Health Services
LOS ANGELES COUNTY

DHS Expected Practices

Specialty: Women's Health and Addiction Medicine

Subject: Identifying and Treating Substance Use Disorders During Pregnancy and the Peripartum Period

Date: October 27, 2022

Purpose:

- To provide evidence-based guidance on identifying and treating substance use disorders for patients within DHS during their pregnancies and the peripartum period.
- To formalize an ethical process for offering toxicology testing to patients who are pregnant and through the peripartum period. To provide guidance on mandated reporting to child protective services with regards to maternal urine toxicology.

Rationale: Untreated substance use disorder (SUD) during pregnancy can lead to morbid outcomes for both patients, their developing pregnancies, and their families. Overdose death is one of the leading causes of maternal mortality.

Target Audience: All DHS providers, social workers, and behavioral health clinicians and staff.

Please Note

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

As with all expected practices, clinicians should exercise their own clinical judgment to ensure that patients get appropriate care as needed.

Doing so may include contacting a consultant or re-eConsulting if they feel that recommendations are not aligned with the expected practices described here, doing so is warranted, or if the patient's condition changes.

Expected Practice:
Overview of recommendations:

1. All pregnant patients should be screened with a validated tool for substance use, such as 4Ps (Appendix A).
2. Urine toxicology should not be included in universal screening, and should only be collected when medically indicated, after obtaining explicit consent from the patient.
3. Patients with a substance use disorder should be counseled on and offered medications for addiction treatment along with referral to further services.

Screening for substance use disorders in prenatal and perinatal care

All pregnant and postpartum patients whose substance status is otherwise unknown should be screened for substance use upon initiation of prenatal care using a validated screening instrument or standardized questions. Repeat screening should be considered during each trimester and during the postpartum period. [1,4,5,13]

Screening is universally used for asymptomatic patients with population-level risks. While all tools like NIDA and ASSIST may be used in pregnant patients, we recommend using the 4Ps, which is validated for obstetric patients.[14]

The 4 Ps:

1. Parents: Did any of your parents have problems with alcohol or other drug use?
2. Partner: Does your partner have a problem with alcohol or drug use?
3. Past: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
4. Present: In the past month, have you consumed any alcohol, used any tobacco products, or used other drugs?

Results:
High risk = Yes to Present use
Moderate risk = No to Present use & yes to Past use +/- yes to Parents and Partner
Low risk = No to all or yes only to Parents or Partner

If high risk:
Patients can be administered the ASSIST, which is available in ORCHID as a standalone Ad Hoc form: Open Ad Hoc, then Ambulatory Care, then scroll to the last column: Substance Use Disorder Screening.

Patients with previous or current diagnosis of substance use disorder (SUD) or with obvious medical sequela of SUD should be assessed for readiness to make changes (Appendix E) and offered treatment/referral appropriately. *See FAQ: Patients with prior diagnosis of SUD.*

Use of the 4Ps screening tool will result in one of three recommendations:

1. Patient may be high risk: Recommend provider assess for substance use disorder
2. Patient may be moderate risk: Consider brief intervention and frequent visits.
3. Patient may be low risk: Provide standard advice and counseling about substance use in pregnancy.

Suggested management based on 4P screening results

High Risk Patients: Diagnosis of SUD

Patients who screen positive should be assessed for diagnosis of SUD. Any clinician can make a diagnosis of SUD, which can be further subdivided by severity (see DSM-5 diagnostic criteria in **Appendix A**).

All patients diagnosed with SUD should be offered medications for addiction treatment (MAT) when indicated and offered referral to substance use disorder treatment, along with frequent provider visits.

Patients in the highest risk group should be offered a referral to SUD treatment. Readiness to make changes can be assessed using the Readiness Ruler (see **Appendix B).**

Patients who decline referrals to SUD treatment should continue to receive non-judgmental prenatal care with a harm reduction approach and be scheduled for frequent provider visits.

Moderate Risk Patients: Brief Intervention

Patients that do not meet diagnostic criteria for SUD can be stratified to mild, moderate, or high risk of developing SUD. Patients in all risk groups should receive a brief intervention to encourage risk reduction. See **Appendix C** for the workflow describing subsequent intervention steps that following screening based on patient risk level.

Patients in the moderate risk group should receive patient-centered counseling that highlights the patient's goals and discrepancies between current behavior and reaching those goals using motivational interviewing. See **Appendix D** on motivational interviewing techniques. Patients at moderate risk should be scheduled for frequent provider visits.

Low Risk Patients

Brief interventions for low-risk patients should be provided with affirmation of their low-risk status and provided with anticipatory guidance addressing substance use in pregnancy.

Treatment for Substance Use Disorders - Medications and Behavioral Interventions

Medications are available to treat opioid, alcohol, and tobacco use disorder – these are collectively referred to as medications for addiction treatment (MAT). There is some evidence for medication to treat stimulant use disorder like methamphetamines. Medications for addiction treatment can be started in any setting, are safe to initiate via telehealth, protect the patient and their pregnancy, and prevent subsequent, substance-related morbidity and mortality. Patients benefit from starting medications for addiction treatment even if they are not yet ready for abstinence. Additionally, medications for alcohol and/or opioid use disorder should be continued throughout and beyond the peripartum period.

Opioid use disorder
Buprenorphine/naloxone is a first-line medication within DHS for patients who are pregnant, and DHS's Expected Practices related to treating opioid use disorder can be found via http://lacounty.sharepoint.com/sites/dhs-ccl/Addiction%20Medicine/Forms/AllItems.aspx.

Please note: due to high prevalence of fentanyl contamination in illicit opioids as well as stimulants such as methamphetamine, **it is recommended to prescribe Narcan to all patients with opioid and/or stimulant use.**

Alcohol use disorder
Naltrexone is an appropriate option for pregnant patients who are not using opioids from any source. DHS's Expected Practices related to treating alcohol use disorder can be found via http://lacounty.sharepoint.com/sites/dhs-ccl/Addiction%20Medicine/Forms/AllItems.aspx

Tobacco use disorder
Nicotine replacement therapy is available for pregnant patients who do not respond to psychosocial treatments. DHS's Expected Practices related to treating tobacco use disorder can be found via http://lacounty.sharepoint.com/sites/dhs-ccl/Addiction%20Medicine/Forms/AllItems.aspx

Consultation and referrals

- DHS on-call providers are available to help DHS providers prescribe medications for addiction treatment. **The MAT Consultation Line** number is live from 8a-12a daily, seven days per week at 213-288-9090. Most clinic and medical centers have facility-specific MAT services.
- Non-urgent assistance with medications for addiction treatment is available through Specialty **eConsult** to: Addiction Medicine – Medications for Addiction Treatment.
- Referrals to **Kick It California** for pregnant patients with tobacco use disorder are available through the ORCHID order "Specialty Referral for Smoking Cessation" as well as through Community Resource Linkage eConsult to the Smoker's Helpline.
- Referrals to **psychosocial treatment for non-tobacco substance use disorders** for DHS-empaneled patients can be made through the clinic's substance use disorder counselor. Additionally, local MAMA's Neighborhood program coordinators can

perform a warm handoff to a client engagement and navigation services worker with the LA DPH Substance Abuse Prevention and Control.
- Patients can also self-refer for specialty SUD care through the **LA County Substance Abuse Service Helpline** (SASH 844-804-7500).

Support for partners and family members affected by substance use

Partners and family members may also benefit from connection to MAT services and the MAT Consultation line (above) or eConsult to Addiction Medicine welcomes referrals for care for a family member or non-birthing partner.

Health equity-based approach to toxicology testing

Routine screening should not include toxicology testing of pregnant patients. Do not order urine toxicology without a medical indication and informed consent. Toxicology testing should be focused on the clinical questions that can be resolved with obtaining toxicology information. Urine toxicology testing is not recommended to be used as part of a universal screening algorithm by multiple organizations including ACOG, ASAM, and SAMHSA .[1,13,14] Research on barriers to care for pregnant persons with substance use has found that fear of adverse or punitive social and legal consequences is often cited as the reason for delaying entry or avoiding pregnancy related care. A harm-reductive approach, of providing prenatal care for patients with ongoing use, can decrease the harms associated with substance use during pregnancy .[6, 11, 12]

Maternal urine toxicology testing is not diagnostic for parental functional impairment. A positive toxicology result does not automatically indicate that a child is at risk of abuse or neglect. Toxicology information is neither sufficient nor necessary to diagnose SUD. It does not inform on quantity or frequency of use. There are many substances that are not detected with DHS toxicology testing, as well as false positives that can result with common medications in pregnancy.

Medical indications for toxicology may include (but are not limited to):
- Obtunded or comatose patient
- Objective symptoms of acute intoxication or withdrawal
- Management of a patient in treatment for substance use disorder
- Assessment of preterm labor
- Evaluation of severe hypertensive disorders
- Evaluation of intrauterine fetal demise
- Evaluation of neonatal hypoglycemia
- Evaluation of suspected and uncertain neonatal withdrawal syndromes

If toxicology is medically indicated, explicit consent should be obtained from the pregnant patient. There is a narrow exception for emergent conditions in which patients have a documented lack of medical capacity to consent to toxicology testing. Patients have a right to

decline toxicology testing and continue to receive appropriate medical services without a coercive or punitive response.

The consent for obtaining maternal urine toxicology, and documentation thereof, should include each of the following points, explicitly reviewed with and understood by the patient: [7, 9]

- A description of why the test is indicated and the clinical question being addressed
- The benefits of testing
- The potential for false results and how confirmation testing will be conducted
- How results will be followed up and communicated to the patient
- Legal implications of test results

Confirmation of toxicology results

Urine toxicology immunoassay testing yields presumptive results which warrant additional, confirmatory testing tailored to unexpected positives and pertinent negatives. Providers should also be familiar with the limitations of the available DHS toxicology test, including the potential for cross-reactive false positives and false negatives, depending upon the patient's individual medical circumstances.

Mandated reporter requirements and perinatal substance use

DHS providers should complete a report to Department of Child and Family Services (DCFS) when there is clear evidence that a child may be at risk of abuse or neglect (see **Appendix E**). Reporting may be done in concert with social work.

A urine toxicology result alone is insufficient to support child endangerment but does support that the patient may require an assessment of parental functional impairment. Assessments of parental impairment are based on a credible medical history, physical exam, and psychosocial evidence.

When there is doubt about impairment, a social worker can assist the evaluation of patient. In ambulatory settings, place an ORCHID order for Specialty Referral to Social Work to link patients to a social worker assessment. For patients in whom there is uncertainty or disagreement about referral, consider convening a multidisciplinary meeting with obstetric and pediatric providers and social work.

If there is clear evidence of parental impairment, a report should only be filed when there is a child in the patient's care. This is either at birth or earlier if the patient has other children in their custody.

When filing a DCFS report, patients should be informed that both objective and subjective factors are used by the team to determine appropriateness for filing a report. Inform patients that the process for reporting includes a discussion with a social worker. When feasible, offer patients the option to speak directly with the DCFS. For patients in whom a report will likely be made,

inform them that a report to DCFS results in an assessment, not an automatic family separation. DCFS is committed to supporting parental function to maintain intact families whenever feasible.

Appendix A: DSM-5 Criteria for Substance Use Disorder [15]

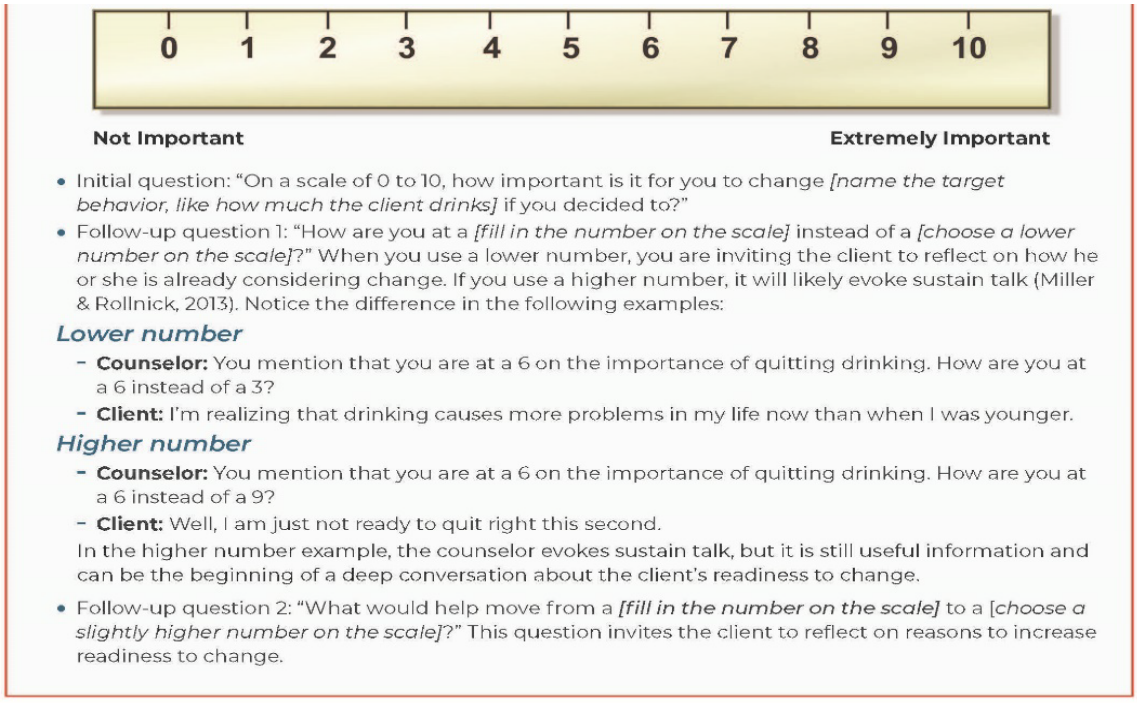
A problematic pattern of use leading to clinically significant impairment or distress is manifested by two or more of the following within a 12-month period:

1. Often taken in larger amounts over a longer period than was intended
2. A persistent desire or unsuccessful efforts to cut down or control use
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the substance's effects
4. Craving or a strong desire or urge to use the substance
5. Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home
6. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by its effects
7. Important social, occupational, or recreational activities are given up or reduced because of use
8. Recurrent use in situations in which it is physically hazardous
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
10. Tolerance
11. Withdrawal

Severity specifiers are based on the number of diagnostic criteria met by the patient at the time of diagnosis:

- Mild: 2-3 criteria
- Moderate: 4-5 criteria
- Severe: 6+ criteria

Appendix B: Readiness Ruler

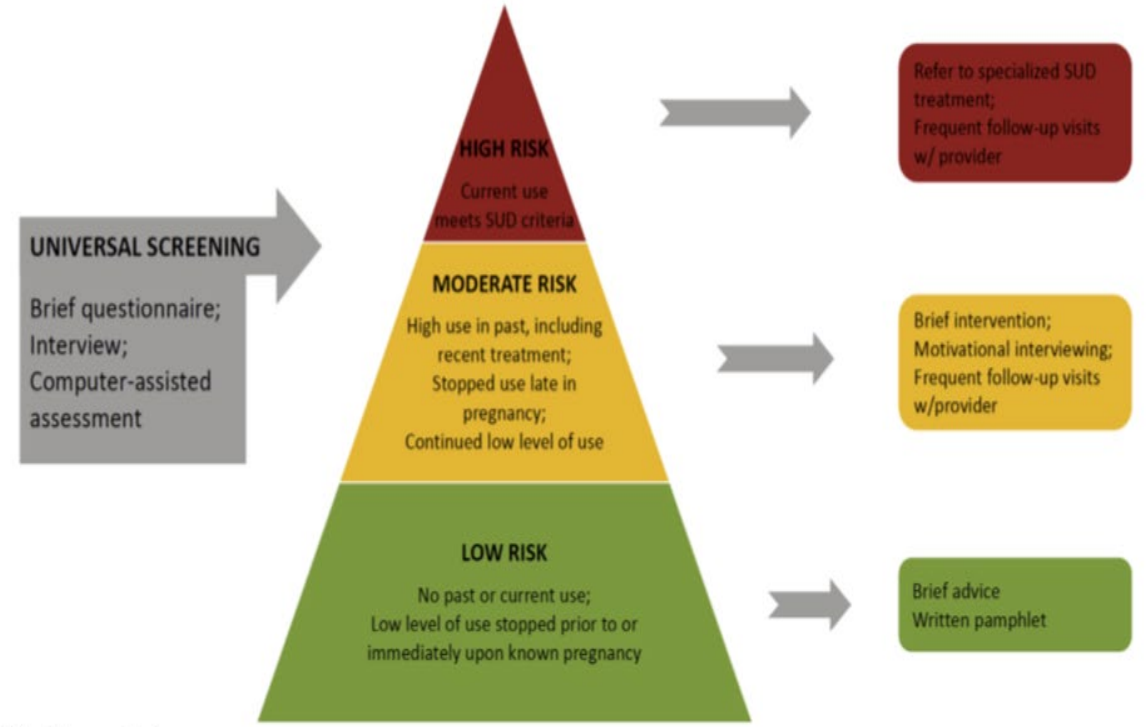


Motivational Interviewing as a Counseling Style, chapter 3 in Enhancing Motivation for Change in Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series No. 35. SAMHSA, 2019. http://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003 - accessed 4/15/2020

Appendix C: Brief Interventions for Substance Use in Pregnancy [14]

FIGURE 1

Risk pyramid for assessment of substance use during pregnancy



SUD, substance use disorder.

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

Appendix D: Example of Brief Intevention With Motivational Interviewing [14]

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?"

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

Appendix E: California Mandated Reporter Legislation

Mandated reporter requirements are based on the federal Child Abuse Prevention Treatment Act (CAPTA) and Comprehensive Addiction and Recovery Act (CARA) legislation (CAPTA-SAMHSA 2017). This legislation requires states to identify, report, and create plans of safe care for substance exposed infants and their families. In California, the Child Abuse and Neglect Reporting Act 11165.13 states "a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made." These policies leave it to the discretion of the medical provider to determine what constitutes sufficient reason to report.

11165.13.
For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department, and not to a law enforcement agency.
(Amended by Stats. 2000, Ch. 916, Sec. 11. Effective January 1, 2001.)

123605.
(a) Each county shall establish protocols between county health departments, county welfare departments, and all public and private hospitals in the county, regarding the application and use of an assessment of the needs of, and a referral for, a substance exposed infant to a county welfare department pursuant to Section 11165.13 of the Penal Code.
(b) The assessment of the needs shall be performed by a health practitioner, as defined in Section 11165.8 of the Penal Code, or a medical social worker. The needs assessment shall be performed before the infant is released from the hospital.
(c) The purpose of the assessment of the needs is to do all of the following:
(1) Identify needed services for the mother, child, or family, including, where applicable, services to assist the mother caring for her child and services to assist maintaining children in their homes.
(2) Determine the level of risk to the newborn upon release to the home and the corresponding level of services and intervention, if any, necessary to protect the newborn's health and safety, including a referral to the county welfare department for child welfare services.
(3) Gather data for information and planning purposes.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)[16]

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