

Kansas Maternal and 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 disorders¹. 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 home². 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 death³.

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 suggest that about 5 percent of pregnant women use one or more addictive substances⁴. 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).

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/introduction>

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

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>

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 pregnancy⁵.

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 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

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>

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 stillbirth⁶.

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 communities⁷.

Examples of substance use risks 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.
- 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. Babies of mothers who chronically take opioid medications prescribed for pain or who are abusing those medications may be born with a physical dependency, causing withdrawal—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

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.

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 prevention⁸.

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 of 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 period⁹. 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 for providers to 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.

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 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

⁸ 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>

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

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 Tool:

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 administer¹⁰. The ASSIST is also on the Kansas Department for Aging and Disability Services' (KDADS) approved screening tools list for KanCare reimbursement.

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

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'

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

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/

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 services¹¹. 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 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 woman¹². 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

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 gynecologic 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>

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 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 within the 'Provider Resources' 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 present¹³.

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 use. The provider completes an assessment to gather and analyze information

¹³ American College of Obstetricians and Gynecologists. 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>

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/substance-use-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 care¹⁴.

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, 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'.

¹⁴ American Addiction Centers. Drug and Alcohol Rehab Centers for Pregnant Women. Retrieved from <https://americanaddictioncenters.org/rehab-guide/pregnant-women>

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 drugs¹⁵. 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 session¹⁶. 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 postpartum depression, such as the Edinburgh Postnatal Depression Scale, can be administered, and clinicians should ask directly about possible substance use relapse¹⁷.

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/cf/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

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

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>

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 care¹⁸.

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 lifetime¹⁹. Examples include:

- 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;
- 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.

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>

Description of Algorithms and Workflows:

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 is being 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 is 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.