West Virginia Perinatal Partnership 2008
Committee on Drug Use During Pregnancy
Sub Committee on Medical Guidelines
Report and Recommendations

Updated and Revised September 15, 2009

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INTRODUCTION

Substance abuse during pregnancy has been identified as an issue critical to the health of mothers and babies. But the issue of how to identify substance abusing pregnant women accurately and quickly and refer them to treatment early is a dilemma for many providers of maternity care.

Accordingly, the West Virginia Perinatal Partnership identified (in the 2008 Workplan) a goal to "draft medical guidelines for obstetrical providers to use statewide for (identifying and) treating drug use during early pregnancy and referral for treatment" and to "base (these) guidelines on the ACOG and AAP guidelines." The Workplan named an additional goal to "develop a training program to be taken statewide to train maternity care providers regarding the implementation of the recommended medical legal guidelines."

Next, an informal survey of West Virginia health care providers was conducted to locate already existing protocols/guidelines for screening, testing, and referral to treatment for substance abusing pregnant women. Very few written guidelines were found. Screening was often limited to a social history that included the questions do you smoke, drink alcohol, or use illicit drugs and if so, how much/how often, and was it during this pregnancy? And drug testing was initiated primarily for those who admitted to drug use or whose risk factors indicated high risk for such behavior. Referral to treatment was the most difficult step identified by providers who expressed lack of knowledge of the process.

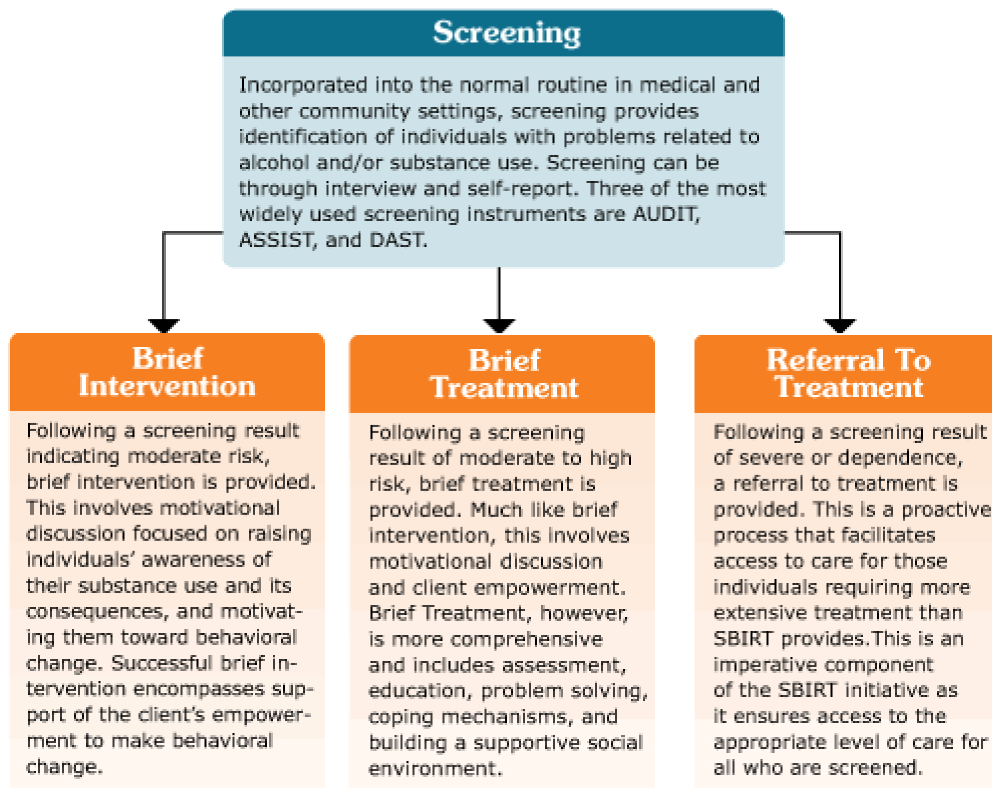
Time constraints, knowledge deficit, perceived lack of resources, legal implications, and provider discomfort with the difficult subject of substance abuse in pregnancy were issues further identified. This document represents the work of the Sub-Committee on Medical Guidelines to address these concerns.

I. THE CORE COMPONENTS OF SUBSTANCE ABUSE EVALUATION

The model for substance abuse screening, assessment, and referral to treatment comes from the mental health/substance abuse field.

I. SBIRT Core Components

The theoretical framework and programmatic structure of SBIRT programs may vary, but the core components of SBIRT remain and can be defined as follows:



From the US Department of Health and Human Resource, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (www.samhsa.gov)

The SBIRT Initiative

Described as a "comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are developing these disorders" the SBIRT Initiative represents a paradigm shift in the provision of treatment for substance abuse and use. Whereas the primary focus has been specialized treatment for persons with more severe substance abuse or those who met the criteria for Substance Abuse Disorder, the SBIRT Initiative targets those with nondependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. Screening determines the severity of substance abuse and identifies the appropriate level of intervention. Brief intervention or brief treatment occurs at the community level and then referral for more specialized services may be outside the community (www.samhsa.gov).

Application of SBIRT to Maternity Care

With this base in the mental health /substance abuse field, the screening, assessment, brief intervention, brief treatment, and referral to specialized services of the pregnant patient can be accomplished in the same manner through an integrated system. And early identification and intervention in the case of nondependent substance users can be established resulting in further improvement in maternal and neonatal outcomes.

II. SUBSTANCE ABUSE EVALUATION IN PRENATAL CARE

Screening

A number of clinical methods have been used over the years to detect substance abuse. They include blood tests, urine toxicology screens, and risk assessment based on clinical experience. But early-stage substance abusers are rarely identified by these means. In spite of the popularity of urine toxicologies (in response to illicit drug use), these screens are able to identify only fairly recent use of a substance and provide no information about frequency or length of use. Women who have not used drugs in the day or two prior to a prenatal visit will not be identified. Urine blood and breath tests are all unreliable indicators of alcohol use as alcohol is metabolized quickly and is unlikely to be detected in body fluids. Risk assessment based on clinical experience may identify some users but is heavily dependent on the practitioner’s attitudes and experiences and may reflect significant bias. The majority of at-risk women who do not fit stereotypic molds will be missed. ***The most effective method for detecting substance abuse remains a universal screening tool***.

Substance Abuse is a Major Problem during Pregnancy

- Depending on geographical location, it is estimated that 1-40% of pregnant women have used illicit drugs or prescription drugs one or more times during pregnancy (AAP, ACOG, 2007)

- Substance Abuse contributes to obstetric and pediatric complications, including fetal alcohol syndrome, prematurity, and abruptio placenta

- Early identification leads to early intervention and reduces risks to mother and baby and reduces workload to the already overburdened health care system

Screening Tools are the Most Effective Initial Method of Determining Risk for Substance Abuse

- Laboratory tests and urine toxicologies are ineffective **initial** screening tools for determining substance abuse
- Quick, brief questionnaires have been demonstrated to be effective in prenatal care for assessing alcohol and drug use

- At risk and early-stage substance abusers as well as high risk substance abusers will be identified with screening tools

Screening is defined here as any method used to identify risk of substance abuse during pregnancy including self-report, interview, and observation. Guidelines for Perinatal Health (6th Edition, American Academy of Pediatrics and The American College of Obstetrics and Gynecology, 2007) recommends universal screening of all pregnant women at their initial prenatal visit and further states that the "use of specific screening questionnaires may improve detection".

The Uniform Maternal Screening Act

See Addendum 1 for a discussion of this legislation and the legal implications of screening and testing for substance abuse in pregnancy.

Benefits of Universal Screening

- Allows for early intervention and/or referral to treatment
- Increases the identification of substance users
- Improves provider skills and comfort with addressing the issue
- Provides opportunity for education re: the risks of alcohol, illicit drugs, prescription drugs, and tobacco
- Enhances public awareness and may prevent substance use/abuse in the future

Screening Questionnaires

- Are interview- based or self- administered screening tools that effectively determine risk and/or allow self-reporting

- Are designed to be a brief, quick method of assessing alcohol or drug use during the prenatal visit.

Role of Healthcare Provider in Screening

- Screening shall be done at least once each trimester

- All health care professionals have the basic skills to identify and refer at-risk women for treatment

- Providers can make the difference

- Each practice will screen all pregnant **and** post partum women and include this in peer and chart review protocols

- Screening shall be performed by a healthcare provider or other staff with an ongoing relationship with the patient

- Staff should be trained in interview techniques for screening
- for drug and alcohol use

- If questionnaire is administered by someone other than the primary obstetric provider, the provider should review the findings and follow-up plan of care.

- The roles of team members will be reviewed with the patient: primary provider, clinic nurse, social worker, public health nurse, chemical dependency treatment provider, etc.

- Screening findings will be documented as well as patient response, education, counseling, and plan of care

How to Use a Screening Tool

- Administer face-to-face, patient to provider

- Be empathetic, nonjudgmental and supportive when asking about use; consider patient's needs and life situation

- Observe provider/patient confidentiality

- Make it a routine part of prenatal care; making it routine decreases subjectivity, discomfort and bias

- Use screening tool with every patient, not just those in whom substance abuse is suspected

- Screening should be culturally appropriate and offered in patient's primary language

- Ideally, all women should be screened at each encounter; as trust develops, the patient is more likely to disclose

- Include inquiries into substance abuse problems in the woman's parents, partner, and past as well as this pregnancy

- Screen prior to pregnancy at primary care or family planning encounters to identify and stop use before pregnancy

Assessment

Assessment is the comprehensive evaluation of a patient's risk status during pregnancy and postpartum. This includes objective and subjective information such as **follow-up** screening and laboratory testing. Assessment results in a diagnosis and plan of care.

- Specialized assessment, such as chemical dependency assessments, may follow initial screening in the form an in-depth questionnaire and may include urine or blood testing as appropriate.

- The follow-up screening questionnaire includes questions about substances used (alcohol, illegal drugs, prescription pills or medications), how often, how much, and ideally, about use during the month before the pregnancy and during the last month.

- Urine and blood testing are the next steps in assessment after a positive follow-up (in-depth) screen.

Laboratory Testing

- "Universal screening of women and newborns for substance abuse using biological specimens is not recommended" (AAP, ACOG, 2007)

- Use of laboratory testing may be indicated as part of antenatal, intrapartal and postpartal monitoring or follow up to positive initial risk assessment

- If testing is to be performed, inform the patient of the reason for the test, the procedures involved, and document her consent to do so (informed consent). When patient returns, review test results and document her response.

Brief Interventions

- Use the screening tool as an opportunity to educate about the adverse effects of tobacco, alcohol, drug and other substance use and the benefits of stopping while pregnant. Use as a prevention strategy as well as an educational tool.

- Stress benefits of abstinence from substances and offer to help the patient achieve it

- Educate support staff in the importance of a positive and nonjudgmental attitude in establishing a trusted and welcoming environment

- Know how to respond, including risks of use, benefits of stopping, response to both positive and negative screens from tools

Negative Screen from Tool

- Review benefits of abstinence from substances

- Continue to screen throughout pregnancy and postpartum at least once per trimester

Positive Screen from Tool

- Review the report with her

- State your health concern/risks for the mother and her baby; include objective information about the consequences of specific substances

- State your belief that you know the mother wants her baby to be as healthy as possible and that she can improve the health of her baby by stopping use of alcohol and drugs

- State the need to stop using and your willingness to work together to achieve this

- Discuss the benefits of treatment, referral and follow up

- Discuss possible strategies for her to stop, e.g., individual counseling, 12-step programs, and other treatment programs.

- Suggest a referral for a more in-depth assessment by a specialist. Know your resources: maintain a current list of local resources. If possible make the appointment while the patient is in the office

- Make a follow-up appointment and maintain interest in her
- progress; support her efforts to change

- Maintain communication with the chemical dependency
- treatment provider to monitor progress

- Monitor and follow up with co-existing psychiatric conditions

- Be positive. Emphasize the benefits of abstaining and the sooner the better. It's never too late

- Brief intervention techniques (15 minutes) have been shown to have a significant impact on reduction of alcohol and drug use (Chasnoff and McGourty, I Am Concerned…)

Educational Messages

- Educate all women and their partners pre-pregnancy, throughout pregnancy and postpartum

- Use age-, developmentally- and culturally-appropriate messages

- Include the benefits of stopping use at any time during pregnancy

- Emphasize total abstinence and **zero tolerance**

- In addition to the primary obstetric provider, educational messages may be provided by the community childbirth educator, outreach worker, community health nurse or other health care staff

- Include breastfeeding issues (per ACOG/AAP recommendations)

- And include parenting issues (like the importance of having a “straight” Mom as opposed to a “high” Mom; a consistent caregiver/role model)

Brief Treatment and Referral

The Process

By definition, Brief Treatment follows a screen of moderate to high risk for substance abuse and is more comprehensive than Brief Intervention (which may be accomplished in the course of a prenatal visit or antepartum hospital visit). Brief treatment of the *OB* patient includes educational messages at each prenatal visit *as well as* referral to outpatient community services such as a 12-Step Program, Community Mental Health Center, private Behavioral Health provider, etc. And Referral follows a screening result of severe dependence and a chemical dependency treatment program is indicated.

1. Identify public and private resources on both the local and state levels. Be sure to identify forms of payment accepted by the various resources.
2. Start with local resources.
    a. Local 12-step programs (Alcoholics Anonymous, Narcotics Anonymous) are a good place to start.
    b. County substance abuse services, hospital treatment programs, mental health programs, etc. are also a good start.
    c. The RFTS staff person in your community may be of assistance. Try Right From the Start www.wvdhhr.org/rfts or call 1-800-642-8522 or 304-558-5388 for Systems Point of Entry to request contact information (Regional Care Coordinators) who may be able to coordinate the appropriate referral.
    d. Identify methadone maintenance programs in the community and refer if appropriate.
    e. Refer to Behavioral Health provider in your community who is comfortable treating substance abuse in pregnant women.
3. Try state-wide resources.
    a. Call the Statewide Substance Abuse Coordinator Merrit Moore 304-558-3847 for a referral.
    b. Or call WVDHHR Bureau for Behavioral Health and Health Facilities Division of Alcoholism and Drug Abuse 304-558-2276 for list of Substance Abuse Coordinators for various regions
    c. Look online for state specific resources at http://www.mentalhealth.samhsa.gov/publications/allpubs/stateresourceguides/westvirginia01.asp or try the WV Office of Behavioral Health and Health Facilities, Division for Adult Mental Health Services http://www.wvdhhr.org/bhhf/adultmh.asp
    d. Find a physician in your area prescribing buprenorphine (Subutex) for opioid addiction (http://www.wvdhhr.org) and consult or refer patient there.
    e. Call Women’s Treatment Programs and see if they have beds (a referral from a medical provider is not necessary; the patient herself can do this)

f. Visit the West Virginia Prescription Drug Abuse website www.wvRXabuse.org and/or call the Hotline 1-866-WVQUITT (1-866-987-8488)

Women's Treatment Programs (State Funding)

Prestera Center, PO Box 8068, Huntington, WV 25705
Kim Miller, Manager of Women's Addiction and Treatment Services
304-525-4673 X4506 or kim.miller@presteracenter.org (for all Renaissance programs)

Renaissance Women's and Children's Program (Long-Term Residential Program for Women and Women with Children) 1933 Artisan Avenue, Huntington, WV 25703 304-525-4024
12 beds for women with children

Renaissance Mattie V. Lee (Long Term Residential and Transitional Living Program for Women and Women with Children) 810 Donnally Street, Charleston,WV 25301
8 beds for women and women with children in 6 ½ months of residential addictions treatment. Pregnant women accepted. Website: www.prestera.org

Renaissance Annex (Long Term Residential Program for Women), 1701 Eighth Avenue, Huntington, WV 25703 304-697-1280
5 beds for single women in 6-12 months of residential addictions treatment
Pregnant women accepted; website: www.prestera.org

Renaissance Mary Woefel (Long Term Residential Program for Women with co-occurring diagnoses of substance abuse and a major mental illness) 921 23rd St. Huntington, WV 25701
6 beds for single women in 6-12 months of residential addictions treatment; Pregnant women accepted; Website: www.prestera.org

Prestera's Addictions Recovery Center (PARC) West, 1420 Washington Avenue, Huntington, WV 25704; Tami Smith, Residential Director 304-697-1790 X2545
21-28 day program; Pregnant women accepted; website:www.prestera.org

MOTHER (Long Term Residential Program for Women and Women with Children) FMRS Health Systems, Inc., 101 South Eisenhower Drive, Beckley, WV 25801
Kathy Armentrout, Associate Director, 304-256-7100 To make a referral, call 304-256-7146 and ask for Case Manager-Female Referrals
30 beds; 6 month residential program; pregnant women accepted

Amity Center, Westbrook Health Services, 1011 Mission Drive, Parkersburg, WV 26101; Dee Prince, Director; For referrals, call 304-485-1781
13 beds; 28 day stay; inpatient facility; pregnant women accepted

Women's Genesis Program, Westbrook (Long Term Residential Program for Women and Women with Children) 2121 7th Street, Parkersburg, WV 26101
Halfway house for women working with CPS on custody issues
10 women and their children (includes Mirador, Cross Roads, and Branches of Hope)

Mid-Ohio Valley Fellowship Home (Long Term Residential Program for Women and Women with Children) 1030 George Street, Parkersburg, WV 26101
For referral call, 304-485-3341
10 beds women w/ or w/o children; pregnant women accepted

New Beginnings Extended Care Program for Women
(Women's Long Term Residential), Valley Health Care
202 Columbia Street, Fairmont, WV 26554
3-6 months extended care program; pregnant women accepted
ACT unit (28 day inpatient)
10 beds (but only 4 are female) pregnant women accepted
Call Intake Services Coordinator @ 304-363-2228 X4330

Chestnut Ridge Hospital, Morgantown
Acute Care Detox; generally 3-5 day stay but usually 2+weeks for pregnant opiate users; call 1-800-WVU-MARS for referral; 10 beds

East Ridge, Martinsburg
Director of Outpatient Substance Abuse Treatment Program 304-263-2037
Intake/Hotline 304-263-8954

Rea of Hope Charleston (Long term Residential Program for Women)
1429 Lee Street Charleston, WV 25301 Marie Beaver 304-344-5363

Methadone Clinics (Privately Owned)

Beckley Treatment Center, 175 Philpott Lane, Beaver, WV 25813 304-254-9262 (Raleigh Co.)

Charleston Treatment Center, 2157 Greenbrier Street, Charleston, WV 25311 304-344-5924 (Kanawha Co.)

Clarksburg Treatment Center, 706 Oakmound Rd., Clarksburg, WV 26301 304-622-7511 (Harrison Co.)

Huntington Treatment Center 135 4th Avenue, Huntington, WV 25701 304-525-5691 (Cabell Co.)

Martinsburg Institute, 183 Monroe Street, Martinsburg, WV 25401 304-263-1101 (Berkeley Co.)

Parkersburg Treatment Center, 400 Berry's Run Road, Parkersburg, WV 26104 304-420-2400 (Wood Co.)

Wheeling Treatment Center, RR1 Box 256A, Triadelphia, WV 26059 304-547-9197 (Ohio Co.)

Williamson Treatment Center, 1609 West Third Street, Williamson, WV 25661 304-235-0026 (Mingo Co.)

III. Perinatal SART (Screening, Assessment, Referral and Treatment)
(http://www.ntiupstream.com)

Dr. Ira Chasnoff and associates at the Children's Research Triangle in Chicago, Illinois are leading researchers in the field of maternal drug use during pregnancy and the effects on newborns and children. Together with organizational consultant Rich McGourty, PhD, Chasnoff has researched and developed the program known as Perinatal SART (Screening, Assessment, Referral, and Treatment) for evaluation of maternal substance abuse during pregnancy. This program is marketed through their consulting business known as NTI Upstream.

Much of Chasnoff and associates work is published in the obstetric literature. Some is available for purchase through the website. And the expertise and support in designing and implementing a program specific to your community is available through the Perinatal SART Upstream Solution Training Program. (See website for more information).

Briefly (from the Upstream Solution, Facts and Figures), **Screening** is through the 4P's Plus screening instrument. Screening takes place in prenatal care settings. All women are screened for substance use. Screening asks the question "Who might be using alcohol, tobacco, or other drugs?'

> **Assessment** is the continuation of the 4P's Plus. Those women who screen positive are given a field assessment to determine if they are in fact using alcohol, tobacco, or other drugs. Assessment asks the question "Who is using?"
>
> **Referral** for a full assessment and appropriate treatment is for those women who are determined to be using substances. A "warm handoff" referral occurs in the prenatal care setting and requires coordination between agencies.
>
> **Treatment** refers to high-quality, gender-specific substance abuse treatment that is appropriate for the circumstances of the pregnant woman. This can range from Brief Interventions in the prenatal setting to support groups, outpatient treatment or a residential program. (Chasnoff and McGourty, "I Am Concerned…)

Application of Perinatal SART in West Virginia

The Perinatal SART program is actively working in eight counties in the Morgantown area in conjunction with the West Virginia Healthy Start/HAPI (Helping Appalachian Parents and Infants) Project. Screening for substance abuse as well as intimate partner violence is done by Designated Care Coordinators from the Right From The Start program as part of the Initial

Client Assessment (and every trimester thereafter) in the patient's home. Reports to the OB provider generate further assessment as needed. Brief Interventions and Referral are also instituted by the RFTS staff who are trained using the "I am Concerned…" Pre-Treatment Manual and the "I am Concerned…" Training Video by NTI. For more information contact Penny Womeldorff at pwomeldorff@hsc.wvu.edu.

IV. Medical Interventions

Medical Interventions for the Substance Abusing Pregnant Woman or the Pregnant Woman in Chemical Dependency Treatment

Prenatal Care

- HIV, Hepatitis C testing if not already done

- Increased antepartum fetal surveillance (i.e. weekly NSTs after 32 wks gestation, q 4 wks u/s for AFI and interval growth)

- Random urine drug/blood alcohol laboratory testing in the OB office/clinic and/or evidence of same in the chemical dependency treatment setting is essential.

- The establishment of routine communication between the maternity care provider and the chemical dependency treatment provider is imperative.

- Must consider method for prescribing methadone or Subutex while patient is hospitalized and pre-arrange (if necessary).

- Discuss contraceptive methods and make a plan.

- Discuss breastfeeding and alcohol/drug use issues.

Intrapartum

- Complete H&P including recent drug use

- Consider repeat hepatitis screen, RPR/VDRL, and rapid HIV screen

- Urine drug/blood alcohol laboratory testing

- Alert Pediatrician/Nursery staff

- Obtain Social worker referral

- Manage pain as appropriate; epidural preferred if possible

Postpartum

- Prescription of Methadone/Subutex in the hospital as previously arranged

- Non-narcotic analgesia for postpartum discomfort

- Encourage and provide contraceptive method as early as possible

- Follow-up with substance abuse provider

- Urine drug/blood alcohol testing at postpartum office visit

Breastfeeding

- Risks and benefits of breastfeeding should be reviewed between the patient and her provider

- Women who are using illicit drugs should not breastfeed.

- Women in the United States who have HIV or AIDS should not breastfeed.

- The use of prescribed methadone is no longer a contraindication to breastfeeding (American Academy of Pediatrics).

- Breastfeeding women with a positive history of substance abuse during pregnancy should be tested periodically during the lactating period

Interconceptional/Primary Care

- Screen all women at annual visit

- Use screening as Educational tool with Prevention focus

- Stress importance of being substance free as part of well woman care

Random Hospital Visits

- Initial substance abuse screening

- Follow-up screening/laboratory testing as discussed above under Assessment

- Medical indications for laboratory testing include previous + urine toxicology, methadone or Subutex use, + HIV/hepatitis, premature labor and/or delivery, third trimester IUFD, abruption, IUGR, PROM, frequent requests for prescription pain medications, absent or erratic prenatal care

- See **Prenatal Care** and **Intrapartum** care above for further medical management

- Brief Interventions, Brief Treatment and Referral as necessary

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Addendum 1

LEGAL IMPLICATIONS

Effective July 5, 2009, the WV Office of Maternal, Child and Family Health (OMCFH) is charged with creating the Advisory Council on Maternal Risk Assessment. The advisory council created by the Uniform Maternal Screening Act (Senate Bill 307, passed April 6, 2009) will work with OMCFH to develop a universal screening tool for the purposes of identifying at-risk and high-risk pregnancies. The goal is statewide uniformity in discovering the at-risk and high-risk pregnancies to assure appropriate care during these pregnancies. Secondary goals include uniform data collection to assist in identifying trends so that public health officials can gain a better understanding of the conditions in the state and can develop responsive methodology to address the problems. The Act does include some specific privacy protections for the screening tool and for the Advisory Council.

As of now, the Advisory Council and risk assessment tool are in the initial stages. The screening tool will not be mandatory until such time as it goes through the WV legislative rule-making process (likely in 2010). Accordingly, using the current recommended screening protocol is voluntary.

The normal physician-patient privacy protections protect the medical records to the extent permitted by law. A patient's records may be shared for treatment, payment and health care operations except where West Virginia law or other federal law is more specifically protective. A patient's records may be disclosed pursuant to proper court process. A patient's records may be disclosed upon a signed, written authorization.

Federal law (42 CFR Part 2) provides specific protections for persons who receive alcohol and other drug treatment from a facility that in any way receives some federal benefit {most facilities}. Information that a person is receiving or has received assistance at such a facility cannot be disclosed without specific written consent from the patient. A generalized consent form is not sufficient.

West Virginia law defines addiction as:
a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following occurring within thirty days prior to the filing of the petition [for involuntary commitment] W.Va. Code § 27-1-11.

West Virginia law defines inebriate as:
anyone over the age of eighteen years who is incapable or unfit to properly conduct himself or herself, or his or her affairs, or is dangerous to himself or herself or others, by reason of periodical, frequent or constant drunkenness, induced either by the use of alcoholic or other liquors, or of opium, morphine, or other narcotic or intoxicating or stupefying substance. § W.Va. Code § 27-1-4**.**

West Virginia law defines mental illness as: a manifestation in a person of significantly impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion and physical well- being. § 27-1-2

West Virginia law provides specific protections for the treatment records for mentally ill patients, though it is not at all clear that this includes records for patients with a diagnosis of addiction or inebriation. The law states:

Communications and information obtained in the course of treatment or evaluation of any client or patient are confidential information. Such confidential information includes the fact that a person is or has been a client or patient, information transmitted by a patient or client or family thereof for purposes relating to diagnosis or treatment, information transmitted by persons participating in the accomplishment of the objectives of diagnosis or treatment, all diagnoses or opinions formed regarding a client's or patient's physical, mental or emotional condition; any advice, instructions or prescriptions issued in the course of diagnosis or treatment, and any record or characterization of the matters hereinbefore described. It does not include information which does not identify a client or patient, information from which a person acquainted with a client or patient would not recognize such client or patient, and uncoded information from which there is no possible means to identify a client or patient. §27-3-1(a).

Therefore, while West Virginia law is unclear, if a patient has a charted substance abuse problem with charted mental illness, records should not be released without following the specific disclosure rules set forth in § 27-3-2 (as amended in 2008).

The disclosure rules require:

Confidential information shall not be disclosed, except:
(1) & (2) In a proceeding ...to disclose the results of an involuntary examination …;

(3) Pursuant to an order of any court based upon a finding that the information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this section;

(4) To provide notice to the federal National Instant Criminal Background Check System, established pursuant to section 103(d) of the Brady Handgun Violence Prevention Act … ;

(5) To protect against a clear and substantial danger of imminent injury by a patient or client to himself, herself or another;

(6) For treatment or internal review purposes, to staff of the mental health facility where the patient is being cared for or to other health professionals involved in treatment of the patient; and

(7) Without the patient's consent as provided for under the Privacy Rule of the federal Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. §164.506 for thirty days from the date of admission to a mental health facility if: (i) The provider makes a good faith effort to obtain consent from the patient or legal representative prior to disclosure; (ii) the minimum

information necessary is released for a specifically stated purpose; and (iii) prompt notice of the disclosure, the recipient of the information and the purpose of the disclosure is given to the patient or legal representative. Records can always be released with a patient's specific, written and signed consent. Treatment can not in any way be contingent on the giving of consent. **§27-3-2**

In the event of uncertainty when a records request or subpoena is received, a provider should seek the advice of legal counsel.

Addendum 2

Suggested Screening Tool (The 4P's) and Follow-Up Assessment

1. Has either one of your **P**arents had a problem with alcohol or drugs?
2. Does your **P**artner have problem with alcohol or drugs?
3. Have you had a problem with alcohol or drugs in the **P**ast?
4. Have you used any drugs or alcohol during this **P**regnancy?

Any yes answer to questions indicate use or significant risk of use. Yes answers to questions 3 and 4 require follow-up assessment of frequency, dose, and pattern (5-7).

5. What kind of alcohol (beer, wine, liquor)/drugs (heroin, cocaine, prescription medications, methamphetamines, marijuana) do you use?
6. During the month before you were pregnant, how many times a week did you drink ____(alcohol)/use _____(drugs)?
7. And how many bottles/cans/shots/glasses of____(alcohol)/how much____ (name the drug) did you use each time that you drank/used drugs during the month before you were pregnant?