care provider and a health care provider with addiction medicine expertise, and appropriate 42 CFR Part 2-compliant consent for release of information should be obtained from the patient to allow exchange of information between the health care providers. Given the unique needs of pregnant women with an opioid use disorder, health care providers will need to consider modifying some elements of prenatal care (such as expanded STI testing, additional ultrasound examinations to assess fetal weight if there is concern for fetal growth abnormalities, and consultations with various types of health care providers) in order to meet the clinical needs of the patient's particular situation. Continuity of care, including ensuring consistent daily dosing of buprenorphine or methadone, is critical to success. For women, including pregnant women, with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with higher relapse rates, which lead to worse outcomes. More research is needed to assess the safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal. Infants born to women who used opioids during pregnancy should be monitored by a pediatric care provider for neonatal abstinence syndrome. Multidisciplinary long-term follow-up should

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include medical, developmental, and social support. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families. Obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/OpioidUseinPregnancy.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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Evidence Synthesis

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SCREENING IN PRIMARY CARE SETTINGS FOR ILLICIT DRUG USE: ASSESSMENT OF SCREENING INSTRUMENTS — A SUPPLEMENTAL EVIDENCE UPDATE FOR THE U.S. PREVENTIVE SERVICES TASK FORCE

U.S. Department of Health and Human Services

Agency for Healthcare Research and Quality

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Screening in Primary Care Settings for Illicit Drug Use: Assessment of Screening Instruments — A Supplemental Evidence Update for the U.S. Preventive Services Task Force

Introduction

Two approaches have been proposed for identifying illicit drug use and drug abuse among patients seen in routine clinical encounters: toxicologic tests of blood or urine, and standardized screening questionnaires. This report focuses only on the second approach. While toxicologic testing can provide objective evidence of drug use, false-positive results due to cross-reactions, contamination, or mislabeled specimens are always possible. More importantly, these tests do not distinguish between occasional users and individuals who are dependent on or otherwise impaired by drug use.

At the time the USPSTF last examined the use of standardized screening questionnaires for detecting potential drug problems among patients, few screening instruments had been developed specifically for that purpose, and none had been validated in prospective studies. Since 1996, a diverse group of questionnaires for detecting drug misuse has become available. Most of these are modifications of validated alcohol screening instruments. Some were developed for self-administration by patients; others are screening tools for clinicians or clinical practice staff to administer and score; still others are simply a list of questions intended to guide clinician interviews. The instruments vary significantly in length and in the amount of time required to complete them. A number of the questionnaires have yet to be examined for accuracy, reliability, and clinical utility.

To be of benefit in primary care settings, a standardized screening instrument must not only be accurate and reliable in detecting patients with a potential problem: it must also be short and easy to administer so that an undue burden is not placed on the patient or practice staff when it is applied in the busy practice setting. The goals of this review were (1) to identify standardized instruments described in the medical literature that have been designed for detecting use/abuse of illicit drugs; (2) to select those instruments reasonably short enough to have the potential for routine use in a busy primary care practice setting; (3) to determine the extent of published evidence about the accuracy (sensitivity and specificity) and the reliability of potentially useful instruments, and rate the quality of that evidence; and (4) to determine the extent to which validated instruments have been assessed for feasibility and utility when applied in primary care practice settings and among various patient populations.

Methods

We undertook a systematic review of documents identified as of August 2006, from a number of databases. We aimed to identify appropriate, validated screening instruments for the detection of drug misuse among asymptomatic patients seen in ambulatory general medical settings.

We first searched the Substance Abuse Screening and Assessment Instruments database (http://adai.washington.edu/instruments) maintained by the University of Washington's Alcohol and Drug Abuse Institute. This regularly updated, comprehensive database contains information on more than 310 questionnaires and interviews that have been offered for detecting or assessing patients with alcohol and/or drug problems. Information on each questionnaire in the database was examined and questionnaires were eliminated from further consideration using the following exclusion criteria:

(1) Instrument is designed to detect misuse of alcohol only, or of a single drug.
(2) Instrument is designed primarily for diagnostic purposes or for assessment of those already known to have a substance abuse problem.
(3) Instrument is not available to the public (not yet published, or subject to a fee for reproduction or downloading)
(4) Instrument requires specific training to administer or to score/interpret results.
(5) Instrument contains more than 20 items or takes more than 5 minutes to administer and score.

Using the title or acronym of each remaining questionnaire (i.e., those not excluded using the above criteria), we conducted searches of Ovid Medline and PsychINFO, for the period from 1980 through August 2006, for published evidence in English of the instrument's validity, reliability, and clinical utility. Abstracts of identified articles were screened and rejected if they met the following exclusion criteria:

(1) Not a study of the specified screening instrument
(2) Editorial, letter, or other opinion piece
(3) Study conducted using only a non-English version of the instrument
(4) Study that examined use of the instrument for a purpose other than screening

Full text articles of non-excluded studies were then examined and critically appraised. When available, the following data were extracted from each study:

(1) Type of patient population
(2) Sample size
(3) Reference standard used
(4) Sensitivity
(5) Specificity
(6) Positive predictive value
(7) Negative predictive value
(8) Internal consistency (alpha score)
(9) Test-retest coefficients (kappa values)

We also noted if the instrument measured recent use or lifetime use, and if it had been evaluated for feasibility and/or clinical utility. We asked if assessment studies were conducted in primary care practice settings.

Studies were rated using previously published USPSTF grading scales. Studies were considered of good quality if they used a credible reference standard, interpreted the reference standard independently of the questionnaire, and included more than 100 patients with and without a drug use problem, some of whom were from a general clinic population.

Studies were considered of fair quality if they used a reasonable, although not the best possible, reference standard, interpreted the reference standard independently of the questionnaire, and included a sample size of 50-100.

Studies were considered of poor quality if an inappropriate reference standard was used, there was a potentially biased ascertainment of the reference standard, or the study included a small (<50) sample size.

Results

After our exclusion criteria were applied to all instruments described in the SASAI database, we were left with nine instruments potentially useful for screening for drug misuse in primary care practice settings:

- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST);
- Cut down, Annoyed, Guilty, Eye-opener – Adapted to Include Drugs (CAGE-AID);
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT);
- Drug Abuse Screening Test (DAST);
- Drug Use Disorders Identification Test (DUDIT);
- Relax, Alone, Forget, Friends, Trouble (RAFFT);
- Reduce, Annoyed, Guilty, Start (RAGS);
- Rapid Drug Problems Screen (RDPS),
- Simple Screening Instrument for Substance Abuse (SSI-SA).

The abstracts of a total of 340 articles, identified from literature searches conducted for each of the nine instruments, were reviewed for relevance using the screening criteria noted above. Of these, 37 citations were selected for review of full-text articles. Most of the excluded abstracts were not studies of the specified screening instrument (e.g., the instrument shared its acronym with some other entity). After full-text articles were reviewed, 16 studies were ultimately included that addressed the validity, reliability or clinical utility of the screening instrument. Of these, 2 evaluated ASSIST, 3 evaluated CAGE-AID, 4 evaluated CRAFFT, 4 evaluated DAST, 2 evaluated RAFFT, and 1 evaluated SSI-SA. No studies reporting on assessments of DUDIT, RAGS or RDPS met our criteria for inclusion.

Table 1 provides descriptive information about the length, focus, and method of administering the six screening instruments for which published evaluative studies were identified. The instruments ranged in length from the 4-item CAGE-AID to the 28-item DAST. The DAST was retained for further review based on evidence that a shorter (20-item) version of the instrument has comparable psychometric properties.

The results of 16 studies of the accuracy and reliability of the six instruments are presented in **Table 2**. The sensitivities, specificities, and positive and negative predictive values reported are those noted using the cutoff score for a positive screen recommended by the developers of the instrument. A range of sensitivities and specificities has been noted if no specific score for a positive screen was established for the instrument.

There was fair evidence of accuracy and good evidence of reliability of ASSIST; good evidence of accuracy and fair evidence of reliability of CAGE-AID; good evidence of both the accuracy and reliability of CRAFFT; and fair evidence of both the accuracy and reliability of DAST. No published studies were identified assessing the accuracy of the SSI-SA or the reliability of the RAFFT.

No published study reported on the feasibility or usefulness of any of the instruments when applied in the primary care clinical setting. There was also no evidence on the clinical utility of any instrument in screening pregnant women for drug use or misuse.

Discussion

While a fair amount of work has been completed since 1996 on the development and assessment of standardized instruments for screening for drug use and misuse, several studies were considered to be of only fair quality, due to small patient sample size or the failure to include within the sample patients from a general clinic or practice population. A few studies focusing on the accuracy (sensitivity and specificity) of an instrument were considered of only fair quality since they used some other validated instrument (e.g., POSIT) as their reference standard rather than a structured diagnostic interview.

This review was limited to questionnaires considered brief enough to be potentially useful for screening for drug use/misuse in the primary care setting. Toward this end, we set an arbitrary upper limit of 20 items and/or 5 minutes for administration/scoring of the instrument. When assessed, the Drug Abuse Screening Test (DAST), the longest of the instruments considered in this review, was shown to be an accurate and reliable test. The sensitivity and/or specificity of instruments consisting of six or fewer items were lower, though still acceptable. Further testing is needed to determine the optimal tradeoff between questionnaire length and accuracy/reliability of the instrument.

It has yet to be shown how well some of these instruments perform in screening large populations of patients in general medical clinics or practices, where a lower prevalence of drug misuse problems can be expected. For the CAGE-AID, CRAFFT, DAST and RAFFT, more than one published study provided calculations of the instrument's predictive value. Negative predictive values of greater than 90% were noted consistently for each instrument except the RAFFT, which had a NPV of 51-87%. However, more than two-fold variations in positive predictive value were noted between studies of the CAGE-AID, CRAFFT and DAST. Studies reporting the lower PPVs (<30%) were typically conducted among more general, non-selected patient populations in which a

lower prevalence of drug problems can be expected. The positive and negative predictive values of ASSIST were not reported in published studies assessing this test.

The greatest gap in the evidence noticed in this review was the lack of studies that shed light on the feasibility and usefulness of applying screening instruments within a busy practice. Debriefing interviews conducted at the end of the initial testing of ASSIST (1) measured clarity, ease of use, and potential response bias, but the clinical utility of this or other instruments in an actual practice setting has yet to be assessed. In addition to data on rates of offering and completing the screens, qualitative data are needed on the acceptability of the additional burden placed on patients, clinicians, and staff when the test is used routinely in practice.

Conclusion

There is fair evidence that standardized questionnaires considered short enough to be potentially useful in the practice setting have acceptable accuracy and reliability in screening for drug use/misuse. One instrument (the CRAFFT) has been adequately validated for screening adolescents for drug use/misuse. Three instruments of various lengths (ASSIST, CAGE-AID, and DAST-20) have been validated for screening adults. The evidence is not sufficient, however, to establish the positive predictive value of these tests when used in a general medical patient population with a predictably lower prevalence of drug use/misuse. The available evidence does not permit one to determine the overall clinical utility of these instruments when applied in a busy primary care practice setting, and especially in screening pregnant women for drug use.

Table 1: Questionnaire Instruments Evaluated for Drug Misuse Screening

Instrument	#items/ Time required	Target population	Measures recent or lifetime use?	Administered by patient or clinician?
ASSIST	8 items	Adults	Recent and lifetime	Clinician
CAGE-AID	4 items	Adults	Lifetime	Clinician
CRAFFT	6 items	Adolescents	Lifetime	Patient
DAST	28/20 items/* 5 minutes	Adults	Lifetime	Patient
RAFFT	5 items	Adults or adolescents	Lifetime	Patient
SSI-SA	16 items	Adults or Adolescents	Lifetime	Clinician or patient

* The 20-item version of DAST was found to have psychometric properties comparable with the original 28-item version.

Table 2: Results of Studies Assessing Questionnaires for Drug Misuse Screening

Instrument/ Author (Reference #)	Study Population	Sample Size	Reference Standard	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Internal Consistency (alpha)	Test-Retest (kappa)
ASSIST WHO (1)	60% in drug Rx 40% from gen'l med facility	236						0.85-0.91	0.58-0.90
ASSIST Newcombe (2)	Primary care, Drug treatment	150	Other instrument	90%	78%	Not reported	Not Reported		
CAGE-AID Brown (3)	Academic Community FP	124	Diagnostic Interview	79%	77%	78%	78%		
CAGE-AID Hinkin (4)	Elderly abusers & non-abusers	976	Clinical Interview	81-92%	48-72%	12-18%	98-99%		
CAGE-AID Leonardson(5)	Am Indians at Diabetic clinic	50						0.92	
CRAFFT Knight (6)	Adolescents with known drug use	99	Personal Experience Inventory	92%	82%	Not reported	Not Reported	0.79	
CRAFFT Knight (7)	Adolescent Clinic	538	Structured diagnostic interview	76%	94%	83%	91%	0.68	

Instrument/ Author (Reference #)	Study Population	Sample Size	Reference Standard	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Internal Consistency (alpha)	Test-Retest (kappa)
CRAFFT Cummins (8)	Am-Indian adolescents in clinics/schools	70	Structured interview (CASI-A)	86%	76%	29%	98%	0.81	
CRAFFT Levy (9)	Adolescent clinic	93							0.71-0.86
DAST Skinner (10)	Drug/alcohol Abuse clients	256						0.92	
DAST Staley (11)	Psychiatric Patients	250	Diagnostic Interview	82-96%	81-91%	63-75%	94-98%	0.92	
DAST El-Bassel (12)	Adult workers	176						0.92	0.70
DAST McCann (13)	Adults evaluated for ADHD	143	Diagnostic Interview	85%	71%	23%	98%	0.92	
RAFFT Bastiaens (14)	Adolescents in ER with psych problem	226	Diagnostic Interview	89%	69%	73%	87%		
RAFFT Bastiaens (15)	Adults seen in psych ER	215	Neuropsych Interview	84%	67%	91%	51%		
SSI-SA Knight (16)	Adolescent Clinic	173						0.83	0.9

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Substance Use and Depression in Home Visiting Clients: Home Visitor Perspectives on Addressing Clients' Needs

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The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) under the Affordable Care Act has significantly expanded evidence-based home visiting services for pregnant women and new mothers at risk for child maltreatment (Health Resources and Services Administration, 2015). Home visiting (HV) is the most widely used child maltreatment prevention strategy across the country, and typical models provide high-risk parents with education about child development and effective parenting, as well as linkages to childcare, medical, and early intervention services (Azzi-Lessing, 2013). In line with their primary goal of child maltreatment prevention, most HV programs target pregnant women and new mothers with significant behavioral health risks known to be associated with impaired parenting such as substance use and mental health problems. However, the HV workforce is comprised of a wide range of professional and educational backgrounds, with many programs staffed largely by paraprofessionals who lack the necessary clinical training and skills to address challenging behavioral health risks (Paulsell, Del Grosso, & Supplee, 2014). While this discrepancy between client need and workforce qualification has long been recognized, the MIECHV legislation provided new impetus for action to address this mismatch by requiring state HV systems to demonstrate improvement on benchmark outcomes related specifically to maternal mental health (U.S. Department of Health and Human Services, 2014). Consequently, initiatives to bolster HV capacity to address maternal behavioral health have begun to emerge within HV networks.

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Much of the work to date in this area has focused on maternal depression (MD), and has included mandated depression screening within HV, providing mental health consultation to home visitors, and integrating mental health treatment into home visits (Ammerman, Putnam, Teeters, & van Ginkel, 2014; Le, Perry, Mendelson, Tandon, & Munoz, 2015; Price, Gray, & Thacker, 2015; Rowan, Duckett, & Wang, 2015; Segre, O'Hara, Brock, & Taylor, 2012; Segre, Stasik, O'Hara, & Arndt, 2010; Tandon, Leis, Mendelson, Perry, & Kemp, 2014; Yonkers et al., 2009). In contrast, maternal substance use (SU) has received comparatively little attention within HV behavioral health initiatives, and is often an exclusion criterion from studies examining the impact of depression interventions (e.g., (Ammerman et al., 2011; Segre et al., 2010)). Maternal SU is a significant risk factor for child maltreatment (Dubowitz et al., 2011), is often co-morbid with depression (Connelly, Hazen, Baker-Ericzen, Landsverk, & McCue Horwitz, 2013), and is prevalent among pregnant and parenting women (Substance Abuse and Mental Health Services Administration, 2014), the population served by HV programs. Expansion of existing behavioral health initiatives within HV to include SU is sorely needed. In order to inform the development of an enhancement to HV aimed at addressing both SU and MD, the current study presents the results of a survey that asked home visitors to report on their current practices, knowledge and perceived self-efficacy, perceived barriers, and training needs regarding SU and MD in their clients. This research emanates from one state network's interest in advancing its practice in addressing maternal behavioral health within HV, and is aligned with the national HV research priorities of supporting the development of a competent workforce and strengthening HV effectiveness (Home Visiting Research Network, 2013).

Importance of Expanding HV Capacity to Address Maternal Substance Use

Expanding HV capacity to address maternal SU in addition to depression is important for several reasons. First, SU is prevalent among mothers served by HV programs and is associated with increased risk for negative outcomes. According to the latest report from the MIECHV national evaluation, nearly 40% of HV clients reported binge drinking or using illegal drugs in the three months prior to program entry (Michalopoulos et al., 2015). Maternal SU during pregnancy and in the early childhood years is associated with increased risk for child maltreatment as well as a host of negative child developmental outcomes (Dubowitz et al., 2011; Institute of Medicine & National Research Council, 2014). Moreover, substance using mothers are at high risk for losing their children to the child protective system (Berger, Slack, Waldfogel, & Bruch, 2010). Home visitors are present in the home during the critical early months, and, with proper training and support, have the potential to identify and address SU and associated problems early, prior to negative impacts on parenting and child outcomes. Second, the presence of client behavioral health risks such as SU has been associated with more difficult engagement in HV and attenuated program impacts (Azzi-Lessing, 2013; Green, Tarte, Harrison, Nygren, & Sanders, 2014). Equipping home visitors with strategies to enhance engagement for high-risk substance using families as well as to assist them in accessing needed treatment could improve outcomes for these families.

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Finally, the few studies that have directly assessed home visitor perceptions of their ability to manage client behavioral health risks have found that home visitors feel that they are lacking in important training and practical skills in this area. For example, one study found that home visitors' ability to recognize mental health and SU problems in their clients was generally below 50%, based on a comparison of home visitor records with positive screen data (Duggan et al., 2004). Rates of referral for services were similarly low (Duggan et al., 2007; Jones-Harden, Denmark, & Saul, 2010; Tandon, Parillo, Jenkins, & Duggan, 2005), with one study finding no service linkages for SU, and a linkage rate of only 2% for mental health (Duggan et al., 2004). In a study asking home visitors to report on difficult situations encountered in HV, inability to connect families with needed mental health services and addressing SU were rated as among the most difficult (LeCroy & Whitaker, 2005). Across studies, home visitors reported feeling generally ill-equipped to effectively address these issues with clients (Eddy et al., 2008; Jones-Harden et al., 2010; LeCroy & Whitaker, 2005; Tandon et al., 2005), and required more training and supervision targeted specifically at addressing client behavioral health risks (Tandon, Mercer, Saylor, & Duggan, 2008; Zeanah, Larrieu, Boris, & Nagle, 2006).

Beginning to Address the Need: Existing Behavioral Health Initiatives within HV

It has been suggested for more than a decade that HV programs shift their focus to more directly target maternal behavioral health risk factors for child maltreatment (Chaffin, 2004; Duggan et al., 2004), and there is a growing body of literature documenting attempts to do so (Ammerman et al., 2011; Boris et al., 2006; Chamberlain, 2008; Eddy et al., 2008; Gray & Price, 2014; Segre et al., 2010; Tandon et al., 2014). Nearly all of the attempts to date have focused on MD, and have included teaming paraprofessional home visitors with mental health consultants (Boris et al., 2006), integrating evidence-based mental health interventions, such as cognitive behavioral therapy and interpersonal therapy, into home visits (Ammerman et al., 2014; Gray & Price, 2014; Tandon et al., 2014), and training home visitors to implement brief behavioral health interventions (Segre et al., 2010). Accumulating results from these initiatives have been largely positive, suggesting that enhancing HV with research-supported mental health interventions can be effective in reducing client symptoms of depression (Ammerman et al., 2013; Segre, Brock, & O'Hara, 2015; Tandon et al., 2014). It is yet unknown whether similar impacts could be achieved by integrating interventions targeted at SU into HV programs.

To inform efforts to develop interventions targeting SU within HV, more systematic and comprehensive data are needed on the degree to which paraprofessional home visitors currently address SU in their clients that includes knowledge, current practices, training, and barriers to fully addressing client SU concerns. While several studies have surveyed home visitors on their perceived ability to address client behavioral health risks (e.g.,(Duggan et al., 2004; LeCroy & Whitaker, 2005; Tandon et al., 2008; Tandon et al., 2005)), these studies have generally not focused on SU specifically as distinct from mental health. With a couple of notable exceptions (Duggan et al., 2004; Tandon et al., 2005), studies conducted to date have grouped mental health and SU together into a single category of risk factors for child

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maltreatment. Additionally, these studies were all conducted prior to the MIECHV legislation and its accompanying emphasis on addressing maternal behavioral health, particularly depression, within HV. Finally, these studies did not assess barriers at both the system-level and client-level that may prevent home visitors from being able to adequately address behavioral health concerns in their clients. Potential systemic barriers that have been shown to prevent access to treatment among pregnant and parenting women include lack of available treatment options, long waiting lists, lack of transportation and childcare, and insurance or other payment difficulties (Green, Rockhill, & Furrer, 2006; Rosen, Tolman, & Warner, 2004). Barriers at the client-level may include stigma, fear of losing custody of their children, fear of confidentiality violation, and prior negative experiences with treatment (Abrams, Dornig, & Curran, 2009; Leis, Mendelson, Perry, & Tandon, 2011; O'Mahen & Flynn, 2008). The current study provides more recent data from home visitors in a single state who reported on their current practices regarding addressing SU and MD in their clients, including screening, referral for treatment, and assisting clients in overcoming common barriers to treatment attendance. Home visitors also reported on their knowledge, perceived self-efficacy, training, and barriers at both the system and client levels regarding addressing client SU and MD. Examination of potential differences in the extent to which home visitors address SU compared to MD across these distinct domains, as well as what may predict these differences, can help inform the development of strategies for supporting HV programs to better address client SU.

Study Goals and Hypotheses

The study goals were (1) to compare the self-reported current practices of home visitors regarding SU and MD in their clients, and (2) to examine the degree to which differences in home visitor current practices regarding SU and MD can be explained by home visitor education, years of experience, prior training, self-reported knowledge of and perceived self-efficacy with the risk area, and home visitor perceptions of barriers at both the system and client levels. Given the recent national focus on enhancing HV to address MD, we hypothesized that home visitors would report more extensive management of MD compared to SU, as defined by their current practices. We also hypothesized that home visitor current practices in both risk areas would be predicted by more education, experience, and training, greater knowledge and perceived self-efficacy with the risk area, and lower perceived system-level and client-level barriers.

Method

This study was reviewed by the governing Institutional Review Board (IRB) and was determined to be exempt from IRB oversight, as it reports on anonymous survey data.

Participants

Study participants included 159 home visitors from the Healthy Families America (HFA; N = 104) or Parents as Teachers (PAT; N = 54) programs in a single northeastern state. Both HFA and PAT are included in the MIECHV list of evidence-based HV models (U.S. Department of Health and Human Services, 2014), and are widely implemented across the country (Donelan-McCall, Eckenrode, & Olds, 2009; Harding, Galano, Martin, Huntington,

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& Schellenbach, 2007; Zigler, Pfannenstiel, & Seitz, 2008). Home visitors were recruited for participation in an anonymous survey at a mandatory state-wide HV networking meeting (October, 2013) hosted by the umbrella agency responsible for providing training and technical assistance to the state's HV programs. Survey participation was offered to all home visitors attending the meeting and 159 home visitors completed the survey on paper at the networking meeting, representing approximately 85% of the total number of HFA and PAT home visitors in the state at that time.

The study sample was 96% female, 20% White, 22% African American, 50% Latino/a, 3% Multiracial, and 4% of other racial/ethnic background. Education level of home visitors included high school or GED (12%), some college (33%), college graduate (42%), some post-college education (6%) or graduate degree (8%). Home visitors were 36 years old on average (SD = 11.9; Range 20 to 76 years), with an average of 4.25 years of experience as home visitors (SD = 4.30), and 3.25 years working for their current program (SD = 3.58).

Study Measure: Home Visitor Survey

Adaptation of home visitor survey. The survey used in this study is an adapted version of a survey developed in a prior study to assess the management of maternal depression among primary care physicians (Leiferman, Dauber, Heisler, & Paulson, 2008; Leiferman, Dauber, Scott, Heisler, & Paulson, 2010). The conceptual model underlying the physician survey, grounded in the Health Belief and Social Ecological models, posited that the likelihood that physicians will address MD in their practice is impacted by their prior knowledge and training, level of self-efficacy (including confidence and comfort level with the topic), and barriers at the individual and system levels. The physician survey was administered to 217 primary care physicians and exploratory factor analysis was conducted, trimming items until adequate fit was achieved. The final structural model for the physician survey, described in Leiferman and colleagues (Leiferman et al., 2010), demonstrated good fit: (χ^2 (71) = 122.006, CFI = .959, TLI = .941, RMSEA = .058). Though the individual and system-level barriers scales were not retained in the final model for the physician survey due to lack of statistical significance in predicting physician practice, we felt it was important to include them in the current study analyses given the different service context being assessed (home visiting vs. primary care) and the importance of examining barriers for informing the design of interventions to address service gaps in the home visiting context.

The process of adapting the physician survey for the home visiting context included the following steps. First, we developed an initial draft of proposed adaptations based on a review of relevant literature, focus groups with home visitors, and discussions with HV program administrators. Second, the adapted item set was reviewed for content validity and accuracy by a panel of researchers, HV supervisors, and HV administrators. Finally, the item set was narrowed based on panel feedback. The majority of items on the final home visitor survey were identical to those on the original physician survey, with the following adaptations made. First, we extended the survey to evaluate SU as well as MD, using parallel items for both constructs. Second, the original physician survey assessed barriers via dichotomous check-boxes, and we converted these to Likert-scale items in the home visitor survey, a modification that was expected to improve the measure's psychometric properties.

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Third, we adapted the language of several of the barriers items to ensure we were assessing barriers relevant to the home visiting context (e.g., "Clients are afraid that they will lose custody of their children if they admit to feeling depressed/using substances"). Finally, we adapted the training items from the original survey to assess home visitors' training needs to inform intervention design.

The final home visitor survey consisted of 9 demographic items, 35 items on MD, and 36 items on SU[1]. With one exception, the survey contained parallel items for MD and SU to facilitate comparisons across the two risk domains. Survey respondents were asked to rate the extent of their agreement with a series of statements assessing their knowledge of each risk area, perceived self-efficacy addressing each risk area with clients, and perceived system- and client-level barriers to addressing risk with clients. Each of these items was rated on a 6-point Likert scale ranging from Strongly Disagree to Strongly Agree. Examination of item distributions revealed that most items had few scores at the most extreme ends of the scale. Therefore, prior to conducting factor analysis, the original 6-point response scale was recoded into a 4-point scale, collapsing the two agreement anchors (Strongly Agree and Agree) as well as the two disagreement anchors (Strongly Disagree and Disagree) in order to create more favorable distribution properties for analysis (Nunnally & Bernstein, 1994). The final response scale was: 1=Disagree; 2=Somewhat Disagree; 3=Somewhat Agree; 4=Agree. Eight additional items per risk area assessed home visitors' current practices regarding the frequency with which they assess, screen, refer, follow up, and help clients overcome barriers to treatment for MD and SU. These items were rated on a 5-point Likert scale ranging from Always to Never.

Several additional survey items assessed home visitors' prior training and perceived need for future training in the areas of MD and SU. These items were not included in the Confirmatory Factor Analysis because only a single item assessing prior training was used in the predictive models; thus, there was no need to create a latent factor for training. The items on perceived need for future training are presented to provide additional descriptive information for intervention planning; these were not included in formal analyses. For each risk area, home visitors indicated whether they had ever received any of five types of formal training, including formal coursework, workshops, conferences, seminars, and web-based training. Training was operationalized as the number of types of formal training received for each risk domain (range 0-5). Finally, home visitors rated the extent of their agreement with three statements per risk area regarding their desire for more formal training, desire for standardized procedures for addressing MD and SU within home visiting, and willingness to implement standardized screening for each risk area. These items were rated on a 6-point Likert scale from Strongly Agree to Strongly Disagree. The hypothesized factor structure underlying the survey items is depicted in Figure 1. Based on prior work with the physician survey (Leiferman et al., 2010), we expected that survey items would cluster into four latent scales per risk domain: knowledge and self-efficacy, client-level barriers, system-level barriers, and current practices.

[1]Note that the original survey also included 30 items on domestic violence that were parallel to the maternal depression and substance use items. However, survey validation analyses did not support the use of the domestic violence scales, so these items are not included in study analyses.

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Confirmatory factor analysis—Confirmatory factor analysis (CFA) was conducted to confirm the hypothesized four-factor structure of the home visitor survey for the purpose of creating valid scales for analysis. Because we were able to construct a viable theoretical factor structure based on the results of the exploratory factor analysis (EFA) conducted on the physician survey (Leiferman et al., 2010), we did not conduct an additional EFA on the home visitor survey. Due to power concerns, all analyses were conducted separately for MD and SU risk domains. CFA proceeded according to the following steps. First, we examined intercorrelations among all items expected to load on each hypothesized latent factor (see Figure 1 for the items expected to load on each factor). On several occasions, there were two items within the same proposed latent factor subscale that were highly correlated with one another. For example, within the proposed knowledge and self-efficacy scale, the item, "I feel confident in my ability to recognize MD/SU in my clients" was highly correlated with "I am familiar with the signs and symptoms of MD/SU" (MD: $r = 0.52$, $p < 0.01$; SU: $r = 0.71$, $p < 0.01$) as well as with "I feel comfortable talking about MD/SU with clients" (MD: $r = 0.44$, $p < 0.01$; SU: $r = 0.49$, $p < 0.01$). In these instances, the item that was highly correlated with other items was excluded from further analyses. Second, a series of preliminary CFA models was conducted to determine whether the items corresponding to each latent factor adequately loaded on that factor. Poor performing items were trimmed as needed to achieve adequate fit for each model, with adequate fit defined as RMSEA values of .08 and below and CFI values of .90 and above (Browne & Cudeck, 1993). Once adequate fitting models were established for each latent factor, final measurement models were fit for the MD and SU risk domains respectively.

The final CFA measurement models are depicted in Tables 1 (MD) and 2 (SU). For MD, the initial full measurement model did not converge. To achieve model convergence, we freed the first factor loadings on each latent factor and fixed all factor variances to 1 (Nunnally & Bernstein, 1994). The final MD measurement model demonstrated adequate fit: $\chi^2(146) = 203.81$, $p < 0.01$, CFI = 0.92, RMSEA = 0.05. For SU, the initial full measurement model converged with good fit: $\chi^2(113) = 220.34$, $p < 0.001$, CFI = 0.96, RMSEA = 0.08.

For both MD and SU, the final models included the following four factors: *Knowledge and Self-Efficacy*, *System-Level Barriers, Client-Level Barriers*, and *Current Practices*. The *Knowledge and Self-Efficacy* scale included 6 items for MD and 4 items for SU. For MD, factor loadings were below 0.40 for all items except for one ("I feel comfortable talking about depression with clients"), and Cronbach's alpha for the scale was very low ($\alpha = 0.05$). For the SU *Knowledge and Comfort* scale, two items had factor loadings above 0.40, and Cronbach's alpha for the scale was 0.47. Despite low evidence of internal consistency for both MD and SU, this scale was retained for three main reasons. First, this scale demonstrated good fit in the preliminary CFA models for both MD ($\chi^2(9) = 8.91$, p = 0.45, CFI = 1.00, RMSEA = 0.00; 90% CI: 0.00 – 0.09) and SU ($\chi^2(2) = 0.34$, p = 0.85, CFI = 1.00, RMSEA = 0.00; 90% CI: 0.00 – 0.09). Second, despite the modest factor loadings in the final measurement models, inclusion of these scales did not detract from the overall good fit of the full measurement model for both MD and SU. Finally, knowledge and self-efficacy were important constructs in the conceptual model underlying the survey, and assessing the contribution of home visitor knowledge and self-efficacy to their current practices in order to

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inform intervention development was an important study goal, so the scales were retained on substantive grounds.

System-Level Barriers included 4 items each for MD and SU. For MD, factor loadings were at or above 0.65 for all items except one ("It generally takes a long time to get an appointment with a mental health professional"), and alpha was adequate at 0.50. For SU, all items had factor loadings above 0.40, with three out of the four items loading above 0.75. This scale showed good internal consistency for SU ($\alpha = 0.68$). *Client-Level Barriers* included 5 items each for MD and SU. For MD, factor loadings ranged from 0.58 for "Clients feel bad about themselves when told they have depression," and "Asking clients about depression would ruin the trusting relationship we have developed," to 0.66 for "Clients often deny feeling depressed." Factor loadings were somewhat lower for SU, however all but one item had loadings above 0.40 ("Clients feel bad about themselves when told they have a substance use problem"), and two items had loadings above 0.70. Internal consistency for the *Client-Level Barriers* scale was good for MD ($\alpha = 0.66$) and adequate for SU ($\alpha = 0.52$).

The final scale, *Current Practices*, included four items each for MD and SU. The three items in the original scale that measured specific ways home visitors helped clients overcome barriers to treatment ("How often do you help clients organize transportation"; "How often do you help clients organize payment"; "How often do you help clients arrange childcare") were combined into a single item by averaging the scores on the three items in the original scale. This was done due to high levels of collinearity among these three items that was contributing to poor fit in the CFA. All items on the final *Current Practices* scale for MD and SU had factor loadings above 0.70, and internal consistency was very high for both MD ($\alpha = 0.84$) and SU ($\alpha = 0.91$).

Scale scores for each latent factor were calculated by averaging the scores for all items loading on the corresponding factor. The resulting scale scores for *Current Practices*, *Knowledge and Self-Efficacy*, *System-Level Barriers*, and *Client-Level Barriers* were then used as the independent and dependent variables in study analyses.

Data Analysis Plan

First, paired samples *t*-tests were conducted on the four survey subscales (*Current Practices, Knowledge and Self-Efficacy*, *System-Level Barriers*, and *Client-Level Barriers*) to examine differences between SU and MD. Next, predictors of home visitors' *Current Practices* were assessed via two linear regression models, one for SU and one for MD. Full models were conducted including all potential predictors (education, training, experience, *Knowledge and Self-Efficacy*, *System-Level Barriers*, and *Client-Level Barriers*). Finally, descriptive statistics on home visitors' desire for additional formal training, desire for standardized procedures within home visiting, and willingness to implement standardized screening for the two risk areas are presented to inform the extent to which home visitors are open to training and practice enhancement in these areas.

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Results

Preliminary Descriptive Statistics

Descriptive statistics on all study variables are contained in Table 3. As shown in the table, approximately half of the sample had graduated from college (55.3%), and about a third had more than five years of experience in HV, another third had between two and five years of experience, and 35% had less than one year of experience in HV. Home visitors reported receiving an average of about one type of formal training in MD or SU. Average scores on the *Knowledge and Self-Efficacy* scale were 3.03 (SD = 0.35) for MD and 2.84 (SD = 0.47) for SU, out of a possible range of 1 to 4, with higher scores representing greater knowledge and comfort. Regarding MD, average scores for *System-Level Barriers* (M = 3.34, SD = 0.57) were higher than those for *Client-Level Barriers* (M = 2.64, SD = 0.59). For SU, home visitors reported about the same level of *System-Level Barriers* (M = 3.05, SD = 0.72) and *Client-Level Barriers* (M = 3.19, SD = 0.44). For both barriers scales, possible scores ranged from 1 to 4, with higher scores representing more perceived barriers. The average score on MD *Current Practices* was 3.11 (SD = 1.00), which corresponds to "sometimes" on the response scale, and the average score on SU *Current Practices* was 2.37 (SD = 1.18), corresponding to "rarely" on the response scale.

Bivariate correlations among all potential predictor variables were examined to assess for multicollinearity prior to conducting regression analyses. Being a college graduate was significantly correlated with having less than one year of HV experience ($r = 0.45$, $p<0.01$), and with less *Knowledge and Self-Efficacy* with SU ($r = -0.26$, $p < 0.01$). Having more than five years of experience in HV was associated with having more formal training in both MD ($r = -0.20$, $p < 0.05$) and SU ($r = -0.24$, $p < 0.01$). More training in SU was associated with greater *Knowledge and Self-Efficacy* regarding SU ($r = 0.29$, $p < 0.01$); however, this was not the case for MD. For MD, greater perceived *Client-Level Barriers* was associated with less *Knowledge and Self-Efficacy* ($r = -0.23$, $p < 0.01$) and more *System-Level Barriers* ($r = 0.21$, $p < 0.01$). For SU, greater perceived *Client-Level Barriers* was associated with fewer perceived *System-Level Barriers* ($r = -0.25$, $p < 0.01$). All significant correlations were in the low to moderate range, and thus did not pose issues of multicollinearity for the regression analyses.

Comparison of MD and SU on Survey Subscales

Paired samples *t*-tests were conducted to compare home visitor scores on *Current Practices, Knowledge and Self-Efficacy*, *System-Level Barriers*, and *Client-Level Barriers* across the two risk domains (MD and SU). Significant differences between the two risk domains were found for *Current Practices* ($t(155) = 10.94$, $p < 0.001$, $d = 0.89$), *Knowledge and Self-Efficacy* ($t(158) = 4.30$, $p < 0.001$, $d = 0.35$), *System-Level Barriers* ($t(158) = 5.30$, $p < 0.001$, $d = 0.43$), and *Client-Level Barriers* ($t(158) = -13.23$, $p < 0.001$, $d = 1.08$). Means and standard deviations for each subscale by risk domain are presented in Table 3. Scores on *Current Practices, Knowledge and Self-Efficacy*, and *System-Level Barriers* were significantly higher for MD compared to SU, and *Client-Level Barriers* were higher for SU compared to MD. Following the guidelines established by Cohen for the interpretation of effect size magnitude (Cohen, 1988), effect sizes were large for *Current Practices* and

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Client-Level Barriers and small to moderate for *Knowledge and Self-Efficacy* and *System-Level Barriers*.

Potential Predictors of Home Visitor Current Practices in MD and SU

Linear regressions were conducted to examine potential predictors of home visitor *Current Practices* in managing MD and SU (see Table 4). A separate regression was conducted for each risk domain. Potential predictors included: college graduate (yes vs. no); up to one year experience in home visiting (vs. more than five years); two to five years of experience in home visiting (vs. more than five years); number of types of formal training received in MD or SU (range 0 to 5); *Knowledge and Self-Efficacy* scale score; *System-Level Barriers* scale score; and *Client-Level Barriers* scale score.

For MD, higher scores on the *Current Practices* scale were predicted by more types of formal depression training (B (SE) = 0.26 (0.08), $p < 0.01$, $\beta = 0.27$) and higher scores on the *Knowledge and Self-Efficacy* subscale (B (SE) = 0.55 (0.24), $p < 0.05$, $\beta = 0.19$). For SU, higher scores on the *Current Practices* scale were significantly predicted only by higher scores on the *Knowledge and Self-Efficacy* scale (B (SE) = 0.56 (0.21), $p < 0.05$, $\beta = 0.22$). Both training and experience predicted SU *Current Practices* at a trend-level, with more training (B (SE) = 0.17 (0.09), $p = 0.07$, $\beta = 0.16$) and more than five years of experience (compared to less than one year) (B (SE) = -0.48 (0.26), $p = 0.07$, $\beta = -0.19$) associated with higher scores on SU *Current Practices*.

Home Visitor Openness to Practice Enhancements Focused on MD and SU within HV

Home visitors reported on their desire for additional formal training, desire for standardized procedures within HV to address SU and MD, and willingness to use a standardized screening tool with their clients. These data are presented here descriptively to further inform intervention planning in this area. The vast majority of home visitors reported a desire for more formal training in MD (80.4%) and SU (84.6%). Additionally, more than 70% either agreed or strongly agreed with the statement "I wish there were standard procedures for dealing with MD/SU within HV" (71.4% for MD, 77.4% for SU). Finally, more than 80% expressed willingness to use a standardized screening tool to help them recognize MD (84.8%) or SU (83.3%) in HV clients.

Discussion

This study presents results of a survey of home visitors within a single state who self-reported on their practices in managing (identifying and addressing) client SU and MD within the context of two widely used and empirically supported HV models. As expected given the current emphasis on MD under MIECHV, home visitors reported managing MD more extensively than SU. However, the extent to which home visitors reported currently managing both risk areas corresponded to approximately "rarely" or "sometimes" on the survey response scale. Thus, the degree to which home visitors currently identify and address both SU and MD in their clients is relatively low, by their own report. This finding is consistent with prior studies that found that paraprofessional home visitors infrequently

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identified and responded to behavioral health risks in their clients (Duggan et al., 2004; Tandon et al., 2005).

Home visitors reported greater knowledge and perceived self-efficacy regarding MD compared to SU. Additionally, they perceived system-level barriers such as long waiting lists, insurance, and lack of transportation and childcare to be greater for MD compared to SU and client-level barriers, including client reluctance to discuss the problem and client fears related to child custody, to be greater for SU compared to MD. The past decade has seen increased recognition of the prevalence of depression among pregnant and postpartum women and the consequent risk posed to family functioning and child development (Goodman et al., 2011; Paulson, Dauber, & Leiferman, 2006). As a result, early childhood intervention systems, including HV programs, have begun to institute policies regarding screening and referral to treatment for MD (Horowitz, Murphy, Gregory, & Wojcik, 2009; Price & Masho, 2014; Rowan et al., 2015; Segre et al., 2012). Thus, home visitors may have had more training and more experience with MD compared to SU, increasing their perceived self-efficacy and decreasing their perception of client-level barriers such as stigma and fear of custody loss. It is possible that increased experience with the mental health treatment system due to the new focus on depression in HV heightened their awareness of systemic barriers to accessing treatment. However, further inquiry is needed to confirm these explanations.

Overall, few predictors of the extensiveness of home visitor management of SU and MD were found in the current study. Greater home visitor reported knowledge and self-efficacy with MD and SU predicted more extensive management of each risk domain respectively, and is consistent with other studies that have found that home visitors' personal comfort level discussing difficult topics impacts whether and how they address them with clients (Rollans, Schmied, Kemp, & Meade, 2013). Additionally, more training was associated with more extensive management of both risk domains, though this was significant only for MD. Surprisingly, home visitor reported system- and client-level barriers did not predict current practices in either of the risk domains in this study. It is possible that factors that were not measured in this study may explain home visitors' practices regarding managing client behavioral health risks. For example, other studies have found that home visitor psychological characteristics, as well as characteristics of the home visitor-client relationship, are important predictors of home visitor behaviors in their work with high-risk families (Jones-Harden et al., 2010). Specifically, home visitor self-reported anxiety has been shown to be associated with the likelihood of addressing sensitive topics with clients, with highly anxious home visitors less likely to address poor mental health in clients (McFarlane et al., 2010). Home visitors may also experience burnout and secondary traumatic stress that often occurs in providers serving high-risk families and may detract from their ability to adequately address clients' needs (Gill, Greenberg, Moon, & Margraf, 2007; Jones-Harden et al., 2010). While these variables were not measured in the current study, they will clearly be important to look at in future studies.

Prior studies have suggested that home visitors lack adequate training to address client behavioral health risks (Duggan et al., 2004; LeCroy & Whitaker, 2005; Tandon et al., 2008). Our findings lend some support to this point, as home visitors with less training

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reported less extensive management of both MD and SU. However, more than 75% of home visitors in the study sample reported receiving at least one type of formal training in both risk domains, though the quality and intensity of training is not known. Home visitors in the current sample also reported high levels of confidence and perceived self-efficacy addressing both risk domains. Despite this, the majority of home visitors also reported a desire for additional training and for standardized procedures for addressing SU and MD with HV clients. Taken together, study findings largely support the need for interventions to enhance home visitor capacity to address SU and MD in their clients that would include enhanced training coupled with specific practice-based strategies targeted at client behavioral health.

Limitations

This study has several limitations that must be considered in interpreting the findings. First, the study sample was selective, including home visitors representing only two of the myriad HV program models as implemented in a single state, thus generalizability of findings is limited. Second, as indicated above, potential important predictive variables, such as home visitor psychological characteristics, were not measured in this study. Third, although the survey instrument used in this study was not a standardized validated tool, the constructed scales were based on a sound conceptual model used in a prior study (Leiferman et al., 2010) and demonstrated good fit in confirmatory factor analysis. However, further psychometric evaluation would be needed to fully validate the survey as a measurement tool. Finally, all data were self-reported by home visitors and thus present only a single perspective on very complex issues. Recent qualitative research suggests that HV clients' views of their own depressive symptoms and their preferred way of receiving help differs from their home visitors' perceptions (Price & Cohen-Filipic, 2013). Complementary surveys assessing client perspectives as well as perspectives of treatment providers, program supervisors and administrators, and other stakeholders would provide a more complete picture, particularly of the potential barriers to home visitor management of client behavioral health risks and client access to needed services. A larger-scale survey of home visitors, administrators, and clients that includes a larger sample, multiple perspectives on management of behavioral health risks within HV, and a larger spectrum of potential predictive variables is currently underway as part of the MIECHV-funded research program, and will provide further information to guide HV programs in addressing client behavioral health risks.

Implications and Future Directions

Study findings lend further support to several areas of need that have been increasingly stated by HV researchers and other stakeholders. First, HV programs must do more to support home visitors in identifying behavioral health risks such as SU and MD in their clients and promoting access to treatment (Green et al., 2014; Paulsell et al., 2014). MIECHV legislation has already resulted in many local HV programs placing increased emphasis on maternal behavioral health risks (Michalopoulos et al., 2015). In the recently released first report from the national HV evaluation, MIHOPE, more than 90% of HFA home visitors believed it was their responsibility to recognize and address mental health and SU in their clients (Michalopoulos et al., 2015). However, about a quarter of home visitors felt that their programs did not provide them with adequate strategies and tools for

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addressing these issues and about 30% felt that they were not adequately trained in these areas. In the MIHOPE sample, many local programs reported having formal policies for screening clients for behavioral health needs, however only 20% had systematic protocols for how to respond to positive screens (Michalopoulos et al., 2015). It is being increasingly recognized that home visitors are not routinely equipped with the requisite skills and tools to engage high-risk families, identify specific risk factors, and navigate complex systems to assist families in accessing needed services (Azzi-Lessing, 2013). Second, HV researchers have suggested the need for more intensive and reflective supervision to provide essential support to home visitors in intervening with the highest risk families (Azzi-Lessing, 2013; Jones-Harden et al., 2010). Qualitative studies of home visitor experiences suggest that the day-to-day of working with high-risk families takes an emotional toll, and adequate supervisory support as well as peer support is necessary to prevent burnout (Dmytryshyn, Jack, Ballantyne, Wahoush, & MacMillan, 2015; Gill et al., 2007). Third, systematic consultation with service providers is a high priority, as formal collaborations with mental health and substance use providers are required to adequately meet the needs of high-risk families (Jones-Harden et al., 2010). Because HV alone is not sufficient to adequately address the complex needs of vulnerable families, it must be viewed as one part of a larger, coordinated system of care that includes both child and adult services (Azzi-Lessing, 2013).

As described in the Introduction, there have been several attempts to systematically integrate assessment and treatment for MD into HV programs. Results of these studies support the potential of integrating mental health interventions into HV for reducing client symptoms of depression. Whether or not similar approaches could work for SU is still an open question. Additionally, the approach of delivering behavioral health treatment directly in the home is costly and requires the availability of licensed mental health counselors, resources that are lacking in most statewide HV systems. A potential alternative is the integration of standardized behavioral health screening implemented by home visitors followed by brief intervention aimed at linking clients to needed services. This approach is based on the Screening Brief Intervention and Referral to Treatment (SBIRT) model that is widely used for SU problems in primary care settings (Substance Abuse and Mental Health Services Administration, 2013), and has demonstrated notable success in improving access to treatment and reducing SU for adult substance users, though results are not definitive (Agerwala & McCance-Katz, 2012; Babor et al., 2007). SBIRT has not been systematically attempted and evaluated within HV to date, however, arguably, this approach has potential as a way to address SU and mental health in the HV context. While SBIRT approaches may be more cost-effective than home-based treatment, they would rely on the skill of the home visitor to identify client risks, motivate the client to engage in treatment, and coordinate with service providers to eliminate barriers to treatment access. Additionally, the success of SBIRT is dependent on the availability and accessibility of quality community-based treatment services for home visitors to make referrals to (Babor et al., 2007). To be effective within HV, such an approach must include behavior- and skills-based training for home visitors, collaborative partnerships with behavioral health providers, minimal additional burden, and adequate supervisory practical and emotional support for home visitors (Azzi-Lessing, 2013; Dmytryshyn et al., 2015; Home Visiting Research Network, 2013; Jones-Harden et al., 2010; Tandon et al., 2008). The survey results presented in the current study

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were used to inform the development of a protocol to integrate standardized screening for SU, as well as for MD and domestic violence, into HV, followed by a brief intervention targeted at motivation and engagement of clients into needed services. A pilot feasibility test of this protocol is currently underway and results will be forthcoming.

Surveys such as the one used in the current study can be helpful in revealing service gaps and the particular barriers at play to inform the development of model enhancements and interventions to increase HV program capacity to address client behavioral health risks. However, additional research is needed that includes the perspectives of clients, administrators, and other stakeholders in addition to home visitors, to elucidate the individual, organizational, and systemic factors that determine how and to what extent maternal behavioral health risks are addressed within HV programs. Such research is being conducted as part of the ongoing national MIECHV-funded HV evaluation, and will be instrumental in informing the development of targeted strategies to expand HV program capacity to better meet the needs of the highest risk families while simultaneously supporting the practical and emotional needs of the HV workforce.

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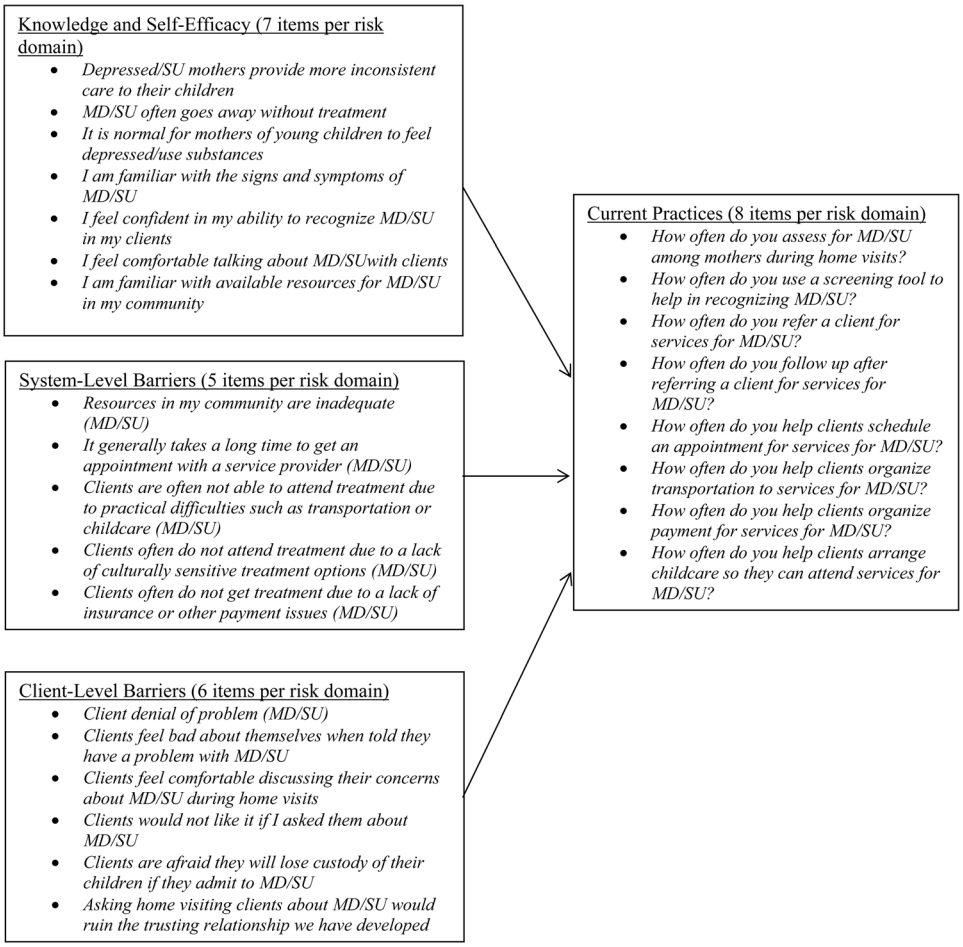

Figure 1.

Hypothesized factor structure underlying the home visitor survey. MD = Maternal Depression; SU = Substance Use.

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Table 1

Maternal Depression final CFA measurement model: Item factor loadings and scale internal consistency

	Estimate	S.E.	Estimate/S.E.	p-value	Cronbach's Alpha
Factor 1: Knowledge and Self-Efficacy					0.05
Depressed mothers provide more inconsistent care to their children.	-0.18	0.09	-1.91	0.06	
Maternal depression often goes away without treatment.	-0.24	0.10	-2.45	0.01	
It is normal for mothers of young children to feel depressed.	-0.10	0.10	-1.05	0.30	
I am familiar with the signs and symptoms of depression.	0.26	0.10	2.58	0.01	
I feel comfortable talking about depression with clients.	0.44	0.14	3.19	0.001	
I am familiar with available mental health resources in my community.	0.20	0.11	1.79	0.07	
Factor 2: Systems-Level Barriers					0.50
It generally takes a long time to get an appointment with a mental health professional.	0.36	0.10	3.63	0.000	
Clients are often not able to attend treatment for maternal depression due to practical difficulties such as transportation or childcare.	0.72	0.11	6.67	0.000	
Clients often do not attend treatment for maternal depression due to a lack of culturally sensitive treatment options	0.70	0.09	7.76	0.000	
Clients often do not get treatment for maternal depression due to a lack of insurance or other payment issues.	0.65	0.11	6.03	0.00	
Factor 3: Client-Level Barriers					0.66
Clients often deny feeling depressed.	0.66	0.08	8.65	0.000	
Clients feel bad about themselves when told they have depression.	0.58	0.08	7.74	0.000	
Clients would not like it if I asked them about depression symptoms.	0.65	0.07	9.22	0.000	
Clients are afraid that they will lose custody of their children if they admit to feeling depressed.	0.60	0.08	7.90	0.000	
Asking clients about depression would ruin the trusting relationship we have developed.	0.58	0.10	5.63	0.000	
Factor 4: Current Practices					0.84
Refer clients for treatment of maternal depression.	0.72	0.05	15.82	0.000	
Follow up after referring a client for treatment of maternal depression.	0.71	0.06	12.67	0.000	
Help clients schedule appointments for treatment for maternal depression.	0.90	0.03	27.23	0.000	
Help clients overcome barriers to treatment for maternal depression (e.g., transportation, payment, childcare).	0.81	0.05	16.85	0.000	

Note. χ^2 (146) = 203.81, $p < 0.01$; RMSEA = 0.05 (90% CI: 0.03, 0.07), $p = 0.49$; CFI = 0.92; TLI = 0.90.
Factor variances fixed at one.

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Table 2

Substance use final CFA measurement model: Item factor loadings and scale internal consistency

	Estimate	S.E.	Estimate/S.E.	p-value	Cronbach's Alpha
Factor 1: Knowledge and Self-Efficacy					0.47
Some amount of getting high is normal in mothers of young children and does not interfere with parenting.	0.21	0.13	1.59	0.11	
I am familiar with the signs and symptoms of substance use problems.	0.59	0.10	6.02	0.000	
I feel comfortable talking about substance use with clients.	0.39	0.10	3.90	0.000	
I am familiar with available substance use treatment resources in my community.	0.84	0.09	8.93	0.000	
Factor 2: Systems-Level Barriers					0.68
It generally takes a long time to get an appointment at a substance use treatment program	0.41	0.09	4.80	0.000	
Clients are often not able to attend treatment for substance use due to practical difficulties such as transportation or childcare.	0.80	0.05	15.11	0.000	
Clients often do not attend treatment for substance use due to a lack of culturally sensitive treatment options	0.76	0.05	14.11	0.000	
Clients often do not get treatment for substance use due to a lack of insurance or other payment issues.	0.77	0.06	12.07	0.000	
Factor 3: Client-Level Barriers					0.52
Clients often deny that their substance use is a problem.	0.45	0.11	4.22	0.000	
Clients feel bad about themselves when told they have a substance use problem.	0.36	0.11	3.39	0.001	
Clients would not like it if I asked them about their substance use.	0.78	0.08	9.40	0.000	
Clients are afraid that they will lose custody of their children if they admit to using substances.	0.43	0.10	4.34	0.000	
Asking clients about substance use would ruin the trusting relationship we have developed.	0.70	0.08	8.85	0.000	
Factor 4: Current Practices					0.91
Refer clients for treatment of substance use.	0.90	0.02	49.35	0.000	
Follow up after referring a client for treatment of substance use.	0.85	0.03	29.82	0.000	
Help clients schedule appointments for treatment for substance use.	0.94	0.01	65.10	0.000	
Help clients overcome barriers to treatment for substance use (e.g., transportation, payment, childcare).	0.94	0.02	41.68	0.000	

Note. χ^2 (113) = 220.34, $p < 0.01$; RMSEA = 0.08 (90% CI: 0.06, 0.09), $p < 0.01$; CFI = 0.96; TLI = 0.95.

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Table 3

Descriptive statistics on all study variables

	Mean (SD) or N (%)
College graduate (N, %)	88 (55.3%)
Up to one year experience in home visiting (N, %)	56 (35.2%)
Two to five years of experience in home visiting (N, %)	48 (30.2%)
More than five years of experience in home visiting (N, %)	50 (31.4)
Number of types of formal depression training received (M, SD)	1.30 (1.03)
Number of types of formal substance use training received (M, SD)	1.11 (1.11)
Maternal Depression knowledge and self-efficacy (M, SD)	3.03 (0.35)
Substance Use knowledge and self-efficacy (M, SD)	2.84 (0.47)
Maternal Depression system level barriers (M, SD)	3.34 (0.57)
Substance Use system level barriers (M, SD)	3.05 (0.72)
Maternal Depression client level barriers (M, SD)	2.64 (0.59)
Substance Use client level barriers (M, SD)	3.19 (0.44)
Maternal Depression current practices (M, SD)	3.11 (1.00)
Substance Use current practices (M, SD)	2.37 (1.18)

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Table 4

Predictors of home visitor current practices in managing depression and substance use

	Maternal Depression[a]			Substance Use[b]		
	B (SE)	B	t	B (SE)	B	t
College graduate	-0.14 (1.01)	-0.07	-0.78	0.21 (0.22)	0.09	0.96
Training	0.26 (0.08)	0.27	3.30***	0.17 (0.09)	0.16	1.84 $^{\psi}$
Up to one year experience	-0.14 (0.22)	-0.07	-0.61	-0.48 (0.26)	-0.19	-1.82 $^{\psi}$
2-5 years experience	0.18 (0.20)	0.09	0.93	-0.14 (0.23)	-0.06	-0.60
Knowledge and self-efficacy	0.55 (0.24)	0.19	2.32 *	0.56 (0.21)	0.22	2.62 **
System-level barriers	0.06 (0.14)	0.03	0.42	0.13 (0.13)	0.08	1.00
Client-level barriers	0.02 (0.14)	0.01	0.13	-0.18 (0.22)	-0.07	-0.82

Note.

[a] $R^2 = 0.16$, Adjusted $R^2 = 0.12$.

[b] $R^2 = 0.14$, Adjusted $R^2 = 0.10$.

$^{\psi}$ $p<0.10$,

* $p<0.05$,

** $p<0.01$

Evidence Synthesis
Number 58, Part 1

Screening in Primary Care Settings for Illicit Drug Use: Staged Systematic Review for the United States Preventive Services Task Force

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Structured Abstract

Background. Illicit drug use and abuse are serious problems among adolescents, adults, and pregnant women in the United States, and approximately 3.2% of the population age 12 and over meet criteria for a drug use disorder. Many individuals with drug use disorders have co-existing mental and physical health conditions.

Purpose. To update the 1996 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for drug misuse in primary care. The USPSTF previously concluded there was insufficient evidence to recommend for or against routine screening for drug misuse. This report describes a staged, systematic review that assessed whether the evidence for selected critical key questions is now sufficient for the USPSTF to make a recommendation on this topic.

Data sources. Ovid MEDLINE, PsycINFO, and the Cochrane Database of Systematic Reviews, from 1994 through April 2006. Literature searches were supplemented with materials recommended by experts in the field and from reference lists in included articles.

Study Selection. We developed an analytic framework and identified five critical key questions (KQ) to examine evidence sufficiency in a causal chain linking primary care screening for drug misuse to treatment outcomes and longer-term health benefits of reductions in illicit drug use. We focused on the most prevalent and/or harmful substances: illicit opiates, cocaine, and cannabis. Using inclusion/exclusion criteria specific to each critical KQ, we reviewed a total of 4587 abstracts for all key questions and 41 full-text articles for inclusion regarding direct evidence of health benefits of drug screening programs in primary care, 127 articles for inclusion regarding drug misuse treatment outcomes in primary care-screened populations, and 79 articles for inclusion regarding improvements in health or mortality following reduction in or cessation of illicit drug use. Inclusion criteria for drug misuse treatment articles required randomized controlled or controlled trial designs comparing a treatment to placebo or minimal treatment control; comparative effectiveness trials were excluded. Using USPSTF and other published methods, we critically appraised studies using quality criteria specific to their design. We listed studies excluded from analysis and rationales for their exclusion.

Data Extraction. We abstracted, critically appraised, and synthesized 28 articles meeting our criteria for all critical KQs. Abstracted elements were arrayed in evidence tables, using abstraction criteria specific to each KQ.

Data Synthesis and Results. We qualitatively summarized the findings, with an emphasis on the best available evidence for each critical KQ and the overall coherence of the evidence. We found no evidence addressing the effects on health outcomes of screening in primary care settings to identify and treat drug misuse among asymptomatic individuals. We found no evidence that drug misuse treatment affects health outcomes among individuals screened in primary care, and found little qualifying evidence in non-screened (treatment-seeking) populations. We found fair to good evidence that various drug misuse treatments—including pharmacotherapies and behavioral interventions—effectively reduce opiate, cocaine, or marijuana misuse. All but one of the 17 included drug misuse treatment trials were conducted among treatment-seeking, instead of primary-care-screened populations. The exception was a brief motivational intervention that reduced cocaine and opiate use among primary care patients

identified through screening for use of these substances. We found less consistent evidence of drug misuse treatment effects on social and legal outcomes, although behavioral counseling interventions for cannabis misuse appear to reduce cannabis-related problems. We found fair evidence that stopping or reducing drug misuse is related to reduced mortality and morbidity, although none of this evidence was derived from individuals screened for drug misuse in primary care settings.

Conclusions. Although many advances in drug misuse treatment have occurred during the past decade, the vast majority of trials have been conducted among treatment-seeking populations, and thus the relevance of outcomes from such studies is of uncertain applicability to asymptomatic primary care populations that could be screened for drug misuse. Evidence that reducing or stopping drug misuse is associated with improved health outcomes similarly derives from non-screened or treatment-seeking populations, and the generalizability of these findings to general primary care populations may be limited.

Full report (120 pages) can be viewed in

Provider Resources/Recommendation and

Opinion Statements

portion of toolkit

This online-first article will have minor typographical differences from the final, printed version.

Annals of Internal Medicine | Clinical Guideline

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: U.S. Preventive Services Task Force Recommendation Statement

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force*

Description: Update of the 2004 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening and behavioral counseling interventions in primary care to reduce alcohol misuse.

Methods: The USPSTF reviewed new evidence on the effectiveness of screening for alcohol misuse for improving health outcomes, the accuracy of various screening approaches, the effectiveness of various behavioral counseling interventions for improving intermediate or long-term health outcomes, the harms of screening and behavioral counseling interventions, and influences from the health care system that promote or detract from effective screening and counseling interventions for alcohol misuse.

Population: These recommendations apply to adolescents aged 12 to 17 years and adults aged 18 years or older. These recommendations do not apply to persons who are actively seeking evaluation or treatment for alcohol misuse.

Recommendation: The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (Grade B recommendation)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents. (I statement)

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* For a list of USPSTF members, see the Appendix (available at www.annals.org).

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The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Summary of Recommendations and Evidence

The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (B recommendation)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents. (I statement)

See the **Figure** for a summary of the recommendations and suggestions for clinical practice.

Appendix Table 1 describes the USPSTF grades, and **Appendix Table 2** describes the USPSTF classification of levels of certainty about net benefit (both tables are available at www.annals.org).

Rationale

Importance

The USPSTF uses the term "alcohol misuse" to define a spectrum of behaviors, including risky or hazardous alcohol use (for example, harmful alcohol use and alcohol abuse or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts resulting in increased risk for health consequences. For example, the National Insti-

See also:

Print
Summary for Patients

U.S. Preventive Services TASK FORCE
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Figure. **Screening and behavioral counseling interventions in primary care to reduce alcohol misuse.**

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U.S. Preventive Services TASK FORCE
www.USPreventiveServicesTaskForce.org

SCREENING AND BEHAVIORAL COUNSELING INTERVENTIONS IN PRIMARY CARE TO REDUCE ALCOHOL MISUSE
CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population	Adults aged 18 y or older	Adolescents
Recommendation	Screen for alcohol misuse and provide brief behavioral counseling interventions to persons engaged in risky or hazardous drinking. Grade: B	No recommendation. Grade: I statement

Screening Tests	Numerous screening instruments can detect alcohol misuse in adults with acceptable sensitivity and specificity. The USPSTF prefers the following tools for alcohol misuse screening in the primary care setting: 1) AUDIT 2) Abbreviated AUDIT-C 3) Single-question screening, such as asking, "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 y) or more drinks in a day?"	
Behavioral Counseling Interventions	Counseling interventions in the primary care setting can improve unhealthy alcohol consumption behaviors in adults engaging in risky or hazardous drinking. Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions. Brief multicontact behavioral counseling seems to have the best evidence of effectiveness; very brief behavioral counseling has limited effect.	
Balance of Benefits and Harms	There is a moderate net benefit to alcohol misuse screening and brief behavioral counseling interventions in the primary care setting for adults aged 18 y or older.	The evidence on alcohol misuse screening and brief behavioral counseling interventions in the primary care setting for adolescents is insufficient, and the balance of benefits and harms cannot be determined.
Other Relevant USPSTF Recommendations	The USPSTF has made recommendations on screening for illicit drug use and counseling and interventions to prevent tobacco use. These recommendations are available at www.uspreventiveservicestaskforce.org.	

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.

AUDIT = Alcohol Use Disorders Identification Test; AUDIT-C = AUDIT-Consumption.

tute on Alcohol Abuse and Alcoholism (NIAAA) and the U.S. Department of Agriculture define "risky use" as consuming more than 4 drinks on any day or 14 drinks per week for men, or more than 3 drinks on any day or 7 drinks per week for women (as well as any level of consumption under certain circumstances) (1, 2). "Harmful alcohol use" (defined by the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision) is a pattern of drinking that causes damage to physical or mental health (3).

"Alcohol abuse" (defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) is drinking that leads an individual to recurrently fail in major home, work, or school responsibilities; use alcohol in physically hazardous situations (such as while operating heavy machinery); or have alcohol-related legal or social problems (4). "Alcohol dependence" (or alcoholism) (defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) includes physical cravings and withdrawal symptoms, frequent consumption of alcohol in larger amounts than intended over longer periods, and a need for markedly increased amounts of alcohol to achieve intoxication (4).

An estimated 30% of the U.S. population is affected by alcohol misuse, and most of these persons engage in risky use. More than 85 000 deaths per year are attributable to alcohol misuse; it is the estimated third leading cause of preventable deaths in the United States (5, 6).

Detection

The USPSTF found adequate evidence that numerous screening instruments can detect alcohol misuse in adults with acceptable sensitivity and specificity.

Benefits of Detection and Behavioral Counseling Interventions

The USPSTF found adequate evidence that brief behavioral counseling interventions are effective in reducing heavy drinking episodes in adults engaging in risky or hazardous drinking. These interventions also reduce weekly alcohol consumption rates and increase adherence to rec-

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ommended drinking limits. Direct evidence about the effectiveness of brief behavioral counseling interventions in pregnant women engaging in alcohol use is more limited. However, studies in the general adult population show that such interventions reduce alcohol consumption and increase adherence to recommended drinking limits among women of childbearing age.

The USPSTF found insufficient evidence on the effect of screening for alcohol misuse and brief behavioral counseling interventions on outcomes in adolescents.

Harms of Detection and Behavioral Counseling Interventions

There are minimal data to assess the magnitude of harms of screening for alcohol misuse or of consequent brief behavioral counseling interventions in any population. However, no studies have identified direct evidence of harms. Thus, given the noninvasive nature of the screening process and behavioral counseling interventions, the related harms are probably small to none.

USPSTF Assessment

The USPSTF concludes with moderate certainty that there is a moderate net benefit to screening for alcohol misuse and brief behavioral counseling interventions in the primary care setting for adults aged 18 years or older.

The evidence on screening for alcohol misuse and brief behavioral counseling interventions in the primary care setting for adolescents is insufficient, and the balance of benefits and harms cannot be determined.

Clinical Considerations

Patient Population Under Consideration

The B recommendation applies to adults aged 18 years or older, and the I statement applies to adolescents aged 12 to 17 years. Although pregnant women are included, this recommendation is related to decreasing risky or hazardous drinking, not to complete abstinence, which is recommended for all pregnant women. These recommendations do not apply to persons who are actively seeking evaluation or treatment for alcohol misuse.

Screening Tests

The USPSTF considers 3 tools as the instruments of choice for screening for alcohol misuse in the primary care setting: the Alcohol Use Disorders Identification Test (AUDIT), the abbreviated AUDIT-Consumption (AUDIT-C), and single-question screening (for example, the NIAAA recommends asking, "How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?").

Of available screening tools, AUDIT is the most widely studied for detecting alcohol misuse in primary care settings; both AUDIT and the abbreviated AUDIT-C have good sensitivity and specificity for detecting the full spectrum of alcohol misuse across multiple populations. The AUDIT comprises 10 questions and requires approximately 2 to 5 minutes to administer; AUDIT-C comprises 3 questions and takes 1 to 2 minutes to complete. Single-question screening also has adequate sensitivity and specificity across the alcohol-misuse spectrum and requires less than 1 minute to administer.

Behavioral Counseling Interventions

Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions. They may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling. For the purposes of this recommendation statement, the USPSTF uses the following definitions of intervention intensity: very brief single contact (≤5 minutes), brief single contact (6 to 15 minutes), brief multicontact (each contact is 6 to 15 minutes), and extended multicontact (≥1 contact, each >15 minutes). Brief multicontact behavioral counseling seems to have the best evidence of effectiveness; very brief behavioral counseling has limited effect (5, 6).

The USPSTF found that counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because brief behavioral counseling interventions decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood alcohol concentration [BAC]), indirect evidence supports the effect of screening and brief behavioral counseling interventions on important health outcomes, such as the probability of traumatic injury or death, especially that related to motor vehicles.

Although screening detects persons along the entire spectrum of alcohol misuse, trials of behavioral counseling interventions in primary care settings largely focused on risky or hazardous drinking rather than alcohol abuse or dependence. Limited evidence suggests that brief behavioral counseling interventions are generally ineffective as singular treatments for alcohol abuse or dependence. The USPSTF did not formally evaluate other interventions (such as pharmacotherapy or outpatient treatment programs) for alcohol abuse or dependence, but the benefits of specialty treatment are well-established and recommended for persons meeting the diagnostic criteria for alcohol dependence.

Screening Intervals

Evidence is lacking to determine the optimal interval for screening for alcohol misuse in adults.

Suggestions for Practice Regarding the I Statement

In deciding whether to screen adolescents for alcohol misuse and provide behavioral counseling interventions,

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primary care providers should consider the following factors.

Potential Preventable Burden

In 2010, approximately 14% of adolescents in the 8th grade and 41% in the 12th grade reported using alcohol at least once within the past 30 days; 7% and 23%, respectively, reported consuming at least 5 or more drinks on a single occasion (an episode of heavy use) within the previous 2 weeks (7). Motor vehicle crashes are the leading cause of death for adolescents (8); according to the Substance Abuse and Mental Health Services Administration, about 4% of 16-year-olds and 9% of 17-year-olds in 2009 drove under the influence of alcohol at least once during the previous year (9). Thirty-seven percent of traffic deaths among youth aged 16 to 20 years involve alcohol, and these deaths frequently involve alcohol-impaired drivers with lower BACs than other age groups (10).

Costs

Behavioral counseling interventions are associated with a time commitment ranging from 5 minutes to 2 hours, spread over multiple contacts. There are potential financial costs for parents and caregivers from lost work hours and travel to and from the provider.

Potential Harms

Potential harms associated with screening for alcohol misuse include anxiety, stigma or labeling, and interference with the clinician–patient relationship. Although evidence is very limited, no direct harms were identified for any population in available studies.

Current Practice

Research suggests that although most pediatricians and family practice clinicians report providing some alcohol prevention services to adolescent patients, they do not universally or consistently screen and counsel for alcohol misuse (11). Barriers to screening and counseling include a perceived lack of time, familiarity with screening tools, training in managing positive results, and available treatment resources (12).

Useful Resources

The AUDIT and AUDIT-C screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions (www.integration.samhsa.gov/clinical-practice/screening-tools). Further details about the single-question screening method, as well as resources on primary care–feasible behavioral interventions, are available from the NIAAA (http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf).

The Community Preventive Services Task Force recommends electronic screening and brief intervention to reduce excessive alcohol consumption. Electronic screening and brief intervention uses electronic devices (for example, computers, telephones, or mobile devices) to facilitate screening persons for excessive drinking and delivering a brief intervention, which provides personalized feedback about the risks and consequences of excessive drinking. Delivery of personalized feedback can range from being fully automated (computer-based) to interactive (provided by a person over the telephone). At least 1 part of the brief intervention must be delivered by an electronic device. Electronic screening and brief intervention can be delivered in various settings, such as health care systems, universities, or communities. The Community Task Force found limited information on the effectiveness of electronic screening and brief intervention among adolescents.

The Community Preventive Services Task Force has also evaluated public health interventions (those that occur outside of the clinical practice setting) to prevent excessive alcohol consumption. It recommends instituting liability laws for establishments that sell or serve alcohol, increasing taxes on alcohol, maintaining limits on days and hours of the sale of alcohol, and regulating alcohol outlet density in communities as effective in preventing or reducing alcohol-related harms. It also recommends enhanced enforcement of laws prohibiting the sale of alcohol to minors. More information about the Community Preventive Services Task Force's recommendations on alcohol misuse is available at www.thecommunityguide.org/alcohol/index.html.

The Cochrane Collaboration has performed 2 systematic reviews to evaluate the effects of universal school- and family-based prevention programs to prevent or reduce alcohol misuse in young people. Although not entirely consistent across studies, evidence generally supported the effectiveness of certain school-based psychosocial and developmental programs, such as the Life Skills Training Program, the Unplugged Program, and the Good Behavior Game (13). Similarly, evidence generally supported small but positive effects from family-based interventions in preventing alcohol misuse in young people (14).

The USPSTF has made recommendations on screening for and interventions to decrease the unhealthy use of other substances, including illicit drugs and tobacco. More information can be found at www.uspreventiveservicetaskforce.org.

Other Considerations

Research Needs and Gaps

Alcohol misuse among adolescents is an important public health problem. Limited evidence is available to assess the effects of screening and behavioral counseling in adolescents, and high-quality studies specifically addressing this population are needed. Although there is adequate evidence that brief behavioral counseling interventions im-

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prove several intermediate outcomes for persons engaging in risky or hazardous drinking, there is little direct evidence describing the ultimate effect of these interventions on longer-term morbidity, mortality, or quality of life. Most trials of behavioral counseling for screening-detected alcohol misuse focused on risky or hazardous alcohol use; future research is needed to help explain whether persons engaging in harmful drinking or alcohol abuse might benefit from behavioral counseling interventions in the primary care setting. Finally, detailed information about the relative comparative effectiveness of specific behavioral counseling components or approaches is largely lacking, as is focused guidance on how to individualize treatment decisions for a given subpopulation.

Discussion

Burden of Disease

Alcohol misuse is a common issue across U.S. primary care populations; approximately 21% of adults report engaging in risky or hazardous drinking (15), and the prevalence of current alcohol dependence is about 4% (16). Alcohol misuse contributes to a wide range of health conditions, such as hypertension, gastritis, liver disease and cirrhosis, pancreatitis, certain types of cancer (for example, breast and esophageal), cognitive impairment, anxiety, and depression (17). Alcohol misuse has also been implicated as a major factor in morbidity and mortality as a result of trauma, including falls, drownings, fires, motor vehicle crashes, homicide, and suicide (18). Alcohol use in pregnancy is linked to a pattern of developmental abnormalities known as the fetal alcohol syndrome, which occurs in about 0.2 to 1.5 per 1000 live births in the United States (19).

Scope of Review

The USPSTF commissioned a systematic evidence review of randomized, controlled trials and nonrandomized trials with controls or comparators published between 1985 and 2011 on screening and behavioral counseling interventions for alcohol misuse in adults, adolescents, and pregnant women. The review also included individual systematic evidence reviews with or without meta-analyses done between 2006 and 2011. The following topics were examined: direct evidence of the effectiveness of screening for improving health outcomes, the accuracy of various screening approaches, the effectiveness of various behavioral counseling interventions for improving intermediate (such as rate of alcohol consumption or number of heavy drinking episodes) or long-term (such as alcohol-associated morbidity or mortality) health outcomes, the harms of screening and behavioral counseling interventions, and influences on the health care system that promote or detract from effective screening and counseling interventions for alcohol misuse.

Accuracy of Screening Tests

Numerous screening instruments can detect some or all of the drinking categories included in the spectrum of alcohol misuse. Tests include single-question screening; AUDIT; the Cut-Down, Annoyed, Guilty, and Eye-Opener (CAGE) questionnaire and related tests designed specifically for pregnant women, such as the Tolerance, Annoyed, Cut-Down, and Eye-Opener (T-ACE) and Tolerance, Worried, Eye-Openers, Amnesia, Kut-Down (TWEAK); the Michigan Alcoholism Screening Test; the Rapid Alcohol Problems Screen; and the Alcohol-Related Problems Survey, among others. Several of these tests also have abbreviated versions.

Five fair- to good-quality systematic reviews compared different screening test characteristics in primary care populations (5, 6). Overall, the full AUDIT instrument, the abbreviated AUDIT-C, and single-question screening (asking, "How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?") have the best performance characteristics for detecting the full spectrum of alcohol misuse in adults, young adults, and pregnant women; therefore, the USPSTF prefers these screening approaches.

The AUDIT shows an optimal balance of sensitivity and specificity for detecting all forms of alcohol misuse when cutoff points of 4 or more (sensitivity, 84% to 85%; specificity, 77% to 84%) or 5 or more (sensitivity, 70% to 92%; specificity, 73% to 94%) are used; use of higher cutoff points increases specificity to an extent but reduces sensitivity. The sensitivity and specificity of AUDIT-C are best balanced at cutoff points of 4 or more (74% to 76% and 80% to 83%, respectively) and 3 or more (74% to 88% and 64% to 83%, respectively). Single-question screening has a reported sensitivity of 82% to 87% and specificity of 61% to 79% (5, 6). However, the sensitivity of these screening tests varies by sex and achieving similar sensitivity for women requires a cutoff 1 point lower than that for men. Although the CAGE questionnaire has frequently been used in primary care settings as a low-burden screening tool for alcohol disorders, it has comparatively poor sensitivity for identifying risky or hazardous drinking, particularly among older adults (14% to 39%) and pregnant women (38% to 49%) (5).

None of the identified systematic reviews provided information about the use of screening tests in adolescents.

Effectiveness of Screening and Behavioral Counseling Interventions

None of the published studies directly evaluated the effect of screening and consequent behavioral counseling interventions for alcohol misuse compared with no screening on alcohol-related morbidity or mortality in any population. However, the USPSTF did find adequate evidence that brief counseling interventions in adults with screening-detected risky or hazardous drinking positively affect several unhealthy drinking behaviors, including

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heavy episodic (binge) drinking, high average weekly intake of alcohol, and consumption above recommended intake limits.

Twenty-three randomized, controlled trials (11 of which were performed in the United States) compared the effects of behavioral counseling interventions with usual care in adults with screening-detected alcohol misuse. Most interventions evaluated were either brief or brief multicontact behavioral counseling interventions that were directly provided by primary care physicians. The mean age of participants was generally between 30 and 50 years (5, 6).

Studies show that behavioral counseling interventions reduce binge drinking. "Binge drinking" is heavy per-occasion alcohol use; the NIAAA defines it as a pattern of drinking that results in a BAC of 0.08% or higher, generally when men consume 5 or more drinks and women consume 4 or more drinks on 1 occasion within about 2 hours (20). Meta-analysis from 7 trials showed that behavioral counseling interventions resulted in a 12% absolute increase in the proportion of adult participants with screening-detected risky or hazardous drinking who reported no heavy drinking episodes after 1 year compared with the control group (95% CI, 7% to 16%). Subgroup analyses suggest that single-contact interventions may be less effective or ineffective compared with multicontact approaches (5, 6).

In younger adults (such as college age), 3 trials provided evidence that behavioral counseling interventions reduced the frequency of heavy drinking episodes by about 1 day per month (average baseline, 6 to 7 heavy drinking days per month) at 6 months of follow-up (21–23). The evidence was insufficient to evaluate whether there are relative differences in the effect for older adults (aged 65 years or older).

Behavioral counseling interventions also reduce the total number of drinks per week consumed by adults with screening-detected risky or hazardous drinking. A standard drink is defined as 12.0 oz of beer, 5.0 oz of wine, or 1.5 oz of liquor. Meta-analysis of 10 trials reporting on this outcome showed that adults receiving behavioral counseling interventions reduced their average weekly consumption of alcohol from a baseline of 23 drinks to approximately 19 drinks per week at 12 months of follow-up compared with the control group (absolute difference, 3.6 fewer drinks per week [CI, 2.4 to 4.8]) (5, 6). Among younger adults, data from 3 trials conducted in the United States showed that average consumption decreased from a baseline of about 15 drinks to 13 drinks per week at 6 months of follow-up (21–23). Two studies provided information about the effect of behavioral counseling on weekly alcohol consumption rates in older adults; pooled analysis showed that consumption decreased from an average of about 16 drinks to about 14 drinks per week at 12 months of follow-up (24, 25).

On the basis of a meta-analysis of 9 relevant trials, the absolute proportion of adults with screening-detected risky or hazardous drinking who reported not exceeding recommended drinking limits over 12 months increased by 11% (CI, 8% to 13%) in participants receiving behavioral counseling interventions compared with the control group (5, 6). The definition and rationale of a given recommended limit of alcohol consumption may vary to some degree across guidelines, making this outcome slightly more subjective than the others evaluated by the USPSTF.

A commonly cited standard developed by the NIAAA recommends that healthy adult men aged 65 years or younger have no more than 4 drinks per day and no more than 14 drinks per week and healthy adult women and all adults older than 65 years have no more than 3 drinks per day and no more than 7 drinks per week. The NIAAA also recommends lower levels of consumption or abstinence for adults who receive medications that interact with alcohol, have a health condition exacerbated by alcohol, or are pregnant (26). For older adults (aged 65 years or older), 2 studies showed an absolute increase of 9% (CI, 2% to 16%) in the proportion of risky or hazardous drinkers who adhered to recommended drinking limits after behavioral counseling at 1 year of follow-up (24, 25). There was not enough evidence to assess whether there are relative differences in the effect for younger adults.

A single study meeting inclusion criteria was identified for pregnant women. In this trial, 250 pregnant women with a gestational age of 28 weeks or less were randomly assigned to comprehensive assessment only or assessment and a 45-minute behavioral counseling intervention. The study found a sustained reduction in the daily consumption of alcohol in both groups (with no significant difference between them); it also found that women who abstained from alcohol at baseline in the behavioral intervention group were more likely to do so than women in the control group (86% vs. 72%; $P = 0.04$) (27). Only 1 study meeting inclusion criteria included women who were breastfeeding (28), and they made up less than 30% of the total population. However, as previously described, multiple studies in the general adult population showed that behavioral counseling interventions reduce alcohol consumption and increase adherence to recommended drinking limits among women of childbearing age.

No studies meeting inclusion criteria were identified for the effects of brief behavioral counseling interventions on screening-detected alcohol misuse in adolescents.

Few studies of behavioral counseling interventions for alcohol misuse have rigorously examined longer-term health outcomes, such as alcohol-related morbidity or mortality. Meta-analysis of 6 studies did not find a significant effect of behavioral counseling interventions on all-cause mortality (rate ratio, 0.52 [CI, 0.22 to 1.2]), although findings generally trended favorably for the intervention groups. However, because none of the studies was designed or powered to detect a difference in mortality, it is difficult to draw any firm conclusions about the true effect (5, 6). A sizable body of observational evidence does show a link

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between increasing alcohol consumption levels and risk for traumatic injury or death.

A 2010 systematic review and meta-analysis of case–control and case-crossover studies evaluating the association between level of acute alcohol consumption and probability of an injury related to a motor vehicle crash found a rapidly increasing dose–response relationship between the 2 variables. For the consumption of 24 g of alcohol (or about 2 standard drinks) within a 6-hour period, the odds ratio of being injured in a motor vehicle crash is 2.20 compared with no alcohol intake; at 4 to 5 drinks consumed (a rough proxy for the NIAAA definition of a heavy drinking episode), the odds ratio is about 5.00 to 10.00, and after 10 drinks, the odds ratio is 52.00 (29). A review of case–control roadside surveys evaluating the relationship between BAC in drivers involved in motor vehicle crashes compared with those not involved in incidents found that the relative probability of a motor vehicle crash resulting in injury or death increased sharply after attainment of a BAC of about 0.08% (relative risk ranged from about 2 to 4 at a BAC of 0.08% compared with a BAC of 0.00%, with sharper increases at higher BACs) (30).

Screening for alcohol misuse will detect persons engaging in a spectrum of unhealthy drinking behaviors, not just risky or hazardous drinking. However, most available studies of behavioral counseling interventions focused on risky or hazardous drinking and either specifically excluded persons with alcohol dependence or used enrollment criteria that necessarily restricted participation by such persons. The limited evidence available for persons with alcohol dependence suggests that brief behavioral counseling interventions may be ineffective in this population (5, 6). The effectiveness of behavioral counseling in primary care settings for persons engaging in harmful alcohol use or alcohol abuse is uncertain.

Although the USPSTF did not formally assess the evidence on interventions for alcohol dependence, a range of treatment options with established efficacy exists, including 12-step programs (such as Alcoholics Anonymous), intensive outpatient or inpatient treatment programs, and pharmacotherapy. However, the relative effectiveness of the various treatment approaches has not been systematically examined in randomized trials and the USPSTF was unable to identify any trials of pharmacotherapy in the primary care setting.

Potential Harms of Screening and Behavioral Counseling

Very limited evidence is available on the harms of screening and behavioral counseling for alcohol misuse. Possible harms include anxiety, labeling, discrimination, or interference with the doctor–patient relationship. An additional effect might be a consequent increase in smoking or illicit substance use, if persons receiving screening or behavioral counseling interventions for risky drinking replace 1 harmful substance with another.

No studies directly evaluated the harms of screening; few studies reported information about harms resulting from behavioral counseling interventions. Two studies found no changes in anxiety levels among adults with screening-detected alcohol misuse receiving behavioral counseling, and 5 studies qualitatively described that cigarette consumption seemed unchanged among adults receiving counseling interventions (5, 6). No specific information was available for the adolescent population. No direct evidence of harm from screening or behavioral counseling for alcohol misuse was identified in any study; given the noninvasive nature of these practices, the adverse effects are likely to be small to none.

Estimate of Magnitude of Net Benefit

Adequate evidence supports a moderate beneficial effect of screening for alcohol misuse followed by brief behavioral counseling interventions in adults engaged in risky or hazardous drinking. Unhealthy drinking behaviors in this population, including heavy episodic drinking, high daily or weekly levels of alcohol consumption, and exceeding recommended drinking limits, can all be reduced through screening and behavioral counseling in the primary care setting. Although limited specific evidence for pregnant women was found, the USPSTF determined that available studies of behavioral counseling interventions for alcohol misuse in the general adult population apply to pregnant adult women.

Available studies have not focused on the effect of screening and behavioral counseling on longer-term health outcomes, such as alcohol-related disease or death. However, epidemiologic evidence supports an association between increasing alcohol consumption and increased risk for morbidity and mortality related to a motor vehicle crash, providing indirect support that counseling interventions—which reduce acute and sustained alcohol intake levels—can help improve some health outcomes in alcohol misuse (29, 30). A large body of observational evidence also links alcohol use in pregnant women with an increased risk for subsequent birth defects (31, 32).

Given the noninvasive nature of screening and counseling interventions for alcohol misuse, the USPSTF assessed the range of probable harms to be small to none. Therefore, given moderate benefit and little to no associated harm, the USPSTF concludes with moderate certainty that the net benefit of screening adults, including younger adults, for alcohol misuse and providing brief behavioral counseling interventions for those engaged in risky or hazardous drinking is moderate.

No studies were identified that addressed screening and behavioral counseling interventions for alcohol misuse in adolescents. As such, the USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling for alcohol misuse in this population.

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Response to Public Comments

A draft version of this recommendation statement was posted on the USPSTF Web site from 24 September 2012 to 22 October 2012. Several comments indicated that the USPSTF should more clearly emphasize the need for more research on screening and counseling interventions for alcohol misuse in the adolescent population; this was added to the Research Needs and Gaps section. Some comments requested the inclusion of recommended screening instruments; links to these tools were added to the Useful Resources section. Several comments indicated that there was insufficient explanation of the distinctions between risky drinking and alcohol dependence, as well as what constitutes "binge" drinking or a "drink"; expanded definitions and examples were added to the Rationale and Discussion sections.

Update of Previous Recommendation

This recommendation replaces the 2004 recommendation. In this update, the USPSTF has clarified that it defines alcohol misuse as encompassing the full spectrum of unhealthy drinking behaviors, from risky drinking to alcohol dependence, rather than limiting its meaning to just risky, hazardous, or harmful drinking (because screening will detect a broad range of unhealthy drinking behaviors). However, the USPSTF emphasizes that evidence on the effectiveness of brief behavioral counseling interventions in the primary care setting remains largely restricted to persons engaging in risky or hazardous drinking.

Recommendations of Others

The American Society of Addiction Medicine recommends that primary care providers routinely screen for the presence of alcohol use problems in patients, screen for risk factors for development of alcohol dependence, and provide appropriate interventions (33). The NIAAA encourages primary care clinicians to incorporate alcohol screening and interventions into their practices and provides specific tools to implement these activities (26).

The American College of Obstetricians and Gynecologists states that obstetrician–gynecologists have a key role in screening and providing brief intervention, patient education, and treatment referral for their patients who drink alcohol at risk levels. For pregnant women and those at risk for pregnancy, it is important that obstetrician–gynecologists give compelling and clear advice to avoid alcohol use or provide assistance for achieving abstinence or effective contraception to women who require help (34).

The American Academy of Pediatrics recommends that clinicians screen all adolescent patients for alcohol use with a formal, validated screening tool, such as the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) substance abuse screening test, at every health supervision visit and appropriate acute care visits and respond to screening results with the appropriate brief intervention (35).

From the U.S. Preventive Services Task Force, Rockville, Maryland.

Disclaimer: Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

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Requests for Single Reprints: Reprints are available from the USPSTF Web site (www.uspreventiveservicestaskforce.org).

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Appendix: U.S. Preventive Services Task Force

Members of the U.S. Preventive Services Task Force at the time this recommendation was finalized† are Virginia A. Moyer, MD, MPH, *Chair* (American Board of Pediatrics, Chapel Hill, North Carolina); Michael L. LeFevre, MD, MSPH, *Co-Vice Chair* (University of Missouri School of Medicine, Columbia, Missouri); Albert L. Siu, MD, MSPH, *Co-Vice Chair* (Mount Sinai School of Medicine, New York, and James J. Peters Veterans Affairs Medical Center, Bronx, New York); Linda Ciofu Baumann, PhD, RN (University of Wisconsin, Madison, Wisconsin); Kirsten Bibbins-Domingo, PhD, MD (University of California, San Francisco, San Francisco, California); Susan J. Curry, PhD (University of Iowa College of Public Health, Iowa City, Iowa); Mark Ebell, MD, MS (University of Georgia, Athens, Georgia); Glenn Flores, MD (University of Texas Southwestern, Dallas, Texas); Francisco A.R. García, MD, MPH (Pima County Department of Health, Tucson, Arizona); Adelita Gonzales Cantu, RN, PhD (University of Texas Health Science Center, San Antonio, Texas); David C. Grossman, MD, MPH (Group Health Cooperative, Seattle, Washington); Jessica Herzstein, MD, MPH (Air Products, Allentown, Pennsylvania); Wanda K. Nicholson, MD, MPH, MBA (University of North Carolina School of Medicine, Chapel Hill, North Carolina); Douglas K. Owens, MD, MS (Veteran Affairs Palo Alto Health Care System, Palo Alto, and Stanford University, Stanford, California); William R. Phillips, MD, MPH (University of Washington, Seattle, Washington); and Michael P. Pignone, MD, MPH (University of North Carolina, Chapel Hill, North Carolina). Joy Melnikow, MD, MPH, a former USPSTF member, also contributed to the development of this recommendation.

† For a list of current Task Force members, go to www.uspreventiveservicestaskforce.org/members.htm.

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Appendix Table 1. **What the USPSTF Grades Mean and Suggestions for Practice**

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer/provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Appendix Table 2. **USPSTF Levels of Certainty Regarding Net Benefit**

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies; inconsistency of findings across individual studies; limited generalizability of findings to routine primary care practice; and lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies; important flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; findings that are not generalizable to routine primary care practice; and a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

* The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.

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Office of the Surgeon General

U.S. Surgeon General's Advisory: Marijuana Use and the Developing Brain

I, Surgeon General VADM Jerome Adams, am emphasizing the importance of protecting our Nation from the health risks of marijuana use in adolescence and during pregnancy. Recent increases in access to marijuana and in its potency, along with misperceptions of safety of marijuana endanger our most precious resource, our nation's youth.

KNOW THE RISKS. TAKE ACTION. PROTECT OUR FUTURE.

Background

Marijuana, or cannabis, is the most commonly used illicit drug in the United States. It acts by binding to cannabinoid receptors in the brain to produce a variety of effects, including euphoria, intoxication, and memory and motor impairments. These same cannabinoid receptors are also critical for brain development. They are part of the endocannabinoid system, which impacts the formation of brain circuits important for decision making, mood and responding to stress[1].

Marijuana and its related products are widely available in multiple forms. These products can be eaten, drunk, smoked, and vaped[2]. Marijuana contains varying levels of delta-9-tetrahydrocannabinol (THC), the component responsible for euphoria and intoxication, and cannabidiol (CBD). While CBD is not intoxicating and does not lead to addiction, its long-term effects are largely unknown, and most CBD products are untested and of uncertain purity[3].

Marijuana has changed over time. The marijuana available today is much stronger than previous versions. The THC concentration in commonly cultivated marijuana plants has increased three-fold between 1995 and 2014 (4% and 12% respectively)[4]. Marijuana available in dispensaries in some states has average concentrations of THC between 17.7% and 23.2%[5]. Concentrated products, commonly known as dabs or waxes, are far more widely available to recreational users today and may contain between 23.7% and 75.9% THC[6].

The risks of physical dependence, addiction, and other negative consequences increase with exposure to high concentrations of THC[7] and the younger the age of initiation. Higher doses of THC are more likely to produce anxiety, agitation, paranoia, and psychosis[8]. Edible marijuana takes time to absorb and to produce its effects, increasing the risk of unintentional overdose, as well as accidental ingestion by children[9] and adolescents[10]. In addition, chronic users of marijuana with a high THC content are at risk for developing a condition known as cannabinoid hyperemesis syndrome, which is marked by severe cycles of nausea and vomiting[11].

This advisory is intended to raise awareness of the known and potential harms to developing brains, posed by the increasing availability of highly potent marijuana in multiple, concentrated forms. These harms are costly to individuals and to our society, impacting mental health and educational achievement and raising the risks of addiction and misuse of other substances. Additionally, marijuana use remains illegal for youth under state law in all states; normalization of its use raises the potential for criminal consequences in this population. In addition to the health risks posed by marijuana use, sale or possession of marijuana remains illegal under federal law notwithstanding some state laws to the contrary.

Marijuana Use during Pregnancy

Pregnant women use marijuana more than any other illicit drug. In a national survey, marijuana use in the past month among pregnant women doubled (3.4% to 7%) between 2002 and 2017[12]. In a study conducted in a large health system, marijuana use rose by 69% (4.2% to 7.1%) between 2009 and 2016 among pregnant women[13]. Alarmingly, many retail dispensaries recommend marijuana to pregnant women for morning sickness[14].

Marijuana use during pregnancy can affect the developing fetus. THC can enter the fetal brain from the mother's bloodstream and may disrupt the endocannabinoid system, which is important for a healthy pregnancy and fetal brain development[1]. Moreover, studies have shown that marijuana use in pregnancy is associated with adverse outcomes, including lower birth weight[15]. The Colorado Pregnancy Risk Assessment Monitoring System reported that maternal marijuana use was associated with a 50% increased risk of low birth weight regardless of maternal age, race, ethnicity, education, and tobacco use[16].

The American College of Obstetricians and Gynecologists holds that "[w]omen who are pregnant or contemplating pregnancy should be encouraged to discontinue marijuana use. Women reporting marijuana use should be counseled about concerns regarding potential adverse health consequences of continued use during pregnancy"[17]. In 2018, the American Academy of Pediatrics recommended that "…it is important to advise all adolescents and young women that if they become pregnant, marijuana should not be used during pregnancy"[18].

Maternal marijuana use may still be dangerous to the baby after birth. THC has been found in breast milk for up to six days after the last recorded use. It may affect the newborn's brain development and result in hyperactivity, poor cognitive function, and other long-term consequences[19], [20], [21]. Additionally, marijuana smoke contains many of the same harmful components as tobacco smoke[22]. No one should smoke marijuana or tobacco around a baby.

Marijuana Use during Adolescence

Marijuana is also commonly used by adolescents4, second only to alcohol. In 2017, approximately 9.2 million youth aged 12 to 25 reported marijuana use in the past month and 29% more young adults aged 18-25 started using marijuana[23]. In addition, high school students' perception of the harm from regular

marijuana use has been steadily declining over the last decade[24]. During this same period, a number of states have legalized adult use of marijuana for medicinal or recreational purposes, while it remains illegal under federal law. The legalization movement may be impacting youth perception of harm from marijuana.

The human brain continues to develop from before birth into the mid-20s and is vulnerable to the effects of addictive substances[25], [26]. Frequent marijuana use during adolescence is associated with changes in the areas of the brain involved in attention, memory, decision-making, and motivation. Deficits in attention and memory have been detected in marijuana-using teens even after a month of abstinence[27]. Marijuana can also impair learning in adolescents. Chronic use is linked to declines in IQ, school performance that jeopardizes professional and social achievements, and life satisfaction[28]. Regular use of marijuana in adolescence is linked to increased rates of school absence and drop-out, as well as suicide attempts[29].

Marijuana use is also linked to risk for and early onset of psychotic disorders, such as schizophrenia. The risk for psychotic disorders increases with frequency of use, potency of the marijuana product, and as the age at first use decreases[30]. Adolescent marijuana use is often also associated with other substance use[31], [32]. In 2017, teens 12-17 reporting frequent use of marijuana showed a 130% greater likelihood of misusing opioids23. Marijuana's increasingly widespread availability in multiple and highly potent forms, coupled with a false and dangerous perception of safety among youth, merits a nationwide call to action.

You Can Take Action

No amount of marijuana use during pregnancy or adolescence is known to be safe. Until and unless more is known about the long-term impact, the safest choice for pregnant women and adolescents is not to use marijuana. Pregnant women and youth--and those who love them--need the facts and resources to support healthy decisions. It is critical to educate women and youth, as well as family members, school officials, state and local leaders, and health professionals, about the risks of marijuana, particularly as more states contemplate legalization.

Science-based messaging campaigns and targeted prevention programming are urgently needed to ensure that risks are clearly communicated and amplified by local, state, and national organizations. Clinicians can help by asking about marijuana use, informing mothers-to-be, new mothers, young people, and those vulnerable to psychotic disorders, of the risks. Clinicians can also prescribe safe, effective, and FDA-approved treatments for nausea, depression, and pain during pregnancy. Further research is needed to understand all the impacts of THC on the developing brain, but we know enough now to warrant concern and action. Everyone has a role in protecting our young people from the risks of marijuana.

Information for Parents and Parents-to-be

You have an important role to play for a healthy next generation.

- Review the facts to understand the risks associated with marijuana use during pregnancy.

- Check out these Frequently Asked Questions about marijuana use and pregnancy.
- Learn about marijuana safety for children and pregnant and breastfeeding women.
- Start a conversation with your kids: Marijuana: Facts Parents Need to Know.
- Keep your adolescent from using marijuana and other drugs: Keeping Youth Drug Free - PDF.
- Watch the Message to Parents from NIH/NIDA

Information for Youth:

You have an important role to play for a healthy next generation.

- Want to know how marijuana affects brain development? Get the facts.
- Learn key techniques on how to resist peer pressure: Above the Influence.
- Learn how to help friends stop using marijuana with Letter to Teens
- Get around-the-clock free advice and referrals: Substance Abuse and Mental Health Administration (SAMHSA) National Helpline (1-800-662-HELP (4357).

Information for States, Communities, Tribes, and Territories:

You have an important role to play for a healthy next generation.

- Learn how communities and schools can act: Preventing Marijuana Use among Youth & Young Adults.
- Find key messages for communities at www.samhsa.gov/marijuana.
- Get training and educational resources for your community: Prevention Technology Transfer Centers.

Information for Health Professionals:

You have an important role to play for a healthy next generation.

- Learn how you can integrate marijuana education into prenatal care visits: Marijuana Pregnancy & Breastfeeding Guidance - PDF.
- Get advice on talking with adolescents and parents about marijuana use from the American Academy of Pediatrics guidance for clinicians.
- Read the American College of Obstetricians and Gynecologists position on Marijuana use during pregnancy and lactation.

Footnotes

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ABM Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015

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A central goal of The Academy of Breastfeeding Medicine is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

Purpose

The choice of breastfeeding by a pregnant or newly postpartum woman with a history of past or current illegal/illicit drug abuse or legal substance use or misuse is challenging for many reasons. The purpose of this protocol is to provide literature-based guidelines for the evaluation and management of the woman with substance use or a substance use disorder who is considering breastfeeding.

Background

Illicit drug use and legal substance use/abuse remain a significant problem among women of childbearing age. The 2013 National Survey on Drug Use and Health revealed that among pregnant women 15–44 years of age in the United States, 5.2% had used illicit drugs in the past month, 9.4% reported current alcohol use, 2.3% reported binge drinking, 0.4% reported heavy drinking during the pregnancy, and 15.4% reported cigarette use in the past month.[1]

The healthcare provider presented with a pregnant or recently postpartum woman with a history of current or past illegal drug abuse or legal drug use or misuse who desires to breastfeed often faces multiple significant challenges. Substance use disorders frequently engender behaviors or conditions that independently signify risk for the breastfed infant, in addition to the drug exposure per se. These mothers may have coexisting risk factors such as low socioeconomic status (although substance use crosses all socioeconomic lines), low levels of education, poor nutrition, and little to no prenatal care. Multiple drug use is common, in addition to the use of other harmful legal substances, including tobacco and alcohol. Illicit drugs are frequently mixed and extended with dangerous adulterants that can pose additional threats to the health of the mother and the infant. Drug users are at high risk for infections such as human immunodeficiency virus and/or hepatitis B and C. Psychiatric disorders that require pharmacotherapeutic intervention are more prevalent with substance use, making breastfeeding an even more complicated choice, as breastfeeding may not be recommended for women taking some psychotropic medications.

Despite the myriad factors that may make breastfeeding a difficult choice for women with substance use disorders, drug-exposed infants, who are at a high risk for an array of medical, psychological, and developmental issues, as well as their mothers, stand to benefit significantly from breastfeeding. Although many of the factors listed above may pose a risk to the infant, the documented benefits of human milk and breastfeeding must be carefully and thoughtfully weighed against the risks associated with the substance that the infant may be exposed to during lactation. Confounding many efforts to examine longer-term developmental outcomes in infants exposed to some substances is the lack of data evaluating infants who were not exposed during pregnancy but only during lactation.

Ideally, women with substance use disorders delivering an infant and desiring to breastfeed are engaged in comprehensive healthcare and substance abuse treatment during pregnancy, but this is not always the case. Substance abuse treatment for these women is often not available, not gender specific, and not comprehensive, forcing the mother's healthcare provider

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during and after pregnancy to rely on maternal self-report and a ''best guess'' at adequacy of services, compliance to treatment, length of ''clean'' time, community support systems, etc. In a recent retrospective study in the United Kingdom, significantly lower rates of breastfeeding initiation occurred in mothers who used illicit substances or opioid maintenance therapy during pregnancy (14% versus 50% of the general population).[2] In Norway, among opioid-dependent women on opioid maintenance therapy, 77% (compared with 98% in the general population) initiated breastfeeding after delivery.[3]

The specific terms used to describe use and misuse of various legal and illegal substances continue to evolve and may vary from country to country and among different organizations. The 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* combines the previous categories of substance abuse and substance dependence into the category single substance use disorder, which is measured on a continuum from mild to severe.[4]

Of important note is that we would like to make it clear that drugs of any type should be avoided in pregnant and breastfeeding women, unless prescribed for specific medical conditions. The casual use of drugs—legal, illegal, illicit, dose appropriate or not—still may have ramifications for the developing fetus and infant that we have yet to determine, and hence, in general, drugs of all types should be avoided unless medically necessary.

Specific Substances

Perhaps the most critical challenge facing the healthcare provider for the woman with a substance use disorder who wishes to breastfeed is the lack of research leading to evidence-based guidelines. Table 1 gives two online Web sites, one in English and one in both English and Spanish, that are kept updated and are easily accessible for current information on drugs and breastfeeding. There have been several comprehensive reviews of breastfeeding among substance-using women, essentially concluding that breastfeeding is generally contraindicated in mothers who use illegal drugs.[5–8] (III) (Quality of evidence [levels of evidence I, II-1, II-2, II-3, and III] is based on the U.S. Preventive Services Task Force Appendix A Task Force Ratings[9] and is noted throughout this protocol in parentheses.) Yet, research on individual drugs of abuse remains lacking and difficult to perform. Pharmacokinetic data for most drugs of abuse in lactating women are sparse and based on small numbers of subjects and case reports.[7] Most illicit drugs are found in human milk, with varying degrees of oral bioavailability.[7] Phencyclidine hydrochloride has been detected in human milk in high concentrations,[10] as has cocaine,[11] leading to infant intoxication.[12] There is little to no evidence to describe the effects of even small amounts of other drugs of abuse and/or their metabolites in human milk on infant development aside from those discussed further below.

Methadone

For pregnant and postpartum women with opioid dependence in treatment, methadone maintenance has been the treatment of choice in the United States, Canada,[13] and many other countries. In contrast to other substances, concentrations of methadone in human milk and the effects on the infant have been studied. The concentrations of methadone found in human milk are low, and all authors have concluded that women on stable doses of methadone maintenance should be encouraged to breastfeed if desired, irrespective of maternal methadone dose.[3,14–22] (II-1, II-2, II-3) Previously, no apparent effects of methadone exposure prenatally and in human milk were reported on infant neurobehavior at 30 days.[19] Recently an ongoing longitudinal follow-up study of methadone-exposed infants with 200 methadone-exposed and nonexposed, demographically matched families has shown neurocognitive delays in methadone-exposed 1-month-old infants compared with nonexposed infants. When retested at 7 months, methadone-exposed infants were similar to nonexposed, comparison infants. At 9 months of age, 37.5% of this sample of methadone-exposed infants showed clinically significant motor delays (≥ 1.5 standard deviation) compared with low but typical development in the comparison group.[21] Exposed infants typically have high environmental risk profiles, which continue at birth, posing ongoing risk to the developing child.

The current thought is that environmental risk factors combine with prenatal exposures to promote epigenetic changes in gene expression and methylation patterns that have both immediate and long-term implications related to developmental programming.[22] Note that these findings relate to infants exposed to methadone both prenatally and after birth via breastfeeding, and there is little information available on infants with chronic methadone exposure via breastfeeding alone.

In addition, about 70% of infants born to women prescribed methadone during pregnancy will experience neonatal abstinence syndrome (NAS),[23] the constellation of signs and symptoms often presenting following in utero opioid exposure. Infants with significant NAS can experience difficulties with attaching and sucking/swallowing during breastfeeding that can impact their ability to breastfeed.

Table 1. Online Web Sites with Updated Breastfeeding and Drug Information

Web site	*URL*	*Language*
U.S. National Library of Health, National Institute of Health, U.S. Department of Health and Human Services, ''LactMed''	http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm	English
e-Lactancia	http://e-lactancia.org/	English
Association for Promotion and Cultural and Scientific Research of Breastfeeding Under a Creative Commons International License	(Also contains medical prescriptions, phytotherapy, homeopathy and other alternative products, cosmetic and medical procedures, contaminants, maternal and infant diseases and more)	Spanish

However, given that there is increasing evidence supporting the conclusion that there is a reduction in the severity and duration of treatment of NAS when mothers on methadone maintenance therapy breastfeed, breastfeeding for these dyads should be encouraged.[3,17–19] (II-1, II-3) Unfortunately, the rate of breastfeeding initiation in this cohort is generally low, less than half that reported in the U.S. general population.[24] A small recent qualitative study demonstrated that lack of support from the healthcare community and misinformation about the dangers of breastfeeding while on methadone therapy are significant, yet modifiable, barriers to breastfeeding success in these women.[25] Given the benefits to these mothers and infants to remain on methadone maintenance therapy and breastfeed, it is important for us to provide robust ongoing support for this vulnerable group.

Buprenorphine

Buprenorphine is a partial opioid agonist used for treatment of opioid dependency during pregnancy in some countries and increasingly in the United States. Multiple small case series have examined maternal buprenorphine concentrations in human milk. All concur that the amounts of buprenorphine in human milk are small and are unlikely to have short-term negative effects on the developing infant.[26–31] In one study, 76% of 85 maternal–infant pairs breastfed, with 66% still breastfeeding 6–8 weeks postpartum. The breastfed infants had less severe NAS and were less likely to require pharmacological intervention than the formula-fed infants, similar to methadone discussed above, although this did not reach statistical significance with the size of the sample studied.[31]

Other opioids

Use of opioids in the United States has increased substantially over the last decade. A retrospective cross-sectional analysis of NAS in hospital births in the years from 2000 to 2009 found an increase in incidence from 1.2 to 3.39 per 1,000 births. Antepartum maternal opioid use was also found to have risen from 1.19 to 5.63 per 1,000 hospital births from 2000 to 2009; any use of opioids was included in data collection.[32] A recent Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Report* highlighted data demonstrating that approximately one-third of women of reproductive age filled a prescription for opioids each year between 2008 and 2012.[33]

When use of narcotics during pregnancy is determined to be consistent with an opioid use disorder rather than a modality for short-term pain relief, consideration of initiation of maintenance methadone or buprenorphine as previously discussed is strongly encouraged,[13,34,35] and these mothers should be supported in breastfeeding initiation. (III) Short courses of most other low-dose prescription opioids can be safely used by a breastfeeding mother,[36,37] but caution is urged with codeine, as *CYP2D6* ultra-rapid metabolizers may experience high morphine (metabolite) blood levels, and there has been a single case report of a breastfeeding neonatal death after maternal use.[38] (III) Information is lacking on the safety of breastfeeding when moderate to high doses of opioids are used for long periods of time. There is also a lack of information available about transitioning mothers from short-acting opioids to opioid maintenance therapy while breastfeeding rather than during pregnancy.

Marijuana

Uniform guidelines regarding the varied use of marijuana by breastfeeding mothers are difficult to create and cannot hope to cover all situations. The legality of possessing and using marijuana varies greatly from country to country; in the United States, there are increasing numbers of states where it is legal for ''medicinal use'' with a prescription, and a few states where it is legal for ''recreational use,'' but under federal law, it remains illegal in all states. Therefore, basing recommendations on marijuana use and concurrent breastfeeding from a purely legal standpoint becomes inherently complex, problematic, and impossible to apply uniformly across all settings and jurisdictions. As laws shift and marijuana use becomes even more common in some areas, it becomes increasingly important to carefully weigh the risks of initiation and continuation of breastfeeding while using marijuana with the risks of not breastfeeding while also considering the wide range of occasional, to regular medical, to heavy exposure to marijuana.

In addition to the potential legal risk, the health risks to the infant from the mother's marijuana use must be carefully considered. Δ^9-Tetrahydrocannabinol (THC), the main compound in marijuana, is present in human milk up to eight times that of maternal plasma levels, and metabolites are found in infant feces, indicating that THC is absorbed and metabolized by the infant.[39] It is rapidly distributed to the brain and adipose tissue and stored in fat tissues for weeks to months. It has a long half-life (25–57 hours) and stays positive in the urine for 2–3 weeks,[40] making it impossible to determine who is an occasional versus a chronic user at the time of delivery by urine toxicology screening. Evidence regarding the effects of THC exposure on infant development via breastfeeding alone is sparse and conflicting,[41,42] and there are no data evaluating neurodevelopmental outcomes beyond the age of 1 year in infants who are only exposed after birth. Also notable in this discussion of risk is that the potency of marijuana has been steadily increasing, from about 3% in the 1980s to 12% in 2012, so data from previous studies may no longer even be relevant.[43] Additionally, current concern over marijuana use during lactation stems from possible infant sedation and maternal inability to safely care for her infant while directly under its influence; however, this remains a theoretical problem and has not been well established in the literature.[44]

Human and animal evidence examining the behavioral and neurobiological effects of exposure to cannabinoids during pregnancy and lactation shows that the endocannabinoid system plays a crucial role in the ontogeny of the central nervous system and its activation, during brain development. As Campolongo et al.[45] concluded, cannabinoid exposure during critical periods of brain development can induce subtle and long-lasting neurofunctional alterations. Several preclinical studies highlight how even low to moderate doses during particular periods of brain development can have profound consequences for brain maturation, potentially leading to long-lasting alterations in cognitive functions and emotional behaviors.[45] Exposure to second-hand marijuana smoke by infants has been associated with an independent two times possible risk of sudden infant death syndrome (SIDS)[46] (III); because breastfeeding reduces risk of SIDS, this needs to be additionally considered. Thus careful

contemplation of these issues should be fully incorporated into the care plans of the lactating woman in the setting of THC use. Breastfeeding mothers should be counseled to reduce or eliminate their use of marijuana to avoid exposing their infants to this substance and advised of the possible long-term neurobehavioral effects from continued use. (III)

Alcohol

Use of alcohol during pregnancy is strongly discouraged, as it can cause fetal alcohol syndrome, birth defects, spontaneous abortion, and premature births, among other serious problems.[47,48] (III) Many women who significantly decrease or eliminate their alcohol intake during pregnancy may choose to resume consuming alcohol after giving birth, with approximately half of breastfeeding women in Western countries reported to consume alcohol at least occasionally.[49] Alcohol interferes with the milk ejection reflex, which may ultimately reduce milk production through inadequate breast emptying.[50] (III) Human milk alcohol levels generally parallel maternal blood alcohol levels, and studies evaluating infant effects of maternal alcohol consumption have been mostly mixed, with some mild effects seen in infant sleep patterns, amount of milk consumed during breastfeeding sessions, and early psychomotor development.[50] (III) Possible long-term effects of alcohol in maternal milk remain unknown. Most sources advise limiting alcohol intake to the equivalent of 8 ounces of wine or two beers, and waiting 2 hours after drinking to resume breastfeeding.[5–7,35] (III) To ensure complete elimination of alcohol from breastmilk, mothers may consult a normogram devised by the Canadian Motherisk program to determine length of time needed based on maternal weight and amount consumed.[51] (III)

Tobacco

Approximately two-thirds as many pregnant women as nonpregnant women smoke tobacco, with decreasing numbers of women smoking as pregnancy progresses.[1] Many mothers quit during pregnancy. but postpartum relapse is common. with about 50% resuming tobacco use in the first few months after birth.[52–54] Data on the epidemiology of breastfeeding mothers who smoke cigarettes remains complex, and smoking in many series has been found to be associated with reduced rates of breastfeeding.[55,56] Nicotine and other compounds are known to transfer to the infant via milk, and considerable transfer of chemicals via second-hand smoke also occurs when infants are exposed to environmental tobacco smoke. Increases in the incidence of respiratory allergy in infants and in SIDS are just two significant well-known risks of infant exposure to environmental tobacco smoke.[8] (III) Most sources endorse promotion of breastfeeding in the setting of maternal smoking while vigorously supporting smoking cessation.[57] (III) Some smoking cessation modalities (nicotine patch, nicotine gum, and possibly buproprion) are compatible with breastfeeding and can be encouraged in many circumstances.[6,7,58] (III)

Recommendations

General (Circumstances favorable with consideration)

Infants of women with substance use disorders, at risk for multiple health and developmental difficulties, stand to benefit substantially from breastfeeding and human milk, as do their mothers. A prenatal plan preparing the mother for parenting, breastfeeding, and substance abuse treatment should be formulated through individualized, patient-centered discussions with each woman. This care plan should include instruction in the consequences of relapse to drug or excessive alcohol use during lactation, as well as teaching regarding potential for donor milk, formula preparation, and bottle handling and cleaning should breastfeeding be or become contraindicated. In the perinatal period each mother–infant dyad should be carefully and individually counseled on breastfeeding prior to discharge from maternity care. This evaluation must consider several factors, including (III)

- drug use and substance abuse treatment histories, including medication-assisted treatment with methadone or buprenorphine
- medical and psychiatric status
- other maternal medication needs
- infant health status (to include ongoing evaluation for NAS and impact on ability to breastfeed)
- the presence or absence and adequacy of maternal family and community support systems
- plans for postpartum care and substance abuse treatment for the mother and pediatric care for the child.

Optimally, the woman with a substance use disorder who presents a desire to breastfeed should be engaged in treatment pre- and postnatally. Maternal written consent for communication with her substance abuse treatment provider should be obtained prior to delivery if possible. (III)

Any discussion with mothers who use substances with sedating effects should include counseling on safely caring for her infant and instruction on safe sleep practices. (III)

Encourage women under the following circumstances to breastfeed their infants (III):

- Engaged in substance abuse treatment; provision of maternal consent to discuss progress in treatment and plans for postpartum treatment with substance abuse treatment counselor; counselor recommendation for breastfeeding
- Plans to continue in substance abuse treatment in the postpartum period
- Abstinence from drug use for 90 days prior to delivery; ability to maintain sobriety demonstrated in an outpatient setting
- Toxicology testing of maternal urine negative at delivery
- Engaged in prenatal care and compliant.

Opioids/narcotics

- Encourage stable methadone- or buprenorphine-maintained women to breastfeed regardless of dose
- Management of mothers who use chronic opioid therapy for pain should be closely supervised by a chronic pain physician who is familiar with pregnancy and breastfeeding (III):

  a. Length of time on these medications, total dose, and whether the medications were used during pregnancy should all help inform the decision of whether breastfeeding may be safely undertaken in certain cases.

b. Judicious amounts of oral narcotic pain medication, when used in a time-limited situation for an acute pain problem, are generally compatible with continued breastfeeding if supervision and monitoring of the breastfeeding infant are adequate.[36,37]

- Rapidly increasing narcotic dosing in a breastfeeding mother should prompt further evaluation and reconsideration of the safety of continued breastfeeding.

Nicotine

- Counsel mothers who smoke cigarettes after giving birth to reduce their intake as much as possible, and not to smoke around their infant, to reduce infant exposure to second-hand smoke. Smoking cessation and nicotine replacement modalities such as nicotine patches and gum may be useful for some mothers. (III)
- Give mothers who smoke tobacco additional support, as maternal smoking appears to be an independent and associated risk factor for noninitiation and early cessation of breastfeeding, to help ensure its success. (III)

Alcohol

- Counsel mothers who wish to drink occasional alcohol that alcohol easily transfers into human milk. Recommendations from the American Academy of Pediatrics, the World Health Organization, and others advise waiting 90–120 minutes after ingesting alcohol before breastfeeding, or expressing and discarding milk within that time frame.[5,6,7,35] (III)

Cannabis (THC)

- Information regarding long-term effects of marijuana use by the breastfeeding mother on the infant remains insufficient to recommend complete abstention from breastfeeding initiation or continuation based on the scientific evidence at this time. However, extrapolation from in utero exposure and the limited data available helps to inform the following recommendations (III):

a. Counsel mothers who admit to occasional or rare use to avoid further use or reduce their use as much as possible while breastfeeding, advise them as to its possible long-term neurobehavioral effects, and instruct them to avoid direct exposure of the infant to marijuana and its smoke.
b. Strongly advise mothers found with a positive urine screen for THC to discontinue exposure while breastfeeding and counsel them as to its possible long-term neurobehavioral effects.
c. When advising mothers on the medicinal use of marijuana during lactation, one must take into careful consideration and counsel on the potential risks of exposure of marijuana and benefits of breastfeeding to the infant.
d. The lack of long-term follow-up data on infants exposed to varying amounts of marijuana via human milk, coupled with concerns over negative neurodevelopmental outcomes in children with in utero exposure, should prompt extremely careful consideration of the risks versus benefits of breastfeeding in the setting of moderate or chronic marijuana use. A recommendation of abstaining from any marijuana use is warranted.
e. At this time, although the data are not strong enough to recommend not breastfeeding with any marijuana use, we urge caution.

General (Circumstances contraindicated or requiring more caution)

Counsel women under any of the following circumstances not to breastfeed (III):

- Not engaged in substance abuse treatment, or engaged in treatment and failure to provide consent for contact with counselor
- Not engaged in prenatal care
- Positive maternal urine toxicology screen for substances other than marijuana at delivery [see (b) above]
- No plans for postpartum substance abuse treatment or pediatric care
- Women relapsing to illicit drug use or legal substance misuse in the 30-day period prior to delivery
- Any behavioral or other indicators that the woman is actively abusing substances
- Chronic alcohol use.

Evaluate carefully women under the following circumstances, and determine appropriate advice for breastfeeding by discussion and coordination among the mother, maternal care providers, and substance abuse treatment providers (III):

- Relapse to illicit substance use or legal substance misuse in the 90–30-day period prior to delivery
- Concomitant use of other prescription medications deemed to be incompatible with lactation
- Engaged later (after the second trimester) in prenatal care and/or substance abuse treatment
- Attained drug and/or alcohol sobriety only in an inpatient setting
- Lack of appropriate maternal family and community support systems
- Report that they desire to breastfeed their infant in order to either retain custody or maintain their sobriety in the postpartum period.

In the United States, women who have established breastfeeding and subsequently relapse to illegal drug use are counseled not to breastfeed, even if milk is discarded during the time period surrounding relapse. There are no known pharmacokinetic data to establish the presence and/or concentrations of most illicit substances and/or their metabolites in human milk and effects on the infant, and this research is unlikely to occur given the ethical dilemmas it presents. The lack of pharmacokinetic data for most drugs of abuse in recently postpartum women with substance use disorders precludes the establishment of a ''safe'' interval after use when breastfeeding can be reestablished for individual drugs of abuse. Additionally, women using illicit substances in the postnatal period may exhibit impaired judgment and secondary behavioral changes that may interfere with the ability of the mother to care for her infant or to breastfeed adequately. Passive drug exposures may pose additional risks to the infant. Therefore, any woman relapsing to illicit drug use or legal substance misuse after the establishment of lactation should be

provided an appropriate human milk substitute (donor milk, formula) and intensified drug treatment, along with guidance on how to taper milk production to prevent mastitis. (III)

The woman with a substance use disorder who has successfully initiated breastfeeding should be carefully monitored, along with her infant, in the postpartum period. Ongoing substance abuse treatment, postpartum care, psychiatric care when warranted, and pediatric care are important for women with substance use disorders. Lactation support is particularly important for infants experiencing NAS and their mothers. Communication among all care providers involved with the health, welfare, and substance abuse support of the mother and the child should provide an interactive network of supportive care for the dyad. (III)

Recommendations for Future Research

1. Long-term randomized controlled trials or paired cohort evaluations of infants exposed to methadone or buprenorphine via human milk, including infant developmental assessments
2. Further evaluations of maternal milk and plasma and infant plasma pharmacokinetic data regarding prescription opioids and lactation, especially for mothers who were on chronic high-dose medications during pregnancy that are continued when breastfeeding
3. Long-term controlled evaluations of infants exposed to marijuana via human milk, to include infants and later neurodevelopmental outcomes, including those exposed to marijuana in a controlled manner, such as with legalized medical marijuana
4. Evaluation of nicotine replacement patches, gum, and vaporized cigarettes as substitutes for tobacco smoking in pregnant and lactating women, to determine if these can or should be widely recommended in place of tobacco products.

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ABM protocols expire 5 years from the date of publication. Evidence-based revisions are made within 5 years or sooner if there are significant changes in the evidence.

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KDADS STANDARD POLICY

Policy Name:	Process for approval to provide Screening, Brief Intervention and Referral for Treatment (SBIRT) services to Medicaid-eligible patients	**Policy Number:**	BHS/MCO 503
Commission:	Behavioral Health Services	**Date Established:**	11/21/13
Applicability:	Substance Use Disorder, SBIRT	**Date Last Revised:**	08/14/17
Contact:	Behavioral Health Services Commissioner	**Date Effective:**	11/21/13
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Revision History: 09/03/14, 8/14/17			

Purpose

This policy establishes the process practitioners must complete prior to administering and billing Screening, Brief Intervention and Referral of Treatment (SBIRT) services to Medicaid-eligible patients in Kansas.

Summary

Practitioners providing SBIRT services to Medicaid-eligible patients in Kansas must complete the training and credentialing processes required by this policy. The policy requires practitioners to complete an online training program approved by the Kansas Department for Aging and Disability Services (KDADS) with a proficiency test score of 80% or greater; and

1. Individual practitioners shall submit documentation of training completion and professional licensure to:
    a. (Prior to 7/1/18):
        i. The KanCare Managed Care Organization(s) (MCOs) whose managed care patients the provider intends to serve; and
        ii. The Kansas Medical Assistance Program (KMAP) for fee-for-service patients
    b. (Effective 7/1/18 and after the new enrollment process begins) KMAP for both managed care and fee-for-service patients
2. Facilities shall maintain documentation of training completion and professional licensure for each practitioner performing SBIRT services in the facility. The policy requires the facility to attest that the facility will only bill for SBIRT services if the employee performing the service has met the training and certification requirements.

Entities/Individuals Impacted

KanCare MCOs
Kansas Medical Assistance Program
SBIRT practitioners

Policy Name:	Process for approval to provide Screening, Brief Intervention and Referral for Treatment (SBIRT) services to Medicaid-eligible patients	Policy Number:	BHS/MCO 503
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I. Policy

Providers who wish to provide Screening, Brief Intervention and Referral for Treatment (SBIRT) as a billable service to Medicaid-eligible patients in Kansas must meet the credentialing and training requirements set forth by the Kansas Department for Aging and Disability Services (KDADS)/Behavioral Health Services (BHS) in this policy prior to billing for the service.

II. Procedures

To become approved to provide SBIRT services to Medicaid-eligible patients in Kansas:

1) A health care professional shall be currently licensed in good standing as a physician, physician's assistant, nurse practitioner, psychiatrist, nurse, dentist, or certified health educator in the state of Kansas or currently licensed in good standing by the Kansas Behavioral Sciences regulatory board as a psychologist, social worker, professional counselor, marriage and family therapist or addiction counselor.

2) Practitioners must complete an online SBIRT training course approved by KDADS.
   a) A complete list of online training courses approved by KDADS will be maintained on the KDADS website (www.kdads.ks.gov) under the Behavioral Health Services tab.
   b) The SBIRT practitioner must complete all coursework and pass the proficiency test with a score of 80% or greater.

3) **Individual Practitioners**: At the time of enrollment, re-credentialing or revalidation individual practitioners shall submit the SBIRT training certificate of completion documenting a proficiency test score of 80% or greater; and current professional license and/or certificate to:
   a) (Prior to 7/1/18):
      i) The MCOs whose managed care patients the provider intends to serve as follows:
         (1) *Amerigroup Kansas, Inc*. – e-mail to the Credentialing Department at KS1Credentialing@Amerigroup.com
         (2) *Sunflower Health Plan* – e-mail to the Provider Relations Department at providerrelationsKS@cenpatico.com
         (3) *United Healthcare Community Plan* – fax to the service authorization number at (855) 268-9392

      ii) The KMAP Application/Training Department for fee-for-service patients as directed on the KMAP website.

b) (Effective 7/1/18 and after with the new enrollment process): the KMAP Application/Training Department for both managed care and fee-for-service patients as directed on the KMAP website.

4) **Facilities:** Facilities shall maintain documentation of training completion and professional licensure for each practitioner performing SBIRT services in the facility. At the enrollment, re-credentialing or revalidation, facilities billing for SBIRT services for both managed care and fee-for-service patients must attest that the facility will only bill for SBIRT services if the employee performing the service has met the training and certification requirements described in this policy. The attestation form can be found on the KMAP website and should be submitted to the KMAP Application/Training Department as directed on the KMAP website.

III. Documentation/Quality Assurance

A. **Provider Requirements** – This policy requires practitioners to complete the online training course with a proficiency test score of 80% and above. Individual practitioners must submit professional licensure/certification and SBIRT training documentation to the appropriate entity(ies) as described in this policy prior to administering and billing SBIRT services to Medicaid-eligible patients. Facilities must submit attestation to KMAP prior to administering and billing SBIRT services to Medicaid-eligible patients.

B. **Documentation** – This policy requires:

1. Individual practitioners to provide a copy of the SBIRT online training certificate of completion and documentation of the provider's license and/or certificate as a healthcare professional in good standing to the appropriate MCO(s)
2. Facilities to maintain documentation of satisfactory training completion and professional licensure for each practitioner providing SBIRT services in the facility. The facility shall submit attestation to KMAP.

C. **Quality Assurance** – The MCOs shall monitor provider compliance for the providers billing for services within their network providing SBIRT services. KMAP shall monitor provider compliance for the providers billing for SBIRT services for fee-for-service patients.

IV. Definitions

Screening, Brief Intervention, and Referral for Treatment (SBIRT): SBIRT is an evidence-based approach for identifying patients who use alcohol or other drugs at increased levels of risk with the goal of reducing and preventing related health consequences, diseases, accidents, and injuries.

Policy Name:	Process for approval to provide Screening, Brief Intervention and Referral for Treatment (SBIRT) services to Medicaid-eligible patients	Policy Number:	BHS/MCO 503
Commission:	Behavioral Health Services	Date Established:	11/21/13
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42 U.S.C. §1396a et seq

Related Information

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RELATED CONTENT:

BHS/MCO 504 Screening, Brief Intervention and Referral for Treatment (SBIRT) Services:
http://www.kdads.ks.gov/provider-home/training-registration-and-surveys/medicaid-mental-health-service-provider-training/trainings/sbirt-information

Applicable KMAP Provider Manual(s)

KDADS STANDARD POLICY

Policy Name:	Screening, Brief Intervention and Referral for Treatment (SBIRT) Services	**Policy Number:**	BHS/MCO 504
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Purpose

This policy establishes the process for administering Screening, Brief Intervention and Referral for Treatment (SBIRT) to Medicaid-eligible patients in Kansas.

Summary

Practitioners administering and billing for SBIRT services provided to Medicaid-eligible patients in Kansas must follow the process outlined in this policy.

Entities/Individuals Impacted

KanCare Managed Care Organizations (MCOs)
Kansas Medical Assistance Program (KMAP)
SBIRT practitioners

I. Policy

Screening, Brief Intervention and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other drugs at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents and injuries. Practitioners must follow these requirements set by the Kansas Department for Aging and Disability Services (KDADS) for screening patients in order to bill for SBIRT services provided to Medicaid-eligible patients.

II. Procedures

A. Requirements:

1. Become an approved SBIRT practitioner by completing the online training approved by KDADS with a proficiency test score of 80% or greater and supplying the appropriate professional licensure and training documentation to the appropriate entity as described in BHS/MCO 503.

2. Provide SBIRT services in an approved service location. Approved provider service locations are as follows: primary medical care practices, acute medical care facilities, rural health clinics, critical access hospitals, federally qualified health centers, licensed substance use disorders treatment centers, Indian Health Centers, and community mental health centers.

3. Conduct a brief screening using the approved questions and/or screening tools.

B. Approved Brief Screens: The SBIRT practitioner will conduct a brief screen using a screening tool appropriate for the patient's age and reason for screening. To access approved brief screening tools, please see:

1. the Prescreen section of the "Chart of Evidence-Based Screening Tools for Adults and Adolescents" found on the National Institute on Drug Abuse website.; or

2. the "Alcohol Screening and Brief Interview for Youth" screening tool found on the National Institute of Alcohol and Alcoholism (NIAAA) website.

C. Full Screens: If the client has a positive brief screen, the SBIRT practitioner will proceed to a full screen using one of the evidence-based screening tools appropriate for the patient's age and reason for screening. Full screens are limited to one per person per year. If a patient has previously had a full screen for SBIRT services, a second full screen may not be completed sooner than one year from the date of the patient's previous full screen. To access the evidence-based full screening tools, please see:

1. the National Institute on Drug Abuse website, specifically, the Full Screen section of the "Chart of Evidence-Based Screening Tools for Adults and Adolescents;" or

2. the NIDA-Modified ASSIST screening tools found on the National Institute on Drug Abuse website.

D. Brief Intervention: One to three follow-up contacts are typically provided to assess and promote progress and to evaluate the need for additional services. These services are provided in 15 minute units, up to 16 billable units per enrollment year or rolling 12-month period based on the patient's treatment plan. No more than four (4) units of Brief Intervention may be billed per patient in one day.

E. Documentation: Providers shall maintain documentation in the patient's health record. At minimum, documentation shall include the date/time (beginning and ending), the results of the full screen, brief intervention and any appropriate referrals. The person performing the screening and/or intervention should be clearly noted.

F. Billing Codes and Reimbursement Rates:

1. **H0049** – *Alcohol and/or drug screening* – Medicaid rate = $24.00. H0049 may be used when an individual receives only an alcohol or drug full screen and may only be billed once per person per year. If a patient has previously had a full screen for SBIRT services, a second full screen may not be completed sooner than one year from the date of the patient's previous full screen.

2. **H0050** – *Alcohol and/or drug services, brief intervention, per 15 minutes* – Medicaid rate = $24.00. H0050 may be used if only a brief intervention was completed.

3. **99408** – *Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes (brief intervention)* – Medicaid rate = $24.00. 99408 may be used for patients who receive a full screen and one brief intervention (time to implement is between 15 – 30 minutes) and may only be billed once per person per year. If a patient has previously had a full screen for SBIRT services, a second full screen may not be completed sooner than one year from the date of the patient's previous full screen.

4. **99409** – *Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes; full screen* – Medicaid rate = $48.00. 99409 may be used for patients who receive a full screen and one brief intervention (time to implement is greater than 30 minutes) and may only be billed once person per year. If a patient has previously had a full screen for SBIRT services, a second full screen may not be completed sooner than one year from the date of the patient's previous full screen.

Rural Health Clinics (RHCs), Federally Qualified Health Clinics (FQHCs) and Indian Health Centers shall be reimbursed their respective encounter rates.

A provider may bill the following codes in combination for one patient based on the SBIRT service(s) provided:

- H0049 and H0050 (no more than a total of four units of intervention per patient in one day)
- 99408 and H0050 (no more than a total of four units of brief intervention per patient in one day)
- 99409 and H0050 (no more than a total of four units of intervention per patient in one day)

G. Patient Privacy: Federally-assisted programs conducting SBIRT shall protect patient information according to HIPAA and 42 CFR Part 2. Please see the Substance Abuse Confidentiality Regulations section of the SAMHSA (Substance Abuse and Mental Health Services Administration) website for the definition of a federally-assisted program and more guidance.

Documentation/Quality Assurance

A. **Provider Requirements** – This policy requires all practitioners providing SBIRT services to be approved as stated in policy BHS/MCO 503.

B. **Documentation** – This policy requires practitioners to document screening results and any follow-up in the patient's record.

C. **Quality Assurance** – Each MCO will monitor provider compliance for the providers providing SBIRT services to managed care patients in its network. KMAP shall monitor provider compliance for the providers billing for SBIRT services for fee-for-service patients.

III. Definitions

Brief Intervention: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. A healthcare professional engages in a short conversation with a patient exhibiting potentially risky substance use behaviors, and provides feedback and advice to the patient.

Brief Screen: A rapid, proactive procedure used to identify individuals who may have a substance use disorder condition, or be at risk for a substance use disorder condition before obvious manifestations occur. A healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. A brief alcohol and/or drug screen is considered an integral part of a routine care and is not separately reimbursed.

Full Screen: Full screens more definitively categorize a patient's substance use. Full Screens are indicated for patients who have positive brief screens and for patients with signs, symptoms, and medical conditions that suggest the patient engages in risky or problematic drinking or drug use. Full screens are reimbursed separately, and are limited to one per person per year. If a patient has previously had a full screen for SBIRT services, a second full screen may not be completed sooner than one year from the date of the patient's previous full screen.

Referral to Treatment: A healthcare professional provides a referral to brief therapy or additional treatment for patients whose full screen results indicate a need for additional treatment services.

Screening, Brief Intervention and Referral for Treatment (SBIRT): An evidence-based approach for identifying patients who use alcohol and other drugs at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents and injuries.

Policy Name:	Screening, Brief Intervention and Referral for Treatment (SBIRT) Services	Policy Number:	BHS/MCO 504
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http://www.kdads.ks.gov/provider-home/training-registration-and-surveys/medicaid-mental-health-service-provider-training/trainings/sbirt-information

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CHAPTER

1

ISSUE BRIEF

Preventing the Use of Marijuana: Focus on Women and Pregnancy

National estimates show that between 3 and 7 percent of pregnant women report using marijuana while pregnant.[1,2] In 2018, there was a significant decline in illicit drug use by pregnant women. The decrease in marijuana use among pregnant women between 2017 and 2018 (7.1 to 4.7 percent) contributed to this overall decline.[2] A study of self-reported and biochemically tested marijuana use among pregnant women in California found that marijuana use during pregnancy was more common among younger women, with rates as high as 22 percent of pregnant adolescents and 19 percent of pregnant young adults (ages 19–24) screening positive for marijuana use.[3]

To assist clinicians and others in raising awareness of the known and potential harms of marijuana use during pregnancy, this guide focuses on the growing body of evidence related to maternal marijuana use. The evidence from population-based data on potential harms to newborns is mixed. Some studies rely on self-reported data, which can underestimate the proportion of women who are using marijuana and skew study findings. Other factors, such as concurrent substance use, stress, socioeconomic status, and others, can influence the baby's health.

Despite these limitations, evidence is mounting to show that babies born to mothers who report marijuana use are more likely to be preterm and underweight.[4,5,6,7]

Further, there is concern that marijuana is transferred through breast milk to the child.[8,9] The primary psychoactive ingredient in marijuana, delta-9-tetrahydrocannabinol (THC), has been found in breast milk for up to six days after maternal marijuana use.[9] Marijuana may cause problems with a newborn's brain development and may result in hyperactivity, poor function, and other consequences.[10] While further research is needed to establish whether there are adverse effects on infant development, the American Academy of Pediatrics states that breastfeeding is contraindicated in women using illicit drugs.[11]

Evidence suggests that women's concerns about how substances will affect the developing fetus can motivate them to reduce or abstain from substances (e.g., alcohol, tobacco, and illicit drugs) during pregnancy.[12,13] However, relapse tends to rise dramatically from 6 to 12 months following birth among women who abstain from marijuana use during pregnancy.[13] The postpartum period, from birth through approximately 12 months after birth, corresponds to a critical developmental period for infants.

This chapter provides an overview of marijuana use among pregnant and postpartum women, as well as the adverse health consequences for mothers and their babies that may be associated with marijuana use both during and after pregnancy.

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NIH... Turning Discovery Into Health

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Acute Effects*/Health Risks
Tobacco			
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Not scheduled/smoked, snorted, chewed	*Increased blood pressure and heart rate*/chronic lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction
Alcohol			
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	Not scheduled/swallowed	*In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness*/ increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose
Cannabinoids			
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	I/smoked, swallowed	*Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis*/cough; frequent respiratory infections; possible mental health decline; addiction
Hashish	Boom, gangster, hash, hash oil, hemp	I/smoked, swallowed	
Opioids			
Heroin	*Diacetylmorphine:* smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	I/injected, smoked, snorted	*Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing*/constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose
Opium	*Laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
Stimulants			
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/snorted, smoked, injected	*Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behavior; psychosis*/weight loss; insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction **Also, for cocaine**—nasal damage from snorting **Also, for methamphetamine**—severe dental problems
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/swallowed, snorted, smoked, injected	
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	II/swallowed, snorted, smoked, injected	
Club Drugs			
MDMA (methylenedioxymethamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	I/swallowed, snorted, injected	***MDMA****—mild hallucinogenic effects; increased tactile sensitivity, empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping*/ sleep disturbances; depression; impaired memory; hyperthermia; addiction ***Flunitrazepam****—sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination*/addiction ***GHB****—drowsiness; nausea; headache; disorientation; loss of coordination; memory loss*/ unconsciousness; seizures; coma
Flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	*Gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	I/swallowed	
Dissociative Drugs			
Ketamine	*Ketalar SV:* cat Valium, K, Special K, vitamin K	III/injected, snorted, smoked	*Feelings of being separate from one's body and environment; impaired motor function*/anxiety; tremors; numbness; memory loss; nausea ***Also, for ketamine****— analgesia; impaired memory; delirium; respiratory depression and arrest; death* ***Also, for PCP and analogs****—analgesia; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations* ***Also, for DXM****—euphoria; slurred speech; confusion; dizziness; distorted visual perceptions*
PCP and analogs	*Phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/swallowed, smoked, injected	
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	Not scheduled/chewed, swallowed, smoked	
Dextromethorphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	Not scheduled/swallowed	
Hallucinogens			
LSD	*Lysergic acid diethylamide:* acid, blotter, cubes, microdot, yellow sunshine, blue heaven	I/swallowed, absorbed through mouth tissues	*Altered states of perception and feeling; hallucinations; nausea* ***Also, for LSD and mescaline****—increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness; dizziness; weakness; tremors; impulsive behavior; rapid shifts in emotion* ***Also, for LSD***—Flashbacks, Hallucinogen Persisting Perception Disorder ***Also, for psilocybin****—nervousness; paranoia; panic*
Mescaline	Buttons, cactus, mesc, peyote	I/swallowed, smoked	
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	I/swallowed	
Other Compounds			
Anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice, gym candy, pumpers	III/injected, swallowed, applied to skin	***Steroids****—no intoxication effects*/hypertension; blood clotting and cholesterol changes; liver cysts; hostility and aggression; acne; in adolescents—premature stoppage of growth; in males—prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females—menstrual irregularities, development of beard and other masculine characteristics ***Inhalants*** *(varies by chemical)—stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing*/cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death
Inhalants	*Solvents (paint thinners, gasoline, glues); gases (butane, propane, aerosol propellants, nitrous oxide); nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Acute Effects*/Health Risks
Prescription Medications			
CNS Depressants	For more information on prescription medications, please visit http://www.nida.nih.gov/DrugPages/PrescripDrugsChart.html.		
Stimulants			
Opioid Pain Relievers			

** Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.*

*** Some of the health risks are directly related to the route of drug administration. For example, injection drug use can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.*

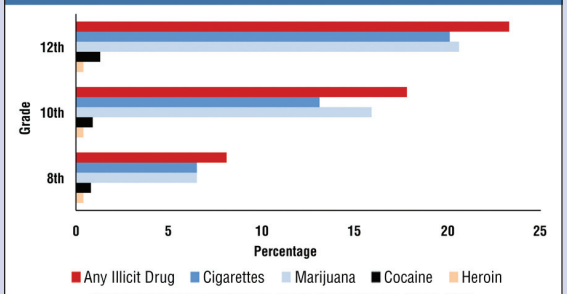
**** Associated with sexual assaults.*

Principles of Drug Addiction Treatment

More than three decades of scientific research show that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives. Based on this research, 13 fundamental principles that characterize effective drug abuse treatment have been developed. These principles are detailed in *NIDA's Principles of Drug Addiction Treatment: A Research-Based Guide.* The guide also describes different types of science-based treatments and provides answers to commonly asked questions.

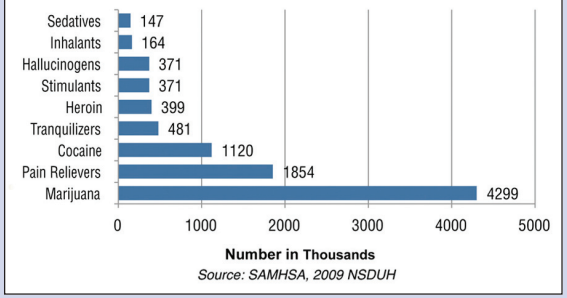
1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs alter the brain's structure and how it functions, resulting in changes that persist long after drug use has ceased. This may help explain why abusers are at risk for relapse even after long periods of abstinence.
2. **No single treatment is appropriate for everyone.** Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success.
3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible.
4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.
5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivations to change, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problemsolving skills, and facilitating better interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Also, for persons addicted to nicotine, a nicotine replacement product (nicotine patches or gum) or an oral medication (buproprion or varenicline), can be an effective component of treatment when part of a comprehensive behavioral treatment program.
8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation and/or social and legal services. For many patients, a continuing care approach provides the best results, with treatment intensity varying according to a person's changing needs.
9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification.
11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. **Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Treatment providers should encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.

U.S. Teens Who Currently Use Illicit Drugs or Cigarettes (Past Month Use)



Source: University of Michigan, Monitoring the Future Study, 2009.

Dependence on or Abuse of Specific Illicit Drugs in Past Year Among Persons 12 or Older, 2009



Source: SAMHSA, 2009 NSDUH

NATIONAL INSTITUTE ON DRUG ABUSE
NIDA DRUGPUBS
RESEARCH DISSEMINATION CENTER

Order NIDA publications from DrugPubs:
1-877-643-2644 or 1-240-645-0228 (TTY/TDD)

Revised March 2011
Reprinted April 2012

This chart may be reprinted. Citation of the source is appreciated.

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

Commonly Abused Prescription Drugs

Visit NIDA at www.drugabuse.gov

National Institutes of Health
U.S. Department of Health and Human Services

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/How Administered	*Intoxication Effects*/Health Risks
Depressants			
Barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital:* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, IV/injected, swallowed	*Sedation/drowsiness, reduced anxiety, feelings of well-being, lowered inhibitions, slurred speech, poor concentration, confusion, dizziness, impaired coordination and memory/*slowed pulse, lowered blood pressure, slowed breathing, tolerance, withdrawal, addiction; increased risk of respiratory distress and death when combined with alcohol
Benzodiazepines	*Ativan, Halcion, Librium, Valium, Xanax, Klonopin:* candy, downers, sleeping pills, tranks	IV/swallowed	
Sleep Medications	*Ambien (zolpidem), Sonata (zaleplon), Lunesta (eszopiclone)*	IV/swallowed	*for barbiturates—euphoria, unusual excitement, fever, irritability/*life-threatening withdrawal in chronic users
Opioids and Morphine Derivatives**			
Codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine:* Captain Cody, Cody, schoolboy; (with glutethimide: doors & fours, loads, pancakes and syrup)	II, III, IV/injected, swallowed	*Pain relief, euphoria, drowsiness, sedation, weakness, dizziness, nausea, impaired coordination, confusion, dry mouth, itching, sweating, clammy skin, constipation/* slowed or arrested breathing, lowered pulse and blood pressure, tolerance, addiction, unconsciousness, coma, death; risk of death increased when combined with alcohol or other CNS depressants
Morphine	*Roxanol, Duramorph:* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
Methadone	*Methadose, Dolophine:* fizzies, amidone, (with MDMA: chocolate chip cookies)	II/swallowed, injected	*for fentanyl*—80–100 times more potent analgesic than morphine
Fentanyl and analogs	*Actiq, Duragesic, Sublimaze:* Apache, China girl, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	II/injected, smoked, snorted	*for oxycodone*—muscle relaxation/twice as potent analgesic as morphine; high abuse potential
Other Opioid Pain Relievers: Oxycodone HCL Hydrocodone Bitartrate Hydromorphone Oxymorphone Meperidine Propoxyphene	*Tylox, Oxycontin, Percodan, Percocet:* Oxy, O.C., oxycotton, oxycet, hillbilly heroin, percs *Vicodin, Lortab, Lorcet:* vike, Watson-387 *Dilaudid:* juice, smack, D, footballs, dillies *Opana, Numorphan, Numorphone:* biscuits, blue heaven, blues, Mrs. O, octagons, stop signs, O Bomb *Demerol, meperidine hydrochloride:* demmies, pain killer *Darvon, Darvocet*	II, III, IV/chewed, swallowed, snorted, injected, suppositories	*for codeine*—less analgesia, sedation, and respiratory depression than morphine *for methadone*—used to treat opioid addiction and pain; significant overdose risk when used improperly
Stimulants			
Amphetamines	*Biphetamine, Dexedrine, Adderall:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	*Feelings of exhilaration, increased energy, mental alertness/*increased heart rate, blood pressure, and metabolism, reduced appetite, weight loss, nervousness, insomnia, *seizures, heart attack, stroke*
Methylphenidate	*Concerta, Ritalin:* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	*for amphetamines—rapid breathing, tremor, loss of coordination, irritability, anxiousness, restlessness/*delirium, panic, paranoia, hallucinations, impulsive behavior, aggressiveness, tolerance, addiction *for methylphenidate*—increase or decrease in blood pressure, digestive problems, loss of appetite, weight loss
Other Compounds			
Dextromethorphan (DXM)	*Found in some cough and cold medications:* Robotripping, Robo, Triple C	not scheduled/swallowed	*Euphoria, slurred speech/*increased heart rate and blood pressure, dizziness, nausea, vomiting, confusion, paranoia, distorted visual perceptions, impaired motor function

** Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use. Schedule II drugs are available only by prescription and require a new prescription for each refill. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.*

*** Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms. Injection is a more common practice for opioids, but risks apply to any medication taken by injection.*

Facts About Prescription Drug Abuse

Medications can be effective when they are used properly, but some can be addictive and dangerous when abused. This chart provides a brief look at some prescribed medications that—when used in ways or by people other than prescribed—have the potential for adverse medical consequences, including addiction.

In 2010, approximately 16 million Americans reported using a prescription drug for nonmedical reasons in the past year; 7 million in the past month.

What types of prescription drugs are abused?

Three types of drugs are abused most often:

- Opioids—prescribed for pain relief
- CNS depressants—barbiturates and benzodiazepines prescribed for anxiety or sleep problems (often referred to as sedatives or tranquilizers)
- Stimulants—prescribed for attention-deficit hyperactivity disorder (ADHD), the sleep disorder narcolepsy, or obesity.

How can you help prevent prescription drug abuse?

- Ask your doctor or pharmacist about your medication, especially if you are unsure about its effects.
- Keep your doctor informed about all medications you are taking, including over-the-counter medications.
- Read the information your pharmacist provides before starting to take medications.
- Take your medication(s) as prescribed.
- Keep all prescription medications secured at all times and properly dispose of any unused medications.

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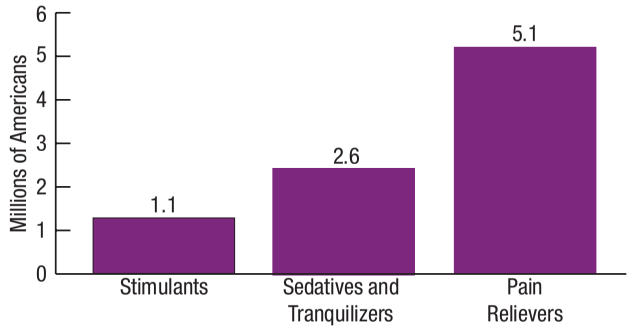
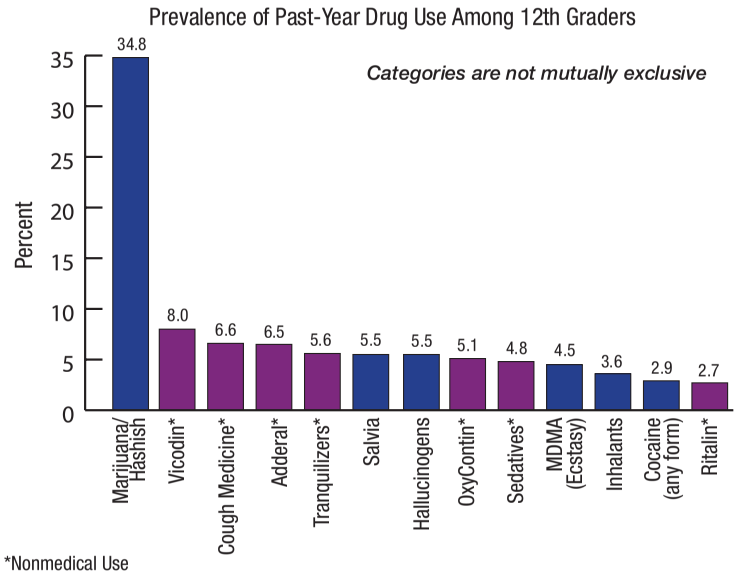
This chart may be reprinted. Citation of the source is appreciated.

~7.0 Million Americans Reported Past-Month Use of Rx Drugs for Nonmedical Purposes in 2010



Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2010

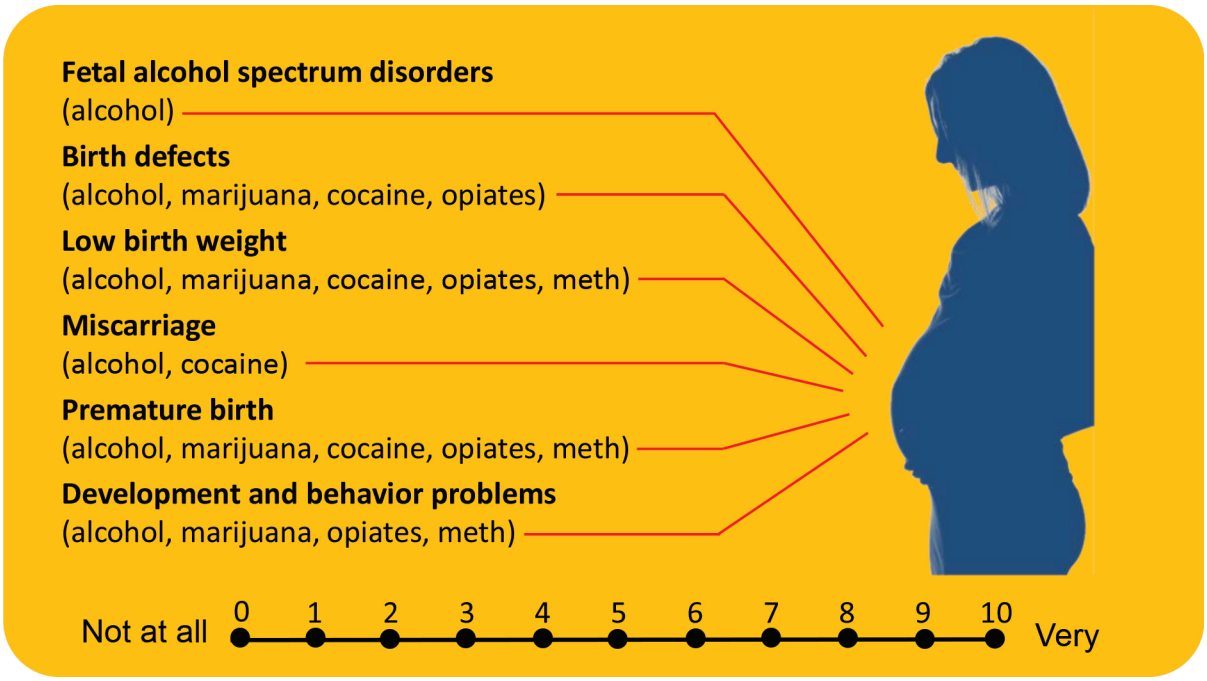
After Marijuana, Prescription and Over-the-Counter Medications* Account for Most of the Commonly Abused Drugs



*Nonmedical Use

Source: University of Michigan, 2010 Monitoring the Future Study

Revised October 2011

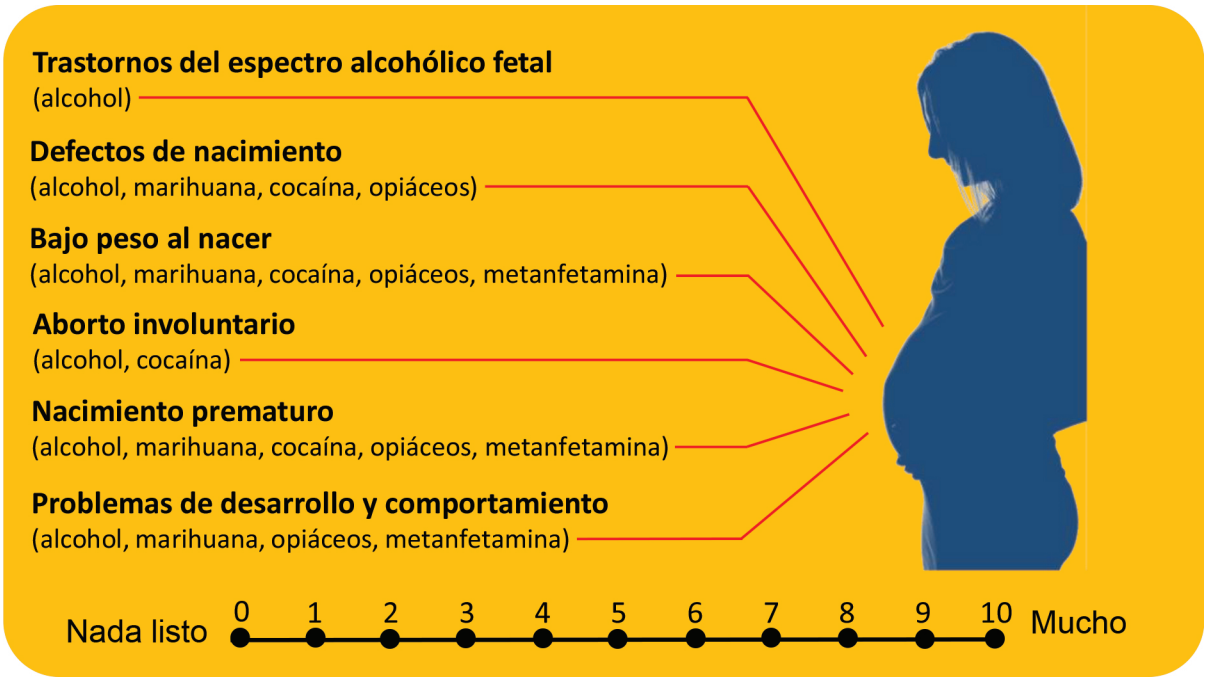


This double-sided card is designed to assist health professionals with delivering brief interventions. The front acts as a visual aid for the patient, while the back (on next page) provides guidance to the health professional.

Raise subject	• "Thank you for completing this questionnaire - is it ok with you if we review your results?" • "Can you tell me more about your past/current drinking or drug use? What does a typical week look like?"
Provide feedback	• "Sometimes patients who give similar answers are continuing to use drugs or alcohol during their pregnancy." • "I recommend all my pregnant patients not to use any alcohol or drugs, because of the risks shown on the front of this card."
Enhance motivation	• "What do you like and what are you concerned about when it comes to your substance use?" • "On a scale of 0-10, how ready are you to avoid drinking/using altogether? Why that number and not a ____ (lower number)?"
Negotiate plan	• Summarize conversation. Then: "What steps do you think you can take to reach your goal of having a healthy pregnancy and baby?" • "Can we schedule a date to check in about this next time?"

Kansas Substance Use Treatment Access Line:
1-866-645-8216

Adapted for use by Kansas Maternal and Child Health programs by the Kansas Department of Health and Environment, Bureau of Family Health with permission from sbirtoregon.org



This double-sided card is designed to assist health professionals with delivering brief interventions. The front acts as a visual aid for the patient, while the back (on next page) provides guidance to the health professional.

Raise subject	• "Gracias por completar este cuestionario - ¿está bien si revisamos sus resultados?" • "¿Puede decirme más sobre su pasado/actual uso de alcohol o drogas? ¿Cómo es una semana típica?"
Provide feedback	• "Algunas veces las pacientes que dan respuestas similares siguen usando drogas o alcohol durante el embarazo. Yo recomiendo a todas mis pacientes embarazadas no usar alcohol ni drogas, debido a los riesgos que se muestran en la parte frontal de esta tarjeta".
Enhance motivation	• "¿Qué le gusta y qué le preocupa al referirse al uso de sustancias?" • "En una escala de 0 a 10, ¿qué tan dispuesta está para dejar de beber/usar drogas por completo? ¿Por qué eligió ese número en lugar de otro ____ (número más bajo)?"
Negotiate plan	• "¿Qué medidas cree que puede tomar para alcanzar su meta de tener un embarazo y bebé saludables? ¿Podemos programar una fecha para verificar sobre esto la próxima vez?"

Kansas Substance Use Treatment Access Line:
1-866-645-8216

Adapted for use by Kansas Maternal and Child Health programs by the Kansas Department of Health and Environment, Bureau of Family Health with permission from sbirtoregon.org

LOW-RISK DRINKING LIMITS

Source: National Institutes of Health

MEN 18–65

No more than:
4 drinks per day
AND no more than:
14 drinks per week

WOMEN 18–65*

No more than:
3 drinks per day
AND no more than:
7 drinks per week

AGE 66+

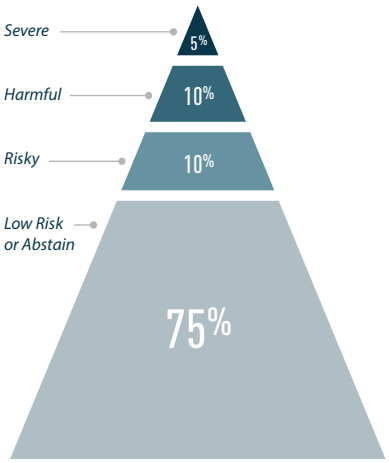
No more than:
3 drinks per day
AND no more than:
7 drinks per week

*Women who are pregnant or breastfeeding should not drink.

WHAT COUNTS AS ONE DRINK?

One drink is:
12-ounce can of beer
5-ounce glass of wine
A shot of hard liquor (1½ ounces)

RISK ZONE PYRAMID



Adapted from World Health Organization

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very

UMKC | SBIRT

Mid-America (HHS Region 7) ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

RISK ZONE	I—LOW RISK	II—RISKY	III—HARMFUL	IV—SEVERE
AUDIT Score	0–3	4–9	10–13	14+
DAST Score	0	1–2	3–5	6+
Description of Zone	"At low risk for health or social complications."	"May develop health problems or existing problems may worsen."	"Has experienced negative effects from substance use."	"Could benefit from more assessment and assistance."

Raise the subject

- Explain your role; ask permission to discuss alcohol/drug use screening forms
- Ask about alcohol/drug use patterns: "What does your alcohol/drug use look like in a typical week?"
- Listen carefully; use reflections to demonstrate understanding

Provide feedback

- Share AUDIT/DAST zone(s) and description; review low-risk drinking limits; explore patient's reaction: "Your score puts you in the _____ zone, which means _____. The low-risk limits are _____. What do you think about that?"
- Explore connection to health/social/work issues (patient education materials): "What connection might there be...?"

Enhance motivation

- Ask about pros/cons: "What do you like about your alcohol/drug use? What don't you like?"
- Explore readiness to change: "On a scale of 0-10, how ready are you to make a change in your alcohol/drug use?"
- If readiness is greater than 2: "Why that number and not a _____ (lower one)?"
  If 0-2: "How would your alcohol/drug use have to impact your life for you to think about changing?

Negotiate plan

- Summarize the conversation (zone, pros/cons, readiness); ask question: "What steps would you be willing to take?"
- If not ready to plan, stop the intervention; offer patient education materials; thank patient
- Explore patient's goal for change (offer options if needed); write down steps to achieve goal; assess confidence
- Negotiate follow-up visit; thank patient

To find a Treatment Provider go to: **findtreatment.samhsa.gov/TreatmentLocator,** or call **800-662-HELP** (4357)

Adapted with permission from

wasbirt·pci
Screening, Brief Intervention and Referral to Treatment
Primary Care Integration

JUNE 2016

SBIRT
Screening, Brief Intervention, and Referral to Treatment
Because drug and alcohol use affects your health, we need to ask everyone about their use. We do this in order to provide you the best care possible. And that's why we ask - everyone.
WE ASK EVERYONE.
WISHARD
SCHOOL OF MEDICINE
INDIANA UNIVERSITY
SAMHSA

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Perinatal Substance Use

5 ways you can improve care during pregnancy and beyond

Pregnancy presents unique opportunities for patients to make positive changes in their substance use. When you become an informed provider you empower patients to make those changes.

Educate Yourself

Learn more about the pharmacology of substance use. Promote evidence-based care by communicating with patients in a way that separates fact from fiction. Understand the cycles of sobriety and relapse so that you can help patients plan for their recovery. Advise on the risks associated with polysubstance use.

Use the Right Words

Know the difference between substance use, substance misuse, and Substance Use Disorders (SUDs). Recognize that substance use is stigmatized and that stigma is a barrier to seeking care. Reject language that shames. Embrace the principles of Harm Reduction as a way to support any positive change.

Screen Every Patient

Talking about substance use should be a routine part of everyone's medical care. Get comfortable discussing it. Ask questions and listen to what your patients have to say. You may be the first person to ever ask.

Get Trained to Offer MAT

Medication Assisted Treatment is the Standard of Care during pregnancy, but there are not enough providers. Contact SAMHSA to become an OTP*. Make naloxone available to all your patients who use opioids.

*opioid treatment program

End the Stigma and Criminalization of Drug Use

Embrace people who use substances. Meet them where they are. Abide by your medical ethics. Practice beneficence. Promote public health. Advocate for decriminalization.

Your Advocacy Matters

Academy of Perinatal Harm Reduction

www.perinatalharmreduction.org

National Perinatal Association

www.nationalperinatal.org

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Your Pregnancy and Substance Use

4 Things you can do to improve your health and lower your risk for complications

Get Prenatal Care

Start early. Go to all your visits. Empower yourself with information so you can make smart decisions. Build relationships with providers who understand Substance Use Disorders (SUDs) and know how to help. Partner with them to reach your goals. But remember, you do not need to be abstinent from substance use to get care. Go now.

Reduce Your Use

There are simple things you can do to limit the harm substances might do.

- Use fewer substances
- Use smaller amounts
- Use less often
- Learn how to use safer

Reducing or quitting smoking is a good place to start. Set your goals, then ask for help.
One of the best things you can do is to stop using alcohol. We know that even small amounts are risky. And when combined with benzos and opioids, alcohol can kill.

Use Medication-Assisted Treatment (MAT) if you are opioid dependent

Methadone and Buprenorphine (Subutex® or Suboxone®) are the "Standard of Care" during pregnancy because they:

- Eliminate the risks of illicit use
- Reduce your risk for relapse
- Can be a positive step towards recovery

Take Good Care of Yourself

You deserve a healthy pregnancy & childbirth.

- Eat healthy and take your prenatal vitamins
- Find the right balance of rest and exercise
- Surround yourself with people who care

Your Health Matters

Academy of Perinatal Harm Reduction
www.perinatalharmreduction.org

National Perinatal Association
www.nationalperinatal.org

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PROVIDER RESOURCES: RELATED WEBSITES AND VIDEOS

SBIRT in Practice

- SBIRT Oregon, Integrating SBIRT into Practice
  SBIRT Oregon is a national leader in SBIRT education and was created in the Department of Family Medicine at Oregon Health and Science University, with funding from the Substance Abuse and Mental Health Services Administration. In addition to video resources, their website offers online curriculum, screening tools and clinic tools available for free use, and workflows on practicing SBIRT.

  Website: https://www.sbirtoregon.org/
  Videos: https://www.sbirtoregon.org/video-demonstrations/
  - Clinic Workflow: https://www.youtube.com/watch?v=KlaCo3zw1PM
  - Directive Communication Towards Behavior Change: https://www.youtube.com/watch?v=cSBsgmgYm8o
  - A Better Way to Screen for Substance Use: https://www.youtube.com/watch?v=jt_I2Yg2Ik4

- University of Missouri Kansas City (UMKC) SBIRT, Integrating SBIRT into Practice
  UMKC SBIRT is funded through Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Videos include information on Brief Interventions for high, moderate, and low risk screening outcomes as well as a video case study highlighting the importance of Universal screening. Additional resources on the website include trainings, tools for clinicians, and patient education handouts.

  Website: http://www.sbirt.care/
  Videos: http://www.sbirt.care/training.aspx

- Johns Hopkins School of Nursing, SBIRT Roleplay (pregnant patient)
  Johns Hopkins School of nursing hosts a Vimeo channel focused entirely on SBIRT. Videos include overview & importance of SBIRT, principles motivational interviewing, pain management & opioid abuse, guidance for referrals, and SBIRT roleplaying. Of particular note is an SBIRT roleplay with a patient who has just received a positive pregnancy result.

  Video: https://vimeopro.com/jhunursing/sbirt/video/87189437
  Vimeo channel: https://vimeopro.com/jhunursing/sbirt

Other Videos/Websites

- Institute for Research, Education, and Training in Addictions (IRETA), Medication Assisted Treatment and Pregnant Women (Webinar)
  IRETA offers a host of resources related to substance use treatment and education including toolkits, trainings, case studies and more. Of note for those working with the perinatal population are two webinars. The first, focused on medication assisted treatment, was designed for physicians, OB and NICU nurses, social workers, nurse practitioners, and other professionals involved in the care of women who may be using drugs during pregnancy. The second is a case study on Kaiser Permanente Northern CA Early Start program which used an integrated model of substance use intervention for pregnant women.

  Webinar (2011: MAT & Pregnant Women): https://ireta.org/resources/issues-of-medication-assisted-treatment-and-pregnant-women/

  Webinar (2014: SBIRT in Early Start Program): https://ireta.org/resources/sbirt-in-early-start-program-an-integrated-model-of-substance-abuse-intervention-for-pregnant-women/

- National Institute of Health (NIH), Pregnancy and Opioid Use
  Four-part video series. Topics include: Babies Born to Women Addicted to Opioids; Findings Prompt Changing Guidelines for Care of Opioid Exposed Babies; Standard of Care for Pregnant Women and with Opioid Use Disorder; Dr. Jones Discusses Program Success with Opioid Dependent Women
  https://www.drugabuse.gov/related-topics/women-drugs/pregnant-concerned-about-opioid-use

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RESOURCES FOR PATIENTS

A. Patient Handouts
1. Alcohol Effects–*English* 208
2. Alcohol Effects–*Spanish* 210
3. Marijuana Effects–*English* 212
4. Marijuana Effects–*Spanish* 214
5. Marijuana: Pregnancy and Newborns 216
6. Methadone Treatment for Pregnant Women (pamphlet) 218
7. Alcohol and Drug Use During Pregnancy 220
8. Alcohol and Drug Use During Pregnancy–*Spanish* 223
9. Smoking Marijuana While Pregnant 226
10. What is Substance Abuse Treatment: A Booklet for Families 228
*Full booklet (40 pages) available in **Patient Resources** portion of digital toolkit*

B. Related Websites and Videos
1. Online Support and Education Resources for Patients 230
2. Substance Use and Pregnancy: Video Resources 231

ALCOHOL:
Is Your Health at Risk?

What counts as ONE DRINK?

One drink is:

One 12-ounce can of beer
One 5-ounce glass of wine
One shot of hard liquor (1.5 ounces)

Are you at risk?

If you use alcohol, taking a look at your drinking pattern and knowing your risks is important for your health, now and in the future. Know the difference between low-risk versus risky or harmful drinking. You owe it to yourself!

What is low-risk drinking?

- For healthy adults age 65 and under:

LOW-RISK DRINKING LIMITS	MEN	WOMEN
On any single DAY	No more than **4** drinks on any **day**	No more than **3** drinks on any **day**
	** AND **	** AND **
Per WEEK	No more than **14** drinks per **week**	No more than **7** drinks per **week**

To stay low risk, keep within BOTH the single-day AND weekly limits.

National Institute on Alcohol Abuse and Alcoholism

- For people over 65: low-risk limits are 3 drinks a day or 7 drinks a week.
- Women who are pregnant or may become pregnant should not drink.

What's risky or harmful drinking?

- **Risky alcohol use** is drinking more than the single-day or weekly amounts shown above.
- **Harmful alcohol use** is drinking more than the single-day or weekly amounts shown above, and having negative effects from drinking such as accidents, not being able to stop drinking, or not doing what you normally do (work, school, family) because of drinking.

What can happen from risky or harmful alcohol use?

- **People who use alcohol at risky or harmful levels** are at greater risk for health problems—cancer, obesity, high blood pressure, stroke, injury, diabetes, accident/death, suicide, and cirrhosis.
- It makes a difference both how much you drink on any day and how often you have a heavy drinking day.
- The more drinks in a day and the more heavy drinking days over time, the greater risk for problems.

Tips for cutting down on alcohol use

- **Measure and Count**. Measure drinks per standard drink size and count how much you drink on your phone, a card in your wallet, or calendar.
- **Set Goals**. Decide how many days a week you want to drink, and how many drinks to have on those days.
- **Pace and Space**. Pace yourself. Sip slowly. Have no more than one drink per hour. Alternate "drink spacers"—non-alcohol drinks (water, soda, or juice).
- **Include Food**. Don't drink on an empty stomach.
- **Avoid "Triggers."** What triggers you to drink? Avoid people, places, and activities that trigger the urge to drink.
- **Plan to Handle Urges**. When an urge hits: remind yourself of reasons for changing, talk it through with someone, do a healthy, distracting activity, or "urge surf" and accept the feeling and ride it out, knowing it will pass.
- **Know your "no."** Have a polite, convincing "no" ready for times when you don't want a drink.

Adapted from US Department of Health and Human Services, NIH, NIAAA

Helpful Links:

http://rethinkingdrinking.niaaa.nih.gov/
http://www.niaaa.nih.gov/alcohol-health
http://findtreatment.samhsa.gov

Mid-America (HHS Region 7)
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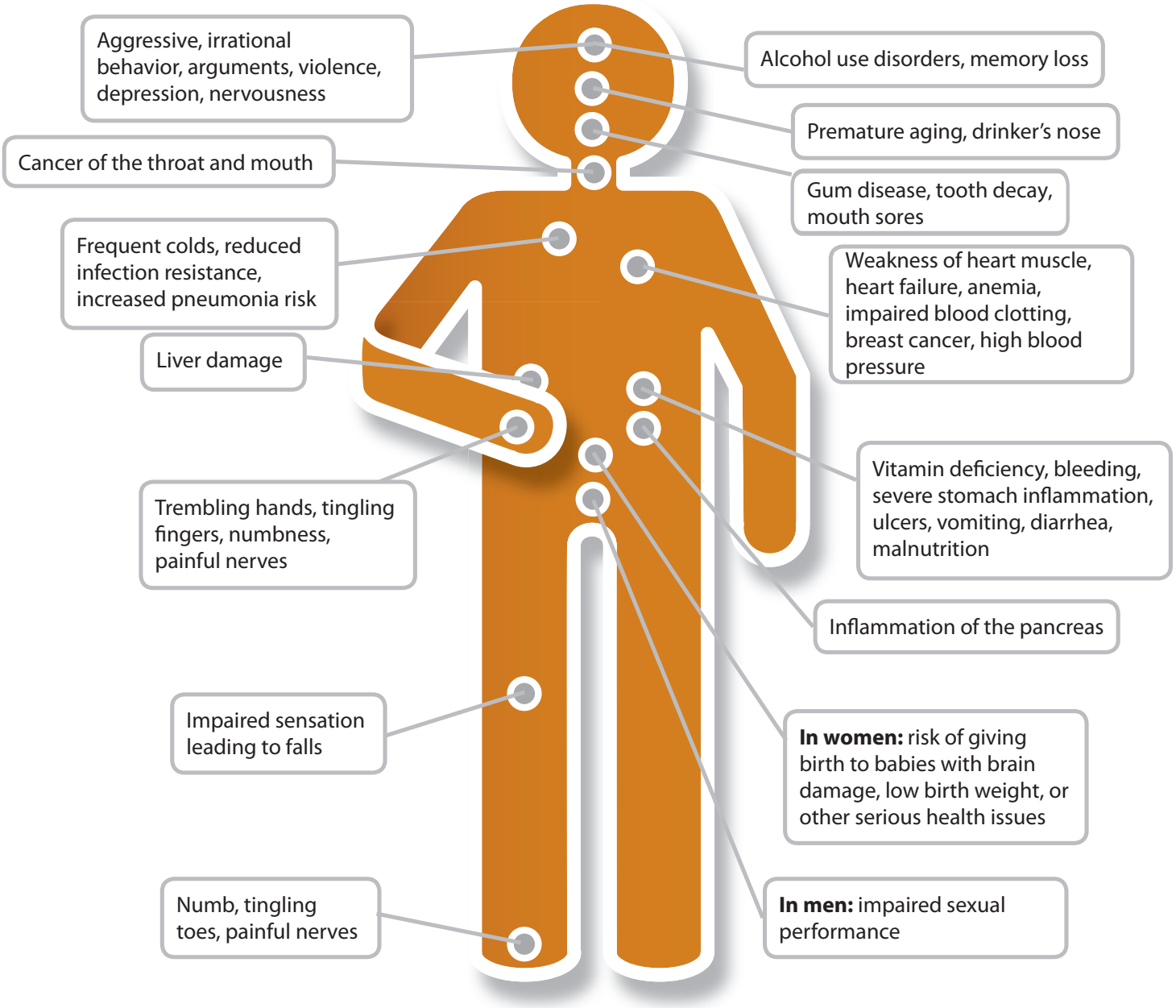
RISKY AND HARMFUL ALCOHOL USE

Effects on the Body



Alcohol can worsen existing health problems:

- Liver disease
- Heart disease and high blood pressure
- Diabetes
- Ulcers and stomach problems
- Depression and anxiety
- Sleep problems

Something to think about:

Risky and harmful alcohol use frequently leads to social, legal, medical, domestic, job, and financial problems. Alcohol may shorten your lifespan and lead to accidental injury or death.

Adapted from: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., and Monteiro, M.G. (2001). The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (Second Edition). World Health Organization; sbirtinaction.org

ALCOHOL
¿Corre riesgo su salud?

¿Qué cuenta como **UNA BEBIDA**?

Un trago es:
Una lata de cerveza de 12 onzas
Una copa de vino de 5 onzas
Un trago de licor fuerte (1.5 onzas)

¿Está corriéndose un riesgo?
Si consume alcohol, examinar su patrón de consumo y conocer sus riesgos es importante para su salud presente y futura. Sepa la diferencia entre beber con bajo riesgo y beber de forma riesgosa o dañina. Se lo debe a su salud.

¿Qué es beber con bajo riesgo?
- Adultos saludables menores de 65 años:

¿QUÉ ES BEBER DE MANERA RIESGOSA?	VARONES	MUJERES
En un solo día	No más de **4** bebidas en un solo día	No más de **3** bebidas en un solo día
	** Y **	** Y **
Por semana	No más de **14** bebidas en una semana	No más de **7** bebidas en una semana

Para mantener bajo el riesgo, respete los límites diarios Y semanales

National Institute on Alcohol Abuse and Alcoholism

- Personas de más de 65 años: los límites de bajo riesgo son 3 bebidas por día o 7 bebidas por semana.
- Las mujeres que estén encinta o pudieran quedar encinta no deben beber.

¿Qué es beber de manera riesgosa?
- **El consumo riesgoso de alcohol** consiste en beber en exceso de los límites arriba mencionados en un solo día o en una semana.
- **El consumo dañino de alcohol** consiste en beber en exceso de los límites diarios o semanales y sufrir efec tos negativos por ello tales como accidentes, no poder dejar de beber, o no poder desempeñar sus actividades normales (trabajo, escuela, familia) por la bebida.

¿Qué puede sucederle si consume alcohol de forma riesgosa o dañina?
- Las personas que consumen alcohol a niveles riesgosos o dañinos corren un riesgo mayor de problemas de salud: cáncer, obesidad, hipertensión, derrames, lesiones, diabetes, accidentes/muerte, suicidios y cirrosis.
- Hace diferencia cuánto bebe en un solo día y la frecuencia con la que tiene días en los que bebe fuertemente.
- Si bebe más por día y tiene más días de bebida fuerte con el paso del tiempo, mayores serán sus riesgos.

Sugerencias para reducir el consumo de alcohol
- **Mida y Cuente**. Mida las bebidas según su tamaño estándar y cuente cuánto ha bebido en su teléfono, en una tarjeta, en su billetera o en un calendario.
- **Fíjese metas**. Decida cuántos días a la semana desea beber y cuántas bebidas consumirá en esos días.
- **Ritmo y espacio**. Fíjese su ritmo. Beba lentamente. No consuma más de una bebida por hora. Alterne «bebidas de espacio» o no alcohólicas (agua, gaseosa o jugo).
- **Incluya alimentos**. No beba con el estómago vacío.
- **Evite los «incitadores»**. ¿Qué cosas le incitan a beber? Evite a las personas, lugares y actividades que le despiertan el deseo de beber.
- **Planifique cómo resistir el deseo**. Cuando le llegue el deseo, recuerde por qué desea cambiar, hable de ello con alguien, realice una actividad saludable que le distraiga, o «aguante el deseo» y acepte el sentimiento, soportándolo con el conocimiento de que pasará.
- **Sepa decir que no**. Prepare un ***no*** cortés pero convincente para las ocasiones en las que no desea beber.

Adaptado del Departamento de Salud y Servicios Humanos de EUA, NIH, NIAAA

Helpful Links:
http://rethinkingdrinking.niaaa.nih.gov/
http://www.niaaa.nih.gov/alcohol-health
http://findtreatment.samhsa.gov

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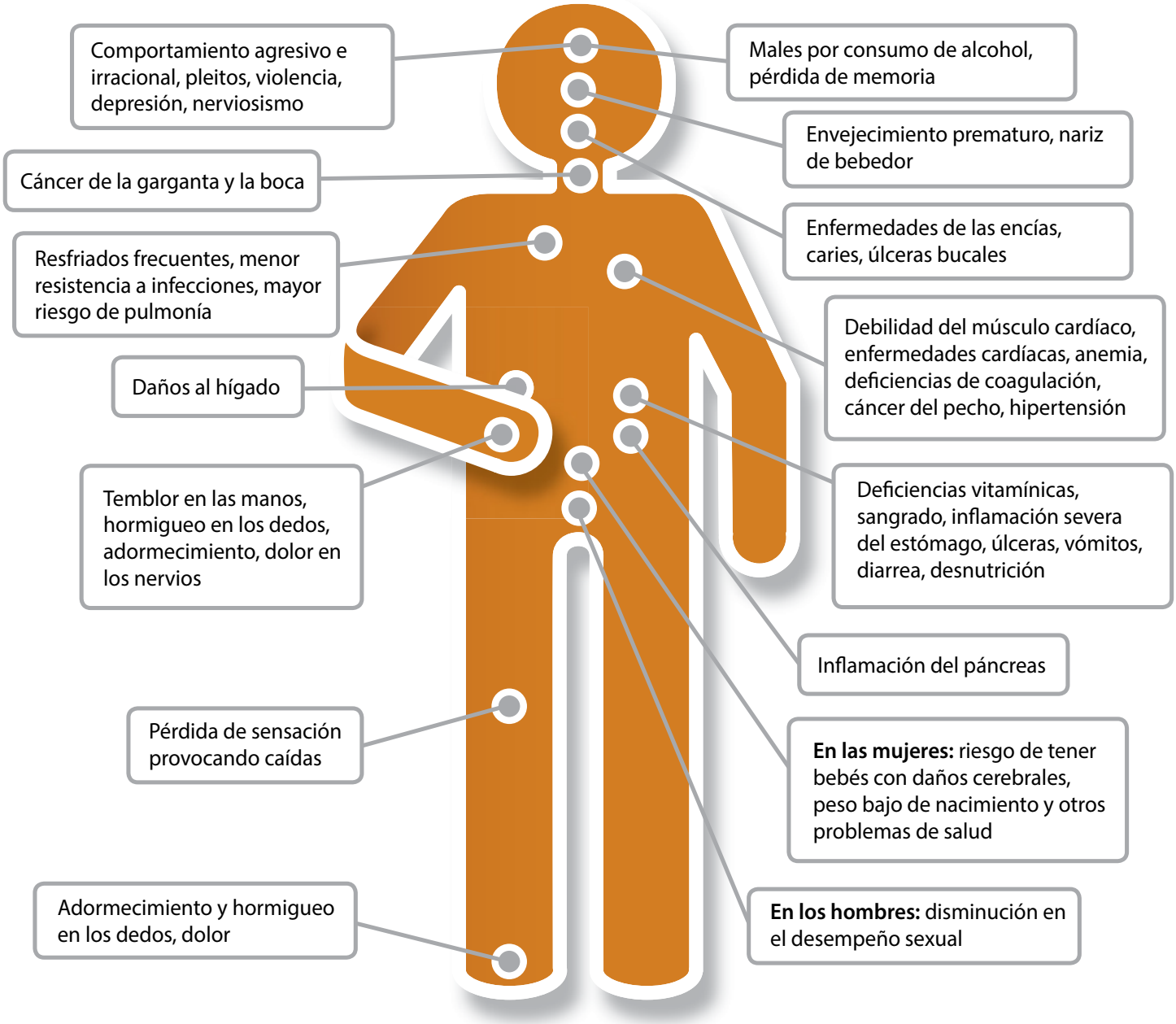
CONSUMO RIESGOSO Y DAÑINO DEL ALCOHOL

Efectos sobre el cuerpo



El alcohol puede agravar problemas existentes de salud:

- Enfermedades del hígado
- Enfermedades cardíacas e hipertensión
- Diabetes
- Úlceras y problemas estomacales
- Depresión y ansiedad
- Problemas para dormir

Algo para pensar:

El consumo del alcohol de manera riesgosa y dañina frecuentemente conduce a problemas sociales, legales, médicos, hogareños, laborales y financieros. El alcohol puede acortar su expectativa de vida y llevar a lesiones accidentales o la muerte.

Adaptado de: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., and Monteiro, M.G. (2001). The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (Second Edition). World Health Organization; sbirtinaction.org

MARIJUANA

Natural, but not harmless.

- Marijuana use contributes to health problems
- It is four times stronger than in the 1980s
- Risky no matter method of use, including smoking, vaporizing, and edibles (food containing marijuana)
- Heavy use in young adults can cause lasting damage to the brain and decrease intelligence
- Marijuana can directly worsen symptoms of anxiety, depression, and schizophrenia

Marijuana can be addictive.

- Marijuana use can lead to addiction, just like with other drugs
- 4.5 million people in the U.S. are addicted
- Chances of addiction are increased:
  - 17% of adolescents who use will become addicted
  - 25-50% of people who use everyday will become addicted
- Withdrawal symptoms include cravings, trouble sleeping, anxiety, appetite loss

Marijuana use impairs driving.

- Doubles a driver's risk of an accident
- Use with alcohol increases risk

Legal does not mean safer.

- Marijuana is not FDA-approved
- There may be some chemicals in marijuana that help a range of illnesses or symptoms
- Lack of clinical evidence supporting benefits
- Benefits do not outweigh health risks

Marijuana and pregnancy.

- Marijuana use during pregnancy affects child development
- Health risks for the child include low birth weight; premature birth; problems with attention, memory, and problem solving; and reduced IQ

Using marijuana with other substances.

- Mixing marijuana and alcohol increases risk for nausea and reactions of panic, anxiety, or paranoia
- Mixing tobacco and marijuana increases risk of developing respiratory diseases and/or cancer

Tips for Cutting Back

Think about changing.

- Why do you use? What do you like about it?
- Why do you want to cut down or stop?

Plan for the change you want.

- Set a goal and date for changing your use. Make it realistic.
- Share your plan with people you trust and ask for support.

Act on your decision.

- *Distract and do something.* Make a list of fun activities unrelated to your use and keep busy.
- *Delay.* Stop and think before using. Wait 15 minutes to ride the craving, and the wave of desire may pass.
- *Plan ahead.* Avoid high-risk situations and people who use.

Have a back-up plan.

- If you haven't achieved your goal yet, that's okay.
- Consider the situation in which you used and see what could be changed next time.
- Review your plan and see if it needs revising.

Helpful Links:

http://easyread.drugabuse.gov/marijuana-effects.php
http://www.drugfree.org/drug-guide/marijuana

Relaxation Alternatives:

Everyday Tai Chi:
http://www.everyday-taichi.com/index.html

3-Minute Breathing Space: http://umurl.us/GUi

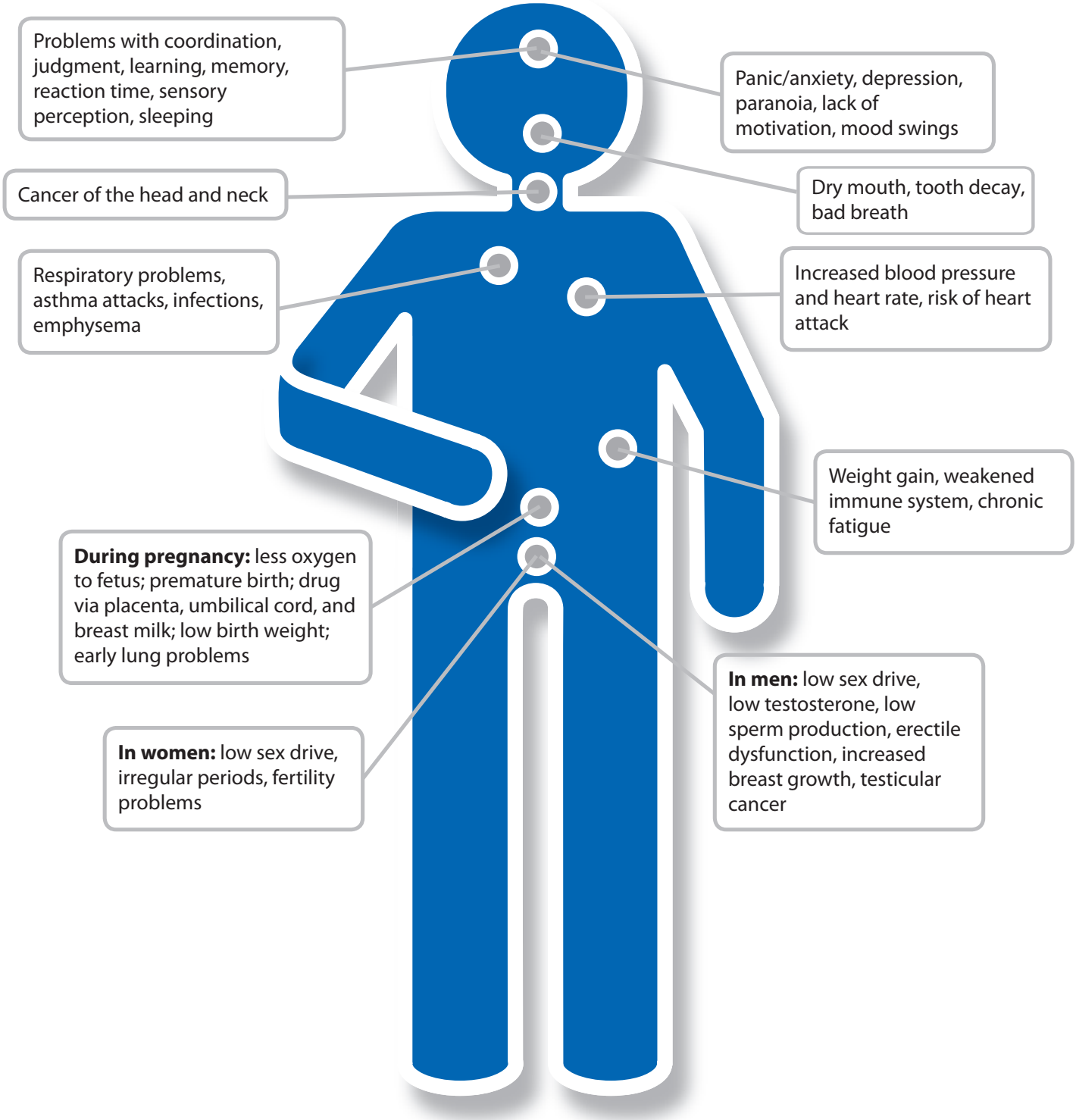
Breathing and Relaxation Exercise:
http://umurl.us/AMF

Body Scan Meditation: http://umurl.us/B0dyScan

Sources: BNI-ART Institute; National Institute on Drug Abuse, http://www.drugabuse.gov/publications/infofacts/marijuana; National Alliance on Mental Illness, http://www.nami.org/Content/NavigationMenu/Hearts_and_Minds/Smoking_Cessation/Marijuana_and_Mental_Illness.htm; University of Washington Alcohol & Drug Abuse Institute, http://learnaboutmarijuanawa.org/factsheets/tobacco.htm; Mixing Cannabis and Alcohol, http://ncpic.org.au/ncpic/publications/factsheets/article/mixing-cannabis-and-alcohol; A Guide to Cutting Down and Stopping Cannabis Use, http://www.knowcannabis.org.uk/images/KClargeguide.pdf

MARIJUANA

Effects on the Body



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Visit www.sbirt.care for more resources!

MARIHUANA

Natural, pero no inofensiva

- El consumo de la marihuana contribuye a los problemas de salud
- Es cuatro veces más potente que la década de 1980
- Es riesgosa, sin importar el método de consumo, incluyendo fumarla, vaporizarla e ingerirla (alimentos que contengan marihuana)
- El consumo fuerte en adultos jóvenes puede causarle daños duraderos al cerebro y reducir la inteligencia
- La marihuana puede empeorar directamente los síntomas de ansiedad, depresión y esquizofrenia

La marihuana puede ser adictiva

- La marihuana puede llevar a la adicción, tal como sucede con otras drogas
- 4,5 millones de personas en EUA están adictas
- Las probabilidades de sufrir adicción han aumentado:
  - 17 % de los adolescentes que la consumen quedarán adictos
  - 25-50 % de las personas que la consumen diariamente quedarán adictas
- El síndrome de abstinencia incluye deseos intensos, problemas para dormir, ansiedad, pérdida del apetito

Sugerencias para reducir el consumo

Piense en cambiar.

- ¿Por qué consume marihuana? ¿Qué es lo que le gusta de ella?
- ¿Por qué desea reducir o suspender el consumo?

Planifique el cambio que desea.

- Fíjese una meta y una fecha para la cual desea cambiar sus hábitos de consumo. Que sea realista.
- Comparta su plan con personas de su confianza y pídales apoyo.

Actúe conforme a su decisión.

- *Distráigase y haga algo.* Prepare una lista de actividades que le entretengan sin relación con el consumo y que le mantengan ocupado.
- *Postergue.* Haga una pausa y medite antes de consumir. Espere 15 minutos soportando el antojo, y la ola del deseo podría pasar.
- *Planifique.* Evite las situaciones de riesgo y las personas que consumen.

Tenga un plan de respaldo

- Si no la logrado su meta aún, eso está bien.
- Considere la situación en la que consumió marihuana y piense cómo podría cambiar para la próxima.
- Examine su plan y vea si necesita modificarlo.

El consumo de la marihuana perjudica la capacidad de conducir

- Duplica el riesgo de que un conductor sufra un accidente
- El consumo junto con alcohol aumenta el riesgo

Legal no significa más seguro

- La marihuana no ha sido aprobada por la FDA
- La marihuana podría contener agentes químicos que ayudan a un grupo de enfermedades o síntomas
- Hay carencia de evidencia clínica que sustente los beneficios
- Los beneficios no sobrepasan los riesgos de salud

La marihuana y el embarazo

- El consumo de marihuana durante el embarazo afecta el desarrollo del bebé
- Los riesgos contra la salud del bebé incluyen bajo peso en nacimiento, nacimiento prematuro, problemas de capacidad de atención, memoria y solución de problemas y bajo cociente intelectual

Consumo de marihuana junto con otras sustancias

- El consumo de marihuana junto con alcohol aumenta el riesgo de sentir náuseas y reacciones de pánico, ansiedad o paranoia
- El consumo de marihuana junto con tabaco aumenta el riesgo de desarrollar enfermedades y/o cáncer en el sistema respiratorio

Enlaces útiles

http://easyread.drugabuse.gov/marijuana-effects.php

http://www.drugfree.org/drug-guide/marijuana

Alternativas para relajarse:

Tai Chi para todos los días:

http://www.everyday-taichi.com/index.html

Espacio para respirar por 3 minutos:

http://umurl.us/GUi

Ejercicios de respiración y meditación:

http://umurl.us/AMF

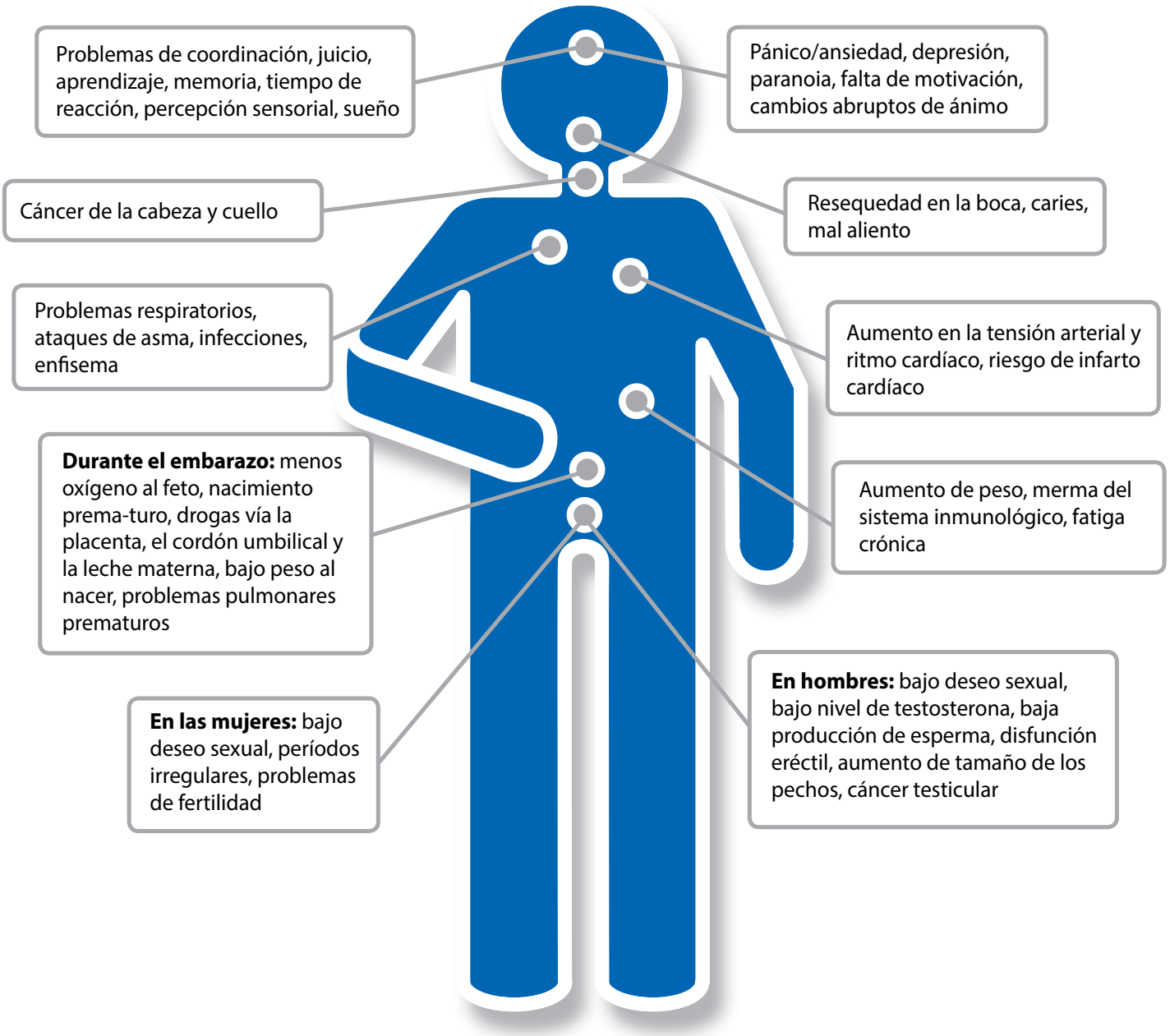
Meditación con exploración corporal:

http://umurl.us/B0dyScan

Fuentes: Instituto BNI-ART; Instituto Nacional sobre Abuso de las Drogas, http://www.drugabuse.gov/publications/infofacts/marijuana; Alianza Nacional para las Enfermedades Mentales, http://www.nami.org/Content/NavigationMenu/Hearts_and_Minds/Smoking_Cessation/Marijuana_and_Mental_Illness.htm; Instituto Contra el Abuso del Alcohol y las Drogas de la Universidad de Washington, http://learnaboutmarijuanawa.org/factsheets/tobacco.htm; Combinación de Cannabis con Alcohol, http://ncpic.org.au/ncpic/publications/factsheets/article/mixing-cannabis-and-alcohol; Guía para Reducir y Suspender el Consumo de Cannabis, http://www.knowcannabis.org.uk/images/KClargeguide.pdf

MARIHUANA

Efectos sobre el cuerpo



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MARIJUANA

PREGNANCY AND NEWBORNS 3

MARIJUANA IS THE MOST COMMON ILLICIT DRUG USED BY PREGNANT WOMEN.[1]

THC (active ingredient) in marijuana can pass into breast milk where nursing infants can ingest it.[3-4]

THERE IS NO KNOWN "SAFE" LEVEL OF MARIJUANA USE DURING PREGNANCY.

15-44 YEAR OLD

4.9%

OF PREGNANT WOMEN REPORT USING MARIJUANA IN THE PAST MONTH[2]

TEENAGERS WHO WERE EXPOSED TO MARIJUANA IN-UTERO MAY HAVE PROBLEMS WITH PAYING ATTENTION, BRAIN FUNCTION, DOING WORK IN SCHOOL, AND LOWER IQ.[4]

This publication was prepared by the Addiction Technology Transfer Center Network Coordinating Office under the cooperative agreement number 1 UR1 TI024236-02 from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). Its contents are solely the responsibility of the Addiction Technology Transfer Center Network Coordinating Office and do not necessarily represent the official view of the Department of Health and Human Services, SAMHSA or CSAT.

www.attcnetwork.org/marijuanalit

Network Coordinating Office
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

1. Day, N. L., Leech, S. L., & Goldschmidt, L. (2011). The effects of prenatal marijuana exposure on delinquent behaviors are mediated by measures of neurocognitive functioning. Neurotoxicology and Teratology, 33(1), 129–136.
2. United States Department of, H., et al., National Survey on Drug Use and Health, 2013. 2014, Inter-university Consortium for Political and Social Research (ICPSR) [distributor].
3. The Adverse Effects of Marijuana (for healthcare professionals). (2011). California Society of Addiction Medicine. Retrieved from: http://www.csam-asam.org/adverse-effects-marijuana-healthcare-professionals.
4. Marijuana Use During Pregnancy and Breastfeeding Systematic Literature Review. (2015, January). Colorado Department of Public Health and Environment Retail Marijuana Public Health Advisory Committee. Retrieved from: https://www.colorado.gov/pacific/cdphe/scientific-literature-review-marijuana-related-health-effects.

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IMPORTANT RESOURCES

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

SAMHSA's National Helpline
1-800-662-HELP (4357)

SAMHSA Store
www.store.samhsa.gov

SAMHSA's Behavioral Health Treatment Services Locator
www.findtreatment.samhsa.gov

SAMHSA's Division of Pharmacologic Therapies
www.dpt.samhsa.gov

SAMHSA's Fetal Alcohol Spectrum Disorders Center for Excellence
www.fascenter.samhsa.gov

SAMHSA's National Center on Substance Abuse and Child Welfare
www.ncsacw.samhsa.gov

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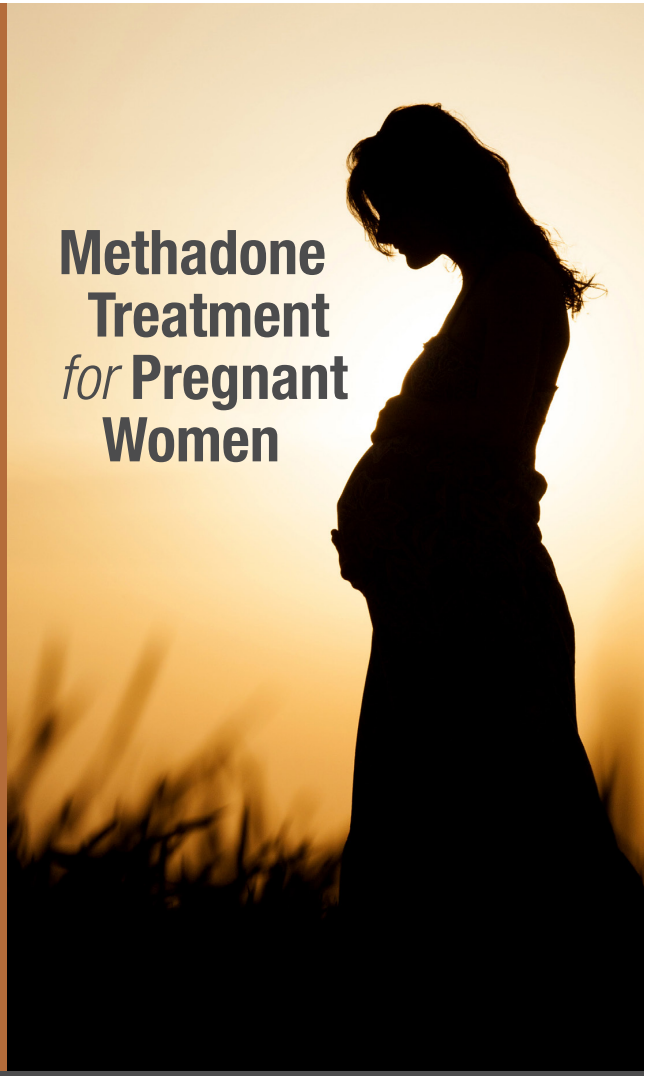
Methadone Treatment *for* Pregnant Women



If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself.

HOW DOES METHADONE MAINTENANCE TREATMENT (MMT) WORK?

Methadone is a long-acting opioid medication used with counseling and other services to treat individuals addicted to short-acting opioid drugs.

Appropriate MMT provides several benefits:

- Reduces or eliminates craving for opioid drugs
- Prevents the onset of withdrawal for 24 hours or more
- Blocks the effects of other opioids
- Promotes increased physical and emotional health
- Raises the overall quality of life of the patient.

MMT can prevent the withdrawal symptoms many drug users experience. Withdrawal for pregnant women is especially dangerous because it causes the uterus to contract and may bring on miscarriage or premature birth.

By blocking withdrawal symptoms, MMT can save your baby's life. Additionally, MMT can help you stop using needles, which is a primary route of infection for drug users. More importantly, it can allow you to regain your quality of life.

INFANT WITHDRAWAL

Undergoing MMT while pregnant will not cause birth defects for your baby, but some infants may go through withdrawal after birth. Withdrawal does not mean the baby is addicted. Studies have shown that your dose of medication has no bearing on whether or not your baby experiences withdrawal.[1] Infant withdrawal usually begins a few days after your baby is born but may begin two to four weeks after birth.

Withdrawal symptoms may last several weeks and commonly include:

- Fussiness/restlessness
- Not eating or sleeping well
- Fever
- Vomiting
- Trembling

Many times a quiet, comfortable environment is enough to provide comfort to your baby. If the symptoms are severe, your baby's doctor may prescribe medicine to help. The doctor also may be able to provide information and support to you on how to make your baby more comfortable without medicine. Once your baby is born, never give methadone or any other medication to your baby without your doctor's approval. Even a small amount can be enough to seriously harm or even kill your baby. Let your doctor manage the baby's withdrawal.

The good news is that babies born to mothers on methadone do as well as other babies. While it is not known for certain what long-term effects the exposure to methadone may have on babies, their health is much better than babies born to mothers on heroin.

It can be reassuring to know that thousands of healthy babies born to methadone-maintained moms develop into normal children.

BREASTFEEDING

For women who are not HIV-positive and who are on methadone, breastfeeding is the best option. Women who are Hepatitis C-positive usually are able to breastfeed but should check with a doctor first.

The benefits of breastfeeding often outweigh the effect of the tiny amount of methadone that enters the breast milk. Though breastfeeding generally is recommended, you should still discuss it with your doctor. If upon a doctor's advice you choose to withdraw from methadone to continue breastfeeding, it is important that you discuss this decision with your treatment provider to avoid a potential return to drug use.

CHILD PROTECTIVE SERVICES (CPS)

In some communities, special programs offer services for mothers in recovery. The support and practical help they provide can make a difference in day-to-day life for you and your child. Ask your local CPS whether such a program is available in your area. CPS caseworkers want to see you provide a healthy, loving, and secure home for your child.

But if you continue to misuse drugs, your CPS caseworker will question your ability to care for your child. Taking good care of a child demands alertness, attention, patience, and good judgment. Taking drugs improperly can affect all of these qualities.

Parenting can be hard and sometimes overwhelming. Every mother needs support. Look to your doctor or treatment counselor for help. If the courts become involved, you may need to consult with a court-appointed attorney. Not all court officials understand that MMT is the recommended course of treatment for pregnant opioid-dependent women and that it reflects a mother's commitment to living a sober and responsible life.

Misusing drugs doesn't necessarily make you a bad parent, but it does make it harder to be a good parent. Continued drug use may make it necessary for your child to be removed from your home. Remember that there are a host of resources and advocacy organizations available to provide support for medication-assisted treatment patients. Many of these resources can be found online at www.dpt.samhsa.gov.

BIRTH CONTROL

If you've been using opiates such as heroin or prescribed opiates such as oxycodone or OxyContin, you may have stopped getting your period. This may cause you to think that you can't get pregnant. If you've stopped getting your period, you actually may be pregnant. If you're not sure, get a pregnancy test from a doctor, pharmacist, or community health center.

As you begin to use less opiates or begin to use methadone, your period likely will return, and your chances of getting pregnant will increase. Use birth control. It's important that you wait until you're completely drug free before you get pregnant. It is equally important that you do not drink any alcohol if you think you might be or you are pregnant. Alcohol use during pregnancy is the leading cause of preventable birth defects.

[1] Berghella, V.; Lim ,P.J.; Hill, M.K.; Cherpes, J.; Chennat, J.; and Kaltenbach, K. Maternal methadone dose and neonatal withdrawal. *American Journal of Obstetrics and Gynecology* 189(2): 312-317, 2003.

Alcohol and drug use during pregnancy

When a pregnant women drinks alcohol or uses drugs during her pregnancy, so does her baby. These substances can pass through the placenta and to the baby through the umbilical cord.

When a baby is exposed to substances, a number of things can go wrong. Below is a list of problems more likely to happen to babies exposed to alcohol, tobacco, and drugs:

Premature birth is a birth that takes place more than three weeks before the baby is due. Premature babies, especially those born earliest, often have medical problems.

Birth defects are problems with how a baby's organs and body parts form, how they work, or how their bodies turn food into energy. Some birth defects need no treatment and others cause disabilities or require medical or surgical treatment.

Low birth weight is when a baby is born weighing less than 5 pounds, 8 ounces. Some low birthweight babies are healthy, even though they're small. But being low birthweight can cause serious health problems for some babies.

Placental abruption is a serious condition in which the placenta separates from the wall of the uterus before birth. The placenta supplies the baby with food and oxygen through the umbilical cord. Placental abruption can cause very heavy bleeding and can be deadly for both mother and baby.

Fetal alcohol spectrum disorders are health problems that can happen to babies when their mothers drink alcohol during pregnancy. The most serious of these is fetal alcohol syndrome. Fetal alcohol syndrome can seriously harm your baby's brain and body.

Miscarriage is when a baby dies in the womb before 20 weeks of pregnancy. **Stillbirth** is when a baby dies in the womb after 20 weeks of pregnancy.

Development and behavior problems may not show up for several years after a baby is exposed to substances during pregnancy. These problems make it harder for a child to learn, communicate and get along with others, take care of her/himself, and can include attention deficit hyperactivity disorder (also called ADHD).

Neonatal abstinence syndrome (NAS) is a group of conditions a newborn can have if his/her mother is addicted to drugs during pregnancy. NAS happens when a baby gets addicted to a drug before birth and then goes through drug withdrawal after birth. What type and how serious an infant's withdrawal symptoms depend on the drug(s) used, how long and how often the birth mother used, how her body breaks the drug down, and whether the infant was born full term or premature.

Alcohol

There is no amount of alcohol that is proven to be safe during pregnancy. Alcohol includes wine, wine coolers, beer and liquor. You may know some women who drank regularly during pregnancy and had seemingly healthy babies. You may know some women who had very little alcohol during pregnancy and had babies with serious health conditions. Every pregnancy is different. Drinking alcohol may hurt one baby more than another. The best way to ensure a healthy baby is to stay away from alcohol altogether.

Your liver works hard to break down the alcohol in your blood. But your baby's liver is too small to do the same and alcohol can hurt your baby's development. That's why alcohol is much more harmful to your baby than to you during pregnancy.

Drinking alcohol during pregnancy can cause **birth defects**, **miscarriage**, **premature birth**, **stillbirth**, **development and behavior problems**, **low birth weight,** and **fetal alcohol spectrum disorders.**

Marijuana

No amount of marijuana has been proven safe to use during pregnancy. Using marijuana over a long time may raise the risk of **premature birth**. Some children born to women who used marijuana during their pregnancies are more likely to have certain **development and behavior problems**. More research is needed, however, to know if these effects come from marijuana use or related her factors, like a poor home environment or the mother's use of other drugs.

Some women use marijuana to treat nausea (sick stomach) during their pregnancy. Women thinking about using medical marijuana while pregnant should check with a health care provider first.

Nursing mothers are advised not to use marijuana. THC (the main chemical in marijuana) can gather in breast milk in high amounts if a pregnant mother uses marijuana often. Some studies show that exposure to THC through breast milk could result in less ability to control body movement at 1 year of age. Because a baby's brain is still forming, THC could affect how the brain grows. New mothers using medical marijuana should talk about their use with the doctor caring for their baby.

Cocaine (coke) and Methamphetamine (meth)

Both cocaine and meth are white powders that are eaten, snorted or mixed with liquid and injected with a needle. Sometimes meth comes as a pill or is made into a clear or white shiny rock (called crystal meth) that can be smoked.

Cocaine use during pregnancy makes **premature birth, low birthweight, miscarriage and placental abruption** more likely to happen.

One study found that babies of women who used meth were more than three times as likely to grow poorly before birth. Even when born at term, these affected babies tend to be born with **low birthweight** and have a smaller-than-normal head circumference.

Use of meth during pregnancy also increases the risk of **premature birth** and **placental abruption**. There also have been cases of **birth defects**, including heart defects and cleft lip/palate, in exposed babies, but researchers do not yet know whether the drug contributed to these defects.

After delivery, some babies who were exposed to meth before birth appear to undergo withdrawal-like symptoms, including jitteriness, drowsiness and breathing problems.

Heroin (smack, junk)

Heroin is a street drug made from poppy plant seeds. It can be a white or brown powder, or it can be a black, sticky goo. Heroin usually is injected with a needle, but it can be smoked or snorted.

Using heroin during pregnancy can be dangerous, even deadly. It may cause serious problems, including: **birth defects, placental abruption, premature birth, low birthweight** and **stillbirth.**

If you're pregnant and using heroin, don't stop taking it without getting treatment from your health care provider first. Quitting suddenly (sometimes called cold turkey) can cause severe problems for your baby, including death. Your health care provider or a drug-treatment center can treat you with drugs like methadone or buprenorphine. These drugs can help you gradually reduce your dependence on heroin in a way that's safe for your baby.

MDMA (ecstasy, molly)

MDMA comes as a pill. It's sometimes called the "love drug" because it makes some people feel very friendly and touchy-feely. It also can make people feel depressed or confused and have a hard time remembering things.

What little research exists on the effects of MDMA use in pregnancy suggests that prenatal MDMA exposure may cause learning, memory, and motor problems in the baby. More research is needed on this topic.

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El alcohol y el consumo de drogas durante el embarazo / Alcohol and drug use during pregnancy

Cuando una mujer bebe alcohol o usa drogas durante su embarazo, también lo hace su bebé. Estas sustancias pueden pasar a la placenta y al bebé a través del cordón umbilical.

Cuando un bebé está expuesto a sustancias, varias cosas pueden salir mal. A continuación se muestra una lista de los problemas con más probabilidad que sucedan a los bebés expuestos al alcohol, tabaco y drogas:

Nacimiento prematuro es un nacimiento que tiene lugar más de tres semanas antes de la fecha prevista del parto. A menudo, los bebés prematuros, especialmente los nacidos más temprano, tienen problemas médicos.

Defectos congénitos son problemas que tienen que ver con la formación y funcionamiento de los órganos y partes del cuerpo de un bebé, o la manera en que sus cuerpos convierten los alimentos en energía. Algunos defectos congénitos no necesitan tratamiento y otros causan discapacidad o requieren tratamiento médico o quirúrgico.

Bajo peso al nacer es cuando un bebé nace con un peso de menos de 5 libras, 8 onzas. Algunos bebés con bajo peso al nacer son saludables, aunque sean pequeños. Pero tener bajo peso al nacer puede causar problemas de salud graves para algunos bebés.

Desprendimiento de placenta es una afección grave en la que la placenta se separa de la pared del útero antes del nacimiento. La placenta suministra alimentos y oxígeno al bebé a través del cordón umbilical. El desprendimiento de placenta puede causar sangrado muy abundante y ser mortal para la madre y el bebé.

Trastornos del espectro alcohólico fetal son problemas de salud que pueden afectar a los bebés cuando sus madres beben alcohol durante el embarazo. El más grave de ellos es el síndrome de alcoholismo fetal. El síndrome de alcoholismo fetal puede dañar seriamente el cerebro y el cuerpo del bebé.

Aborto involuntario es cuando un bebé muere en el útero antes de las 20 semanas de embarazo. **Muerte fetal** es cuando un bebé muere en el útero después de las 20 semanas de embarazo.

Problemas de desarrollo y comportamiento pueden no aparecer durante varios años después de que un bebé está expuesto a sustancias durante el embarazo. Estos problemas hacen más difícil a un niño el aprendizaje, la comunicación y llevarse bien con los demás, cuidar de él mismo, y puede incluir el trastorno por déficit de atención con hiperactividad (también llamado TDAH).

Síndrome de abstinencia neonatal (SAN) es un grupo de afecciones que un recién nacido puede tener si su madre fue adicta a las drogas durante el embarazo. SAN ocurre cuando un bebé se vuelve adicto a una droga antes del nacimiento y luego sufre de abstinencia de la droga después de su nacimiento. El tipo y gravedad de los síntomas de abstinencia de un bebé dependen de la droga utilizada, por cuánto tiempo y con qué frecuencia la madre biológica la utilizó, cómo su cuerpo descompone la droga y si el bebé nació a término o prematuro.

Alcohol

No hay una cantidad de alcohol que se haya demostrado que sea seguro durante el embarazo. El alcohol incluye vino, refrescos de vino, cerveza y licor. Usted puede conocer algunas mujeres que bebían alcohol regularmente durante el embarazo y han tenido bebés aparentemente saludables. Puede conocer algunas mujeres que bebían muy poco alcohol durante el embarazo y han tenido bebés con problemas graves de salud. Cada embarazo es diferente. El consumo de alcohol puede dañar a un bebé más que a otro. La mejor manera de asegurar un bebé saludable es mantenerse alejada del alcohol por completo.

El hígado trabaja duro para descomponer el alcohol en su sangre. Pero el hígado de su bebé es demasiado pequeño para hacer lo mismo y el alcohol puede perjudicar su desarrollo. Es por eso que el alcohol es mucho más perjudicial para su bebé que para usted durante el embarazo.

El consumo de alcohol durante el embarazo puede causar **defectos de nacimiento**, **aborto involuntario**, **parto prematuro**, **muerte fetal**, **problemas de desarrollo y conducta**, **bajo peso al nacer** y **trastornos del espectro alcohólico fetal.**

Marihuana

No hay una cantidad de marihuana que se haya demostrado que sea segura durante el embarazo. El consumo de marihuana durante un largo tiempo puede aumentar el riesgo de **parto prematuro**. Algunos niños nacidos de madres que usaron marihuana durante el embarazo tienen más probabilidades de tener ciertos **problemas de desarrollo y comportamiento**. Se necesita más investigación, sin embargo, para saber si estos efectos provienen del consumo de marihuana o sus factores relacionados, como un ambiente de hogar pobre o el uso de otras drogas por parte de la madre.

Algunas mujeres usan la marihuana para tratar las náuseas (estómago enfermo) durante su embarazo. Las mujeres que piensan consumir marihuana medicinal durante el embarazo deben consultar con un proveedor de atención médica.

Se aconseja a las madres que amamantan no consumir marihuana. El THC (la sustancia química principal de la marihuana) puede acumularse en la leche materna en cantidades altas si una mujer embarazada usa marihuana a menudo. Algunos estudios demuestran que la exposición al THC a través de la leche materna podría dar como resultado una menor capacidad para controlar el movimiento del cuerpo a 1 año de edad. Debido a que el cerebro de un bebé aún se está formando, el THC podría afectar la manera en que se desarrolla el cerebro. Las nuevas madres que usan marihuana medicinal deben hablar acerca de su uso con el médico que cuida de su bebé.

Cocaína (coca) y metanfetamina (meth)

Tanto la cocaína como la metanfetamina son polvos blancos que se comen, inhalan o mezclan con líquido y se inyectan con una aguja. A veces la metanfetamina viene en forma de pastilla o se convierte en una roca brillante clara o blanca (llamada cristal) que puede ser fumada.

El consumo de cocaína durante el embarazo **aumenta la probabilidad de un nacimiento prematuro, bajo peso al nacer, aborto involuntario y desprendimiento de la placenta**.

Un estudio encontró que los bebés de las mujeres que usaron metanfetamina tenían más de tres veces de probabilidad de tener un desarrollo deficiente antes del nacimiento. Incluso cuando nacen a término, estos bebés afectados tienden a **nacer con bajo peso** y tienen la cabeza con una circunferencia más pequeña de lo normal.

El uso de la metanfetamina durante el embarazo también aumenta el riesgo de **parto prematuro** y **desprendimiento de la placenta**. También ha habido casos de **defectos de nacimiento**, incluyendo defectos cardíacos y labio leporino y paladar hendido, en los bebés expuestos, pero los investigadores aún no saben si la droga contribuyó a estos defectos.

Después del parto, algunos bebés que estuvieron expuestos a la metanfetamina antes de nacer presentan síntomas de dependencia, incluyendo nerviosismo, somnolencia y problemas respiratorios.

Heroína (smack, junk)

La heroína es una droga callejera hecha a partir de semillas de la planta de amapola. Puede ser un polvo blanco o marrón, o puede ser una sustancia negra pegajosa. Generalmente, la heroína se inyecta con una aguja, pero puede ser fumada o inhalada.

El uso de la heroína durante el embarazo puede ser peligroso, incluso mortal. Puede causar problemas graves, como: **defectos de nacimiento, desprendimiento de la placenta, parto prematuro, bajo peso al nacer** y **muerte fetal.**

Si usted está embarazada y consume heroína, no pare de hacerlo sin, primero, obtener tratamiento de su proveedor de cuidados médicos. Al dejar de hacerlo repentinamente (a veces llamado en seco), puede causar problemas graves para su bebé, incluyendo la muerte. El médico o un centro de tratamiento de drogas puede tratarla con medicamentos como la metadona o la buprenorfina. Estos medicamentos pueden ayudar a reducir gradualmente su dependencia a la heroína de una manera segura para su bebé.

MDMA (éxtasis, molly)

La MDMA viene en forma de píldora. A veces se le llama la “droga del amor” porque hace que una persona se sienta muy amable y sentimental. También puede hacer que la persona se sienta deprimida o confundida y tenga dificultades para recordar cosas.

La poca investigación que existe sobre los efectos del consumo de MDMA durante el embarazo sugiere que la exposición prenatal a MDMA puede causar problemas de aprendizaje, memoria y de motricidad en el bebé. Se necesita más investigación sobre este tema.

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IS IT SAFE TO SMOKE MARIJUANA WHILE YOU ARE PREGNANT?

Rumors abound that marijuana has no effect on the unborn child, and that it is safe to smoke while pregnant. But research has shown that marijuana use by mom can cause numerous adverse effects on newborns and growing children. Some effects can linger into adulthood.

Birth

3 Years

Newborns:
- Low birth weight and premature delivery
- Increased anxiety and depression symptoms
- Increased emotional reactions
- Reduced separation anxiety

The Developmental Years:
- Less branching in nerve cells
- Reduced ability to pay attention
- Diminished problem-solving skills
- Difficulty with detail-oriented memory
- Decreased ability to organize and prioritize

18 Years

Adulthood:
- Altered brain functions and problems using working memory

22 Years and Beyond

No research has shown any safe level of marijuana use while a woman is pregnant.

Hayatbakhsh, M.R., et al. (2011). *Pediatric Research*, 71(2), 215-219.
Trezza, V., et al. (2012). *Frontiers in Behavioral Neuroscience*, 6, 1-12.
Campolongo, P., et al. (2011). *Psychopharmacology*, 214, 5-15.

USDTL®
The Leader in Newborn Toxicology

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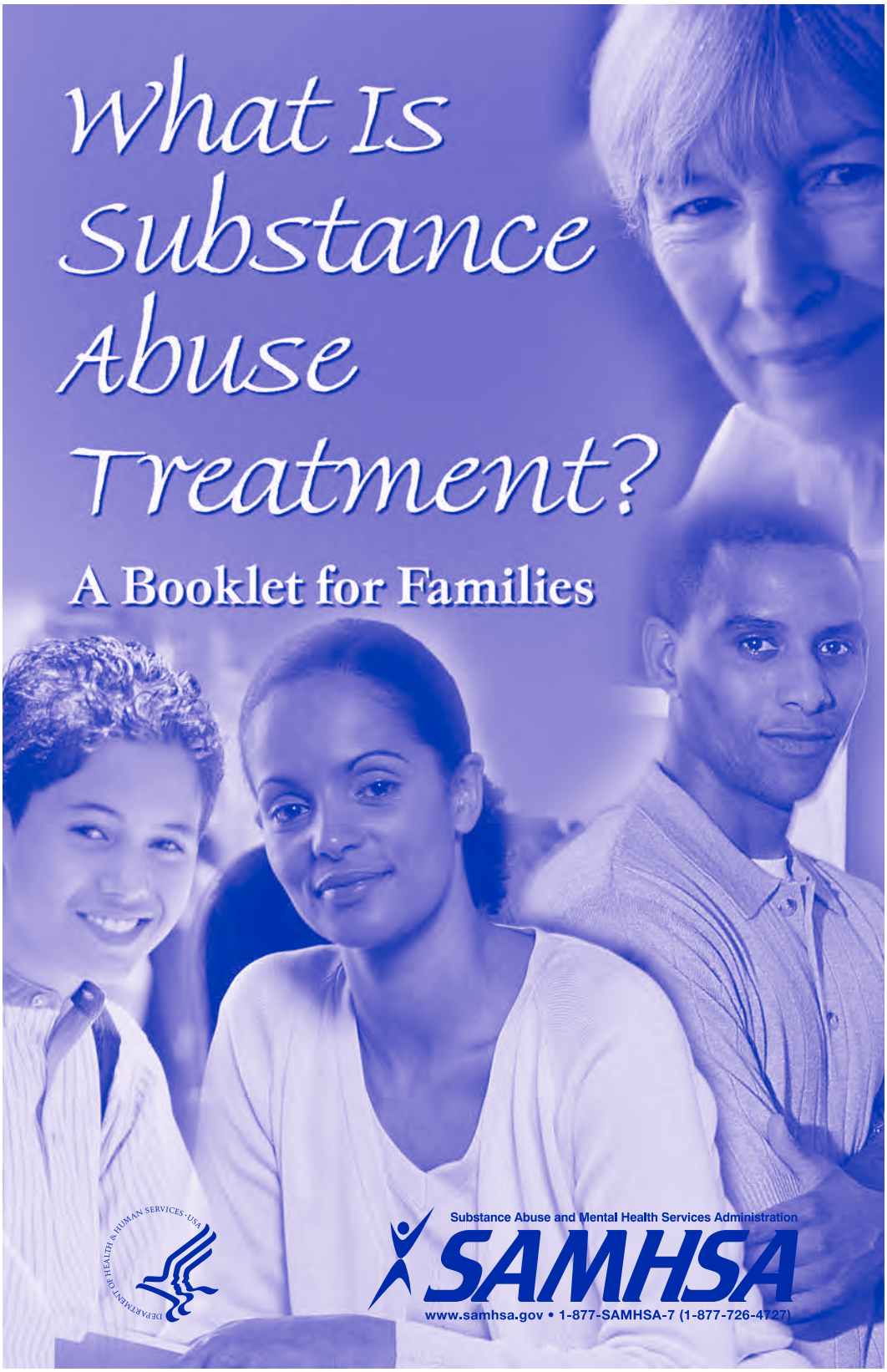

Full brochure (40 pages) available in

Patient Resources

portion of toolkit

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KANSAS MATERNAL & CHILD HEALTH

ONLINE SUPPORT AND EDUCATION RESOURCES FOR PATIENTS

Online support

- Drugrehab.com - Advanced Recovery Systems:
  https://www.drugrehab.com/guides/pregnancy/
- In the Rooms: 11 Benefits of Seeking Online Support in Recovery:
  https://drugabuse.com/benefits-of-online-support-in-recovery/

Patient education resources

- Patient education materials for alcohol and other drugs:
  http://www.sbirt.care/education.aspx
- Methadone flyer for in office use:
  http://bit.ly/MethadoneTrmtFlyer
- Marijuana and Pregnancy:
  http://bit.ly/MarijuanaUsePregnancy
  http://bit.ly/MarijuanaUseInfographic
- What is Substance Abuse Treatment – A booklet for families:
  http://bit.ly/SAMSA_SAT

Additional help

- SAMHSA National Help Line: 1-800-662-HELP (4357)
- Beacon Health Options Substance Use and Treatment Number: 1-866-645-8216
- KDADS CMHC 24-Hour Hotlines:
  http://bit.ly/CMHC24HrCrisisHotline
- Recovery Resource Hub:
  www.recoveryresourcehub.org
- Kansas support groups:
  SupportGroupsInKansas.org

KANSAS MATERNAL & CHILD HEALTH

PATIENT RESOURCES: RELATED WEBSITES AND VIDEOS

- Vanderbilt University Medical Center Child Policy, Incidence and Cost of Neonatal Abstinence Syndrome is Rising
  Companion video to paper published in Pediatrics which describes the increasing incidence and cost of neonatal abstinence syndrome (NAS), a withdrawal syndrome in babies born to moms who use opioids during pregnancy.

  Video: https://www.vumc.org/nas/media/incidence-and-cost-neonatal-abstinence-syndrome-rising
  Paper: http://pediatrics.aappublications.org/content/early/2018/03/21/peds.2017-3520

- National Organization on Fetal Alcohol Syndrome (NOFAS)
  NOFAS has multiple video resources available both as DVDs for purchase and YouTube videos on the topic of fetal alcohol syndrome disorders (FASD). Content ranges from testimonials by mothers who gave birth to children with FASD, children affected by FASD, PSAs, and interviews with professionals on how their work intersects with FAS.

  Website: https://www.nofas.org/video/
  YouTube Channel: https://www.youtube.com/channel/UC0HLie6HmtvCXVZGG9ZLFQA
  Mother who chose to avoid alcohol during pregnancy:
  https://www.youtube.com/watch?v=K45q87izVu8
  OBYN's role in preventing FASD:
  https://www.youtube.com/watch?v=MIqHnvDuphA
  Social Worker and mother experiencing alcohol use disorder:
  https://www.youtube.com/watch?v=Vxwlwr6E_nY
  FASD and Occupational Therapy: https://www.youtube.com/watch?v=23Tkt3jjDFY&list=PLiFZcDuldDA5GQg9a9zh1AmwHeN0KlA_0

- Substance Abuse Mental Health Services Administration (SAMHSA), Marijuana and Pregnancy
  SAMHSA produced video highlighting risks associated with marijuana use during pregnancy and while breastfeeding. Additional information on marijuana use and pregnancy as well as video resources on marijuana use more broadly can be found on this page.
  https://www.samhsa.gov/marijuana/marijuana-pregnancy

- Johns Hopkins Medicine Center for Addiction and Pregnancy (CAP), Beyond Addiction
  Johns Hopkin's CAP is an outpatient program designed to help mothers and infants deal with the physical, emotional, and social problems caused by addiction. This video follows Krystele Kempe, a CAP participant, as she navigated her experiences with pregnancy, homelessness, and addiction. The video also includes interviews with CAP professionals who emphasize the importance of destigmatizing treatment.

  Video (right side of webpage): https://www.hopkinsmedicine.org/news/articles/putting-the-pieces-together
  Research from CAP: https://www.hopkinsmedicine.org/psychiatry/patient_information/bayview/research/CAP_research.html

- Children's Hospital at Dartmouth-Hitchcock (CHaD), Jaye's Story: A Reason for Hope
  First-person account of Opioid addiction during pregnancy and infant born with Neonatal Abstinence Syndrome (NAS). This infant, Jaye, was treated at CHaD using a new care model for infants born with NAS. Dartmouth-Hitchcock Health System houses The Center for Addiction Recovery in Pregnancy and Parenting (CARPP). This network works to support pregnant and parenting women's addiction recovery as well as promote healthy growth and development of children.

  Video: https://youtu.be/2pz9mtM0yiQ
  Website, Provider Resources: https://med.dartmouth-hitchcock.org/carpp/resources-for-providers.html

- Side Effects of Public Media, Pregnant and Addicted
  Side Effects of Public Media is a Health News Initiative led by WFYI Indianapolis Public Media with the aim of reporting on Public Health issues through a personal lens. The video, Fighting an Addiction while Pregnant, and complimentary report, Pregnant and Addicted, highlight the barriers women face when accessing addiction treatment services while pregnant.

  Video: https://youtu.be/UrXUfB94vhc
  News Report: http://apps.sideeffectspublicmedia.org/pregnant-addicted/

- March of Dimes, Prescription medicine before and during pregnancy
  Video published through the March of Dimes organization. The short video addresses women who may be using prescription drugs through a doctor or recreationally and the importance of disclosing this information to a healthcare provider during pregnancy. The website also includes safety guidance for women on alcohol, heroin, marijuana, and tobacco use during pregnancy.

  Video: https://www.marchofdimes.org/pregnancy/cocaine.aspx
  Website: https://www.marchofdimes.org/pregnancy/is-it-safe.aspx

OPIOID RESOURCES

A. Provider Resources
1. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants 236
*Full version (165 pages) available in **Opioid and Pregnancy and Postpartum/ Provider Resources** portion of toolkit*
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CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Full version (165 pages) available in

Opioid and Pregnancy and Postpartum/Provider Resources

portion of toolkit

3 Questions
to Integrate Substance Use Disorder Services into Primary Care

This fact sheet provides information and education including examples of tools and potential mentoring opportunities for those rural healthcare providers beginning to provide or providing substance use disorder treatment services.

Finding resources can be as easy as 1, 2, 3.

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1. What should primary care providers know about substance use disorder — including opioids?

National Institute on Drug Abuse
Advancing Addiction Science Drugs, Brains, and Behavior: The Science of Addiction — VISIT: **https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction**

American Society of Addiction Medicine
RESOURCES — Visit: **https://www.asam.org/resources/patient-resources**

RTI International
Understanding, Preventing and Treating Opioid Abuse
Multidisciplinary Research to Combat the Costs of Opioid Abuse — VISIT: **https://www.rti.org/emerging-issue/understanding-preventing-and-treating-opioid-abuse**

Providers Clinical Support System
Discover the Rewards of Treating Patients with Opioid Use Disorders — VISIT: **https://pcssnow.org/**

Institute for Healthcare Improvement
Health Care Providers Must Act Now to Address the Prescription Opioid Crisis — VISIT: **http://www.ihi.org/resources/Pages/Publications/Health-Care-Providers-Must-Act-to-Address-Prescription-Opioid-Crisis.aspx**

NOSORH
NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH
TEL 888-391-7258 | **FAX** 586-336-4629 | **www.nosorh.org**

2. Where can I find resources?

ON PRESCRIBING:

Affirm Health

Opioid Prescribing Guidelines: A State-by-State Overview — VISIT: https://www.google.com/amp/s/www.affirmhealth.com/blog/opioid-prescribing-guidelines-a-state-by-state-overview%3fhs_amp=true

CDC

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 — VISIT: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm

American College of Physicians

Providers' Clinical Support System for Opioid Therapies — VISIT: https://www.acponline.org/meetings-courses/focused-topics/providers-clinical-support-system-for-opioid-therapies

HHS/Opioids

Safe Opioid Prescribing — VISIT: https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html

National Institute of Drug Abuse

Other Opioid Prescribing Resources — VISIT: https://www.drugabuse.gov/nidamed-medical-health-professionals/opioid-crisis-pain-management/other-opioid-prescribing-resources

CDC

Guideline Resources — VISIT: https://www.cdc.gov/drugoverdose/prescribing/resources.html

Wonder Labs

Alternatives to Addictive Painkillers and Opioids — VISIT: https://www.wonderlabs.com/blog/alternatives-to-addictive-painkillers-and-opioids?ad=-gooopioid&gclid=Cj0KCQjw1pblBRDSARIsACfUG13-SG8aE4NAJ1ZMXi-3fMZb1HPZ9xPVILyDDbv_z-msY4TvOu7OdHJAaAltSEALw_wcB

ON MEDICATION ASSISTED TREATMENT (MAT):

Opioid Prescribing Courses for Health Care Providers

MAT — VISIT: https://www.samhsa.gov/medication-assisted-treatment/training-resources/opioid-courses

ON TREATMENT OPTIONS:

SAMHSA Behavioral Health Treatment Services Locator — VISIT: https://findtreatment.samhsa.gov/locator/home#.XKy3TZhKhPY

SAMHSA's National Helpline
1-800-662-HELP (4357) — VISIT: https://www.samhsa.gov/find-help/national-helpline

Effective Treatments for Opioid Addiction — VISIT: https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction

Probuphine: A Game-Changer in Fighting Opioid Dependence — VISIT: https://www.drugabuse.gov/about-nida/noras-blog/2016/05/probuphine-game-changer-in-fighting-opioid-dependence

Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders — VISIT: https://www.nejm.org/doi/full/10.1056/NEJMoa1505409#t=abstract

Addiction Technology Transfer Center Network
Taking Action to Address Opioid Misuse — VISIT: https://attcnetwork.org/centers/global-attc/taking-action-address-opioid-misuse

SAMHSA
Recovery and Recovery Support — VISIT: https://www.samhsa.gov/find-help/recovery

Opioid Epidemic Practical Toolkit: Helping Faith and Community Leaders Bring Hope and Healing to Our Communities — VISIT: https://www.hhs.gov/about/agencies/iea/partnerships/opioid-toolkit/index.html

3. Where can I find information regarding on-going support/mentoring?

RAND
Opioid TA center — VISIT:
https://www.rand.org/health-care/centers/optic.html

National Institute on Drug Abuse (CME) — VISIT:
https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/cmece-activities

Telehealth can help us combat the opioid crisis —
VISIT: https://www.linkedin.com/feed/update/urn:li:activity:6519228043519619072

Project C.L.E.A.N (Communities Leaders Eliminating the Abuse of Narcotics) — VISIT: https://www.cch-inc.com/images/clean/clean.pdf

Columbus Community Hospital
Project C.L.E.A.N. - Safe Use Not Abuse — VISIT:
https://www.cch-inc.com/en/projectclean

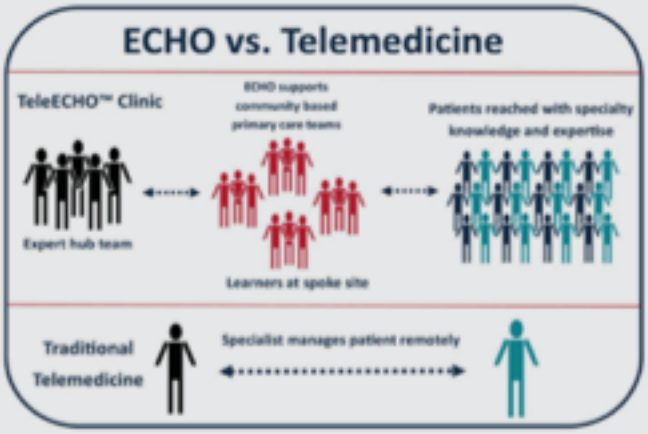
Hennepin Healthcare
Project ECHO — VISIT: https://www.hennepinhealthcare.org/project-echo/

Minnesota Hospital Association
Project ECHO: Extending Opioid Treatment Statewide — VISIT:
https://www.mnhospitals.org/Portals/0/Documents/education/7369_GS03.pdf

TeleECHO as an Educational Model for Treating Opioid Use Disorder — VISIT: https://minnesotaruralhealthconference.org/sites/default/files/5A%20TeleECHO%20as%20an%20Educational%20Model%20for%20Treating%20Opioid%20Use%20Disorder.pdf

CHI St Gabriels Health
Project ECHO — VISIT: https://www.chistgabriels.com/echo/

A Rural Response: Project ECHO



ECHO model is not "traditional telemedicine."
Treating physician retains responsibility for managing patient.

Image provided by Dr. Heather Bell CHI St Gabriels Health

Other Resources:

SAMHSA-HRSA Center for Integrated Health Solutions

Behavioral Health in Primary Care — VISIT: **https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care**

SAMHSA

Rural Opioid Technical Assistance (ROTA) — VISIT: **https://www.samhsa.gov/rural-opioid-technical-assistance-rota**

These resources are in no way an exhaustive list of the many quality resources available at little or no charge to providers serving SUD patients.

Easy as 1, 2, 3....

To find the resources you need to assist the patients you serve.

Contact NOSORH Education and Services Director, Chris Salyers (chris.salyers@nosorh.org) with questions, for discussion or for additional information.

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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: July 26, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: **State Guidance for Implementation of the Treatment for Infants with Neonatal Abstinence Syndrome in Residential Pediatric Recovery Centers provisions of Section 1007 of Pub. L. 115-271, *the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.***

This Informational Bulletin (Bulletin) provides clarification to states about section 1007 of the Substance Use-Disorder Prevention that Promoted Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, entitled "Caring Recovery for Infants and Babies," which added a new section 1902(a)(86) to the Social Security Act (Act) to add an optional provider type of "residential pediatric recovery center" (RPRC) for treatment of infants with Neonatal Abstinence Syndrome (NAS) without any other significant medical risk factors.

Background

Prior to the passage of the SUPPORT for Patients and Communities Act, CMS issued a prior Bulletin addressing "Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants."[1] In this prior Bulletin, CMS discussed the complex condition of NAS, NAS Diagnosis and Treatment, Medicaid Coverage for NAS Treatment for Infants as well as their Mothers, and Potential Payment Options for these Services.

NAS is a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids. Clinically significant neo-natal withdrawal most commonly results from exposure to opioids, but symptoms of neonatal withdrawal have also been noted in infants exposed to antidepressants, anxiolytics, and other non-opioids. NAS is not characterized as an addiction or substance use disorder; rather, it is a medical condition resulting in a physiologic response to the infant's exposure to cessation of the opioid or other substance the mother was using.[2]

Section 1007 of the SUPPORT for Patients and Communities Act, entitled "Caring Recovery for Infants and Babies," added a new section 1902(a)(86) to the Social Security Act (Act) to add an optional provider type, "residential pediatric recovery center," defined as "a center or facility that

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf
[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf

furnishes items and services for which medical assistance is available under the state plan to infants with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors."[3]

In addition, a RPRC "may offer counseling and other services to mothers (and other appropriate family members and caretakers) of infants receiving treatment at such centers if such services are otherwise covered under the State plan under this title or under a waiver of such plan. Such other services may include (A) Counseling or referrals for services, (B) Activities to encourage caregiver-infant bonding, and (C) Training on caring for such infants.[4]

Impact of the Newly Defined Residential Pediatric Recovery Center

Infants with NAS have traditionally been treated in hospital inpatient settings, often with lengthy stays. As the number of infants born with NAS continues to rise,[5] states are increasingly utilizing NAS treatment settings outside of inpatient hospital settings to provide treatment to these infants and their appropriate caretakers. Included in these treatment settings are RPRCs, as newly defined by section 1007 of the SUPPORT for Patients and Communities Act.

RPRCs may treat infants with less severe NAS or care for infants with NAS who are not medically stable and ready to go home, but who are stable enough to transfer to a lower level of care and can be safely discharged from the hospital. Section 1007 of the SUPPORT for Patients and Communities Act defines a RPRC is a "center or facility that furnishes items and services for which medical assistance is available under the State plan to infants with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors."[6]

Under current Medicaid law, medical assistance payment for room and board is only available with respect to the facilities that provide Medicaid-covered, institutionally-based, benefits: nursing facilities, inpatient hospitals, psychiatric hospitals for individuals under age 21, institutions for mental diseases for individuals age 65 or older that otherwise would qualify as an inpatient setting, and intermediate care facilities for individuals with intellectual disabilities that also meet certain federal standards and conditions of participation requirements prescribed by the Secretary. Thus, a RPRC would only be able to receive a Medicaid payment for room and board if the RPRC furnishes services under one of these benefits and meets the applicable requirements.

However, the Medicaid covered services delivered by providers furnishing items and services in a RPRC that is not one of these facilities may be appropriately covered and paid under a variety of Medicaid state plan benefits. Determination and enforcement of any licensing or certification standards for RPRCs will lie within the states' sole purview.

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[3] Section 1902(pp)(1) of the Act.

[4] Section 1902(pp)(2) of the Act.

[5] Dramatic Increase in Maternal Opioid Use Disorder and Neonatal Abstinence Syndrome, National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services 2019 https://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome

[6] Section 1902(pp)(1) of the Act.

For infants with NAS, specific services may include, but are not limited to, assessments, development of care plans, swaddling, feeding, and specialized care of the infants. These services may be covered under a variety of Medicaid state plan benefits provided they meet the requirements for the benefit under which the services are provided. Potential benefit categories include, but are not necessarily limited to, physicians' services; services provided by other licensed practitioners; physical and occupational therapies; speech, hearing and language disorder services; respiratory care services; diagnostic and rehabilitative services; prescription drugs; non-emergency transportation to medical care; and case management.

States have significant flexibility in how they may pay for services for treating infants with NAS. A state may pay providers for medically necessary Medicaid state plan services provided to infants with NAS who are receiving services in the hospital or other facility setting, in a RPRC, or at home and recognize the varied costs of providing care based on the service location or the severity of need. States may also pay for individually covered services or, if determined as a more efficient payment method, may develop bundled rates for services provided to infants by providers like RPRCs. In addition, states may develop methodologies that offer incentives for improved outcomes and quality care.

Inclusion of Mothers, Appropriate Family Members, and Caretakers

Section 1007 of the SUPPORT for Patients and Communities Act permits RPRCs to offer certain services to mothers and other appropriate family members and caretakers that are for the benefit of infants receiving treatment at RPRCs if the services are otherwise covered under the state plan (or a waiver of the state plan). These services may include counseling or referrals for services, activities to encourage caregiver-infant bonding, and training on caring for infants with NAS.[7] Medicaid-covered services are only available to Medicaid-eligible individuals. CMS has previously stated in a Bulletin, however, that whether or not a mother is Medicaid eligible, she may receive some benefit from certain services that are for the direct benefit of the child and directed at treating and promoting the health of the child to reduce or treat the effects of the mother's condition on the child.[8]

The medical literature supports the importance of the involvement of mothers and their physical interaction with the newborns during treatment for NAS.[9] Supporting the mother and other appropriate family members and caretakers alongside the infants provides a direct benefit to the infant, by encouraging the future caretakers to learn and practice specialized strategies to comfort and assist an infant with NAS, which would benefit the infant throughout all phases of treatment.[10]

For these services to a mother, family member, or caretaker who is not Medicaid eligible to be covered, the therapeutic interventions must be for the direct benefit of the infant, meaning the services must actively involve the infant, be directly related to the individualized needs of the

[7] Section 1902(pp)(2) of the Act
[8] Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf
[9] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf
[10] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf

infant and be delivered to the infant and mother together. Finally, the services must be covered under a benefit in section 1905(a) of the Act (e.g. medical or remedial services provided by a physician or other licensed practitioner) or pursuant to a waiver of such plan. In such cases, services that involve a non-Medicaid eligible mother or appropriate family member and caretaker may be billed by the RPRCs for the infant, and claimed by the state as a direct service to the infant.

State Process for SPA Submission

States may need to make changes to their Medicaid state plans through a SPA submission in order to recognize RPRCs as a provider type and, as necessary, update their payment methodologies to describe differences in payments to the RPRCs. To the extent a state chooses to pay for covered services provided within RPRCs differently from other provider types, the state will need to issue a public notice and amend the state plan to comprehensively describe the payment methodology. As with any SPA submission, CMS will request information on the source of non-federal share of the service payments and information on the rate setting methodology. Specific guidance related to SPA submission procedures, including guidance on developing comprehensive methodologies and bundled rates, may be found on Medicaid.gov: https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/medicaid-spa-toolkit/index.html.

Conclusion

Infants experiencing symptoms of NAS are particularly vulnerable medically, as they are experiencing withdrawal from powerful opioids. They require access to treatment that incorporates the best evidence-based practices, and involves their mothers and families to the greatest extent possible, to help them withdraw from exposure to opioids in utero and to lead healthier lives. Section 1007 of the SUPPORT for Patients and Communities Act provides a new optional provider type, RPRCs, for delivery of this critical treatment to infants with NAS. CMS is available to work with states as needed in order to reach these goals. For additional information about this Informational Bulletin, or for states requesting technical assistance, please contact Kirsten Jensen, Director, Division of Benefits and Coverage at Kirsten.Jensen@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

CMCS Informational Bulletin

DATE: July 26, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: **State Guidance for the New Limited Exception to the IMD Exclusion for Certain Pregnant and Postpartum Women included in Section 1012 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Help for Moms and Babies**

The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin (Bulletin) to provide guidance to states on section 1012 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, (SUPPORT for Patients and Communities Act), entitled Help for Moms and Babies. Section 1012 creates a new limited exception to the institution for mental diseases (IMD) exclusion for certain pregnant and postpartum women as discussed below.

Background

Institution for Mental Diseases (IMD) Exclusion

Section 1905(i) of the Social Security Act (Act) defines an IMD as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services."

Under section 1905(a) of the Act[1], there is a general prohibition on Medicaid payment for any services provided to an individual who has not yet attained 65 years of age who is residing in an IMD. This is commonly known as the IMD exclusion, and it applies to any care or services provided to patients residing in an IMD inside or outside of the IMD. There are two exceptions to the IMD exclusion under section 1905(a). First, inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 and older in IMDs can be reimbursed (42 C.F.R. §440.140). Second, inpatient psychiatric hospital services for individuals under age 21 furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility,

[1] Clause (B) following section 1905(a) of the Act.

commonly referred to as a "Psychiatric Residential Treatment Facility" (PRTF), that meet certain requirements, can also be reimbursed (42 C.F.R. §440.160).[2] This is commonly referred to as the "psych under 21" benefit.

Medicaid Coverage for Pregnant and Postpartum Women

Eligibility and coverage of the category of low-income pregnant women is subject to income limits and is mandatory in Medicaid. Pregnant womn, as defined in 42 C.F.R. §435.4, includes the postpartum period, which extends until the last day of the month in which a 60-day period has elapsed after the end of the pregnancy.

Federal law requires states to extend Medicaid eligibility and coverage to categorically needy and medically needy pregnant women who are eligible for Medicaid on the basis of being pregnant. At a minimum, qualified pregnant women are entitled to coverage of pregnancy and pregnancy-related services and services for the treatment of conditions that may complicate pregnancy, when available under the state plan (42 C.F.R. §435.116(d); §435.301(b)(1)(i)). These services are defined by the state and are not necessarily specifically identified or defined in the state plan, but they generally include prenatal care, delivery, postpartum care, family planning services and can also include diagnosis or treatment of illnesses or medical conditions that might threaten the health or well-being of the mother or fetus. Under 42 C.F.R. §440.250(p), states may also provide extended services to pregnant women that are not available to non-pregnant individuals, and may provide these services in greater amount, duration or scope than is provided under the state plan to other individuals eligible for Medicaid, providing the services are 1905(a) coverable services, are related to the pregnancy or are related to any other condition that may complicate pregnancy.[3]

New Limited Exception to the IMD Exclusion for Certain Pregnant and Postpartum Women

Section 1012 of the SUPPORT for Patients and Communities Act creates a new limited exception to the IMD exclusion. Specifically, section 1012(a) states that for a woman who is eligible on the basis of being pregnant (and up to 60-days postpartum), who is a patient in an IMD for purposes of receiving treatment for a substance use disorder (SUD), who is either enrolled under the state plan immediately before becoming a patient in the IMD, or who becomes eligible to enroll while a patient in an IMD, the IMD exclusion shall not be construed to prohibit federal financial participation for medical assistance for items and services provided outside of the IMD to such women.

[2] Section 12005 of the 21st Century Cures Act requires Medicaid reimbursement for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children under age 21 who are receiving inpatient psychiatric hospital services. More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib062018.pdf

[3] §440.210(a)(2), §440.210(a)(3)

Implementation

Section 1012(b) specifies that the effective date of section 1012 was the date of enactment of the SUPPORT for Patients and Communities Act, which was October 24, 2018. CMS encourages all states to implement this provision as quickly as possible to ensure that pregnant women, including women in the postpartum period, receive these important services. Women eligible for this limited exception to the IMD exclusion must either be enrolled as a pregnant woman (or in the 60 day postpartum period) in Medicaid immediately prior to becoming a patient in the IMD or become eligible to enroll in Medicaid as a pregnant woman (or in the 60 day postpartum period) while a patient in an IMD.

Per section 1012(b), some Medicaid state plans may require state legislation in order for the state plan to be amended to add the additional coverage requirements, and CMS shall not consider such state plans as failing to comply with section 1012 of the SUPPORT for Patients and Communities Act before the first day of the first calendar quarter beginning after the close of the first regular session of the state's legislature that begins after October 24, 2018. In the case of a state that has a two-year legislative session, each year of such session shall be deemed to be a separate regular session of the state legislature. States will be expected to be in compliance by October 1, 2020, relative to certain state legislative timeframes.

Conclusion

Women diagnosed with a SUD, who are pregnant or in the 60 day postpartum period, require access not only to effective SUD treatment but also to the full array of mandatory and optional pregnancy and pregnancy-related services available through Medicaid, including treatment of conditions that may complicate pregnancy. Section 1012 of the SUPPORT for Patients and Communities Act provides support for those pregnant and postpartum women facing and/or recovering from substance use disorder, including opioid use disorder, and aids them in their recovery. For additional information about this Bulletin, or for states requesting technical assistance, please contact Kirsten Jensen, Director of Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

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How to Care for a Baby with NAS

Use the Right Words

I was exposed to substances in utero. I am not an addict. And my mother may or may not have a Substance Use Disorder (SUD).

Treat Us as a Dyad

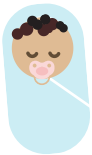
Mothers and babies need each other. Help my mom and me bond. Whenever possible, provide my care alongside her and teach her how to meet my needs.

Support Rooming-In

Babies like me do best in a calm, quiet, dimly-lit room where we can be close to our caregivers.

Promote Kangaroo Care

Skin-to-skin care helps me stabilize and self-regulate. It helps relieve the autonomic symptoms associated with withdrawal and promotes bonding.



Try Non-Pharmacological Care

Help me self-soothe. Swaddle me snugly in a flexed position that reminds me of the womb. Offer me a pacifier to suck on. Protect my sleep by "clustering" my care.

Support Breastfeeding

Breast milk is important to my gastrointestinal health and breast feeding is recommended when moms are HIV-negative and receiving medically-supervised care. Help my mother reach her pumping and breastfeeding goals.

Treat My Symptoms

If I am experiencing withdrawal symptoms that make it hard for me to eat, sleep, and be soothed, create a care plan to help me wean comfortably.

Academy of Perinatal Harm Reduction

www.perinatalharmreduction.org

National Perinatal Association

www.nationalperinatal.org

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OPIOIDS and NAS

When reporting on mothers, babies, and substance use

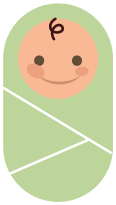
LANGUAGE MATTERS

I am not an addict.

I was exposed to substances in utero. I am not addicted. Addiction is a set of behaviors associated with having a Substance Use Disorder (SUD).

I was exposed to opioids.

While I was in the womb my mother and I shared a blood supply. I was exposed to the medications and substances she used. I may have become physiologically dependent on some of those substances.



NAS is a temporary and treatable condition.

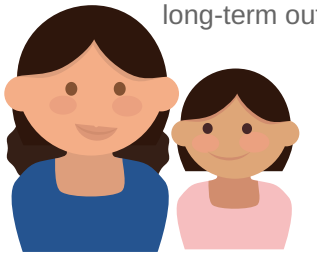
There are evidence-based pharmacological and non-pharmacological treatments for Neonatal Abstinence Syndrome.

My mother may have a SUD.

She might be receiving Medication-Assisted Treatment (MAT). My NAS may be a side effect of her appropriate medical care. It is not evidence of abuse or mistreatment.

My potential is limitless.

I am so much more than my NAS diagnosis. My drug exposure will not determine my long-term outcomes. But how you treat me will. When you invest in my family's health and wellbeing by supporting Medicaid and Early Childhood Education you can expect that I will do as well as any of my peers!



Academy of Perinatal Harm Reduction

www.perinatalharmreduction.org

National Perinatal Association

www.nationalperinatal.org

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Opioid Use Disorder and Pregnancy

Taking helpful steps for a healthy pregnancy

Introduction

If you have an opioid use disorder (OUD) and are pregnant, you can take helpful steps now to ensure you have a healthy pregnancy and a healthy baby. During pregnancy, OUD should be treated with medicines, counseling, and recovery support. Good prenatal care is also very important. Ongoing contact between the healthcare professionals treating your OUD and those supporting your pregnancy is very important.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know, about OUD and pregnancy, as well as the Do's and Don'ts for making sure you have a healthy pregnancy and a healthy baby.

Things to know

- OUD is a treatable illness like diabetes or high blood pressure.
- You should not try to stop opioid use on your own. Suddenly stopping the use of opioids can lead to withdrawal for you and your baby. You may be more likely to start using drugs again and even experience overdoses.
- For pregnant women, OUD is best treated with the medicines called methadone or buprenorphine along with counseling and recovery support services. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- Tobacco, alcohol, and benzodiazepines may harm your baby, so make sure your treatment includes steps to stop using these substances.
- Depression and anxiety are common in women with OUD, and new mothers may also experience depression and anxiety after giving birth. Your healthcare professionals should check for these conditions regularly and, if you have them, help you get treatment for them.
- Mothers with OUD are at risk for hepatitis and HIV. Your healthcare professionals should do regular lab tests to make sure you are not infected and, if you are infected, provide treatment.
- Babies exposed to opioids and other substances before birth may develop neonatal abstinence syndrome (NAS) after birth. NAS is a group of withdrawal signs. Babies need to be watched for NAS in the hospital and may need treatment for a little while to help them sleep and eat.

About OUD

People with OUD typically feel a **strong craving for opioids** and find it hard to cut back or stop using them. Over time, many people **build up a tolerance** to opioids and need larger amounts. They also spend more time looking for and using opioids and less time on everyday tasks and relationships. Those who suddenly reduce or stop opioid use may suffer **withdrawal symptoms** such as nausea or vomiting, muscle aches, diarrhea, fever, and trouble sleeping.

If you are concerned about your opioid use or have any of these symptoms, please check with your **healthcare professionals** about treatment or tapering or find a provider at this website: www.samhsa.gov/find-help.

Do

Do talk with your healthcare professionals about the right treatment plan for you.

Do begin good prenatal care and continue it throughout your pregnancy. These two websites give helpful information on planning for your pregnancy: http://bit.ly/ACOGprenatal and http://bit.ly/CDCprenatal.

Do stop tobacco and alcohol use. Call your state's Tobacco Quit Line at 800-QUIT-NOW (800-784-8669).

Do talk to your healthcare professionals before starting or stopping any medicines.

Do get tested for hepatitis B and C and for HIV.

Do ask your healthcare professionals to talk to each other on a regular basis.

Don't

Don't hide your substance use or pregnancy from healthcare professionals.

Don't attempt to stop using opioids or other substances on your own.

Don't let fear or feeling embarrassed keep you from getting the care and help you need.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy

The healthcare professionals who are treating your OUD and providing your prenatal care need a complete picture of your overall health. Together, they will make sure you are tested for hepatitis B and C and for HIV. They will ask you about any symptoms of depression or other feelings. You should be ready to answer questions about all substances you have used. They need this information to plan the best possible treatment for you and to help you prepare for your baby. These issues may be hard to talk about, but do the best you can to answer their questions completely and honestly. Expect them to treat you with respect and to answer any questions you may have.

Remember: Pregnancy is a time for you to feel **engaged** and **supported**. Work with your healthcare professionals to gain a better understanding of what you need for a healthy future for you and your baby.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Treating Opioid Use Disorder During Pregnancy

Getting the help and support you need from your healthcare professionals

Introduction

Opioid use disorder (OUD) is a treatable disease. When OUD is managed with medicines and counseling, you *can* have a healthy pregnancy and a healthy baby. However, during pregnancy, adjustments to your OUD treatment plan and medicines may be needed.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know about OUD treatment during pregnancy, as well as the Do's and Don'ts for making sure you receive the best treatment possible.

Things to know

- Methadone and buprenorphine are the safest medicines to manage OUD during your pregnancy. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- If you have used opioids, methadone and buprenorphine medicines can help you stop.
- Many pregnant women with OUD worry about neonatal abstinence syndrome (NAS), a group of withdrawal signs that may occur in babies exposed to opioids and other substances before birth. NAS *can* be diagnosed and treated.
- You may need medicine other than those for OUD to treat pain during or after delivery. Other options, such as an epidural and/or a short-acting opioid, can be used to keep you comfortable.
- All hospitals must report to state child welfare agencies when a mother who is using substances gives birth. This report is used to make sure that a safe care plan is in place to deal with both your and your baby's well-being. It is not used to remove your baby from your care. Participating in OUD treatment before and after the birth of your baby shows your commitment to providing a safe, nurturing environment for your baby.

Treatment vs. Withdrawal

Some pregnant women with OUD consider completely withdrawing from using opioids, but seeking treatment is always the most helpful course of action. Withdrawal may make you more likely to start using drugs again and even experience overdoses.

If you are not currently in treatment, talk with your healthcare professionals about treatment medicines and behavioral counseling. If you need to find a provider, visit this website: www.samhsa.gov/find-help.

Do

Do ask about the risks and benefits of taking one of the medicines for OUD during pregnancy.

Do talk to your healthcare professionals about your OUD treatment medicine dose if you are experiencing cravings or withdrawal symptoms.

Do ask your healthcare professionals about counseling and recovery support services.

Do make sure your treatment plan includes steps to treat other medical or behavioral health problems such as depression or anxiety.

Do request that your medical chart includes several ways to address your pain during and right after delivery.

Do ask your healthcare professionals to help you make and keep follow-up visits and to talk to each other on a regular basis.

Don't

Don't consider changing your OUD medicine unless you are taking naltrexone, which has not been studied in pregnancy. Changing your OUD medicine may increase your risk of returning to substance use.

Don't use alcohol or any medicines that might make you sleepy, especially benzodiazepines, when taking OUD medicines.

Don't let your OUD go untreated because you want to prevent your baby from experiencing NAS. Treatment medicines can be used safely during pregnancy and dosing changes will not change the risk or severity of NAS for your baby.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy

Creating a treatment plan requires your healthcare professionals to talk to you about the risks and benefits of different medicines and then together select the one that's best for you. You and your healthcare professionals will also discuss other medical conditions or behavioral health problems that could affect your treatment. Your healthcare professionals will help you decide how best to involve your family and friends in your recovery. They can also suggest support groups to join and other services that can help you throughout your recovery.

Remember: The **benefits** of taking methadone or buprenorphine during pregnancy far outweigh the risks of not treating your OUD. You and your healthcare professionals can **work together** to adjust your treatment plan to achieve success.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Treating Babies Who Were Exposed to Opioids Before Birth

Support for a new beginning

Introduction

Many pregnant women with an opioid use disorder (OUD) worry about harmful effects of opioids to the fetus. Neonatal abstinence syndrome (NAS) is a group of withdrawal signs that may occur in a newborn who has been exposed to opioids and other substances. NAS signs may include high-pitched and excessive crying, seizures, feeding difficulties, and poor sleeping. **NAS is a treatable condition**.

The actions you take or don't take play a vital role in your baby's well-being. Below are some important things to know about what to expect if your baby needs special care after birth, as well as the Do's and Don'ts for understanding and responding to your baby's needs.

Things to know

- A baby born to a mother who used opioids or took OUD medicine during pregnancy is typically observed in the hospital by a medical provider for 4–7 days for any physical signs of NAS. A care plan is created for your baby right away if signs of NAS are noted.
- Some babies with NAS may need medicines such as liquid oral morphine or liquid oral methadone in addition to non-medicine care supports.
- Other parts of treatment in hospitals include rooming-in and putting the baby's crib near your bed. You can also give this type of care to your baby through skin-to-skin contact, gentle handling, swaddling, using pacifiers, breastfeeding, and spending quiet time together.
- Your baby will be able to leave the hospital when he/she is successfully feeding and has been monitored for at least 24 hours after no longer needing medicine (if it is used). Some hospitals may also provide medicine for your baby in an outpatient clinic after he/she has been discharged from the hospital.
- Breastfeeding has many benefits for your baby. Breastfeeding can decrease signs of NAS and reduce your baby's need for medicine and hospitalization. Sometimes, breastfeeding is not recommended, so talk with your healthcare professionals to find out what's right for you and your baby.

Medicine Dose and NAS

If you are taking medicine for your OUD, reducing your dose will NOT help your unborn baby, but it might put your baby at risk. Changing or reducing your OUD medicine while pregnant is not a good idea because it can increase your risk for a return to substance use and might increase the chances of having your baby too early or having a miscarriage. The goal for your OUD medicine dose is to minimize withdrawal and to reduce the chances of going back to substance use.

Do

Do gain the skills and knowledge to understand and respond to your baby's needs. Your baby may need extra contact and cuddling to reduce NAS signs.

Do continue breastfeeding as long as possible when recommended.

Do ask for support so you feel prepared and comfortable with breastfeeding.

Don't

Don't change your medicine or dose of medicine without talking to your healthcare professionals.

Don't be afraid to mention any cravings or urges to use opioids to your healthcare professionals and seek the help you need.

What to expect when you meet with healthcare professionals about OUD treatment after birth

Before you leave the hospital, your healthcare professionals should describe the signs of NAS and provide you with contact information of someone who can help you if you have concerns. They will make sure that you know how to soothe your baby (for example, dimming lights, softly playing white noise, skin-to-skin contact, using a pacifier, and swaddling). They will also explain that the safest sleeping and napping position for a baby is on the back and will show you how to place your baby in the Safe to Sleep position (http://bit.ly/NIHSafeSleep). This position, and having babies sleep in their own space with nothing in the sleep area, reduces the risk of sudden infant death syndrome. You should also expect to have follow-up plans that include home visits and early pediatric follow-up visits (within 5 days of leaving the hospital).

Remember: Before leaving the hospital, make sure you **receive information** on caring for your baby if there are special needs as well as names and contact information of others who can give you additional support.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Good Care for You and Your Baby While Receiving Opioid Use Disorder Treatment

Steps for healthy growth and development

Introduction

If you have an opioid use disorder (OUD), receiving the right medicine along with counseling and recovery support services is important at all stages in your life. From pregnancy to delivery to caring for your baby, addressing your OUD and taking care of yourself is a continuous process. You will be better able to protect and care for your baby with a focus on creating and updating your treatment plan and getting the support you need. In all situations, your commitment to treatment and recovery will go a long way.

After your pregnancy, the actions you take or don't take matter. Below are some important things to know about OUD and caring for your baby, as well as the Do's and Don'ts for creating a healthy environment for your family.

Things to know

- Birth control is important to prevent pregnancies you do not want as well as to ensure proper space between pregnancies. Talk to your healthcare professionals about the full range of birth control options, including long-acting reversible contraception and the best birth control options while you are breastfeeding.
- Breastfeeding is healthy for you and your baby, so you should continue breastfeeding as long as possible. The amount of OUD medicine that passes into breast milk is extremely small. Talk with your healthcare professionals to find out what's best for you and your baby.
- You may need additional treatment and support to help with your recovery. It is important to seek help early!

  1. To find a treatment provider in your area, visit this website: www.samhsa.gov/find-help.
  2. Join a support group: LifeRing (https://lifering.org); Mothers on Methadone (www.methadonesupport.org/Pregnancy.html); Narcotics Anonymous (www.na.org/); Secular Organizations for Sobriety (SOS; www.sossobriety.org/); SMART Recovery (www.smartrecovery.org/); Young People in Recovery (www.youngpeopleinrecovery.org/).

Medicine Dose

Now is a good time to ask your OUD treatment professionals to check your medicine dose. An effective dose during pregnancy may be too high or too low once your baby is born. It is normal to feel tired and stressed, but if these feelings are causing you to have cravings or urges to use opioids again, tell your healthcare professionals.

Do

Do schedule a follow-up visit with your healthcare professionals as soon as possible after you leave the hospital.

Do talk to your healthcare professionals before starting or stopping any medicines.

Do talk to your healthcare professionals about birth control and family planning.

Do continue breastfeeding for as long as possible and ask for support if you need it.

Don't

Don't change the type of OUD medicine right after delivery.

Don't hesitate to ask for help when you are feeling stressed or depressed.

Don't be afraid to tell your healthcare professionals that you are having cravings or urges for opioids.

What to expect when you meet with healthcare professionals about OUD treatment while caring for your baby

If your medicine is no longer working and you feel sleepy or are tempted to start using again, your healthcare professionals can help. Be honest about any cravings or urges you may have to use opioids. The stress that comes with being a new mother may increase these urges.

Your healthcare professionals can offer counseling and other support services. But before they do, they need to know if you have other medical and mental health problems. They will test you for these conditions before you leave the hospital and at your follow-up visits to make sure you get the treatment you need. They will continue to recommend support services that allow you and your baby to receive the high-quality health care that you need.

Your healthcare professionals will work with you to create a birth control plan. Together, you will discuss if you want to have another child, how many children you would like to have, and how you would like to space out the births of your children. At this time, they will check in on how you are doing with breastfeeding and make sure you have the support you need.

Remember: The longer you follow your OUD treatment plan, the better your chances are of **staying in recovery** and strong for your baby. **Counseling** and **support services** are important to keep you and your baby safe and healthy at home.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Prescription Opioids and Heroin

What are opioids?

- Opioids come in different forms, but have similar effects and can harm you.
- At high doses or when combined with other medications or alcohol, opioids can cause people to stop breathing.
- Opioids are prescribed for pain. Examples are hydrocodone, oxycodone, and fentanyl. Some prescription cough syrups also contain opioids.
- Heroin is an illegal opioid made from the opium poppy plant. Heroin is a white or brown powder or a black/dark brown sticky substance.
- Opioids are swallowed, injected, smoked, or snorted.

Using opioids with other substances

- Opioids shouldn't be mixed with other drugs, especially depressants like alcohol, benzodiazepines, and sleeping medications. This greatly increases the risk of overdose and death.
- Mixing cocaine with heroin, called speedballing, also increases the risk of overdose.
- Heroin is sometimes mixed with fentanyl or carfentanil, very powerful opioids that cause overdose and death.

Tips for quitting

Getting started.

- Do not stop taking your opioid medicine suddenly. Lowering your dose too quickly can be dangerous.
- Be aware that withdrawal can occur. Physicians and addiction treatment programs can help with withdrawal.

Know your options.

- *Treatment.* Treatment can include medications, counseling, or a combination. Medications can be provided by a treatment center (residential or outpatient) or provider office.
- *Medications.* Medications include methadone, buprenorphine (Suboxone), and naltrexone. They help manage cravings and withdrawal symptoms, and are used for long-term recovery.
- *Counseling.* Counseling options include cognitive behavioral therapy and motivational interviewing.
- *Peer support groups and recovery supports* are important to help people stay in recovery.

Have naloxone in case of overdose.

- Naloxone is a life-saving tool for people who use opioids. Naloxone reverses opioid overdoses and keeps people from dying from an overdose. It may be available through your healthcare provider, pharmacy, or needle exchange program.

Risks of opioid use

Short Term

- Overdose means taking more of an opioid than your body can handle. Signs of an overdose are small pupils, slowed breathing, cold clammy skin, and unconsciousness. You can stop breathing and die.
- Use can impair learning and ability to drive.

Long Term

- Tolerance means needing more opioids to get the same feeling, which can cause negative effects (see other side).
- Opioids are addictive. Not everyone becomes addicted, but some do. If you have bipolar disorder, anxiety, or problems with alcohol or drugs, talk to your healthcare provider.
- Withdrawal: Symptoms are aches, sweating, nausea, pain, vomiting, chills, and trouble sleeping.
- Pain: Long-term use can lead to an increase in pain.

Opioids and pregnancy

- Use during pregnancy can lead to serious complications.
- But if you are pregnant, do not stop taking opioids without help from a qualified professional.

Do not borrow or share opioids

- Taking opioids that are not prescribed to you is dangerous, and can cause or worsen health problems.
- Pills may look the same but could be different medicines, or have different amounts in each pill. Keep opioids locked up, out of reach of children and teenagers. Most misused medication was taken from someone with a prescription.
- Do not keep extra opioids; destroy them or return them to law enforcement.

Important steps to take if using opioids

- Until you know how the medication affects you, do not use heavy machinery, operate a car, work in unprotected heights, or be responsible for a person who is unable to care for themselves.
- Tell someone you are taking opioids. They should call 911 if you have slowed breathing, cold, clammy skin, or become unconscious.
- Ask your provider if naloxone is something you should have.
- If you need help with pain management, or have health concerns, talk with your healthcare provider. There are other ways to treat pain.

Helpful links

Information on preventing drug overdoses and reducing drug-related harm for opioid users can be found at: http://harmreduction.org. Also, see the www.sbirt.care Resources page for links to more resources.

Sources: Indiana University SBIRT@IU; Institute for Research, Education & Training in Addictions (http://ireta.org/wp-content/uploads/2016/12/Opioids-brochure.pdf)

Prescription Opioids and Heroin

Effects on the Body

Death from overdose, addiction, withdrawal, loss of consciousness

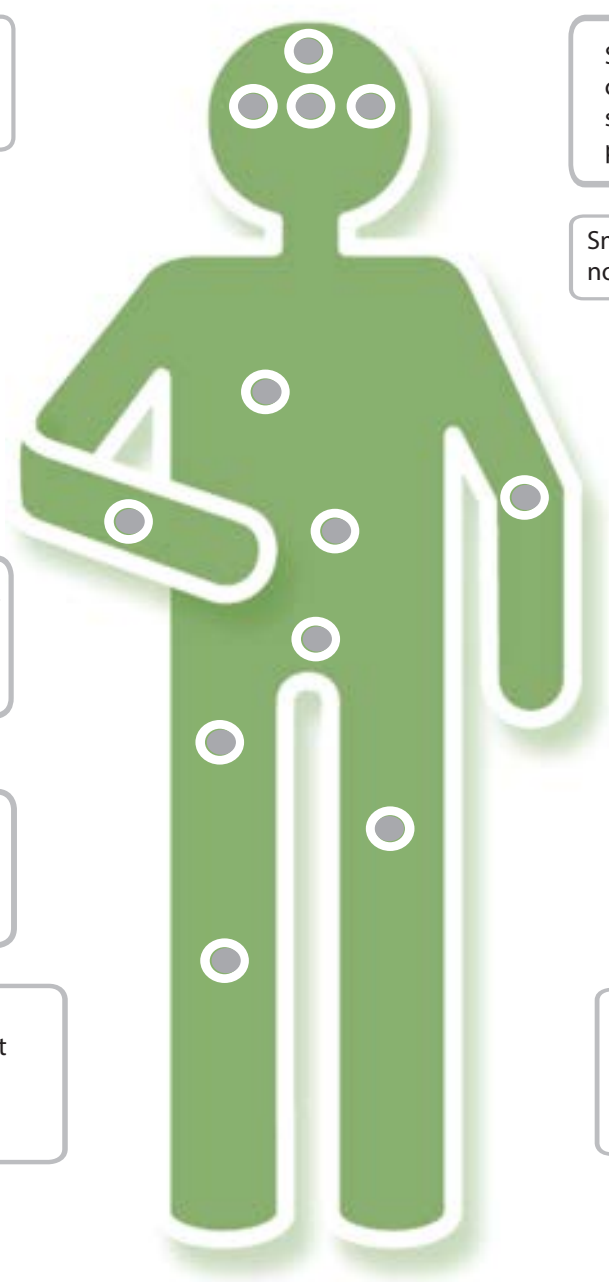
Depression, anxiety

Slowed breathing

Itching and allergic reactions, cold clammy skin, body aches, weakness, increased sensitivity to pain

In women: Decrease in hormones leads to low sex drive, infertility, changes to periods, milky nipple discharge

During pregnancy: Can lead to serious complications, but do not stop taking opioids without getting help from a qualified professional



Slowed reaction time, confusion, dizziness, sleepiness, irritability, problems concentrating

Small pupils, runny nose, yawning

If injected: Higher chance of HIV and Hepatitis B or C, risk of infections including in heart, vein damage, stroke

Constipation, nausea, vomiting, cramps, bloating

Problems urinating

In Men: Decrease in hormones leads to low sex drive, infertility, decreased sexual performance

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ATTC Addiction Technology Transfer Center Network
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Visit www.sbirt.care for more resources!

Opioides con receta y Heroína

¿Qué son los opioides?

- Los opioides vienen en formas diferentes, pero tienen efectos similares y pueden causarle daño
- A dosis elevadas o si se combinan con otros medicamentos o con el alcohol, los opioides pueden causar un paro respiratorio.
- Los opioides se recetan para el dolor. Ejemplos de ellos son la hidrocodona, la oxicodona y el fentanilo. Algunos jarabes de tos vendidos por receta también contienen opioides.
- La heroína es un opioide ilegal derivado de la amapola.
- La heroína se presenta como un polvo blanco o una sustancia pegajosa negra/marrón oscuro.
- Los opioides se ingieren, se inyectan, se fuman o se aspiran.

Uso de opioides junto con otras sustancias

- Los opioides no deben combinarse con otras drogas, en particular con los depresivos tales como el alcohol, benzodiacepinas y sedantes. Esto aumenta enormemente el riesgo de una sobredosis y la muerte.
- La combinación de la cocaína con la heroína, conocida como speedball, también incrementa el riesgo de una sobredosis.
- La heroína algunas veces se combina con el fentanilo o carfentanilo, los cuales son opioides potentes que causan sobredosis y muerte.

Sugerencias para parar

Cómo empezar.

- No deje de tomar su medicamento opioide repentinamente. Reducir su dosis muy rápidamente podría ser peligroso.
- Esté consciente de que puede sufrir síntomas por la abstinencia. Los médicos y programas de tratamiento de adicciones pueden ayudarle a combatirlos.

Conozca sus opciones.

- *Tratamiento.* El tratamiento puede incluir medicamentos, consejería, o una combinación de éstos. Un centro de tratamientos (por reclusión o tratamiento externo) o un consultorio médico puede suministrarle los medicamentos.
- *Medicamentos.* Los medicamentos incluyen metadona, buprenorfina (Suboxone) y naltrexona. Estos ayudan a manejar los deseos intensos y síntomas de abstinencia y se emplean en la recuperación a largo plazo.
- *Consejería.* Las alternativas para consejería incluiyen terapia cognitivo-conductual y entrevistas motivadoras.
- *Los grupos de apoyo y de recuperación* son importantes para ayudar a los individuos a mantenerse en el proceso de recuperación.

Tenga naloxona a la mano en caso de una sobredosis.

- La naloxona es una herramienta salvadora para los que usan opioides. La naloxona invierte las sobredosis de opioides y evita la muerte por sobredosis. Puede obtenerse a través de un profesional de la medicina, una farmacia o programa de intercambio de jeringas.

Riesgos del uso de opioides

A corto plazo

- Una sobredosis significa ingerir una cantidad más grande opioides que la que su cuerpo puede manejar. Señales de una sobredosis son pupilas pequeñas, respiración lenta, piel fría y húmeda y la pérdida del conocimiento. Se puede dejar de respirar y morir.
- El consumo puede perjudicar el aprendizaje y la capacidad de conducir.

A largo plazo

- La tolerancia significa necesitar más opioides para obtener la misma sensación, lo cual puede causarle efectos negativos (véase el dorso).
- Los opioides son adictivos. No todos quedan adictos, pero algunos sí. Si sufre de desorden bipolar, ansiedad o problemas de alcohol o drogas, hable con un profesional de la salud.
- Síntomas de abstinencia: Los síntomas incluyen dolores, sudor, náuseas, vómito, escalofríos e insomnio.
- Dolor: El uso a largo plazo puede causar un aumento en el dolor.

Los opioides y el embarazo

- El uso durante el embarazo puede causar complicaciones graves.
- Pero si está embarazada, no deje de tomar opioides sin la ayuda de un profesional calificado.

No pida opioides prestados ni los comparta

- Tomar opioides que no le han sido recetados es peligroso, y puede causarle problemas de salud.
- Las píldoras podrían verse iguales, pero ser medicamentos diferentes, o tener cantidades diferentes. Mantenga los opioides bajo llave, fuera del alcance de los niños y adolescentes. La mayor parte de los medicamentos mal usados fueron sustraídos de alguien que tenía receta.
- No guarde los opioides sobrantes; destrúyalos o devuélvalos a una farmacia o agencia de la ley.

Pasos importantes si está consumiendo opioides

- Hasta saber cómo le afectarán los medicamentos, no use equipos pesados, conduzca un auto, trabaje a alturas sin protección ni sea responsable del cuidado de una persona que no pueda valerse por sí misma.
- Dígale a alguien que está tomando opioides y que llamen al 911 si su respiración es muy lenta, si tiene piel fría y pegajosa o si pierde el conocimiento.
- Pregunte a su proveedor si debiera tomar naloxona.
- Si necesita ayuda para manejar el dolor, o tiene problemas de salud, hable con su proveedor de atención médica. Hay otras maneras de tratar el dolor.

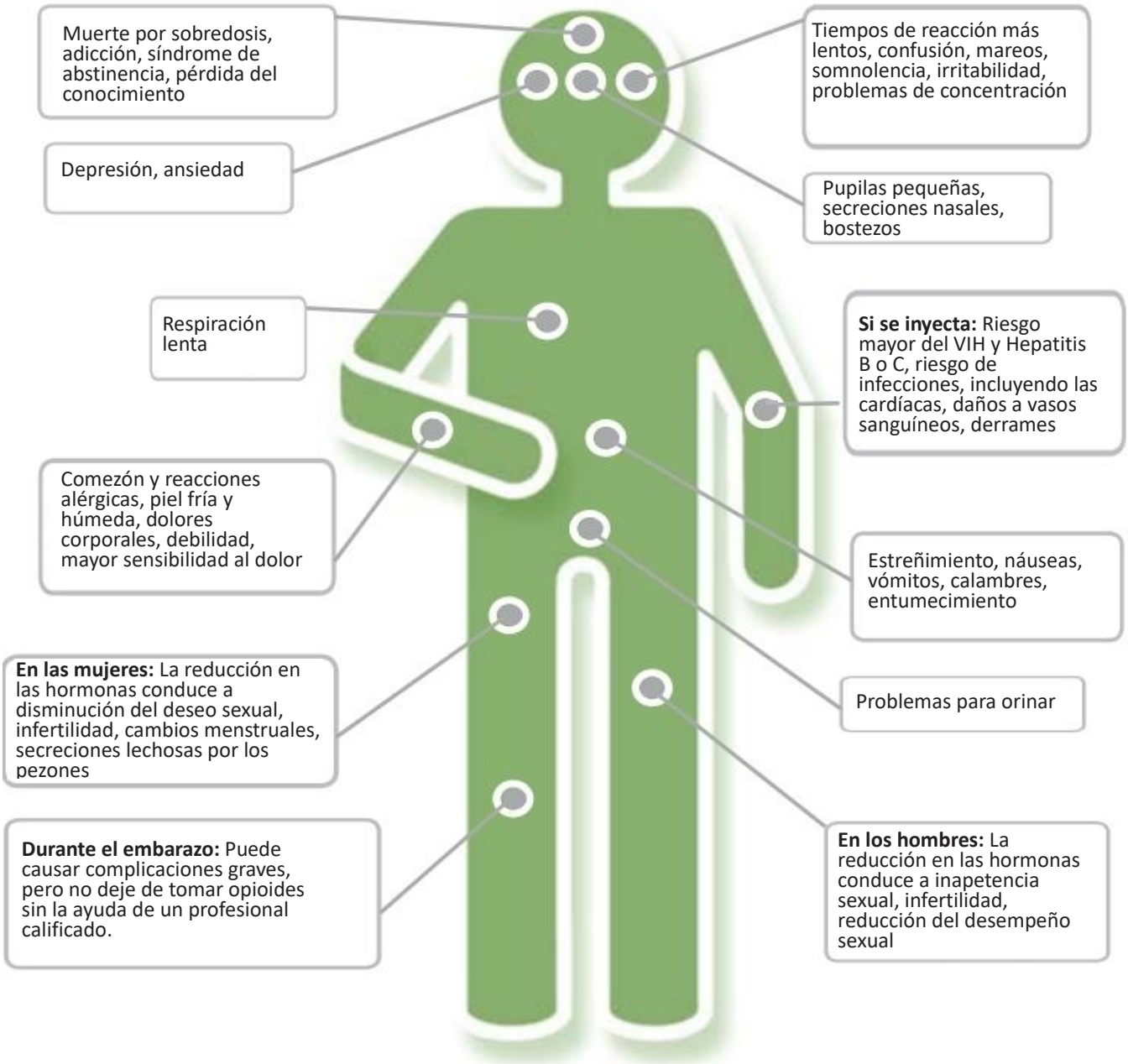
Enlaces útiles

Información para la prevención de sobredosis de drogas y la reducción de daños relacionados con drogas para usuarios de opioides puede hallarse en http://harmreduction.org. También consulte la página de recruros de www.sbirt.care para enlaces adicionales.

Fuentes: Indiana University SBIRT@IU; Instituto para Investigaciones, Educación y Capacitación en Adicciones (http://ireta.org/wp-content/uploads/2016/12/Opioids-brochure.pdf)

Opioides con receta y Heroína

Efectos sobre el Cuerpo



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