# Mother & Baby Substance Exposure Toolkit

## Best Practice No. 1

A part of the California Medication Assisted Treatment Expansion Project

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# Use validated verbal screening and assessment tools to evaluate all pregnant women for substance use disorders

Best Practice No. 1

Outpatient, Labor and Delivery, Nursery/NICU, and Screening, Assessment and Level of Care Determination

## Overview

Implement universal screening for substance use disorder (SUD) with a standardized, evidence-based screening tool at all locations that provide medical care to pregnant women. A universal screening tool for self-reporting of opioid use and identification of risk for opioid use disorder (OUD) should not be confused with toxicology testing (refer to **Best Practice #3** for more on toxicology testing).

## Why we are recommending this best practice

Identification of women with SUD as early as possible in pregnancy is critical in connecting them to treatment. Treatment for SUD, particularly OUD, during pregnancy results in better outcomes for mom and for her newborn.

Drug addiction affects all racial, ethnic, and social groups. Universally screening all women minimizes the potential for implicit bias that can occur when providers use subjective risk factors to determine who should be screened and may also decrease the stigma associated with SUD and screening. Universal screening at the time of entry into prenatal care allows more time to intervene and mitigate the harms associated with SUD in pregnancy and to stabilize the home environment for newborns. If an individual screen is positive for risk of OUD or other SUD, a validated assessment tool (a deeper evaluation intended to solidify a diagnosis and severity of a condition) should be administered to determine the presence and severity of the SUD. It is important to remember that substance use is not synonymous with addiction.

## Strategies for Implementation

- Educate staff on how to administer a validated screening tool and the importance of universal screening in order to reduce implicit bias.

- Initial screening for risk takes little time and can be done at many points within care. Validated screening tools include the NIDA quick screen, 4Ps Plus, and the CRAFFT (for women and adolescents 12-26 years old). Refer to a full list of validated screening tools in the Resources section of this Best Practice.

- Screening should be performed at intake of prenatal care to identify needs as early as

possible and at regular intervals thereafter.

- If screening is positive, use a validated verbal assessment tool to establish the diagnosis and severity of an actual SUD. Ideally, this assessment should immediately follow a positive screen. Examples include, but are not limited to, AUDIT-C (alcohol specific), ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test), and DAST-10 (drug use). For descriptions of these and other validated assessment tools, refer to the AIM Opioid Screening Tools in the Resources section of this Best Practice.

- A positive screening should stimulate a brief intervention and referral to appropriate treatment using resources within your setting and community. *Determining severity of disease is critical in referring to the correct level of care* (refer to **Best Practice #2**).

- Screen all women for coerced sex and the possibility of human trafficking. An Adult Human Trafficking Screening Tool has been created by the US Department of Health and Human Services. Please also see a commentary from *The Journal of Ethics* in the References section of this Best Practice.

- Inquire about polysubstance use. If smoking tobacco or drinking alcohol, provide brief intervention and referral to services. Encourage cessation and refer to cessation services to decrease risk for a variety of adverse pregnancy outcomes and to decrease severity of neonatal abstinence syndrome (NAS). If drinking alcohol, counsel the patient that there is no known safe amount of alcohol during pregnancy. Inform patient/family that alcohol is the leading known cause of birth defects.

### Kayla

Kayla comes to her local community health clinic and asks to be seen for her ongoing problems with back pain and anxiety. Her history elicited the need for a routine pregnancy test. Kayla starts crying when she finds out she is pregnant and it is unclear at first what this means, but through continued discussion the physician realizes that although Kayla didn't plan on getting pregnant now, she definitely wants to continue the pregnancy and is excited about this new possibility.

The physician asks Kayla if it would be ok to ask some questions about Kayla's personal and family history. She explains that they ask these questions of all women who are pregnant to make sure they get the best possible care during pregnancy. With Kayla's permission, the physician reviews Kayla's medical, social, and family histories; she includes an evidence-based screening tool for substance use disorder that takes only a few minutes to administer. It was only through this interview that the physician identified Kayla as a person with possible SUD and was subsequently able to start her on the best possible care pathway to meet her unique needs.

# Resources

1. AIM Opioid Screening Tools.
2. SAMHSA-HRSA Center for Integrated Health Solutions.
3. Council on Patient Safety Women's Health Care Safety Bundle for Obstetric Care for Women with Opioid Use Disorder.
4. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. SAMHSA.
5. Adult Human Trafficking Screening Tool and Guide.
6. Accuracy of Three Screening Tools for Prenatal Substance Use.
7. ACOG Postpartum Toolkit (see screening tools in Table 1 of the Substance Use Disorder section of this toolkit).

# References

1. ACOG committee opinion No 711: opioid use and opioid use disorder in pregnancy. Obstet Gynecol. 2017; 130: e81-94. doi: 10.1097/AOG.0000000000002235.
2. Chasnoff IJ, Mcgourty RF, Bailey GW, et al. The 4P's Plus screen for substance use in pregnancy: clinical application and outcomes. J Perinatol. 2005; 25(6): 368-374. doi:10.1038/sj.jp.7211266.
3. Yonkers KA, Gotman N, Kershaw T, Forray A, Howell HB, Rounsaville BJ. Screening for prenatal substance use. Obstet Gynecol. 2010; 116(4): 827-833. doi:10.1097/aog.0b013e3181ed8290.
4. Wood SP. Trafficked. AMA J Ethics. 2018; 20(12): E1212-1216. doi:10.1001/amajethics.2018.1212.

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Dr. Stockton is Board Certified in both Family Medicine and Addiction Medicine. Candy's passion is providing patient-centered care to pregnant and parenting women with addiction as well as addressing the upstream causes of addiction in her community. She is Chief Medical Officer at the Humboldt IPA, and is a practicing physician at their Priority Care Center. In her role at the IPA, she oversees the developing School Based Health Center Program and is the clinical champion for the Humboldt RISE Project (a county-wide Perinatal Substance Use Disorder project) and Humboldt County's Jail MAT program. She serves as a consultant for the implementation of the Hub and Spoke project in Northern California and for California's Opioid Response Network, based out of UCLA.

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Dr. Carrie Griffin is a family medicine physician who specializes in maternal, child and reproductive health and practices in Humboldt County. She completed her residency at Maine Dartmouth Family Medicine Residency and fellowship at the University of New Mexico. Perinatal substance use is her clinical area of interest and expertise; she currently serves as a mentor for CMQCC's Mother Baby Substance Exposure  initiative and the Humboldt RISE project, a community initiative to promote screening and case management services for women with substance use disorders in pregnancy.