Tri-County Community Action Agency

Implementing SBIRT across an Obstetrics population – Pilot Project with CTC-RI

Resource Guide

June 2019

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient centered medical home

ADVANCING INTEGRATED HEALTHCARE

Tri-County Community Action Agency

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2019

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2019

1. Tri-County CAA Workflows and Job Descriptions for SBIRT Model

SBIRT/OB RESOURCE GUIDE

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TITLE: Integrated Behavioral Health Clinician (LICSW, LCSW)

REPORTS TO: Behavioral Health Director, Health Center Director, Chief Operating Officer, President/CEO

GENERAL RESPONSIBILITIES:

The Integrated Behavioral Health Clinician (LICSW, LCSW) is embedded within the primary care teams and works directly with the teams to assess individuals with behavioral health and/or substance use issues and to provide brief treatment services within the primary care setting. The IBH Clinician will expand the teams' abilities to treat persons with chronic medical conditions that are complicated by lifestyle factors.

ESSENTIAL DUTIES & RESPONSIBILITIES:

- Maintains an active presence on primary care clinical teams. Participates in daily medical team huddles, medical staff meetings, multidisciplinary teams, and individual supervision sessions with coordinator/director.
- Consults with primary care providers in real time to assist patients with psychosocial issues. This is frequently done as a "warm hand off" during hours of clinical operation. Informal consultations and referrals from the primary care providers happens at other times as well.
- Assists the primary care provider in recognizing, treating and managing mental health and psychosocial issues and acts as a contributing member to the primary care team.
- Triages both scheduled and immediate referrals from the medical teams, treating some with brief treatment/intervention and referring others to more appropriate resources. Advises the primary care provider about which patients are better served at the primary care setting and which should be referred for specialty services.
- Provides brief treatment interventions for mild to moderate behavioral health concerns, as well as, crisis intervention. Demonstrates competence in brief assessment, crisis management, triage, diagnosis, as well as, mental health/substance abuse treatment within a brief solution-focused model.
- Conducts patient intakes both for Behavioral Health Services as well as medically Assisted Treatment, focusing on diagnostic and functional evaluations and makes recommendations to the primary care provider concerning the patients' treatment goals and plan.
- Provides consultation and training to the primary care providers to enhance their skill and effectiveness in the treatment of mental health problems.

- Gives primary care providers timely feedback about the patient's care, treatment recommendations, and progress via documentation in the patient's electronic health record and verbal feedback.
- Initiates follow-up to ascertain how patients are doing and to determine if any changes in treatment approaches are indicated.
- Develops, where indicated, relapse prevention plans and helps patients maintain stable functioning.
- Assists in the detection of "at risk" patients and in the development of plans to prevent worsening of their condition.
- Monitors and coordinates the delivery of health services for patients as related to behavioral health care.
- Documents in the patients' electronic health record in a complete and timely manner. All progress will be fully completed and signed within 48 hours of the encounter.
- Keeps the primary care providers fully informed of the patient's needs and progress and works with the providers to formulate treatment plans.
- Works, where indicated, to effect behavioral changes in patients with, or at risk for, physical disorders and helps them to understand healthier lifestyle choices.
- Provides patients with self-management skills and educational information needed so they can be full participants in their own treatment and recovery.
- Helps the patients, where indicated, to cope with chronic conditions like pain and diabetes.
- Assists the patients in complying with any medical treatment initiated by the primary care provider, such as offering strategies to cope with medication side effects.
- Demonstrates customer-centered approach to treatment, as measured by respectful interactions with patients and their families, high patient satisfaction, and lack of patient complaints.
- Places high value on the treatment team, as measured by willingness to meet regularly, work collaboratively, and demonstrate flexibility when consulting with medical providers in the consultation and treatment of new patients, whether they are scheduled or referred as "warm hand-offs" or unscheduled emergencies.
- Demonstrates a thorough understanding of DSM V, as measured by thoroughness and accuracy of diagnostic formulations brought for review to the multidisciplinary team.
- Shows the ability to obtain complete history and full conceptualization of the patient's problem within the time limited session(s), as measured by the quality of the written assessment and the timely case presentation to the multidisciplinary team.
- Demonstrates a thorough knowledge of effective treatment protocols for brief solution-focused interventions and necessary cultural competencies for treating children and adults with mental health / substance abuse issues, as well as, chronic disease lifestyle management.
- Adapts therapeutic strategies to individual characteristics of the patient, including but not limited to, disability, gender, sexual orientation, developmental level, culture, ethnicity, age, health status as measured by return visits and patient satisfaction.
- Participate in meetings, trainings, and supervision required by Agency and other trainings necessary for the maintenance of professional licensure and or/supervisory requests for growth and improvement.

- Performs other duties as requested.

SUPERVISORY RESPONSIBILITIES:
None

QUALIFICATIONS:
To perform this job successfully, an individual must be able to perform each of the essential duties satisfactory. The requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

MINIMUM REQUIREMENTS / KNOWLEDGE / SKILL:

- Ability to read, analyze, and interpret medical documentation, professional journals, and government regulations.
- Ability to write reports and correspondence.
- Ability to effectively present information and respond to questions from providers, hospitals, health center staff and patients and their families.
- Ability to develop effective interpersonal relationships with the health care team, providers, and management staff.
- Ability to perform duties and responsibilities across all life cycles (infants, children, adolescents, adults, prenatal and geriatric) required.
- Commitment to work in community health with the challenges of a high risk, and often uninsured and diverse patient population.
- Proven writing skills to document in a medical record and submit documentation.
- Strong/demonstrated communication skills, written and verbal, required.
- Ability to multi-task and manage concurrent situations.
- Flexibility to deal with noise, frequent interruptions and constant changes in schedules.
- Ability to perform responsibilities in a solution-focused model with appointments usually lasting less than 30 minutes.
- Function well in a team-approach, accepting the fact that they are not in charge of patient's care.
- Proficiency in the identification and treatment of mental disorders
- Computer proficiency in Microsoft Office required.
- Previous experience in Electronic Health Records preferred.
- Knowledge of HIPPA regulations.
- CPR certified.

- **EDUCATION**
  - Masters or Doctorate in social work from an accredited college or university.
  - Licensed Clinical or Independent Clinical Social Worker in the State of Rhode Island (LCSW, LICSW)
  - Previous experience or internship in a medical setting which supports a primary care integration model preferred.
- **LANGUAGE SKILL:**
  - Cultural sensitivity necessary to work with a diverse patient and staff population
  - Bilingual ability in English and Spanish speaking abilities preferred

PHYSICAL DEMANDS:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- The employee frequently is required to stand, walk, and sit.
- Extensive eye contact with a computer screen.

WORK ENVIRONMENT:

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Noise level is moderate.
- Activity is busy, fast-paced.

Employees can be identified at risk of infection. Refer to policy and Hazard Determination Assessment.

AMERICANS WITH DISABILITIES ACT STATEMENT:

External and internal applicants, as well as position incumbents who become disabled, must be able to perform the essential job specific functions (listed within each job specific responsibility) either unaided or with the assistance of a reasonable accommodation to be determined by the organization on a case-by-case basis.

I understand that my performance appraisal will be based, in part, on this job description taking into account any mutually agreed upon exceptions.

_____ _____

Signature of Integrated Behavioral Health Clinician Date

_____ _____

Approval of President/CEO Date

Job Posting

SBIRT Clinician

Tri-County Community Action Agency's Health Center is seeking a full-time SBIRT (Screening, Brief Intervention, and Referral to Treatment) clinician to provide services to patients in the Health Center. Candidates with experience working with individuals struggling with Substance Use issues preferred.

The SBIRT clinician will provide support to providers as well as one or more populations served by the organization (youth, adults, geriatrics, etc.).

Job Responsibilities:

- Conduct screenings with patients using evidence based tools and brief intervention and referral to longer term counseling when deemed appropriate.
- Participate in morning huddles with medical providers, psych NP, MA's and/or IBH staff.
- Participate in NCM/IBH collaboration meetings if pertinent to patients.
- Receive warm-handoffs from medical providers.
- Participate with providers in medical visits for patients when necessary.
- Collaborate with BH providers to ensure continuity of care for patients.
- Manage treatment issues to ensure appropriate level of treatment and work through immediate crisis and appropriately assess risk.
- Educate patients in the process of treatment, overcoming obstacles and resistance.
- Assess patient's readiness to change.
- Documentation of patient contacts in the EHR.
- Collaborate with community providers to ensure referrals to outside treatment facilities occur smoothly.

Qualifications:
Bachelor's Degree
LCDP (ACDP) preferred
Experience in community health, substance abuse, social work or clinical setting preferred.
Experience with brief treatment, motivational interviewing, and readiness to change a plus.

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TITLE: SBIRT Community Health Worker

REPORTS TO: Behavioral Health Director, Health Center Director, Chief Operating Officer, President/CEO

GENERAL RESPONSIBILITIES:

The SBIRT (Screening, Brief Intervention, and Referral to Treatment) Community Health Worker is embedded within the primary care teams and works directly with the teams to assess individuals with substance abuse and/or behavioral health concerns and to provide brief intervention and referral to treatment within the primary care setting.

ESSENTIAL DUTIES & RESPONSIBILITIES:

- Maintains an active presence on primary care clinical teams. Participates in daily medical team huddles, medical staff meetings, multidisciplinary teams, and individual supervision sessions with coordinator/director.
- Consults with primary care providers in real time to assist patients with substance use and/or Behavioral Health concerns. This is frequently done as a "warm hand off" during hours of clinical operation. Informal consultations and referrals from the primary care providers happens at other times as well.
- Assists the primary care provider in recognizing those patients with substance use concerns.
- Triages both scheduled and immediate referrals from the medical teams, treating some with brief treatment/intervention and referring others to more appropriate resources. Advises the primary care provider about which patients are better served at the primary care setting and which should be referred for specialty services.
- Provides brief treatment interventions for mild to moderate substance use and mental health concerns, as well as, crisis intervention. Demonstrates competence in brief assessment, crisis management, triage, diagnosis, as well as, mental health/substance abuse treatment within a brief solution-focused model.
- Conducts patient intakes both for Behavioral Health Services as well as Medically Assisted Treatment, focusing on diagnostic and functional evaluations and makes recommendations to the primary care provider concerning the patients' treatment goals and plan.
- Gives primary care providers timely feedback about the patient's care, treatment recommendations, and progress via documentation in the patient's electronic health record and verbal feedback.
- Initiates follow-up with patients to ascertain how patients are doing and to determine if any changes in treatment approaches are indicated.

- Develops, where indicated, relapse prevention plans and helps patients maintain stable functioning.
- Tracks contact with patients that have received an SBIRT contact.
- Assists in the detection of "at risk" patients and in the development of plans to prevent worsening of their condition.
- Monitors and coordinates the delivery of health services for patients as related to substance us and behavioral health care.
- Documents in the patients' electronic health record in a complete and timely manner. All progress will be fully completed and signed within 48 hours of the encounter.
- Keeps the primary care providers fully informed of the patient's needs and progress and works with the providers to formulate treatment plans.
- Provides patients with self-management skills and educational information needed so they can be full participants in their own treatment and recovery.
- Provide self-care groups for patients as appropriate.
- Demonstrates customer-centered approach to treatment, as measured by respectful interactions with patients and their families, high patient satisfaction, and lack of patient complaints.
- Places high value on the treatment team, as measured by willingness to meet regularly, work collaboratively, and demonstrate flexibility when consulting with medical providers in the consultation and treatment of new patients, whether they are scheduled or referred as "warm hand-offs" or unscheduled emergencies.
- Shows the ability to obtain complete history and full conceptualization of the patient's problem within the time limited session(s), as measured by the quality of the written assessment and the timely case presentation to the multidisciplinary team.
- Demonstrates a thorough knowledge of effective treatment protocols for brief solution-focused interventions and necessary cultural competencies for treating children and adults with substance use and behavioral health concerns.
- Adapts therapeutic strategies to individual characteristics of the patient, including but not limited to, disability, gender, sexual orientation, developmental level, culture, ethnicity, age, health status as measured by return visits and patient satisfaction.
- Monitors progress with AIMS Grant and SBIRT services and provides project feedback and development to team members.
- Participate in meetings, trainings, and supervision required by Agency and other trainings necessary for the maintenance of professional licensure and or/supervisory requests for growth and improvement.

- Performs other duties as requested.

SUPERVISORY RESPONSIBILITIES:
None

QUALIFICATIONS:
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- Ability to develop effective interpersonal relationships with the health care team, providers, and management staff.
- Ability to perform duties and responsibilities across all life cycles (infants, children, adolescents, adults, prenatal and geriatric) required.
- Commitment to work in community health with the challenges of a high risk, and often uninsured and diverse patient population.
- Proven writing skills to document in a medical record and submit documentation.
- Strong/demonstrated communication skills, written and verbal, required.
- Ability to multi-task and manage concurrent situations.
- Flexibility to deal with noise, frequent interruptions and constant changes in schedules.
- Ability to perform responsibilities in a solution-focused model with appointments usually lasting less than 30 minutes.
- Knowledge and proficiency in Motivational Interviewing Skills.
- Function well in a team-approach, accepting the fact that they are not in charge of patient's care.
- Proficiency in the identification and treatment of mental disorders
- Computer proficiency in Microsoft Office required.
- Previous experience in Electronic Health Records preferred.
- Knowledge of HIPPA regulations.
- CPR certified.

- **EDUCATION**
  - Bachelor's Degree in Social Work or a related field.
  - Previous experience or internship in a medical setting which supports a primary care integration model preferred.
- **LANGUAGE SKILL:**
  - Cultural sensitivity necessary to work with a diverse patient and staff population
  - Bilingual ability in English and Spanish speaking abilities preferred

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_____ _____

Signature of Integrated Behavioral Health Clinician Date

_____ _____

Approval of President/CEO Date

Huddles Workflow

To facilitate communication between providers and IBH, assist in identifying patient that may benefit from IBH services, and ensure appropriate screenings are completed.

1) IBH team members complete pre-visit planning prior to huddle (ideally the evening before clinic)
    i) Pre-visit planning includes:
        (1) current BH diagnoses
        (2) current/previous engagement with BH services (OBH, IBH, Psych NP)
            (i) noting missed visits/upcoming appointments
        (3) comorbid conditions that may benefit from IBH intervention.
            (i) Ex: Chronic pain, obesity, diabetes, insomnia, COPD, etc.

2) IBH team member communicates (generally through Brosix) with their assigned provider/MA at the beginning of each clinic to request time to huddle.
3) Huddles are ideally completed during provider admin time prior to start of clinic. This requires provider and MA to be prepared and available during this time. Huddles are meant to be brief and not interfere with clinic flow.
4) During huddle, provider, MA, and IBH review patients. Any needs identified by provider are added to pre-visit planning info.
5) After huddles, IBH team shares info gathered during huddle. Pre-visit planning sheets are kept in central location and are available for review as needed during the day.

IBH Screenings Workflow

Screenings: All patients seen in clinic for new visit, physical exams, new prenatal and/or annual gynecological exams are to be screened for depression, anxiety and substance use. Prenatal patients are also screened at 10, 20 and 30 weeks of pregnancy as well as at their post-partum exam and at follow-up appointments when screens are positive. Screenings are to be completed yearly for all patients age 18 and up. If any screen is positive, they will be repeated at follow-up visits to monitor patients and to ensure that interventions are adequately meeting the patient's needs. The Phreesia patient registration system identifies which patients need updated or follow-up screens and patients are alerted to complete the necessary screens when they check in for their appointment.

Screening tools are all validated, evidence-based measure that have been carefully chosen to meet the needs of the clinic and patient population.

Current screening tools:

PHQ2/9

GAD-7

NIDA

AUDIT/DAST

Screening Procedure:

a) At time of check in, front desk staff will hand the patient the Phreesia patient registration tablet. The patient completes all necessary registration documents on the tablet which includes any necessary screens that are required.

b.) Once the patient is roomed, the Medical Assistant opens the patient's chart and looks at the encounter for the visit for completed screens. The MA enters the screening results into NextGen. If a patient screens positive on any screen (**PHQ 10 and up or a positive answer to question #9, score of 10 and up on the GAD, or any answer in a shaded area of the NIDA**) the MA alerts a member of the IBH team and the IBH team member completes a warm hand-off to review the screens with the patient prior to the provider entering the exam room. PHQ-2, GAD 7 and AUDIT/DAST screenings will be conducted when a positive score (PHQ9 >3, GAD >10, AUDIT/DAST) is identified at all follow-up visits.

Adolescent Patients:

For patients ages 12-17, IBH screenings (PHQ-A and CRAFFT) are completed by the patient on the Phreesia patient registration tablet prior to their WCV. The MA completes the same process as above screens but alerts an IBH team member to see the patient for all completed screens whether they are positive or negative.

IBH Screening and Warm Hand-off Process

2019

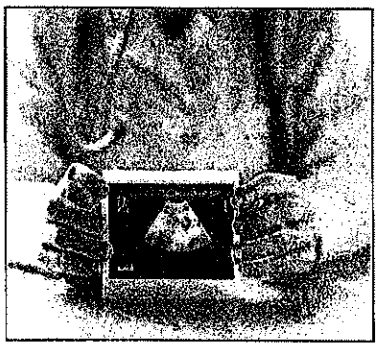
2. Screening for Substance Use During Pregnancy Using an SBIRT Framework

SBIRT/OB RESOURCE GUIDE

Guidance for Medical Providers:

How to Screen Pregnant Patients for Substance Use Disorder and Alcohol Use

RECOMMENDATION



All pregnant women should be educated on the dangers of substance use during pregnancy and screened for substance use disorder and alcohol use, particularly during the first and third trimesters.

The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening with brief intervention and treatment referrals for cannabinoids, alcohol, club drugs, dissociative drugs, hallucinogens, opioids, stimulants, tobacco, and other compounds such as anabolic steroids and inhalants.

BACKGROUND

No amount of alcohol, marijuana, illegal drugs, or tobacco is safe for the mother or baby. Alcohol is still the number one cause of preventable birth defects, and even minimal alcohol exposure can hurt a fetus. Data shows there are short- and long-term negative impacts of alcohol, tobacco, opioids, and other drug use on the mother and baby.

For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

Legal prescription drugs, including opioids, should be closely monitored and used exactly as prescribed. For mothers who consumed opioids legally as part of a treatment plan, their infant will still likely need treatment for neonatal abstinence syndrome (NAS) following birth.

Any pregnant woman who is on legal or illegal opioids should not cease her use immediately or there may be significant risks to the fetus. Conversion to Medication Assisted Treatment (MAT) is preferred for women seeking to discontinue use of illegal or legal opioids during pregnancy (see page 4).

To learn more about MAT treatment locations for pregnant women, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent and Sussex counties.

OPIOIDS AND PAIN MANAGEMENT

Legally prescribed opioids are a proven pipeline to opioid dependence. Nearly 80 percent of heroin users report they started with prescription opioids. And, the benefits of long-term opioid therapy for chronic pain are not well supported by the evidence.

Prescribers of opioids for pain management should consider recommending alternatives to opioid medications, including non-opioid medications, exercise and physical therapy, behavioral therapy, and relaxation techniques. For patient and physician opioid fact sheets and links to new prescription regulations, visit Help is Here: www.helpisherede.com/Health-Care-Providers.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

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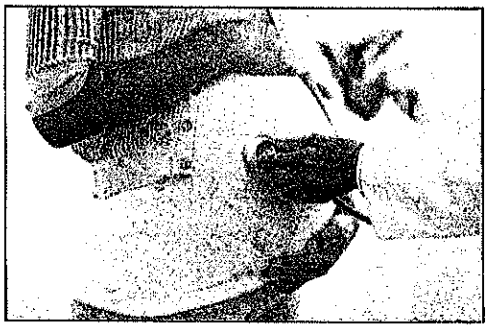
DE THRIVES

CONSIDERATIONS



Substance use disorder is a chronic disease. Similar to diabetes and other illnesses that can harm a mother or her baby during pregnancy, a potential substance use problem should be identified and addressed early through screening using a validated screening tool.

ACOG recommends that routine screening for substance use disorder be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status.

You have an important role in educating women on the dangers of substance abuse during pregnancy, screening women for substance use disorder, and referring those with a potential substance use disorder. The goal is to help the mother and her baby. Education, screening, and referrals should be integrated seamlessly into regular prenatal visits.

Be nonjudgmental and reassuring. You are more likely to get honest responses if the patient feels comfortable and safe. When asking about substances, pregnant patients may naturally be concerned about admitting drug or alcohol use. They may fear stigma or that they will be reported to child protective services.

Pregnant women cannot be penalized for substance use during pregnancy under the law. Medical providers do not have a legal requirement or obligation to report substance use in pregnant women or to perform testing to confirm suspected use. In fact, child protective services will not take a report for behavior while pregnant as that is outside their legal authority.

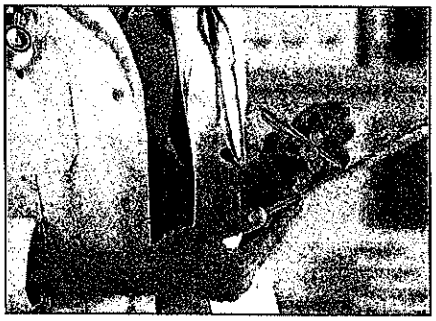
Under federal law, pregnant women must receive priority substance abuse treatment. To learn more about what treatment services are available, visit www.HelpIsHereDE.com.

GENERAL SCREENING RECOMMENDATIONS

STEP ONE: START THE CONVERSATION

Following the SBIRT model (Screening, Brief Intervention and Referral to Treatment), start the conversation in a reassuring and compassionate matter. "Can I ask you about drug or alcohol use? This information is important to working with you to have a healthy pregnancy."

Be reassuring. Be clear the information will not be used against the patient or impact her ability to keep custody of the child. Emphasize the importance of your commitment to help her have a healthy pregnancy.



STEP TWO: DO THE SCREENING

Use the screening tool that works best for your practice and your population. The next page includes three validated screening tools that can be used easily in a health care setting. All seek to identify potential issues that would require further dialogue with the patient and referrals to treatment providers for further assessment.

These screening tools are in the public domain and recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA).

GENERAL SCREENING TOOLS

"Screening" means using a validated screening tool to ask questions aimed at understanding the patient's potential substance use. There are several validated screening tools for pregnant women, including 4P's, T-ACE, and CRAFFT for adolescents and young adults.

THE 4 P'S

4 P's for Substance Abuse:

1. Have you ever used drugs or alcohol during **Pregnancy?**

2. Have you had a problem with drugs or alcohol in the **Past?**

3. Does your **Partner** have a problem with drugs or alcohol?

4. Do you consider one of your **Parents** to be an addict or alcoholic?

Scoring: Any "yes" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "yes" to two or more questions should be referred for further assessment.

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.

T-ACE

ACOG recommends the T-ACE screening tool for alcohol, specifically developed for use with pregnant women. Ask patients four questions:

(T) Tolerance: How many drinks does it take to make you high?

(A) Have people annoyed you by criticizing your drinking?

(C) Have you ever felt you ought to cut down on your drinking?

(E) Eye opener: Have you ever had a drink the first thing in the morning to steady your nerves or get rid of a hangover?

Scoring: Any woman who answers more than two drinks is scored two points. Each "yes" to the additional three questions scores one point. A score of two or more is considered a positive screen, and the woman should be referred for further assessment.

Source: Sokol RJ, Martier SS, Ager JW. 1989. The T-ACE questions: Practical prenatal detection of risk drinking, American Journal of Obstetrics and Gynecology 160 (4).

CRAFFT – SUBSTANCE ABUSE SCREEN FOR ADOLESCENTS AND YOUNG ADULTS

C - Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using drugs or alcohol?

R – Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A – Do you ever use alcohol or drugs while you are by yourself, **ALONE**?

F – Do you ever **FORGET** things you did while using drugs or alcohol?

F – Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T – Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?

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

Source: Center for Adolescent Substance Abuse Research, Children's Hospital of Boston. The CRAFFT screening interview. Boston (MA) CeASAR; 2009.

TOBACCO

While this guidance focuses on alcohol, illegal substances, and prescription drug abuse, screening for tobacco is still recommended. The negative impact of tobacco use on birth outcomes is well documented. If a patient indicates they smoke, consider referrals to the Delaware Quitline for free cessation resources and tools at www.quitsupport.com or by calling **1-866-409-1858.**

STEP THREE: EDUCATE THE PATIENT AND PROVIDE REFERRALS

If the screening tool does not identify a potential problem:

• State law requires that all medical providers serving pregnant women counsel them on the dangers of any alcohol, marijuana, or other drug use during pregnancy. Recommend they cease use with the exception of opioids, which require special considerations and may need to involve Medication Assisted Treatment. For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

If the screening tool does identify a risk for substance use disorder:

• Be clear that you know the mother wants to be as healthy as possible for her baby and herself, and that she can reduce the health risk to them both by stopping the use of alcohol and drugs. If eligible, connect her with a Care Coordinator through her medical insurance.

• Discuss possible strategies for her to stop — individual or group counseling, 12-step program, or substance use disorder treatment. If she is struggling with opioid addiction, Medication Assisted Treatment should be discussed.

• Recommend women visit www.HelpIsHereDE.com or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent or Sussex counties to learn more about services for pregnant women.

MEDICATION ASSISTED TREATMENT

Medication Assisted Treatment (MAT) is an important part of the treatment regimen for pregnant women and is proven to improve outcomes. According to ACOG, "the rationale for Medication Assisted Treatment during pregnancy is to prevent complications from illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to the patient associated with a drug culture." *(ACOG Committee Opinion, Opioid Abuse, Dependence and Addiction in Pregnancy, Number 524, May 2012, page 2).*

The two main medications involved in MAT for pregnant women are methadone and buprenorphine (without Naloxone). The decision regarding the most appropriate medication should be made jointly with the MAT provider, the obstetrician, and the woman.

METHADONE	BUPRENORPHINE (WITHOUT NALOXONE)
• **May have better treatment retention**	• **Probably less severe NAS; works best in patients needing less monitoring**
• **No risk precipitating withdrawal**	• **Reduced risk of overdose during induction**
• **Patients with more severe opioid use disorder**	• **Reduced risk of overdose if children are exposed to medication.**

Source: Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/.

SOURCES

For a full list of sources, call the Division of Public Health at 302-744-4704.

NNEPQIN

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

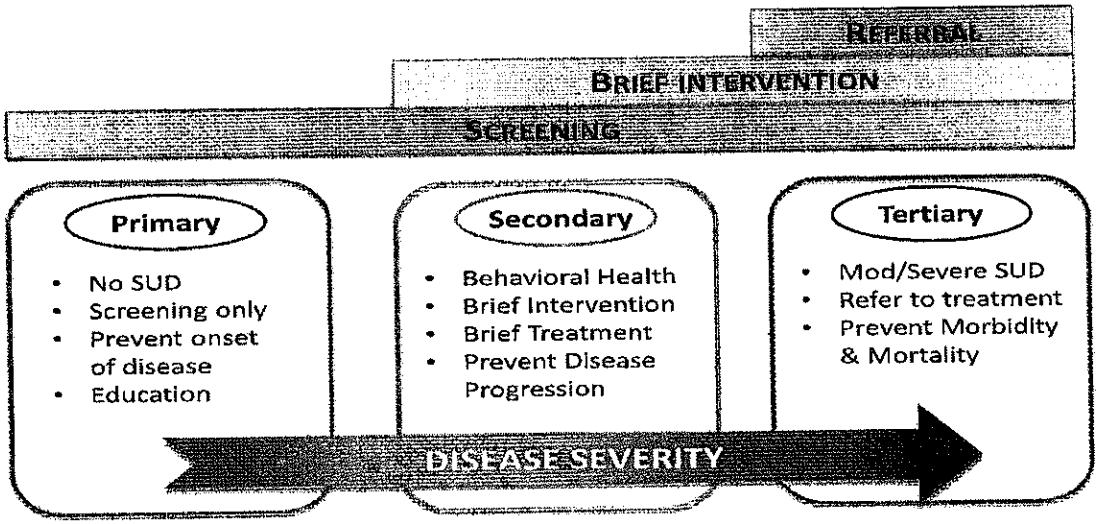
Screening for substance use during pregnancy using an SBIRT framework

Prevention, identification, and reduction of alcohol, tobacco, and drug use during pregnancy and the postpartum period are critical to support the health and wellbeing of women and their infants. Universal screening for drug and alcohol use is an essential first step in identifying women with harmful substance use or use disorders, and linking them with services at the appropriate level of care (World Health Organization [WHO], 2014; Patrick and Schiff, 2017; American College of Obstetricians and Gynecologists [ACOG], 2017; American Society of Addiction Medicine [ASAM], 2016; American College of Nurse Midwives[ASCNM], 2004). Because women often use more than one substance, screening should always include illicit drug, tobacco, and alcohol use.

Perinatal substance use exists across all sociodemographic groups (National Survey on Drug Use and Health, 2015). NNEPQIN recommends a population based approach, in which all pregnant women are screened at entry to maternity care and again in the third trimester and at delivery. It is the responsibility of all maternity care providers to ensure that women who are at increased risk for perinatal substance use have access to follow up assessment, intervention, and are linked to services. A number of screening tools have been validated for use during pregnancy, among these the Substance Use Risk Profile, AUDIT-C (alcohol only), CRAFFT (for women under age 26), ASSIST, 4 Ps Plus are commonly used (Bush, et al, 1998; Chang, et al 2011; Chasnoff, et al, 2005; Hotham, et al, 2013; Yonkers, et al, 2011).

NNEPQIN recommends universal screening for drug and alcohol use at the initiation of prenatal care, using validated instrument(s) and a screening, brief intervention, referral for treatment (SBIRT) framework (Guidelines for Screening for Alcohol, Tobacco, and Drug Use During Pregnancy, 2017). The aim of population based screening is to identify women engaged in harmful use of drugs or alcohol, to provide support, arrange follow up, and make appropriate referrals as indicated by the level of need. The SBIRT approach is specifically recommended in *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018).

Universal screening and layered follow-up in the maternity care context



SBIRT resources contained in this chapter:

I. Developing an SBIRT process:
- Overview of process
- Example process map
- Sample patient letter
- Coding and billing tips

II. Screening:
- Example screening tool from NIAAA

III. Brief Intervention:
- BNI ART algorithm
- SBIRT training video

IV. Referral to Treatment:
- Algorithm for choosing level of care
- Template for local resources
- Sample consent forms

I. Developing an SBIRT process in the maternity care context

SBIRT implementation requires modification of existing clinic workflows. Each context is different. We recommend incorporating SBIRT into the existing intake process for new OB patients, which includes screening for other risk medical risks.

Brief description of a typical SBIRT implementation process

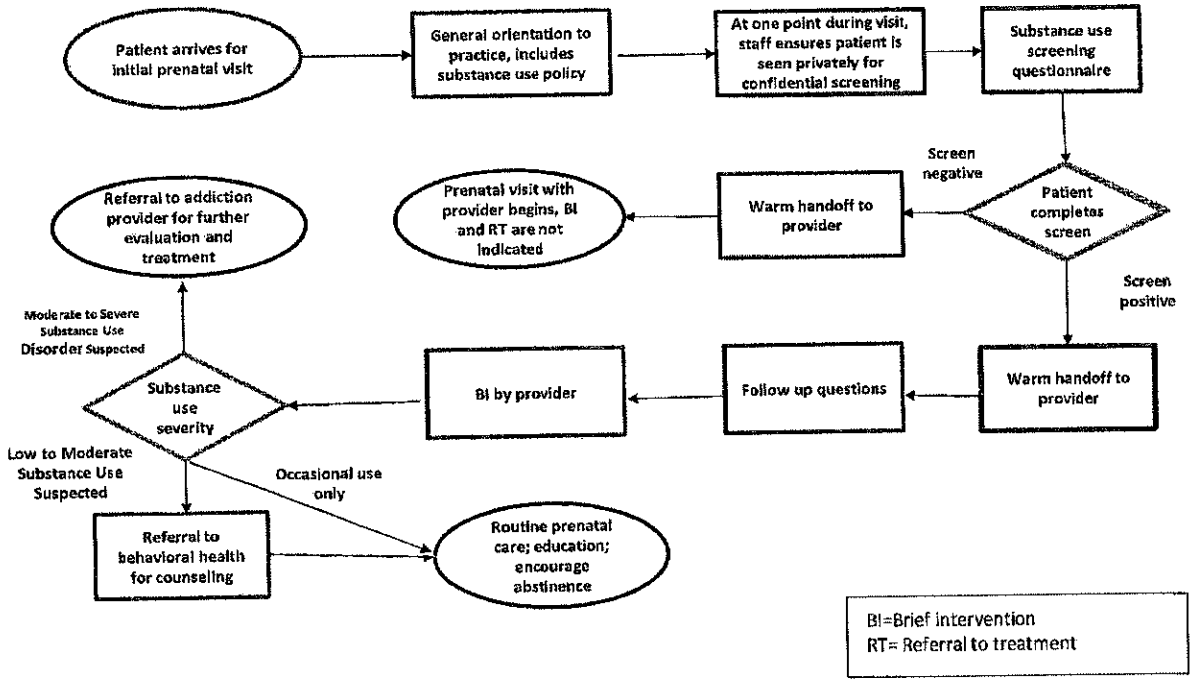
1. **SBIRT Preparation:**
   - Review institutional policies and update as needed to include use of the SBIRT framework for prenatal patients
   - Develop a plan for modifying workflow to incorporate screening
   - Train appropriate staff for screening process
   - Train appropriate staff in brief intervention techniques
   - Identify follow up plan and key personnel when screening is positive
   - Create a list of resources to support women in need of referrals for substance use
   - Identify billing requirements and opportunities
   - Develop patient information script or written materials about substance use screening and institutional policies on substance use
2. **Implementation:**
   - Implement workflow modification to include confidential screening and response
   - Provide information about institutional substance use policy as part of new patient orientation
   - Screen using a validated questionnaire on paper, or the electronic equivalent
   - Ensure a warm handoff occurs from staff performing screening to staff who will address positive screening results
   - Implement Brief Negotiated Interview [BNI] algorithm following positive screening
   - Develop a follow up plan when screening is positive
   - Make referrals if needed
   - Plan follow up at next visit

In the example below, screening is performed by a member of the nursing staff, and brief intervention is performed by an APRN or physician when indicated. This practice has identified both a target addiction treatment program and a behavioral health provider as resources for patients who need help with substance use. These resources may be available inside the practice or may need to be developed externally. *Before implementing SBIRT it is essential to have a plan for referral to treatment when needed.*

Guidance regarding follow up assessment after a pregnant woman disclosures opioid use disorder is discussed in Factsheet 1 of the SAMHSA *Clinical Guidance* document (SAMHSA, 2018, pp 17-24)

An example of a clinic screening process using a validated questionnaire is depicted below. Additional resources for implementing SBIRT into clinical practice workflows is available from the Department of Family Medicine at Oregon Health Sciences University: http://www.sbirtoregon.org/contact-us/

Process Map for SBIRT at Initial OB Visit



SAMPLE PATIENT ORIENTATION LETTER

Congratulations!

Our team looks forward to supporting you through your pregnancy.

An important part of prenatal care is identifying any risks that might exist for you, your pregnancy, or your baby after birth. These might include medical conditions such as diabetes, asthma, depression, or other issues that make it hard to take care of yourself.

Substance use is one concern that could affect the care of you and your baby. Therefore, we ask all of our patients about the use of tobacco, alcohol, or drugs at the first prenatal visit and again in the third trimester.

Facts about substance use during pregnancy:

- Smoking cigarettes and other forms of tobacco may keep oxygen from flowing through the placenta, causing low birth weight and preterm birth
- Alcohol may cause birth defects and problems with brain development, known as "fetal alcohol spectrum disorders"
- Some drugs cause miscarriage, bleeding, or preterm labor
- Other drugs, especially opioids like heroin or oxycodone cause symptoms of withdrawal in newborn babies
- Marijuana may cause problems with learning and depression as children get older
- Drug and alcohol use may affect your ability to care for your new born baby

Federal law requires healthcare providers to report to child protective services when a baby is born affected by drug or alcohol use. Please let us know if you have questions or concerns about any information shared here. If you are a smoker and have been unable to quit, please let us know if you would like a nicotine replacement while you are at our tobacco free campus. We are here to help.

Thank you for choosing to partner with us and including us in your pregnancy journey.

[Your Ob/Gyn Team]

Coding and billing for substance-related services

SBIRT services are reimbursable under the Affordable Care Act. Routine screening using a validated screening tool can be billed as a preventative service. Screening followed by Brief Intervention is billed using the time-based codes described below.

1. **SBIRT**
   - Routine screening without brief intervention: can be performed periodically, must reference use of a validated screening tool.
   - Billing code: 96160
   - If brief intervention is required, may bill for screening and brief intervention as "additional E&M code"
     - if > 15 minute= 99408
     - if > 30 minutes= 99409
   - Must be face to face
   - Include sufficient documentation to support time spent; reference the patient's willingness to change, and describe the plan formulated during the discussion
   - Specify minutes of counseling provided

2. **Tobacco Counseling**
   - Bill as "additional E&M code"
     - If 3-10 minutes= 99406
     - If > 10 minutes= 99407
   - Must be face to face
   - Include sufficient documentation to support time spent; reference the patient's willingness to change, and describe the plan formulated during the discussion
   - Include tobacco-related diagnosis for visit (for example):
     - Tobacco Use Disorder: F17.2

3. **Billing for counseling related to substance use issues for obstetric patients**
   - Counseling must account for > 50% of total visit time
     - D-H requires the number of minutes of counseling be specified
   - Substance-related diagnosis must be included for visit (for example):
     - Tobacco Use Disorder: F17.2
     - Marijuana Use: F12.9
     - Opioid Use Disorder: F11.2
   - If occurring in context of routine OB care, may bill as "additional E&M code"
     - If total visit lasted 10-14 minutes = 99212
     - If total visit lasted 15-24 minutes = 99213
     - If total visit lasted >=25 minutes = 99214

II. SBIRT Process: SCREENING

All pregnant women should be screened using a validated instrument.

- All pregnant women should be informed about the health system's policy on prenatal drug, tobacco, and alcohol use at the first prenatal encounter, as part of their orientation to the practice (see example patient letter)

- Screening for substance use should be conducted while a woman is alone or accompanied only by young children

- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as their reproductive health history, and to safely screen women for domestic violence
    - If a woman cannot be confidentially screened, screening should be deferred

- Timing of screening
    - Screening should be done at initiation of prenatal care, and repeated in the third trimester
    - Screening should also be repeated on admission for delivery

- A number of substance use screening tools have been validated for use during pregnancy. The best tool is the one which is easy to use in a given context

- A positive screen does not equate to a diagnose a substance use disorder, but rather to the need for further exploration about risk of substance exposure during pregnancy

Tri-County Community Action Agency

Implementing SBIRT across an Obstetrics population – Pilot Project with CTC-RI

Resource Guide

June 2019

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient centered medical home

ADVANCING INTEGRATED HEALTHCARE

Tri-County Community Action Agency

Helping people. Changing lives.

2019

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2019

1. Tri-County CAA Workflows and Job Descriptions for SBIRT Model

SBIRT/OB RESOURCE GUIDE

Tri-County
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TITLE: Integrated Behavioral Health Clinician (LICSW, LCSW)

REPORTS TO: Behavioral Health Director, Health Center Director, Chief Operating Officer, President/CEO

GENERAL RESPONSIBILITIES:

The Integrated Behavioral Health Clinician (LICSW, LCSW) is embedded within the primary care teams and works directly with the teams to assess individuals with behavioral health and/or substance use issues and to provide brief treatment services within the primary care setting. The IBH Clinician will expand the teams' abilities to treat persons with chronic medical conditions that are complicated by lifestyle factors.

ESSENTIAL DUTIES & RESPONSIBILITIES:

- Maintains an active presence on primary care clinical teams. Participates in daily medical team huddles, medical staff meetings, multidisciplinary teams, and individual supervision sessions with coordinator/director.
- Consults with primary care providers in real time to assist patients with psychosocial issues. This is frequently done as a "warm hand off" during hours of clinical operation. Informal consultations and referrals from the primary care providers happens at other times as well.
- Assists the primary care provider in recognizing, treating and managing mental health and psychosocial issues and acts as a contributing member to the primary care team.
- Triages both scheduled and immediate referrals from the medical teams, treating some with brief treatment/intervention and referring others to more appropriate resources. Advises the primary care provider about which patients are better served at the primary care setting and which should be referred for specialty services.
- Provides brief treatment interventions for mild to moderate behavioral health concerns, as well as, crisis intervention. Demonstrates competence in brief assessment, crisis management, triage, diagnosis, as well as, mental health/substance abuse treatment within a brief solution-focused model.
- Conducts patient intakes both for Behavioral Health Services as well as medically Assisted Treatment, focusing on diagnostic and functional evaluations and makes recommendations to the primary care provider concerning the patients' treatment goals and plan.
- Provides consultation and training to the primary care providers to enhance their skill and effectiveness in the treatment of mental health problems.

- Gives primary care providers timely feedback about the patient's care, treatment recommendations, and progress via documentation in the patient's electronic health record and verbal feedback.
- Initiates follow-up to ascertain how patients are doing and to determine if any changes in treatment approaches are indicated.
- Develops, where indicated, relapse prevention plans and helps patients maintain stable functioning.
- Assists in the detection of "at risk" patients and in the development of plans to prevent worsening of their condition.
- Monitors and coordinates the delivery of health services for patients as related to behavioral health care.
- Documents in the patients' electronic health record in a complete and timely manner. All progress will be fully completed and signed within 48 hours of the encounter.
- Keeps the primary care providers fully informed of the patient's needs and progress and works with the providers to formulate treatment plans.
- Works, where indicated, to effect behavioral changes in patients with, or at risk for, physical disorders and helps them to understand healthier lifestyle choices.
- Provides patients with self-management skills and educational information needed so they can be full participants in their own treatment and recovery.
- Helps the patients, where indicated, to cope with chronic conditions like pain and diabetes.
- Assists the patients in complying with any medical treatment initiated by the primary care provider, such as offering strategies to cope with medication side effects.
- Demonstrates customer-centered approach to treatment, as measured by respectful interactions with patients and their families, high patient satisfaction, and lack of patient complaints.
- Places high value on the treatment team, as measured by willingness to meet regularly, work collaboratively, and demonstrate flexibility when consulting with medical providers in the consultation and treatment of new patients, whether they are scheduled or referred as "warm hand-offs" or unscheduled emergencies.
- Demonstrates a thorough understanding of DSM V, as measured by thoroughness and accuracy of diagnostic formulations brought for review to the multidisciplinary team.
- Shows the ability to obtain complete history and full conceptualization of the patient's problem within the time limited session(s), as measured by the quality of the written assessment and the timely case presentation to the multidisciplinary team.
- Demonstrates a thorough knowledge of effective treatment protocols for brief solution-focused interventions and necessary cultural competencies for treating children and adults with mental health / substance abuse issues, as well as, chronic disease lifestyle management.
- Adapts therapeutic strategies to individual characteristics of the patient, including but not limited to, disability, gender, sexual orientation, developmental level, culture, ethnicity, age, health status as measured by return visits and patient satisfaction.
- Participate in meetings, trainings, and supervision required by Agency and other trainings necessary for the maintenance of professional licensure and or/supervisory requests for growth and improvement.

- Performs other duties as requested.

SUPERVISORY RESPONSIBILITIES:
None

QUALIFICATIONS:
To perform this job successfully, an individual must be able to perform each of the essential duties satisfactory. The requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

MINIMUM REQUIREMENTS / KNOWLEDGE / SKILL:

- Ability to read, analyze, and interpret medical documentation, professional journals, and government regulations.
- Ability to write reports and correspondence.
- Ability to effectively present information and respond to questions from providers, hospitals, health center staff and patients and their families.
- Ability to develop effective interpersonal relationships with the health care team, providers, and management staff.
- Ability to perform duties and responsibilities across all life cycles (infants, children, adolescents, adults, prenatal and geriatric) required.
- Commitment to work in community health with the challenges of a high risk, and often uninsured and diverse patient population.
- Proven writing skills to document in a medical record and submit documentation.
- Strong/demonstrated communication skills, written and verbal, required.
- Ability to multi-task and manage concurrent situations.
- Flexibility to deal with noise, frequent interruptions and constant changes in schedules.
- Ability to perform responsibilities in a solution-focused model with appointments usually lasting less than 30 minutes.
- Function well in a team-approach, accepting the fact that they are not in charge of patient's care.
- Proficiency in the identification and treatment of mental disorders
- Computer proficiency in Microsoft Office required.
- Previous experience in Electronic Health Records preferred.
- Knowledge of HIPPA regulations.
- CPR certified.

- **EDUCATION**
  - Masters or Doctorate in social work from an accredited college or university.
  - Licensed Clinical or Independent Clinical Social Worker in the State of Rhode Island (LCSW, LICSW)
  - Previous experience or internship in a medical setting which supports a primary care integration model preferred.
- **LANGUAGE SKILL:**
  - Cultural sensitivity necessary to work with a diverse patient and staff population
  - Bilingual ability in English and Spanish speaking abilities preferred

PHYSICAL DEMANDS:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- The employee frequently is required to stand, walk, and sit.
- Extensive eye contact with a computer screen.

WORK ENVIRONMENT:

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Noise level is moderate.
- Activity is busy, fast-paced.

Employees can be identified at risk of infection. Refer to policy and Hazard Determination Assessment.

AMERICANS WITH DISABILITIES ACT STATEMENT:

External and internal applicants, as well as position incumbents who become disabled, must be able to perform the essential job specific functions (listed within each job specific responsibility) either unaided or with the assistance of a reasonable accommodation to be determined by the organization on a case-by-case basis.

I understand that my performance appraisal will be based, in part, on this job description taking into account any mutually agreed upon exceptions.

_____ _____

Signature of Integrated Behavioral Health Clinician Date

_____ _____

Approval of President/CEO Date

Job Posting

SBIRT Clinician

Tri-County Community Action Agency's Health Center is seeking a full-time SBIRT (Screening, Brief Intervention, and Referral to Treatment) clinician to provide services to patients in the Health Center. Candidates with experience working with individuals struggling with Substance Use issues preferred.

The SBIRT clinician will provide support to providers as well as one or more populations served by the organization (youth, adults, geriatrics, etc.).

Job Responsibilities:

- Conduct screenings with patients using evidence based tools and brief intervention and referral to longer term counseling when deemed appropriate.
- Participate in morning huddles with medical providers, psych NP, MA's and/or IBH staff.
- Participate in NCM/IBH collaboration meetings if pertinent to patients.
- Receive warm-handoffs from medical providers.
- Participate with providers in medical visits for patients when necessary.
- Collaborate with BH providers to ensure continuity of care for patients.
- Manage treatment issues to ensure appropriate level of treatment and work through immediate crisis and appropriately assess risk.
- Educate patients in the process of treatment, overcoming obstacles and resistance.
- Assess patient's readiness to change.
- Documentation of patient contacts in the EHR.
- Collaborate with community providers to ensure referrals to outside treatment facilities occur smoothly.

Qualifications:
Bachelor's Degree
LCDP (ACDP) preferred
Experience in community health, substance abuse, social work or clinical setting preferred.
Experience with brief treatment, motivational interviewing, and readiness to change a plus.

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TITLE: SBIRT Community Health Worker

REPORTS TO: Behavioral Health Director, Health Center Director, Chief Operating Officer, President/CEO

GENERAL RESPONSIBILITIES:

The SBIRT (Screening, Brief Intervention, and Referral to Treatment) Community Health Worker is embedded within the primary care teams and works directly with the teams to assess individuals with substance abuse and/or behavioral health concerns and to provide brief intervention and referral to treatment within the primary care setting.

ESSENTIAL DUTIES & RESPONSIBILITIES:

- Maintains an active presence on primary care clinical teams. Participates in daily medical team huddles, medical staff meetings, multidisciplinary teams, and individual supervision sessions with coordinator/director.
- Consults with primary care providers in real time to assist patients with substance use and/or Behavioral Health concerns. This is frequently done as a "warm hand off" during hours of clinical operation. Informal consultations and referrals from the primary care providers happens at other times as well.
- Assists the primary care provider in recognizing those patients with substance use concerns.
- Triages both scheduled and immediate referrals from the medical teams, treating some with brief treatment/intervention and referring others to more appropriate resources. Advises the primary care provider about which patients are better served at the primary care setting and which should be referred for specialty services.
- Provides brief treatment interventions for mild to moderate substance use and mental health concerns, as well as, crisis intervention. Demonstrates competence in brief assessment, crisis management, triage, diagnosis, as well as, mental health/substance abuse treatment within a brief solution-focused model.
- Conducts patient intakes both for Behavioral Health Services as well as Medically Assisted Treatment, focusing on diagnostic and functional evaluations and makes recommendations to the primary care provider concerning the patients' treatment goals and plan.
- Gives primary care providers timely feedback about the patient's care, treatment recommendations, and progress via documentation in the patient's electronic health record and verbal feedback.
- Initiates follow-up with patients to ascertain how patients are doing and to determine if any changes in treatment approaches are indicated.

- Develops, where indicated, relapse prevention plans and helps patients maintain stable functioning.
- Tracks contact with patients that have received an SBIRT contact.
- Assists in the detection of "at risk" patients and in the development of plans to prevent worsening of their condition.
- Monitors and coordinates the delivery of health services for patients as related to substance us and behavioral health care.
- Documents in the patients' electronic health record in a complete and timely manner. All progress will be fully completed and signed within 48 hours of the encounter.
- Keeps the primary care providers fully informed of the patient's needs and progress and works with the providers to formulate treatment plans.
- Provides patients with self-management skills and educational information needed so they can be full participants in their own treatment and recovery.
- Provide self-care groups for patients as appropriate.
- Demonstrates customer-centered approach to treatment, as measured by respectful interactions with patients and their families, high patient satisfaction, and lack of patient complaints.
- Places high value on the treatment team, as measured by willingness to meet regularly, work collaboratively, and demonstrate flexibility when consulting with medical providers in the consultation and treatment of new patients, whether they are scheduled or referred as "warm hand-offs" or unscheduled emergencies.
- Shows the ability to obtain complete history and full conceptualization of the patient's problem within the time limited session(s), as measured by the quality of the written assessment and the timely case presentation to the multidisciplinary team.
- Demonstrates a thorough knowledge of effective treatment protocols for brief solution-focused interventions and necessary cultural competencies for treating children and adults with substance use and behavioral health concerns.
- Adapts therapeutic strategies to individual characteristics of the patient, including but not limited to, disability, gender, sexual orientation, developmental level, culture, ethnicity, age, health status as measured by return visits and patient satisfaction.
- Monitors progress with AIMS Grant and SBIRT services and provides project feedback and development to team members.
- Participate in meetings, trainings, and supervision required by Agency and other trainings necessary for the maintenance of professional licensure and or/supervisory requests for growth and improvement.

- Performs other duties as requested.

SUPERVISORY RESPONSIBILITIES:
None

QUALIFICATIONS:
To perform this job successfully, an individual must be able to perform each of the essential duties satisfactory. The requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

MINIMUM REQUIREMENTS / KNOWLEDGE / SKILL:

- Ability to read, analyze, and interpret medical documentation, professional journals, and government regulations.
- Ability to write reports and correspondence.
- Ability to effectively present information and respond to questions from providers, hospitals, health center staff and patients and their families.
- Ability to develop effective interpersonal relationships with the health care team, providers, and management staff.
- Ability to perform duties and responsibilities across all life cycles (infants, children, adolescents, adults, prenatal and geriatric) required.
- Commitment to work in community health with the challenges of a high risk, and often uninsured and diverse patient population.
- Proven writing skills to document in a medical record and submit documentation.
- Strong/demonstrated communication skills, written and verbal, required.
- Ability to multi-task and manage concurrent situations.
- Flexibility to deal with noise, frequent interruptions and constant changes in schedules.
- Ability to perform responsibilities in a solution-focused model with appointments usually lasting less than 30 minutes.
- Knowledge and proficiency in Motivational Interviewing Skills.
- Function well in a team-approach, accepting the fact that they are not in charge of patient's care.
- Proficiency in the identification and treatment of mental disorders
- Computer proficiency in Microsoft Office required.
- Previous experience in Electronic Health Records preferred.
- Knowledge of HIPPA regulations.
- CPR certified.

- **EDUCATION**
  - Bachelor's Degree in Social Work or a related field.
  - Previous experience or internship in a medical setting which supports a primary care integration model preferred.
- **LANGUAGE SKILL:**
  - Cultural sensitivity necessary to work with a diverse patient and staff population
  - Bilingual ability in English and Spanish speaking abilities preferred

PHYSICAL DEMANDS:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- The employee frequently is required to stand, walk, and sit.
- Extensive eye contact with a computer screen.

WORK ENVIRONMENT:
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Noise level is moderate.
- Activity is busy, fast-paced.

Employees can be identified at risk of infection. Refer to policy and Hazard Determination Assessment.

AMERICANS WITH DISABILITIES ACT STATEMENT:

External and internal applicants, as well as position incumbents who become disabled, must be able to perform the essential job specific functions (listed within each job specific responsibility) either unaided or with the assistance of a reasonable accommodation to be determined by the organization on a case-by-case basis.

I understand that my performance appraisal will be based, in part, on this job description taking into account any mutually agreed upon exceptions.

_____ _____

Signature of Integrated Behavioral Health Clinician Date

_____ _____

Approval of President/CEO Date

Huddles Workflow

To facilitate communication between providers and IBH, assist in identifying patient that may benefit from IBH services, and ensure appropriate screenings are completed.

1) IBH team members complete pre-visit planning prior to huddle (ideally the evening before clinic)
    i) Pre-visit planning includes:
        (1) current BH diagnoses
        (2) current/previous engagement with BH services (OBH, IBH, Psych NP)
            (i) noting missed visits/upcoming appointments
        (3) comorbid conditions that may benefit from IBH intervention.
            (i) Ex: Chronic pain, obesity, diabetes, insomnia, COPD, etc.

2) IBH team member communicates (generally through Brosix) with their assigned provider/MA at the beginning of each clinic to request time to huddle.
3) Huddles are ideally completed during provider admin time prior to start of clinic. This requires provider and MA to be prepared and available during this time. Huddles are meant to be brief and not interfere with clinic flow.
4) During huddle, provider, MA, and IBH review patients. Any needs identified by provider are added to pre-visit planning info.
5) After huddles, IBH team shares info gathered during huddle. Pre-visit planning sheets are kept in central location and are available for review as needed during the day.

IBH Screenings Workflow

Screenings: All patients seen in clinic for new visit, physical exams, new prenatal and/or annual gynecological exams are to be screened for depression, anxiety and substance use. Prenatal patients are also screened at 10, 20 and 30 weeks of pregnancy as well as at their post-partum exam and at follow-up appointments when screens are positive. Screenings are to be completed yearly for all patients age 18 and up. If any screen is positive, they will be repeated at follow-up visits to monitor patients and to ensure that interventions are adequately meeting the patient's needs. The Phreesia patient registration system identifies which patients need updated or follow-up screens and patients are alerted to complete the necessary screens when they check in for their appointment.

Screening tools are all validated, evidence-based measure that have been carefully chosen to meet the needs of the clinic and patient population.

Current screening tools:

PHQ2/9

GAD-7

NIDA

AUDIT/DAST

Screening Procedure:

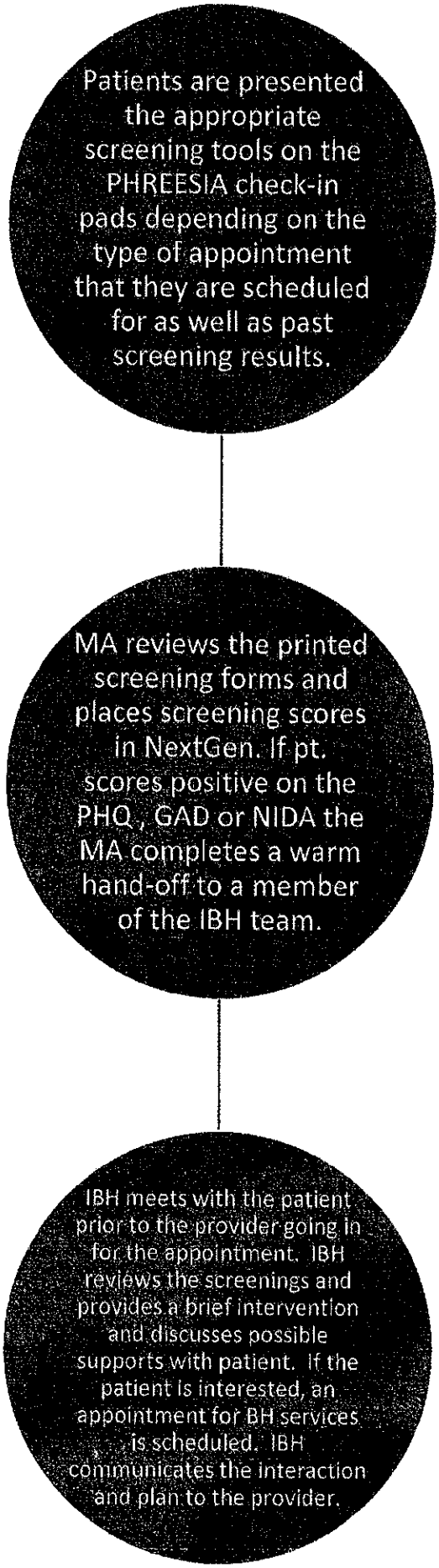
a) At time of check in, front desk staff will hand the patient the Phreesia patient registration tablet. The patient completes all necessary registration documents on the tablet which includes any necessary screens that are required.

b.) Once the patient is roomed, the Medical Assistant opens the patient's chart and looks at the encounter for the visit for completed screens. The MA enters the screening results into NextGen. If a patient screens positive on any screen (**PHQ 10 and up or a positive answer to question #9, score of 10 and up on the GAD, or any answer in a shaded area of the NIDA**) the MA alerts a member of the IBH team and the IBH team member completes a warm hand-off to review the screens with the patient prior to the provider entering the exam room. PHQ-2, GAD 7 and AUDIT/DAST screenings will be conducted when a positive score (PHQ9 >3, GAD >10, AUDIT/DAST) is identified at all follow-up visits.

Adolescent Patients:

For patients ages 12-17, IBH screenings (PHQ-A and CRAFFT) are completed by the patient on the Phreesia patient registration tablet prior to their WCV. The MA completes the same process as above screens but alerts an IBH team member to see the patient for all completed screens whether they are positive or negative.

IBH Screening and Warm Hand-off Process



2019

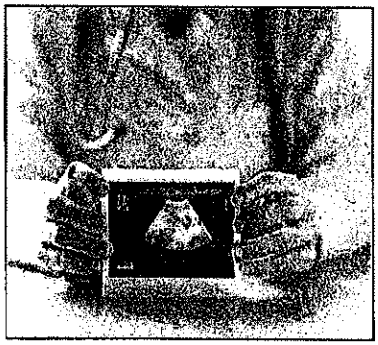
2. Screening for Substance Use During Pregnancy Using an SBIRT Framework

SBIRT/OB RESOURCE GUIDE

Guidance for Medical Providers:

How to Screen Pregnant Patients for Substance Use Disorder and Alcohol Use

RECOMMENDATION



All pregnant women should be educated on the dangers of substance use during pregnancy and screened for substance use disorder and alcohol use, particularly during the first and third trimesters.

The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening with brief intervention and treatment referrals for cannabinoids, alcohol, club drugs, dissociative drugs, hallucinogens, opioids, stimulants, tobacco, and other compounds such as anabolic steroids and inhalants.

BACKGROUND

No amount of alcohol, marijuana, illegal drugs, or tobacco is safe for the mother or baby. Alcohol is still the number one cause of preventable birth defects, and even minimal alcohol exposure can hurt a fetus. Data shows there are short- and long-term negative impacts of alcohol, tobacco, opioids, and other drug use on the mother and baby.

For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

Legal prescription drugs, including opioids, should be closely monitored and used exactly as prescribed. For mothers who consumed opioids legally as part of a treatment plan, their infant will still likely need treatment for neonatal abstinence syndrome (NAS) following birth.

Any pregnant woman who is on legal or illegal opioids should not cease her use immediately or there may be significant risks to the fetus. Conversion to Medication Assisted Treatment (MAT) is preferred for women seeking to discontinue use of illegal or legal opioids during pregnancy (see page 4).

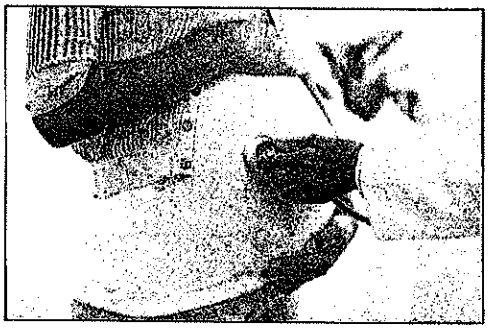
To learn more about MAT treatment locations for pregnant women, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent and Sussex counties.

OPIOIDS AND PAIN MANAGEMENT

Legally prescribed opioids are a proven pipeline to opioid dependence. Nearly 80 percent of heroin users report they started with prescription opioids. And, the benefits of long-term opioid therapy for chronic pain are not well supported by the evidence.

Prescribers of opioids for pain management should consider recommending alternatives to opioid medications, including non-opioid medications, exercise and physical therapy, behavioral therapy, and relaxation techniques. For patient and physician opioid fact sheets and links to new prescription regulations, visit Help is Here: www.helpisherede.com/Health-Care-Providers.

CONSIDERATIONS



Substance use disorder is a chronic disease. Similar to diabetes and other illnesses that can harm a mother or her baby during pregnancy, a potential substance use problem should be identified and addressed early through screening using a validated screening tool.

ACOG recommends that routine screening for substance use disorder be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status.

You have an important role in educating women on the dangers of substance abuse during pregnancy, screening women for substance use disorder, and referring those with a potential substance use disorder. The goal is to help the mother and her baby. Education, screening, and referrals should be integrated seamlessly into regular prenatal visits.

Be nonjudgmental and reassuring. You are more likely to get honest responses if the patient feels comfortable and safe. When asking about substances, pregnant patients may naturally be concerned about admitting drug or alcohol use. They may fear stigma or that they will be reported to child protective services.

Pregnant women cannot be penalized for substance use during pregnancy under the law. Medical providers do not have a legal requirement or obligation to report substance use in pregnant women or to perform testing to confirm suspected use. In fact, child protective services will not take a report for behavior while pregnant as that is outside their legal authority.

Under federal law, pregnant women must receive priority substance abuse treatment. To learn more about what treatment services are available, visit www.HelpIsHereDE.com.

GENERAL SCREENING RECOMMENDATIONS

STEP ONE: START THE CONVERSATION

Following the SBIRT model (Screening, Brief Intervention and Referral to Treatment), start the conversation in a reassuring and compassionate matter. "Can I ask you about drug or alcohol use? This information is important to working with you to have a healthy pregnancy."

Be reassuring. Be clear the information will not be used against the patient or impact her ability to keep custody of the child. Emphasize the importance of your commitment to help her have a healthy pregnancy.

STEP TWO: DO THE SCREENING

Use the screening tool that works best for your practice and your population. The next page includes three validated screening tools that can be used easily in a health care setting. All seek to identify potential issues that would require further dialogue with the patient and referrals to treatment providers for further assessment.

These screening tools are in the public domain and recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA).

GENERAL SCREENING TOOLS

"Screening" means using a validated screening tool to ask questions aimed at understanding the patient's potential substance use. There are several validated screening tools for pregnant women, including 4P's, T-ACE, and CRAFFT for adolescents and young adults.

THE 4 P'S

4 P's for Substance Abuse:

1. Have you ever used drugs or alcohol during **Pregnancy?**

2. Have you had a problem with drugs or alcohol in the **Past?**

3. Does your **Partner** have a problem with drugs or alcohol?

4. Do you consider one of your **Parents** to be an addict or alcoholic?

Scoring: Any "yes" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "yes" to two or more questions should be referred for further assessment.

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.

T-ACE

ACOG recommends the T-ACE screening tool for alcohol, specifically developed for use with pregnant women. Ask patients four questions:

(T) Tolerance: How many drinks does it take to make you high?

(A) Have people annoyed you by criticizing your drinking?

(C) Have you ever felt you ought to cut down on your drinking?

(E) Eye opener: Have you ever had a drink the first thing in the morning to steady your nerves or get rid of a hangover?

Scoring: Any woman who answers more than two drinks is scored two points. Each "yes" to the additional three questions scores one point. A score of two or more is considered a positive screen, and the woman should be referred for further assessment.

Source: Sokol RJ, Martier SS, Ager JW. 1989. The T-ACE questions: Practical prenatal detection of risk drinking, American Journal of Obstetrics and Gynecology 160 (4).

CRAFFT – SUBSTANCE ABUSE SCREEN FOR ADOLESCENTS AND YOUNG ADULTS

C - Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using drugs or alcohol?

R – Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A – Do you ever use alcohol or drugs while you are by yourself, **ALONE**?

F – Do you ever **FORGET** things you did while using drugs or alcohol?

F – Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T – Have you ever gotten **in TROUBLE** while you were using alcohol or drugs?

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

Source: Center for Adolescent Substance Abuse Research, Children's Hospital of Boston. The CRAFFT screening interview. Boston (MA) CeASAR; 2009.

TOBACCO

While this guidance focuses on alcohol, illegal substances, and prescription drug abuse, screening for tobacco is still recommended. The negative impact of tobacco use on birth outcomes is well documented. If a patient indicates they smoke, consider referrals to the Delaware Quitline for free cessation resources and tools at www.quitsupport.com or by calling **1-866-409-1858.**

STEP THREE: EDUCATE THE PATIENT AND PROVIDE REFERRALS

If the screening tool does not identify a potential problem:

• State law requires that all medical providers serving pregnant women counsel them on the dangers of any alcohol, marijuana, or other drug use during pregnancy. Recommend they cease use with the exception of opioids, which require special considerations and may need to involve Medication Assisted Treatment. For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

If the screening tool does identify a risk for substance use disorder:

• Be clear that you know the mother wants to be as healthy as possible for her baby and herself, and that she can reduce the health risk to them both by stopping the use of alcohol and drugs. If eligible, connect her with a Care Coordinator through her medical insurance.

• Discuss possible strategies for her to stop — individual or group counseling, 12-step program, or substance use disorder treatment. If she is struggling with opioid addiction, Medication Assisted Treatment should be discussed.

• Recommend women visit www.HelpIsHereDE.com or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent or Sussex counties to learn more about services for pregnant women.

MEDICATION ASSISTED TREATMENT

Medication Assisted Treatment (MAT) is an important part of the treatment regimen for pregnant women and is proven to improve outcomes. According to ACOG, "the rationale for Medication Assisted Treatment during pregnancy is to prevent complications from illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to the patient associated with a drug culture." *(ACOG Committee Opinion, Opioid Abuse, Dependence and Addiction in Pregnancy, Number 524, May 2012, page 2).*

The two main medications involved in MAT for pregnant women are methadone and buprenorphine (without Naloxone). The decision regarding the most appropriate medication should be made jointly with the MAT provider, the obstetrician, and the woman.

METHADONE	BUPRENORPHINE (WITHOUT NALOXONE)
• **May have better treatment retention**	• **Probably less severe NAS; works best in patients needing less monitoring**
• **No risk precipitating withdrawal**	• **Reduced risk of overdose during induction**
• **Patients with more severe opioid use disorder**	• **Reduced risk of overdose if children are exposed to medication.**

Source: Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/.

SOURCES

For a full list of sources, call the Division of Public Health at 302-744-4704.

NNEPQIN

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

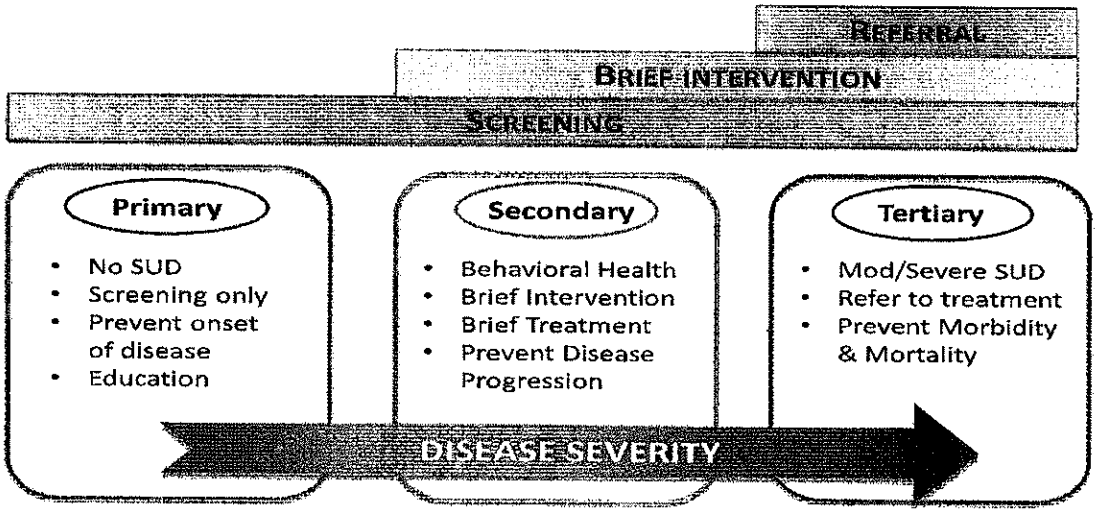
Screening for substance use during pregnancy using an SBIRT framework

Prevention, identification, and reduction of alcohol, tobacco, and drug use during pregnancy and the postpartum period are critical to support the health and wellbeing of women and their infants. Universal screening for drug and alcohol use is an essential first step in identifying women with harmful substance use or use disorders, and linking them with services at the appropriate level of care (World Health Organization [WHO], 2014; Patrick and Schiff, 2017; American College of Obstetricians and Gynecologists [ACOG], 2017; American Society of Addiction Medicine [ASAM], 2016; American College of Nurse Midwives[ASCNM], 2004). Because women often use more than one substance, screening should always include illicit drug, tobacco, and alcohol use.

Perinatal substance use exists across all sociodemographic groups (National Survey on Drug Use and Health, 2015). NNEPQIN recommends a population based approach, in which all pregnant women are screened at entry to maternity care and again in the third trimester and at delivery. It is the responsibility of all maternity care providers to ensure that women who are at increased risk for perinatal substance use have access to follow up assessment, intervention, and are linked to services. A number of screening tools have been validated for use during pregnancy, among these the Substance Use Risk Profile, AUDIT-C (alcohol only), CRAFFT (for women under age 26), ASSIST, 4 Ps Plus are commonly used (Bush, et al, 1998; Chang, et al 2011; Chasnoff, et al, 2005; Hotham, et al, 2013; Yonkers, et al, 2011).

NNEPQIN recommends universal screening for drug and alcohol use at the initiation of prenatal care, using validated instrument(s) and a screening, brief intervention, referral for treatment (SBIRT) framework (Guidelines for Screening for Alcohol, Tobacco, and Drug Use During Pregnancy, 2017). The aim of population based screening is to identify women engaged in harmful use of drugs or alcohol, to provide support, arrange follow up, and make appropriate referrals as indicated by the level of need. The SBIRT approach is specifically recommended in *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018).

Universal screening and layered follow-up in the maternity care context



SBIRT resources contained in this chapter:

I. Developing an SBIRT process:
- Overview of process
- Example process map
- Sample patient letter
- Coding and billing tips

II. Screening:
- Example screening tool from NIAAA

III. Brief Intervention:
- BNI ART algorithm
- SBIRT training video

IV. Referral to Treatment:
- Algorithm for choosing level of care
- Template for local resources
- Sample consent forms

I. Developing an SBIRT process in the maternity care context

SBIRT implementation requires modification of existing clinic workflows. Each context is different. We recommend incorporating SBIRT into the existing intake process for new OB patients, which includes screening for other risk medical risks.

Brief description of a typical SBIRT implementation process

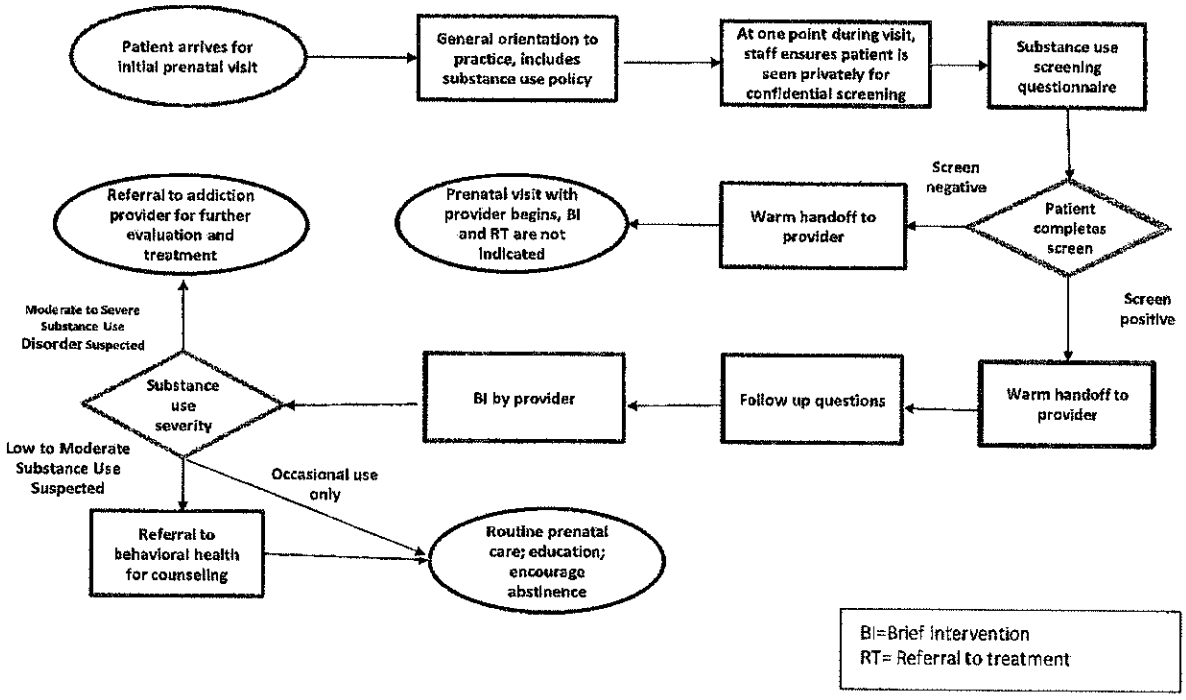
1. **SBIRT Preparation:**
   - Review institutional policies and update as needed to include use of the SBIRT framework for prenatal patients
   - Develop a plan for modifying workflow to incorporate screening
   - Train appropriate staff for screening process
   - Train appropriate staff in brief intervention techniques
   - Identify follow up plan and key personnel when screening is positive
   - Create a list of resources to support women in need of referrals for substance use
   - Identify billing requirements and opportunities
   - Develop patient information script or written materials about substance use screening and institutional policies on substance use
2. **Implementation:**
   - Implement workflow modification to include confidential screening and response
   - Provide information about institutional substance use policy as part of new patient orientation
   - Screen using a validated questionnaire on paper, or the electronic equivalent
   - Ensure a warm handoff occurs from staff performing screening to staff who will address positive screening results
   - Implement Brief Negotiated Interview [BNI] algorithm following positive screening
   - Develop a follow up plan when screening is positive
   - Make referrals if needed
   - Plan follow up at next visit

In the example below, screening is performed by a member of the nursing staff, and brief intervention is performed by an APRN or physician when indicated. This practice has identified both a target addiction treatment program and a behavioral health provider as resources for patients who need help with substance use. These resources may be available inside the practice or may need to be developed externally. *Before implementing SBIRT it is essential to have a plan for referral to treatment when needed.*

Guidance regarding follow up assessment after a pregnant woman disclosures opioid use disorder is discussed in Factsheet 1 of the SAMHSA *Clinical Guidance* document (SAMHSA, 2018, pp 17-24)

An example of a clinic screening process using a validated questionnaire is depicted below. Additional resources for implementing SBIRT into clinical practice workflows is available from the Department of Family Medicine at Oregon Health Sciences University: http://www.sbirtoregon.org/contact-us/

Process Map for SBIRT at Initial OB Visit



SAMPLE PATIENT ORIENTATION LETTER

Congratulations!

Our team looks forward to supporting you through your pregnancy.

An important part of prenatal care is identifying any risks that might exist for you, your pregnancy, or your baby after birth. These might include medical conditions such as diabetes, asthma, depression, or other issues that make it hard to take care of yourself.

Substance use is one concern that could affect the care of you and your baby. Therefore, we ask all of our patients about the use of tobacco, alcohol, or drugs at the first prenatal visit and again in the third trimester.

Facts about substance use during pregnancy:

- Smoking cigarettes and other forms of tobacco may keep oxygen from flowing through the placenta, causing low birth weight and preterm birth
- Alcohol may cause birth defects and problems with brain development, known as "fetal alcohol spectrum disorders"
- Some drugs cause miscarriage, bleeding, or preterm labor
- Other drugs, especially opioids like heroin or oxycodone cause symptoms of withdrawal in newborn babies
- Marijuana may cause problems with learning and depression as children get older
- Drug and alcohol use may affect your ability to care for your new born baby

Federal law requires healthcare providers to report to child protective services when a baby is born affected by drug or alcohol use. Please let us know if you have questions or concerns about any information shared here. If you are a smoker and have been unable to quit, please let us know if you would like a nicotine replacement while you are at our tobacco free campus. We are here to help.

Thank you for choosing to partner with us and including us in your pregnancy journey.

[Your Ob/Gyn Team]

Coding and billing for substance-related services

SBIRT services are reimbursable under the Affordable Care Act. Routine screening using a validated screening tool can be billed as a preventative service. Screening followed by Brief Intervention is billed using the time-based codes described below.

1. **SBIRT**
   - Routine screening without brief intervention: can be performed periodically, must reference use of a validated screening tool.
   - Billing code: 96160
   - If brief intervention is required, may bill for screening and brief intervention as "additional E&M code"
     - if > 15 minute= 99408
     - if > 30 minutes= 99409
   - Must be face to face
   - Include sufficient documentation to support time spent; reference the patient's willingness to change, and describe the plan formulated during the discussion
   - Specify minutes of counseling provided

2. **Tobacco Counseling**
   - Bill as "additional E&M code"
     - If 3-10 minutes= 99406
     - If > 10 minutes= 99407
   - Must be face to face
   - Include sufficient documentation to support time spent; reference the patient's willingness to change, and describe the plan formulated during the discussion
   - Include tobacco-related diagnosis for visit (for example):
     - Tobacco Use Disorder: F17.2

3. **Billing for counseling related to substance use issues for obstetric patients**
   - Counseling must account for > 50% of total visit time
     - D-H requires the number of minutes of counseling be specified
   - Substance-related diagnosis must be included for visit (for example):
     - Tobacco Use Disorder: F17.2
     - Marijuana Use: F12.9
     - Opioid Use Disorder: F11.2
   - If occurring in context of routine OB care, may bill as "additional E&M code"
     - If total visit lasted 10-14 minutes = 99212
     - If total visit lasted 15-24 minutes = 99213
     - If total visit lasted >=25 minutes = 99214

II. SBIRT Process: SCREENING

All pregnant women should be screened using a validated instrument.

- All pregnant women should be informed about the health system's policy on prenatal drug, tobacco, and alcohol use at the first prenatal encounter, as part of their orientation to the practice (see example patient letter)

- Screening for substance use should be conducted while a woman is alone or accompanied only by young children

- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as their reproductive health history, and to safely screen women for domestic violence
    - If a woman cannot be confidentially screened, screening should be deferred

- Timing of screening
    - Screening should be done at initiation of prenatal care, and repeated in the third trimester
    - Screening should also be repeated on admission for delivery

- A number of substance use screening tools have been validated for use during pregnancy. The best tool is the one which is easy to use in a given context

- A positive screen does not equate to a diagnose a substance use disorder, but rather to the need for further exploration about risk of substance exposure during pregnancy

Example screening tool:

Alcohol and Other Drug Screening Questions
NIAAA Guidelines

1) **On average, how many days per week do you drink alcohol (beer, wine, liquor)?**

2) **On a typical day when you drink, how many drinks do you have?**

_____ days per week x ____drinks per day = ____drinks per week

Positive Screen: Above NIAAA Guidelines
>14 drinks/week for men
>7 drinks/week for women or men over 65 years
Any use of alcohol for pregnant women

3) **What is the maximum number of drinks you had in a 2-hour period during the last month?**

Positive Screen: Above NIAAA Guidelines
5+ drinks/2hrs for men
4+ drinks/2hrs for women
>1 drink/day for adults over 65 years
Any use of alcohol for pregnant women

4) **How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?**

https://www.integration.samhsa.gov/clinical-practice/sbirt/Brief-negotiated_interview_and_active_referral_to_treatment.pdf)

III. SBIRT process: BRIEF INTERVENTION

A positive screen indicates the presence of at-risk substance use at some point, but does not necessarily identify current substance use or risk to the mother or fetus. For example, a woman might screen positive for moderate alcohol use prior to pregnancy, but has since discontinued drinking. However, a positive screen should always be followed up with a discussion about current and anticipated future risk.

- Pregnant women who screen positive for prenatal drug or alcohol use should meet with an obstetric provider for brief intervention and a discussion about follow up. When indicated, a referral should be made to the appropriate level of care (see decision tree, below).
- If a woman has discontinued substance use due to pregnancy, brief advice is indicated to congratulate her, and to advise against returning to risky use after the baby is born.
- In providing a brief intervention, providers should strive to use evidence based approaches such as the Brief Negotiated Interview described below, but do not require extensive training in Motivational Interviewing skills.
- The obstetric provider performing the brief intervention will provide information to a woman about and document discussion regarding:
    - Potential harm of identified substance(s) used to the fetus and newborn
    - Discuss specific risks of identified substances used with breastfeeding
    - Explore indication for and acceptance of follow up care, including referral to Behavioral Health or Addiction Medicine specialist
    - Review Institutional policy regarding urine toxicology testing during pregnancy and upon admission for labor
    - Review institutional policy regarding collection of urine and/or meconium for drug of abuse screening for the newborn
    - Advise patient regarding Federal and State requirements for mandated reporting and development of a Safe Plan of Care for newborns identified as being affected by maternal substance use
    - Offer referral to case management/social worker if available at institution

ACOG recommends that obstetrical providers learn the skills of brief intervention and active referral to treatment (ACOG, 2008; ACOG, 2017). The Brief Negotiated Interview (BNI) developed by the Boston University School of Public Health is a simple approach designed to help providers quickly explore a patient's motivation to change behavior, while eliciting action steps from the patient: https://www.integration.samhsa.gov/clinical-practice/sbirt/Brief-negotiated_interview_and_active_referral_to_treatment.pdf

Brief Intervention Training Video: A virtual training, including examples of brief interventions for marijuana, alcohol, and opioid use during pregnancy (Acquavita, S.P. & Barker, A. (2017). *Online Module to train healthcare providers in SBIRT with pregnant women* [included with permission]). http://cahsmedia2.uc.edu/host/PregnancyModule/story.html

Brief Negotiated Interview (BNI) during pregnancy: Modified from the BNI-ART Institute by Caitlin Barthelmes, MPH *(Used with permission)*

1) BUILD RAPPORT & BRING IT UP	One health issue we discuss with all pregnant patients is alcohol and drug use. Having an honest conversation about these behaviors helps us provide you and your baby the best possible care. You don't have to answer any questions if you feel uncomfortable. Would it be okay to talk for a minute about alcohol/drugs?
2) PROS AND CONS	People use alcohol and drugs for lots of reasons • Help me understand, through your eyes, what do you like about using [X]? • What do you like less about using [X]? • So, on the one hand [PROS], and on the other hand [CONS].
3) INFORMATION & FEEDBACK Elicit Provide Elicit	I have some information on risks of drinking and drug use during pregnancy. Would you mind if I shared them with you? (Refer to appropriate handouts/ cards as needed) **There is no known amount of alcohol that is safe to drink during pregnancy or when trying to get pregnant.** Drinking anything containing alcohol during pregnancy can cause Fetal Alcohol Spectrum Disorders ("FASDs"), which include physical problems, intellectual and behavioral disabilities. Use of drugs during pregnancy can also increase the risk for other pregnancy complications and health problems for your baby and behavioral and developmental problems in childhood. Use of drugs and alcohol while breastfeeding can also have negative effects on your baby. What are your thoughts on any of that?
4) READINESS RULER Reinforce positives	This Readiness Ruler is like the Pain Scale we use in the hospital. On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any kind of changes in your [X] use? You marked ___. That's great. That means you are ___% ready to make a change. Why did you choose that number and not a lower one like a 1 or a 2?
5) ACTION PLAN Affirm ideas Write down steps	What are some steps you could take to reduce the things you don't like about using [X]? What ideas do you have to keep you and your baby healthy and safe? Those are great ideas! Is it okay for me to write down your plan, your own prescription for change, to keep with you as a reminder? What should I write down on here?
6) SEAL THE DEAL Offer appropriate resources Thank patient	I have some additional resources that people sometimes find helpful; would you like to hear about them? • Introduce the XXX team at _____. Offer a warm handoff if possible. • Offer handouts or brochures as appropriate. Thank you for talking with me today.

IV. SBIRT process: REFERRAL TO TREATMENT

Intensity of use, availability of treatment options, and conflicting responsibilities and preferences are critical factors in determining the appropriate level of care for a pregnant woman in need of treatment for substance use disorders. Most women are highly motivated to seek treatment during pregnancy, and a shared decision making approach is essential to ensure that the treatment plan developed is feasible and acceptable. Maternity care practices should maintain a list of substance use treatment providers who accept a variety of insurance types. A simple algorithm (below) outlines key steps in this discussion. Follow up assessments are listed in the Section 01 of this toolkit. Readers are encouraged to review Factsheet 2 of *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018, pp25-33) for supporting evidence and clinical considerations relevant to this discussion.

Understanding levels of care for the treatment of opioid and other substance use disorders:
Treatment for substance use disorders during pregnancy may occur at different levels of intensity and duration. Access to pregnancy specific treatment varies widely by region. Some programs may not accept pregnant women, and many do not allow children to accompany their mothers.

Office-based treatment

Combines behavioral treatment for substance use with buprenorphine/naloxone or buprenorphine monotherapy. Physicians can complete special training to be eligible for a waiver to prescribe buprenorphine for this purpose. Recent changes in Federal legislation will allow Nurse Practitioners and Physicians Assistants to undergo similar training to obtain a buprenorphine waiver starting in 2017.

Methadone maintenance programs

Combine behavioral treatment with daily observed treatment with methadone. In the United States, methadone can only be provided for the treatment of addiction at Opioid Treatment Programs certified by the Substance Abuse and Mental Health Services Administration.

Intensive outpatient program

Intensive Outpatient Treatment usually consists of 9 hours of treatment for substance use disorders per week, although programs vary. Clients often begin treatment in IOP/IOT programs and graduate to weekly office-based treatment once doing well.

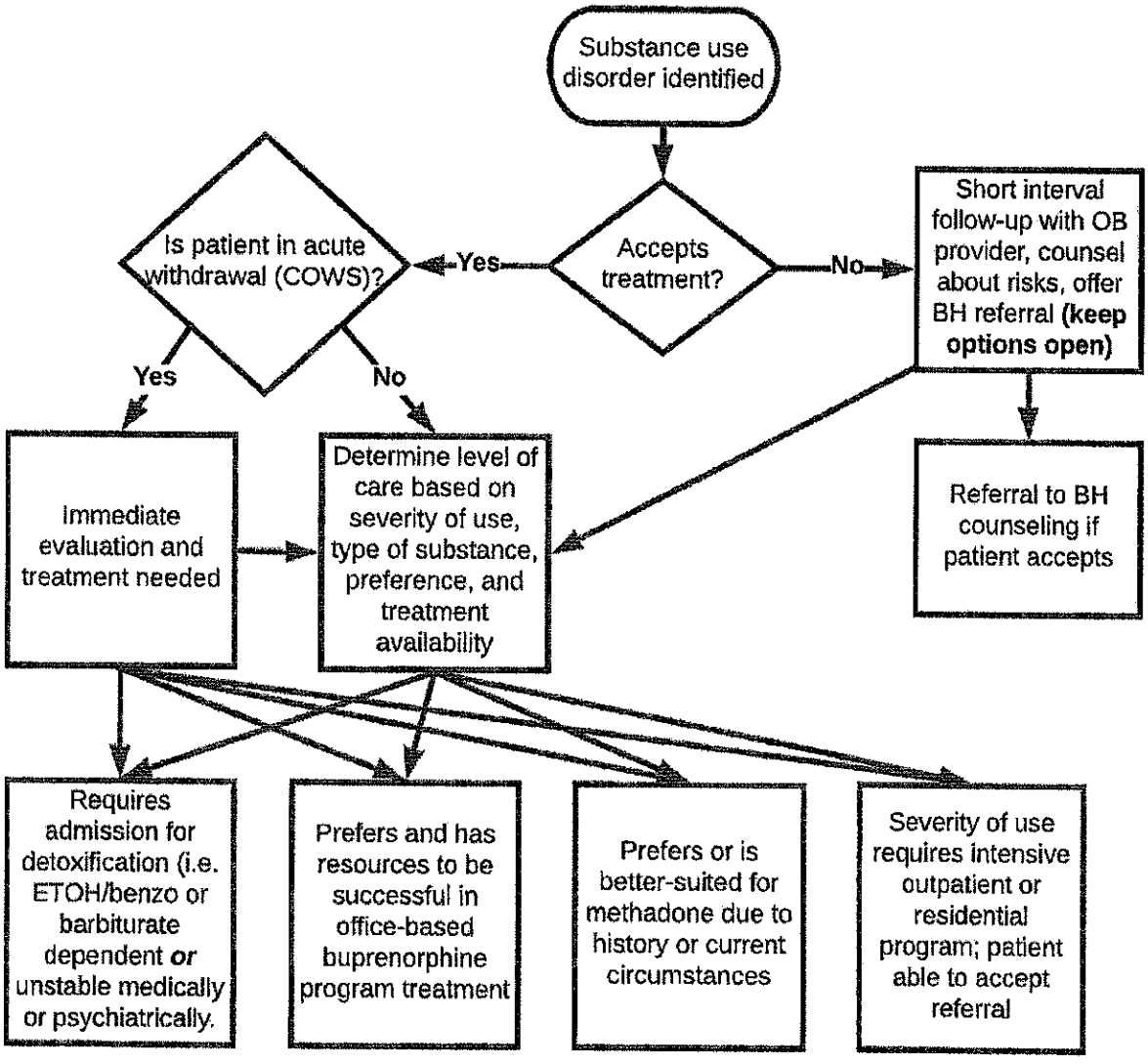
Residential treatment program

Substance use treatment programs which offer daily treatment in a residential setting. Residential programs may or may not be gender-specific. A few residential programs are also equipped to accommodate children whose mothers are seeking treatment.

Additional information about levels of treatment for substance use disorders may be obtained from:

http://asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

Algorithm for determining appropriate level of substance use care



(BH= Behavioral Health clinician; COWS: Clinical Opioid Withdrawal Scale; CIWA: Clinical Institute Withdrawal Scale for Alcohol)

State Treatment Resources

NH Treatment Locator: http://nhtreatment.org/

VT Treatment locator: http://www.healthvermont.gov/adap/treatment/opioids/index.aspx

ME Treatment locator: http://www.maine.gov/dhhs/samhs/help/index.shtml

Local Treatment Providers:

Office-based Buprenorphine Treatment Programs:

Program Name:

Contact:

Program Name:

Contact:

Program Name:

Contact:

Recovery Coaches:

Program Name:

Contact:

Licensed Alcohol and Drug Counselors (LADC)

Program Name:

Contact:

Narcotics Anonymous:

Methadone Maintenance programs

Program Name:

Contact:

Program Name:

Contact:

Intensive Outpatient Program

Program Name:

Contact:

Program Name:

Contact:

Residential Treatment Program

Program Accepts Pregnant Women

Program Name:

Contact:

Program Accepts Women and Children

Program Name:

Contact:

Consent to share information with Treatment Providers

Once a substance use disorder has been diagnosed and a patient referred or treatment started, consent to share information between members of the care team is essential. Additional federal rules protect the privacy and confidentiality of substance use treatment records.

A summary of these rules and sample consent forms may be accessed from PCSS-MAT and the American Osteopathic Academy of Addiction Medicine:
http://c.ymcdn.com/sites/www.aoaam.org/resource/resmgr/Clinical_Tools/Sample_Consent_for_release_o.pdf

A fillable electronic version of the same form is available through PCSS-MAT:
https://www.pdffiller.com/en/project/88623518.htm?f_hash=f7ab01&reload=true

2019

3. SBIRT Screening Tools

SBIRT/OB RESOURCE GUIDE

MASSACHUSETTS GENERAL HOSPITAL
OBSTETRICS & GYNECOLOGY
HARVARD MEDICAL SCHOOL

Substance Use and Performance of Screening Measures During Pregnancy

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Background

- The 2013 National Survey on Drug Use and Health reported that among pregnant women 9% consume alcohol, 15% smoke nicotine cigarettes, and 5% use illicit substances; more recent years have shown increasing rates of maternal opioid use concurrent with the national ~~opiate~~ "epidemic"
- Harmful effects for both mother and offspring render the identification of substance use during pregnancy a public health priority
- Few substance use screening tools have been evaluated in pregnancy, and most have not been validated against a biochemical assay

The current study compared the performance of five substance use screening tools to each other, self-report of daily use over the preceding month, and a urine toxicology screen during pregnancy.

Methods

- In 2016-2017, women age 18 years and over were recruited during prenatal care at three demographically diverse sites
- Phase 1: four existing substance use screeners with published evidence in pregnancy (SURP-P, CRAFFT, WIDUS, and 5Ps), plus the NIDA Quick Screen, administered in counterbalanced order
- Phase 2: completion of a self-report timeline of daily substance use over the preceding month, and collection of urine that was tested for evidence of substance use

Study Population and Distribution of Substance Use

Characteristic	Yale	MGH	WSU	Total
Women enrolled	554	333	333	1220
Age (mean, SD)	28.7 (6.1)	32.6 (4.4)	26.1 (5.1)	29.0 (5.9)
Race/ethnicity (n, %)				
Black, non-Hispanic	172 (31.1)	23 (6.9)	280 (84.1)	475 (38.9)
White, non-Hispanic	187 (33.8)	237 (71.1)	15 (4.5)	439 (36.1)
Hispanic	141 (25.5)	37 (11.1)	12 (3.6)	190 (15.6)
Asian	11 (2.0)	30 (9.0)	4 (1.2)	45 (3.7)
Other	43 (7.8)	6 (1.8)	21 (6.3)	70 (5.7)
Public assistance (n, %)	261 (47.1)	42 (12.6)	236 (70.9)	539 (44.2)
Pregnancy trimester (n, %)				
First	165 (33.0)	85 (25.4)	159 (47.8)	409 (35.5)
Second	187 (33.8)	117 (35.1)	90 (27.0)	394 (32.3)
Third	184 (33.2)	125 (38.4)	84 (25.2)	396 (32.5)
Positive urine toxicology (n, %)				
Any substance	181 (32.7)	26 (7.8)	172 (51.7)	379 (31.1)
Alcohol	3 (0.5)	3 (0.9)	6 (1.8)	12 (1.0)
Tobacco	86 (15.6)	10 (3.0)	66 (19.5)	168 (13.8)
Marijuana	70 (12.6)	7 (2.1)	82 (24.6)	159 (13.0)
Opiates	8 (1.4)	4 (1.2)	8 (2.4)	20 (1.6)
Other (amphetamines, barbiturates, benzodiazepines, cocaine)	14 (2.5)	2 (0.6)	4 (1.2)	20 (1.6)

MGH = Massachusetts General Hospital; WSU = Wayne State University; SD = standard deviation

Performance of Substance Use Screening Measures

Measure of Merit	NIDA	WIDUS	CRAFFT	5Ps	SURP-P
Accuracy	87%	76%	68%	45%	44%
Sensitivity	56%	61%	29%	74%	80%
Specificity	96%	81%	76%	30%	23%
PPV	78%	49%	27%	25%	27%
NPV	83%	87%	78%	82%	85%

PPV = positive predictive value; NPV = negative predictive value

Conclusions

- Substance use in pregnancy is relatively persistent across trimesters; prevalence varies by substance type
- Tobacco and marijuana are the most commonly used substances during pregnancy; alcohol and opioids have lower prevalence but are present across prenatal care sites with varying demographic composition
- Among 5 substance use screening measures tested in pregnancy, there is no single screener with superiority on all measures of merit
- The NIDA Quick Screen shows promising accuracy, specificity, PPV, and NPV, however the screener sensitivity was relatively low, detecting only about half of women known to have positive urine toxicology screens

Implications

- Screeners focusing on symptoms of dependence performed relatively poorly
- Substance use is relatively common in pregnancy, emphasizing the need for a validated prenatal screening tool
- Future analyses will need to consider new screening tools made from existing screening items, combinations of existing measures into multi-step screening, and incorporation of other screening modalities

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

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

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

DRUG ABUSE SCREENING TEST, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

1. Have you used drugs other than those required for medical reasons?	No Yes
2. Do you use more than one drug at a time?	No Yes
3. Are you always able to stop using drugs when you want to?	No Yes
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	No Yes
5. Do you ever feel bad or guilty about your drug use?	No Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No Yes
7. Have you neglected your family because of your use of drugs?	No Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No Yes
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	No Yes
Scoring: Score 1 point for each question answered "Yes".	**Score:**

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No Problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

NIDA Quick-Screen [1]

The NIDA Quick Screen is a free online tool that helps primary care providers screen patients for drug use in general medical settings. The tool asks a pre-screening question regarding alcohol, tobacco, non-medical prescription drug, and illegal drug use.

In the past year, how many times have you used the following?

Drug Type	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol -For Men more than 5 drinks a day -For Women more than 4 drinks a day					
Tobacco products					
Prescription Drugs for Non-Medical Reasons					
Illegal drugs					

The NIDA Quick Screen evaluates whether or not the patient is at risk for each of the substances based on their screening results. The program also provides specific resources for each substance to assist the clinician with next steps.

- For alcohol problems, it recommends continuing screening, assessment, and treatment following the NIAAA guide, *How to Help Patients Who Drink Too Much: A Clinicians Guide.*
- For tobacco, it recommends advising all tobacco users to quit and provides a link to the quick reference guide: *Helping Smokers Quit: A Guide for Clinicians.*"
- For non-medical prescription drugs and for illicit drugs, the NIDA Quick Screen directs the user to continue using the online program and take the full NIDA Modified ASSIST, an 8 question screening tool that is discussed in more detail later in this information guide.

Asking About All Substances: Alcohol, Drugs, and Tobacco

It is important to screen all patients for all substance use: alcohol, drug use (illicit drugs and/or misuse of prescription drugs), and tobacco use. The following instruments screen for all three substances at once.

NIDA Quick Screen

This comprehensive screening tool, screens for alcohol, drug, and tobacco use in adults, consists of only four questions, and takes just a few minutes. It is available online and for free as the first part of the NIDA Drug Screening Tool. This tool first determines whether the patient has used any substances in the past year. If they have not, the survey ends there. Scoring is automatic. Advantages of this system are its comprehensiveness, easy access online, and automatic scoring.

NIDA Quick Screen Questions

1. In the past year, how often have you used alcohol?
   (4+ in one day for women, 5+ in one day for men)

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

2. How often have you used tobacco products in the past year?

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

3. Have you misused prescription drugs during the past year?

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

4. Have you used illegal drugs in the past year?

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

If the patient screens positively for alcohol or tobacco, the provider is directed to assessment tools for those substances. If the patient screens positively for illegal or prescription drug use, the survey continues to a full drug assessment tool, also online, called the NIDA-Modified ASSIST.

NIDA-Modified ASSIST

This online tool follows the NIDA Quick Screen if there is a positive result. It can be used with adults and adolescents and covers most common drugs. It provides assessment detail beyond just screening (WHO, 2004).

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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4. Motivational Interviewing

SBIRT/OB RESOURCE GUIDE

Motivational Interviewing in Integrated Care Settings
Supplemental Handouts

Strategies to Elicit Change Talk

a. Ask Evocative Questions

- "Why would you want to make this change?" **(Desire)**
- "How might you go about it, in order to succeed?" **(Ability)**
- "What at the best reasons for you to do it?" **(Reasons)**
- "How important is it for you to make this change?" **(Need)**
- "What do you think you'll do?" **(Commitment)**

b. Use Change Rulers

Importance Ruler

- "On a scale of 0 – 10, where zero is not at all important, and ten is extremely important, how important is it to you to change _____?"
- "Why you are at a ___ and not a [lower number]?"
- "What might happen that could move you from a ____ to a _____ [one number higher]?"

Confidence Ruler

- "On a scale of 0 - 10, how confident are you that you can _____?"
- "Why you are at a ___ and not a [lower number]?"
- "What would it take for you to be at a _____ [one number higher]?"

c. Explore the Decisional Balance (Pros and Cons)

- "What would be the benefits of making this change?"
- "What are the not so good things about making this change?"

d. Ask for Elaboration (when change language emerges, ask for more detail)

- "In what ways?"
- "How do you see this happening?"
- "Tell me about your past experiences with ____?"
- "What else?"
- "Tell me about the last time _____."
- "Describe a specific example of when this happens."
- "What are some examples of problems you've had with _____?"

e. **Looking Back** (ask about a time before the current concern emerged):
   - "Tell me about a time when things were going well?"
   - "What are the differences between now and before this was a concern?"
   - "What were things like before _____?"
   - "How has this concern interfered with your life?"

f. **Look Forward** (ask about how the future is viewed)
   - "What may happen if things continue as they are (status quo)?"
   - "If you were 100% successful in making the changes you want, what would be different?"
   - "How would you like things to be next year?"

g. **Query Extremes** (ask about the best and worst case scenarios of changing or not changing)
   - "What are the best things that might happen if you do make this change?"
   - "What are the worst things that might happen if you don't make this change?"

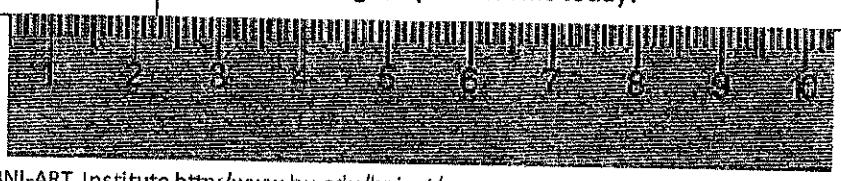
h. **Explore Goals and Values** (ask what the person's guiding values are)
   - "What is most important to you?"
   - "How does this behavior fit with who you are?"
   - "In what ways does this situation conflict with where you see yourself?"
   - "What are the three most important things to you?"

i. **Hypothetical Questions** (when importance and confidence are low)
   - "What might you say to a friend or family member who was in this situation?"
   - "What might happen that would let you know it was time for a change?"
   - "If you were to make this change, how might you go about it?"
   - "Not now, but when the time is right for you, what might your next step be?"

BRIEF NEGOTIATED INTERVIEW (BNI) ALGORITHM*

Tasks	Dialogue
1. Build Rapport • Ask permission • Day in the life	Before we start, I'd like to learn a little more about you. Would you mind telling me a little bit about yourself? What is a typical day like for you? What are the most important things in your life right now? How does your [X] fit in?
2. Explore Pros and Cons • Ask pros and cons • Use reflective listening to highlight key points • Summarize	I'd like to understand more about your [X] use. What do you enjoy/like about [X]? What else? What do you enjoy less or regret about your [X] use? What else? *Explore problems mentioned in appts.* You mentioned ... Can you tell me more about that situation? So, on the one hand you said [PROS], and on the other hand you said [CONS].
3. Provide Feedback • Assess client knowledge • Elicit permission • Provide information • Elicit response	What do you know about the impact [X] might have on your work and/or risks of [X]? Would you mind if I shared some additional information with you? *Provide 1-2 salient points.* What are your thoughts on that?
4. Use Readiness Ruler • Readiness ruler • Ask about lower number	To help me understand how you feel about making a change in your [X] use, [show readiness ruler]... On a scale of 1-10, how ready are you to change any aspect related to your [X] use? Why did you choose a [X] and not a lower number like a 1 or 2? **If they choose "0"**: What would need to happen in your life to consider making a change?

5. Negotiate an Action Plan
• Develop an action plan
  • Client ideas
  • Staff ideas
• Assess confidence
• Ask about lower number
• Explore challenges
• Summarize
• Thank client
	You mentioned some reasons to change. What steps are you willing to do for now to complete your training? What else?
	Share your ideas (if applicable) using the elicit-provide-elicit approach.
	I have a few suggestions that might be helpful. Would you mind if I shared them with you? *Provide 1-2 concrete ideas for action plan.* What are your thoughts on that?
	On a scale of 1-10, how confident (1-10) are you that you could meet these goals?
	Why did you choose a [X] and not a lower number like a 1 or 2?
	What are some challenges to reaching your goal(s)?
	Let me summarize what we've been discussing, and you let me know if there's anything you want to add [review action plan].
	Thanks for being so open with me today!



* Adapted from the BNI-ART Institute http://www.bu.edu/bniart/

Sample Script for Interviewing Parents about Prenatal Alcohol Exposure

Birth Mother Interview (Sample Script)

Thank you for agreeing to talk with me. I want to help make sure we can get _____ as much help as possible.

I will ask you several questions. Some of what we discuss may feel like very personal information. You have the right to not answer any questions you are not comfortable with, or to ask me questions about this interview.

I promise you that the information you give me about these questions will not be used against you in any way. You cannot get in trouble for telling me this information. **Do not make this statement if you cannot guarantee this.*

The only thing that would change this would be if you told me that _____ has been hurt or might get hurt. If I need to tell someone else about something you've told me, I will talk to you about it first.

I'm going to take some notes while we talk to help me remember what we talked about. I'll check with you when we're done talking to make sure that what I wrote down is accurate. Is that okay with you?

The only reason I am asking these questions is to try to help ___ as much as I can.

- Will you tell me a little bit about _____? What is he/she really good at?
- What things are harder for him/her?
- How does _____ do in school?
- What do you like most about _____?
- What are you worried about most for _____?
- All kids have things that they are good at and things that are harder for them. Sometimes those things that are harder are extra hard for a reason, like having dyslexia or having ADHD. Does your child have any things that are hard to do?

Another thing that can make learning or behavior difficult for some kids is FAS. FAS is a medical condition that sometimes happens when a mother drinks alcohol when she is pregnant. Sometimes when this happens, the child can have a harder time with some thinking or other kinds of skills.

Knowing about a diagnosis can help someone in many ways. When we find out about a diagnosis it gives us an idea of what we can do to help, and also what we can do to help other people understand why some things are harder for ___, and can work on helping him/her.

We know that mothers never drink on purpose to make things harder for their children. We also know things now that we didn't know before about drinking while pregnant.

- How far along were you in your pregnancy before you knew you were pregnant?
- This is a long time to remember back. Everybody has a different preference for alcohol. Can you remember, before you got pregnant, what was your usual drinking style? About how much did you drink? How often?
- After you found out you were pregnant, did this change?
- Do you remember drinking alcohol when you were pregnant with ___?
- How about now?
- Did you ever get treatment or help for your drinking?
- (If yes) Who helps you with your sobriety now?
- Who are the people in your life that support you, or that help you when times are hard?
- Let's talk some more about _____. What are your greatest hopes for him/her? What are your fears?
- Is there anything else that you think would be helpful for me to know about _____? Do you have questions about what we've talked about?

Now I'd like to go over the notes I took to make sure I understood things correctly. Please tell me if there's anything that's not quite right, or that you want me to change.

2019

5. Engagement Tips for Working with Families with SU Disorders

SBIRT/OB RESOURCE GUIDE

Massachusetts
Department of Social Services

ENGAGEMENT TIPS FOR WORKING WITH FAMILIES WITH SUBSTANCE USE DISORDERS

June 2006

Developed with
The Institute for Health and Recovery

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Kim Bishop-Stevens
Acting Director
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Introduction

Engagement TIPS
For Working with Families
With Substance Use Disorders

The following Engagement TIPS (and associated **Resource Directory**) grew out of a Substance Abuse Engagement Project piloted in three DSS offices in the Northeast region in 2004-2005. The Engagement Project was designed to engage families with open DSS cases who had documented substance abuse problems, but were not engaged in any type of substance abuse treatment. An Institute for Health and Recovery Family Care Coordinator (FCC) worked closely with DSS social workers and DSS-referred families from the three area offices to engage them in substance abuse treatment.

These Engagement TIPS are a series of suggestions for increasing child safety, well-being and permanency by working with parents who are having problems with alcohol and/or other drugs. They are designed to be a quick resource for DSS professionals. These TIPS include some general information about substance use disorders, as well as specific information about types of substance abuse treatment, how to best approach a parent who may have substance abuse problems, how to engage a parent in treatment, and relevant cultural considerations. The key is to build a relationship with the parents, motivate, develop together a workable service plan, and provide follow-up and support. TIPS can help when you first begin work with a family with a recent 51 A, or when you are dealing with a family with persistent substance abuse concerns. Engagement TIPS is organized into simple topic headings with the most relevant information included. Take a few minutes to look over these TIPS. There may be information here that is new to you or helpful to review. You may want to learn some of this information in greater depth both as preparation for future work and as you work with your current families. Please refer to the **Resource Directory** for information to help you make the best use of resources and referrals.

TIP ONE: A Quick Review of Substance Abuse

[Please refer to DSS protocol or other resources for a more extensive explanation of substance abuse and dependency]

Substance Abuse is the use of alcohol or other drugs that can result in problems for one's children, one's health, work, family or other relationships.

Substance Dependency is increased tolerance to alcohol and/or other drugs, which means that it takes more of the substance to gain the same effect. Substance dependency also means that the person may go through physical withdrawal from the drug if the use is stopped suddenly. Substance dependency is considered an illness which can be treated and for which effective treatment is available.

Many people with substance abuse/dependency do seek help and recover – there is hope.

- Substance abusers do not have to "hit bottom" to realize they need help.
- Substance abuse/dependency is often prevalent in the same family.
- Treatment works. As a result of coping strategies learned in treatment, often the capacity to parent children increases, while risk to children decreases.
- Relapse often occurs and should be considered a part of the recovery process. When the person stabilizes again, they should gain additional insight into their recovery.
- Depression, trauma, domestic violence and other problems often co-occur with the substance abuse.
- Limiting or eliminating substance abuse is central to becoming a better parent and makes other parenting responsibilities easier to carry out.

Treatment

Treatment for substance abuse/dependency is provided in different modalities, ranging from outpatient counseling and peer support groups like AA and NA to residential treatment programs for families. Each family should be assessed individually when determining treatment needs. It is important to become familiar with the resources in your area. See the **Resource Directory** to note these resources and how to access them.

The goals of substance abuse/dependency treatment include:

1. Learning to refrain from the use of alcohol and other drugs.
2. Beginning to learn new coping strategies for everyday life, without drugs.
3. Learning to make decisions related to maintaining abstinence and reducing the ill effects of the drug use. These decisions may involve housing, work, relationships, physical health, and family.
4. Learning harm reduction, which is how to reduce the harmful effects related to substance abuse.
5. Eliminating alcohol and/or other drugs from the body. In some case this may require medical hospitalization as withdrawal can be very serious and even life threatening. Detoxification most often takes from three to five days.

Treatment components may include:

- Medical monitoring.
- Drug and alcohol education.
- Counseling for sobriety.
- Planning for maintenance and recovery.
- Relapse prevention.

Substance Abuse Treatment Programs:

In-patient Detoxification (Acute Treatment Services): Detoxification is used for people who are dependent on alcohol, heroin and other addictive drugs. The focus is on medically monitoring the physical withdrawal symptoms and the beginning of introducing treatment concepts. It is rare for someone to be admitted for detoxification of cocaine or marijuana only, as neither of these substances requires an inpatient medically monitored detox. Detox is usually 3 to 7 days; follow-up treatment is necessary.

Transitional Support Services (T.S.S.): These programs are post-detox, short-term treatment facilities with the capacity of serving clients up to thirty days. Programs are used mostly as a holding place while the client waits for longer term, residential treatment.

Day Treatment: These services provide five days a week programming, several hours each day. Day treatment consists mostly of groups but may include individual counseling.

Intensive Out-patient Programs (I.O.P.)/Partial Hospitalization: Treatment is provided for one-half or full day, three to five days a week. The treatment is primarily group-oriented but can include individual counseling.

Dual-Diagnosis Day Treatment/Partial Hospitalization is similar to day treatment or I.O.P. but to qualify a client needs to have two or more diagnoses, usually substance abuse and a mental health diagnosis.

Outpatient Treatment: Agencies provide individual or group counseling with professionally trained clinicians. Outpatient groups can include substance abuse education, support and skill building.

Residential Substance Abuse Treatment: These residential programs last for six – twelve months. Most programs are for individuals but some are specifically designed for families.

Family Residential Substance Abuse Treatment Programs: These residential programs last for six – twelve months and serve single and two-parent families with children of all ages. Access to and information about these programs can be obtained through the Institute for Health and Recovery's Central Access Department (617-661-3991).

Peer Support: Alcoholics Anonymous and Narcotics Anonymous, while not considered treatment, provide help and support for recovery in communities.

TIP TWO: Parents with Substance Use Disorders

- Usually regard parenting as central to their purpose in life and to their self-esteem.
- Like most parents, care about and want the best for their children.
- Are proud of their children.
- **Are afraid your sole purpose is to remove their children.**
- May not see the ill effects of their use.
- May have tried to quit before and been unsuccessful.
- Fear that they will have to give up their children to enter treatment.
- May be defensive.
- May be ashamed of their use and want to hide the use from you.
- May be open to reducing their use vs. abstinence as a first step.

TIP THREE: Building Relationships is Key

To build a relationship with your client, use a non-judgmental attitude that conveys hope and encouragement. The importance of building a relationship and partnering with parents is a crucial first step in supporting parents' recovery efforts.

A common misperception is that individuals with substance use disorders, especially those with children, are weak, immoral, lazy, good for nothing, and involved with criminal activity. Parents often feel this stigma and may even share these societal views.

If you have worked with a family for a long time and feel frustrated with their progress around substance use/recovery, step back, take a deep breath, and consider a new approach. This could be a new treatment program and/or encouraging Alcoholics Anonymous or Narcotics Anonymous meetings. It also helps to explore with the client on a regular basis what she/he feels has and has not been helpful in his/her recovery process. Consider consulting with your DSS Regional Substance Abuse Coordinator to discuss options for your client. Also, take time to talk about your frustrated feelings. A co-worker or supervisor might have helpful insight, which can validate your feelings.

Keep in mind that the parents can do and want to do what is best for their children.

Provide basic substance abuse education with parents, i.e. substance abuse is an illness; it's treatable; it's not your fault. Connect the parent with others who can provide further education. This can be accomplished through self-help programs or education groups at local outpatient programs.

Operate from a strengths based approach – look for skills/strengths that parents have, not only at their substance abuse. Use strengths as a bridge to approach presenting issues. What positive steps has the parent taken?

TIP FOUR: The First Meeting

a. Before meeting the client, review the prior history obtained by previous worker (51A, Investigation, Assessment).

b. As with any client, treat the person with respect. Find a private place in the home for your meeting or meet in your office. Start with getting to know the parent and learning about his or her strengths. Ask open-ended questions. For example, you might say, "Tell me one thing you are proud about for your children." OR "What do you enjoy about your child/children?"

c. Although time may be short, try to start with getting to know the parent and learning about his or her background and strengths.

d. Ask about:

- Cultural/ethnic backgrounds and traditions. Do not make assumptions. Asking in a respectful way will demonstrate understanding. Ask the person what their ethnicity is. You may be surprised how people self-identify.
- Family life, especially since the 51 A was filed
- Parenting activities
- Peer or other influences
- Work, hobbies, other interests

e. If the parent appears under the influence of alcohol or drugs, reschedule your visit. For example, if you smell alcohol or marijuana or the parent is nodding off or seems unable to focus, do not continue with the meeting. Be direct about why you need to reschedule. "I need to reschedule our appointment as you appear to be intoxicated." If the children are present, alternative child care arrangements need to be arranged.

f. Make sure the parent understands why you are meeting. For example, you might say: "We can talk together about what you see as the issues and how my involvement may be helpful so that you can give your children all the love and attention you desire."

g. Begin early on to assess and help with concrete needs of the children.

h. Identify and focus on strengths. For example, you might say: "You obviously care a great deal about your kids." OR "It sounds like you really want to be a good parent to your children."

i. Think about: Are you able to work honestly with someone who does not share your culture/ethnicity or gender?

TIP FIVE: Consider Cultural Factors

- Are you currently a member of a faith community?
- Have you ever been a member of a faith community?
- Have you ever been to a community healer for help?

- Would you consider a priest/pastor/rabbi/imam (Islam)/spiritual leader (Latino and beyond) as part of your recovery?
- How is alcohol and/or drug use regarded in the family's culture?
- Is it stigmatized?
- Permitted for some groups but not for others?
- Used in celebrations or rituals?
- Sometimes okay but other times not okay to use?
- Have traditions changed around alcohol and drug use, perhaps when people moved to this country?
- Role of the parent in a particular culture, i.e., is mother the nurturer and father the disciplinarian?
- Role of grandparents and other extended family.
- Boundaries around family life, i.e., are things kept private, or is everything out in the open?
- Cultural values around privacy. "We don't air our dirty laundry."
- Cultural values around seeking help. "Only crazy people see a shrink."

Role of gender: A woman may be the identified parent, with a different standard and expectation. For example, women may be held responsible when there is a threat of children being removed. Men are not held to the same standards as women. Women face additional barriers to finding appropriate treatment resources, including securing child care to attend treatment.

Language limitations: A trained interpreter should be at each parent meeting. Do not use children, other family members, or friends as interpreters.

Also, consider the socio-economic status of a family and how that might affect finding resources for treatment.

TIP SIX: As You Proceed, Ask Open-Ended Questions

Examples:

"Tell me about….."

"What do you think is going on…?'

"What options have you tried in the past?"

"What has worked for you?"

"What has not worked for you?"

Open-ended questions naturally lead to the important issues.

Even if time is short make sure you are not distracted. Give the parent your full and undivided attention. If the question goes unanswered, ask follow-up questions and stay focused until questions are answered.

TIP SEVEN: As Parents Warm Up, Ask About More Difficult, Personal Issues

Explore in more detail the effects of substance use and abuse on the children, as well as other issues that are influenced by substance abuse, including.

- Past and present trauma
- Depression
- Mental health concerns
- Domestic Violence
- Medical History
- "Family Secrets"

For example, you might say,

> "From my experience working with other families, many times people have experienced traumatic episodes in their lives that may have affected their substance use. I don't know if this is true for you, but if it is, I am wondering if there is some way I can help you get connected to appropriate support services."

Offer to provide concrete ways to help with parenting issues. Know the parenting services and resources offered in your area, as well as available family support. What is the parent doing right in terms of coping with these problems? Ask the parent how she or he copes with these issues. Acknowledge his or her coping skills. For example, you might say, "I know you have been struggling with your addiction, but it seems like you are really making an effort to do what is best for yourself and your family. It takes a lot of courage for you to talk about this problem with me."

Hold out hope for the future, especially in terms of recovery from substance abuse/dependency.

TIP EIGHT: Get More Information about Substance Use

Ask open-ended questions. For example, if the parent is minimizing alcohol and/or drug use, you might ask:

> "You're telling me you're not using drugs, but you have missed appointments and your children have been late for school. I'm curious about what's going on."

> "I see there is no food in the house, yet I see bottles of alcohol. I'm curious about what is what is going on. "

> "I know you have stopped drinking before. What worked for you then? What didn't work for you then?"

> "Is there anything right now that would keep you from getting help? What may that be?"

You want to know what has worked and not worked for this parent so you can focus your attention and time on what has helped his or her recovery in the past. Then you can give practical suggestions to try now.

TIP NINE: The Service Plan – Substance Use/Abuse

As you develop the service plan with the parent in terms of substance use/abuse, identify and think about how to overcome barriers to treatment, which may include:

- Negative experiences with human services.
- Distrust of helping professionals.
- Past failed attempts at getting sober or reducing use.
- No transportation to treatment.
- Lack of childcare.
- Treatment wait-lists.
- Significant others who may or may not use and therefore may not support treatment. It is important to remember that clients often will not reveal their significant other's substance use.
- Worry about losing their children if they admit to substance use/abuse.
- Distance from children/significant other/family while in residential treatment.
- Limiting children's visitation from weekly to monthly if admitted to residential program.
- Perception that substance abuse treatment is too hard, scary and intimidating.
- Worry that if she or he goes into treatment everyone will know.
- Worry that she or he will fail.

TIP TEN: Developing the Service Plan

As you develop the plan with the parent:

- Consider the child's developmental stage and needs.
- Consider what is needed for the child's physical, emotional and mental health.
- Collaborate with the family and with treatment programs. Make sure you all support the same goals for the family.
- Keep in mind that if the parent is able to limit or stop his or her substance use, this may help to address other parenting concerns.
- Talk with the parent in terms of what is most workable and possible. Remember that parents go through a process of steps when making a change. Consider Prochaska and DiClemente's Stages of Change Model. Where is the parent in terms of recognizing their substance abuse issue? A parent who is denying a problem is not likely to enter a residential program, but may attend an educational group.
- Make sure both you and the parent understand the plan and that it is a collaborative effort with goals and tasks that are comprehensive and achievable. For example, the parent will attend two

AA meetings per week, and will call to schedule an intake appointment for outpatient counseling within the next two weeks.

- Make substance abuse treatment a central part of the service plan. Consider treatment options, for example outpatient versus residential. In what is the parent able and willing to participate? If they find their initial attempts at treatment to be unsuccessful, what else would they be willing to do?

TIP ELEVEN: Relapse

Remember that relapse can happen. This may be due to:

- Narcotics given post-surgery (particularly orthopedic surgery). These narcotics can be triggering. Follow up with prescribing doctor.
- Harboring "secrets" such as uncertainty about sexuality.
- Non-compliance with prescribed medications.
- Untreated depression or other mental health issue.
- Grief and loss, which can include leaving the structure of a program and the peer support that may have been offered there. Many families have not had practice with termination as a process.
- The parent thinking, "Maybe I can use just one more time."
- Unexpected pressures on the parent.
- Pressure from peers to use.
- Keeping friends/partners/family that reinforce drug/alcohol use.
- Not using longer-term supports such as AA.
- Ongoing domestic violence.

Relapse can be a slip rather than a landslide. Help the parent understand that recovery is still attainable. Work with the parent to get back into treatment, perhaps making a change to the treatment plan or accessing other support systems, i.e. friends, religious affiliations, and healthy activities.

Understanding a healthy versus an unhealthy relapse: Is the parent able to learn from the relapse? Are they willing to connect with supports and get back into treatment? What would they do differently next time?

Be compassionate regarding the relapse. A parent may feel shame in "failing" recovery. What supports can you offer?

Work with the treatment program to develop a strong relapse prevention program.

Note: As you work with the parent, do this through the lens of relapse prevention. Remember that relapse prevention requires planning, and is often part of long-term recovery.

TIP TWELVE: Substance Abuse Treatment Discharge

As the parent is discharged or leaving formal treatment, talk with him or her about what will help maintain the changes that she or he made during treatment. Collaborate with the parent, program and family to develop a discharge/relapse prevention plan. Consider if the family will be connected to the treatment program after discharge, i.e., attending aftercare groups for a specified period of time.

Ask open-ended questions. Examples:

"What did you learn in treatment? What were you told about how to maintain change?"

"Let's list five things you can do to help yourself as this point."

"What parenting concerns do you have right now that may get in the way of your continued recovery?"

"If you feel you are running into trouble, who can you call?"

"What do you feel your strengths are? What do you have going for you right now?"

"What are some ways you can help your children at this point in time, and also take care of your recovery?"

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6. Maternal/Fetal/Neonatal Effects of Alcohol, Tobacco, and Other Drugs

SBIRT/OB RESOURCE GUIDE

Maternal/Fetal/Neonatal Effects of Alcohol, Tobacco and Other Drugs

Possible Maternal/Fetal/Neonatal Effects of Alcohol and Other Drugs Commonly Used by Pregnant Women

All women should be screened for substance use (Screening, Brief Intervention and Referral to Treatment) in medical and public health settings, and advised to abstain from prenatal alcohol, tobacco and other drug use. A woman who carries her fetus to term wants to have a healthy baby. Pregnant women who use substances often face stigma and discrimination in medical settings, which can lead to shame and a reticence to pursue medical care. If a woman is unable to stop using substances during pregnancy, she may have a substance use disorder and can benefit from a referral for a substance use assessment and treatment.

Poverty, poor nutrition, limited education, maternal age, maternal stress, limited access to prenatal care, lead exposure, violence, trauma, genetics, epigenetics, and poly-drug use (including tobacco) can impact maternal/fetal/neonatal health and child outcomes. Additionally, the timing, frequency, and dosage of substance use during pregnancy, and the vehicle of drug administration can all cause variations in effect. As a result, few studies have been able to isolate or quantify the effects of individual substances on a pregnant woman or her developing fetus. That being said, research has identified teratogenic effects of prenatal alcohol, tobacco, THC, and methamphetamine exposure.

In some cases the effects can be permanent, debilitating, or irreversible; still, protective environmental factors can mitigate much of the damage. The benefits of the postnatal environment cannot be over-stated: early identification, intervention with the child and family, and a healthy home environment can contribute to significantly improved outcomes and, in many cases, no deficits. Nonetheless, pregnant women, and those intending to become pregnant are advised to abstain from alcohol, tobacco and other drug use.

Alcohol is a Uniquely Dangerous Teratogen

"Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces, by far, the most serious neurobehavioral effects in the fetus."

—Institute of Medicine Report to Congress, 1996

	Alcohol	Tobacco	Opioids	Meth	Cocaine	Marijuana	PCP
Growth deficiency	X	X	X	X	X	X	X
Behavioral problems	X	X	X	X	X	X	X
Cognitive problems	X	X	X	X		X	X
Motor deficits	X	X		X			X
Developmental delays	X	X			X		
Facial anomalies	X	X					X
Physical defects	X	X		X	X		X

Wozniak, 2014

The U.S. Surgeon General recommends that pregnant women, and women who are considering becoming pregnant, abstain from alcohol. No safe levels of alcohol use during pregnancy have been found.

Drug Name (various forms)	**Maternal Effects** *(possible)*	**Fetal Effects** *(possible)*	**Neonatal/Infant Effects** *(possible)*	**Long-term Effects** *(possible)*
Alcohol/ethanol (Hard liquor, beer, wine, wine coolers, etc.)	Tolerance; intoxication; Central Nervous System (CNS), depression; withdrawal; risk for seizures; and damage to liver, heart, stomach, etc. Alcohol withdrawal may cause hypertension, tachycardia, and premature labor. Malnutrition	Abnormalities in growth and development; Central Nervous System disruption; and resultant brain damage. Constriction of blood flow to placenta hinders delivery of nutrients and oxygen Fetal Alcohol Spectrum Disorders Prenatal alcohol exposure (PAE) has been linked to increased risk of preterm birth and to related negative health outcomes. Alcohol's effect on development in infancy may be both direct and mediated by shortened length of gestation.	Neonates born to women who are known to have used alcohol prenatally are at risk of a Fetal Alcohol Spectrum Disorder (FASD): • Growth impairment, • Facial dysmorphia • Central Nervous System abnormalities • Microcephaly • Low birth weight and short length • Neurocognitive Impairment • Irritability • Restlessness • Poor sleep and feeding • Agitation • Increased risk of neonatal mortality Alcohol consumption during lactation is associated with altered postnatal growth, sleep patterns, and psychomotor patterns of the infant.	Cognitive Consequences: • Impaired intellectual functioning and difficulty living 'up to' IQ. • Sensory integration difficulties • Dysregulation of mood and behavior • Poor working memory • Impaired judgment • Impaired language reasoning & processing • Impaired executive functioning • Impaired social adaptive functioning • Substance use disorders • Major Depression • Bipolar Disorder • Antisocial Personality Disorder • ADHD • Learning Disability • Sleep Disorder • Poor fit with societal expectations

Detoxification from alcohol during pregnancy: Women who are dependent upon alcohol and want to undergo detoxification should do so in an inpatient/hospital setting, as medically indicated. The health and well-being of the mother and the fetus should be addressed equally.
The US Preventive Services Task Force recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use

Drug Name (various forms)	**Maternal Effects** *(possible)*	**Fetal Effects** *(possible)*	**Neonatal/Infant Effects** *(possible)*	**Long-term Effects** *(possible)*
Nicotine (cigarettes, cigars, hookah-other forms of combustible tobacco products; smokeless tobacco containing nicotine) **Nicotine** in electronic cigarettes and JUUL exposes mother and developing fetus to nicotine, which impacts maternal health and hurts fetal brain and lung development **Secondhand smoke from cigarettes** includes up to 7000 chemicals, 250 of which are toxic and 69 of which have been shown to cause cancer in people.	Mother's health is negatively impacted by smoking/tobacco use Pregnancy complications due to tobacco use increasing risk of maternal mortality, such as: -vaginal bleeding -ectopic pregnancy -placental abruption -placenta previa Smoking impacts mom's health: -decreased immunity to illnesses -increased risk of heart attack and stroke - causes type 2 diabetes mellitus -risk of colorectal, liver, cervical, throat, bladder and lung cancer Respiratory illnesses: asthma, emphysema, COPD Lower estrogen levels, leading to mood swings, fatigue, and vaginal dryness	Nicotine crosses the placenta. Amniotic fluid and fetal circulation have been found to have higher levels of nicotine than found in the mother's own plasma and blood. Reduced fetal oxygen supply and heart defects. Impaired fetal growth. Causes congenital birth defects such as cleft lip/palate, resulting in nursing/feeding problems, ear infections, hearing loss, speech and language delay, and dental problems. Urinary tract malformations Increased risk for fetal distress, fetal demise, spontaneous abortion (miscarriage), premature labor and stillbirth. Higher risk of being born too early Nicotine can damage a developing baby's brain and lungs Smokeless tobacco can cause sleep apnea in newborns	Small for gestational age Smaller head circumference, which impacts brain size and functions. Heightened developmental risk Challenging temperament Deficits in self-regulation Sleep disruption Orofacial clefts in infants Nicotine is found in breast milk Continued exposure to secondhand smoke causes increased risk for Sudden Infant Death Syndrome (SIDS) as well as respiratory illnesses Thirdhand smoke exposure due to toxins and carcinogens on surfaces	Increased risk of overweight and obesity Higher blood pressure Increased risk of wheezing, asthma, airway hyper-responsiveness, impaired lung function, bronchitis Cognitive-behavioral effects: Behavior regulatory problems Developmental delays ADHD Aggressiveness, decreased social behavior, and depression Externalizing problems Conduct disorders Possible impairment of language development Possible lowered IQ Risk for developing nicotine addiction
Tobacco: Prenatal cessation of tobacco products reduces maternal health risks, risk of pre-term birth and delivering small-for-gestation age neonates. At this time, no studies have been published on the effects of prenatal use in humans of alternative nicotine delivery systems (e-cigarettes, lozenges, etc.). The combination of alcohol and tobacco use heightens the health risks to both mother and child. Smoking interacts with both psychiatric and non-psychiatric medications. These interactions are caused by components of tobacco smoke, and can potentially cause an altered pharmacologic response.				

Citations at end of document

Drug Name (various forms)	Maternal Effects *(possible)*	Fetal Effects *(possible)*	Neonatal/Infant Effects *(possible)*	Long-term Effects *(possible)*
Marijuana/Tetra-hydro-cannabinol (THC)	The effects of one joint on the respiratory system are similar, if not worse, than that of five tobacco cigarettes. CNS depression, but can act as a stimulant; toxic to respiratory system and immune system; increased heart rate, hypotension Labor and delivery complications including prolonged or arrested deliveries, abnormal bleeding, meconium staining, etc. THC use may impair sperm production in males, but not at contraceptive levels. Cannabis use appears to be a risk factor for psychotic disorders when it interacts with a pre-existing vulnerability.	Shorter gestation, some congenital anomalies, including brain development. Frequent use may be associated with low birth weight Vasoconstriction that restricts fetal oxygen supply. Neonates born to exposed mothers were more likely to be born preterm and underweight	Neurological abnormalities resulting from CNS immaturity: • Abnormal responses to light and visual stimuli • Tremulousness • High-pitched cry • Increased tremors and startles. THC is more concentrated in a mother's milk than in her blood, resulting in THC exposure to the breastfeeding child. One study reports that an infant's motor development can be impaired from exposure, though further research is indicated. Postnatal maternal cannabis use may exacerbate deactivating and distancing maternal behavior, adversely impacting attachment and parenting.	Long-term effects include: • Increased Childhood depression • Initiation and frequency of marijuana use by age 14 • Memory deficits • Increased hyperactivity • Impulsivity • Inattention symptoms • Deficits in problem solving skills • Executive functioning impairments

Marijuana: Marijuana contains many of the cancer-causing chemicals found in tobacco. Marijuana can be laced with embalming fluid, ketamine, cocaine, etc. The research is not unified on the impact on fetal/neonatal/child health and development. Dose levels impact effects. The American College of OB/GYNs recently made this recommendation. "Because of concerns regarding impaired neurodevelopment, as well as maternal and fetal exposure to the adverse effects of smoking, women who are pregnant or contemplating pregnancy should be encouraged to discontinue marijuana use. Obstetrician–gynecologists should be discouraged from prescribing or suggesting the use of marijuana for medicinal purposes during preconception, pregnancy, and lactation. Pregnant women or women contemplating pregnancy should be encouraged to discontinue use of marijuana for medicinal purposes in favor of an alternative therapy for which there are better pregnancy-specific safety data. There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged.

Citations at end of document

Drug Name (various forms)	Maternal Effects *(possible)*	Fetal Effects *(possible)*	Neonatal/Infant Effects *(possible)*	Long-term Effects *(possible)*
Heroin and opioid analgesic misuse **(i.e. Percocet, Vicodin, OxyContin, Fentanyl)** The effects of prenatal use of prescription opiates on fetal/neonatal/ child health have not been identified. NOTE: The term *Neonatal Abstinence Syndrome (NAS)* is replaced with *Newborn Opiate Withdrawal Syndrome (NOWS).*	Tolerance, CNS depression Risk for HIV/ AIDS and other infections with injection drug use Malnutrition Acute withdrawal and risk for spontaneous abortion or premature labor	Intrauterine growth restriction Risk of HIV/AIDS infection from mother Low birth weight Vasoconstriction that restricts fetal oxygen supply.	Neonatal is dependent on a variety of factors, i.e. genetics, polydrug use, gestational age, etc. symptoms may include: • Hyperactivity • Irritability/ agitation • High-pitched cry • Increased neuro-muscular tone • Tremors • Seizure risk • Poor feeding • Abnormal sleep • Ventilatory patterns Infants prenatally exposed to MAT tend to have reduced symptoms compared to infants exposed to opiates throughout pregnancy. Infants managed by using the *Eat, Sleep, Console* approach were treated with morphine significantly less frequently than they would have been by using Finnegan scoring. ESC is an effective method for the management of infants with NOWS that limits pharmacologic treatment and may lead to substantial reductions in length of stay.	A healthy postnatal environment, including quality caregiving, can have reparative effects on child well-being. Early identification can contribute to adaptive functioning. Children should be assessed for early motor delays, Attentional problems, and compromised regulatory behaviors. Possible neurological deficits: • Decreased cognitive performance • Disruptive behavior Children born with NOWS have been found to be more likely than children without NOWS to: • Be evaluated for an educational disability • Be diagnosed with developmental delay or speech or language impairment • Receive classroom support or speech therapy

Drug Name (various forms)	Maternal Effects *(possible)*	Fetal Effects *(possible)*	Neonatal/Infant Effects *(possible)*	Long-term Effects *(possible)*
Opioid Treatment during Pregnancy: Pregnant women dependent upon opioids are recommended to use medication-assisted treatment (MAT) with Methadone or Buprenorphine, concomitant with counseling, rather than undergoing a medical detoxification. Methadone, for example, contributes to a 3-fold increase in treatment retention and 3-fold reduction in heroin use compared to detoxification. If detoxification is desired by a woman, avoid using antagonists such as naltrexone or naloxone as they contribute to fetal distress. In the case of an opioid overdose, however, antagonists should be used to save the life of the mother. The severity of NOWS plateaus between maternal methadone doses of 40–60 mg/day; neonates born to women maintained on <50 mg/day were as likely as those born to women maintained on >50 mg/day to require treatment for NOWS. Additionally, among infants born at ≥36 weeks of gestation with NOWS, initial methadone treatment was associated with a shorter length of stay compared with morphine treatment. Among women receiving opioid agonist treatment, prenatal food insecurity appears to be associated with increased risk for neonatal abstinence syndrome pharmacological treatment (Link: https://www.ncbi.nlm.nih.gov/pubmed/30422365).Buprenorphine is a primary care office-based opioid therapy, and can be prescribed only by SAMHSA-approved physicians. Some women may benefit from the more structured, daily dosing of methadone than the monthly office visit for Buprenorphine. Studies support use of Buprenorphine for reduced duration and severity of NOWS. There of little-to-no effect of MAT and pharmacological treatment of NOWS on Infant neurodevelopmental and behavioral outcomes at 5-8 months of age. The World Health Organization recommends breastfeeding for mothers who are stable on opioid replacement therapies, as the benefits of breastfeeding far outweigh the risk of exposure to minimal amounts of opiates in breastmilk.				

Eat, Sleep, Console: ESC is an effective method for the management of infants with NOWS that limits pharmacologic treatment and may lead to substantial reductions in length of stay. The traditional Finnegan Neonatal Abstinence Scoring System (FNASS) assessment approach may lead to unnecessary opioid treatment of infants with NOWS. See Grossman et al for further information.

Therapeutic Handling for Substance-Exposed Newborns includes: Swaddling (see below); Holding or Laying a baby in the "C-position;" Head to Toe Movement; Vertical Rocking; and Clapping baby's bottom. Feeding should always be done in a low stimulus environment: no bright lights, music, noise or other distractions. The baby needs to be relaxed enough to suck. Further approaches can be introduced in in small doses and on a schedule.

A Note on "Swaddling"

A sleep sac is preferable to a swaddle since there is no chance of a sleep sac unraveling and becoming a suffocation hazard. Swaddled/sleep sac-wearing infants should only be placed on their back to sleep. Swaddles need to be done correctly so they don't unravel and become a suffocation hazard. Swaddling should be snug around the chest, but allow for ample room at the hips and knees to avoid exacerbation of hip dysplasia; "arms in" or "arms out" does not matter. As soon as an infant shows any signs of rolling, swaddling and/or use of sleep sacs should be discontinued immediately. Make sure the infant is not over bundled; if their chest is hot to the touch or they are sweating/red, remove layers immediately. These decisions about swaddling should be made on an individual basis, depending on the physiologic needs of the infant. There is a high risk of death if a swaddled infant is placed in or rolls to the prone position.

NOTE: The MA Dept of Early Education & Childcare does not allow for the use of swaddling or sleep sacs in their licensed facilities as they are considered restraints, and restraints are not allowed. In the NICU, sleep sacs/ swaddles are, in fact, used as restrains so that infants can't accidentally pull at the tubes around and connected to them.

Citations at end of document

Drug Name (various forms)	**Maternal Effects** *(possible)*	**Fetal Effects** *(possible)*	**Neonatal/Infant Effects** *(possible)*	**Long-term Effects** *(possible)*
Prescription sedative-hypnotics (Including Benzodiazepams such as Valium, Xanax, Ativan, etc.)	Tolerance, CNS depression Respiratory depression Acute withdrawal with risk of premature labor	Drug accumulates in fetus at greater levels than in mother Fetal depression, abnormal heart rhythm or even death Low birth weight Increased risk for cleft lip or palate	Drug and metabolites may remain in newborn for days or weeks longer than in the mother. May result in jitteriness, attentional difficulties, lethargy, anemia, poor muscle tone, sucking difficulties, CNS depression, Withdrawal may occur Increased risk for hypoglycemia and respiratory problems	Long-term effects not known
Pregnant women with benzodiazepine dependence should undergo a gradual dose reduction, using long-acting benzodiazepines. Long-acting benzodiazepines should only be used for as short a time as is medically feasible in managing benzodiazepine withdrawal. Psychosocial interventions should be offered throughout the period of benzodiazepine withdrawal. Inpatient care should be considered in the withdrawal management of pregnant women with benzodiazepine dependence.				

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Drug Name (various forms)	**Maternal Effects** *(possible)*	**Fetal Effects** *(possible)*	**Neonatal/Infant Effects** *(possible)*	**Long-term Effects** *(possible)*
Stimulants: Cocaine, crack cocaine, amphetamines	CNS and cardio-vascular stimulation: • Increased heart rate • increased blood pressure • vascular constriction Pregnancy is associated with increased sensitivity to cocaine Pregnant women who use cocaine often use alcohol and tobacco Decreased blood flow to placenta Possible placental abruption and bleeding Premature labor Possible growth restriction and fetal hypoxia	Growth restriction (many children experience catch-up growth and are normal weight by 6–12 months) Risk for intrauterine stroke Vasoconstriction that restricts fetal oxygen supply. Possible genito-urinary abnormalities Necrotizing enterocolitis	Intoxication and/or withdrawal. Symptoms may include: • Irritability/ Agitation • Increased muscle tone • Tremors • Jitters • Inconsolability • Increased respiration • Inability to eat • Low birth weight • Limp muscle tone • Prematurity Possible risk for seizures, anemia Early cardiac abnormalities Slower drug excretion in newborn Abnormal sleep and respiratory patterns	Possible developmental delays and expressive language delays Possible long-term deficits in attention and learning, particularly math. Some observation of aggressive behavior, Oppositional Defiant Disorder, and hyperactivity. Visuospatial processing and arithmetic impairment, deficits in reasoning and abstract processing.

Prenatal Detoxification from Amphetamines/Stimulants: While medically supervised detoxification from these drugs is not general practice, inpatient care might be helpful in the withdrawal management of pregnant women with stimulant dependence. The risks of providing short-term appropriate, non-teratogenic medications for short-term management of psychologically distressing symptoms in pregnancy are very low. Therefore, the potential benefits of this approach strongly outweigh the harms of providing psychopharmacological treatment of symptoms, if required, during psychostimulant withdrawal.

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Drug Name (various forms)	**Maternal Effects** *(possible)*	**Fetal Effects** *(possible)*	**Neonatal/Infant Effects** *(possible)*	**Long-term Effects** *(possible)*
Stimulants: Methamphetamine, MDMA (ecstasy)* ** MDMA is classified as a stimulant and a hallucinogen.*	CNS and cardiovascular stimulation: • increased heart rate • increased blood pressure • vascular constriction Weight loss, insomnia Depression Decreased blood flow to placenta Impairments in daily memory, problem solving, impact on social/emotional intelligence Risk of HIV/AIDS with intravenous use Hyperthermia, sudden death	Possible growth restriction Vasoconstriction that restricts fetal oxygen supply.	Congenital malformations, including cardiovascular and musculoskeletal. • Inability to eat • Low birth weight • Limp muscle tone • Prematurity Increased drowsiness and decreased arousal (perhaps in response to maternal depression) Excoriated Buttocks (Meth)	Possible social and communicative problems in first year. Possible aggressive behavior at age 8 and learning problems at age 14, with physical activity challenges.
Note: The misuse of prescription Amphetamines/Stimulants (Ritalin, Adderall, Dexedrine) may have similar effects as illicit drugs, depending on a wide range of factors, including dose and frequency of use. Adequate research studies are lacking.				

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Drug Name (various forms)	**Maternal Effects** *(possible)*	**Fetal Effects** *(possible)*	**Neonatal/Infant Effects** *(possible)*	**Long-term Effects** *(possible)*
Antidepressants (including SSRIs such as Sertraline & fluoxetine and TCAs such as amitriptyline & trazodone) Use of the SSRI Paxil is not recommended for pregnant women.	Under the care of a medical professional, these prescriptions are indicated for the treatment of a range of depressive symptoms. A woman and her primary care provider should determine together the risks and benefits of discontinuing or staying on any psychotropic medication.	Preterm delivery*	Possible PNOWS (Poor Neonatal Adaptation Syndrome) • Respiratory distress • Cyanosis on feeding • Jitteriness and irritability • Low birth weight • Possible impairment of infant development†	Although the majority of studies have not found causality between SSRIs and Autism Spectrum Disorders, one study found that prenatal exposure to SSRIs may contribute to ASD susceptibility, particularly in boys.

Untreated prenatal depression: can pose risks to a mother's ability to care for herself, her fetus and her child. While women with milder depressive symptoms are likely to be safely taken off of these medications, studies recommend that women with more severe depression and/or co-occurring conditions, such as suicidal attempts, substance use disorders, functional incapacitation, or weight loss, should continue medication under medical care. Terminating antidepressants for severely depressed women may result in increased depressive symptoms and reduced sense of self-efficacy, as well as increased difficulty bonding with the newborn and performing regular maternal activities.

* Depression can also be a risk factor of preterm delivery and low birth weight.

† Only 2 studies noted lower than expected ratings on the Bayley Scales of Infant Development, though this could be a result of uncontrolled confounders, such as maternal psychological disorders, post-natal environment, etc.

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A Poem about "Denial" ***Anonymous***

To One Who Has Seen and Understood

Tread gently when you walk into my life,
For around the body of my soul I have gathered
Fragile gossamer, to the floor, of little lies—
Not to deceive you—but to protect me.

Do not pull at them to render my soul naked,
For they hide truths I have not yet the strength to face.
And when they are gone I may perish.
In the cold realities of your judgment I may die.

But let me stand protected awhile.
Talk to me in love, and when I am secure in that
Those lies will fall away as unneeded peel
Revealing the fruit, the feast.

A Mother in Recovery

Personal Reflection: A Motivational Interviewing Native American Meditation

Guide me to be a patient companion,
to listen with a heart as open as the sky.
Grant me vision to see through her eyes
and eager ears to hear her story.
Create a safe and open mesa on which we may walk together.
Make me a clear pool in which she may reflect.
Guide me to find in her your beauty and wisdom,
knowing your desire for her to be in harmony:
healthy, loving, and strong.
Let me honor and respect her choosing of her own path,
and bless her to walk it freely.
May I know once again that although she and I are different,
yet there is a peaceful place where we are one.

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2019

7. RI Resources for Substance Use Treatment

SBIRT/OB RESOURCE GUIDE

BEHAVIORAL HEALTH LINK

A partnership between BHDDH, Horizon Healthcare Partners, and Community Care Alliance

WHAT IS BH LINK?

- A comprehensive program intended to serve those individuals 18+ who are experiencing behavioral health crises (mental health and/or substance use) by establishing a community-based, 24/7 hotline and triage center.

WHY BH LINK?

- Provides immediate access to behavioral healthcare in a community-based, 24/7 facility
- Ensures stability, provides seamless transfer to ongoing care, and reduces unnecessary use of hospital-based services
- Delivers better, more cost-effective behavioral healthcare in Rhode Island

Primary components:

- BH Link Hotline, (414-LINK; 414-5465): a one-stop, statewide 24/7 call-in center that connects people to appropriate care and resources, when they or someone they care about is experiencing a behavioral healthcare crisis
- BH Link Triage Center: a 24/7 community-based walk-in/drop-off facility where clinicians connect people to immediate, stabilizing emergency behavioral health services, and long-term care and recovery supports

The BH Link Hotline and Triage Center will provide immediate treatment and help for people and connect them to appropriate care, 24 hours a day, 7 days a week with access to the following services:		
Crisis Management and Stabilization	Psychiatric Consultation Services	Connections to Treatment and Recovery Support
Clinical Assessment	Peer Support	Connections to Recovery Housing
System Navigation	Mobile Crisis Response	Care Management
Emergency Medication Prescribing	Continued Engagement and Connection to Follow-Up Services	Skilled Nursing

WHY BH LINK MAKES SENSE:

Current Challenge: People are using emergency departments for behavioral health crises, which are costly and often do not provide the appropriate level of care.

BH Link Solution: By treating people at the Triage Center, we can deliver the right care in the right setting to people in crisis at a fraction of the cost.

Current Challenge: Law enforcement and other first responders want to be helpful to people experiencing a mental health and/or substance use crisis, but they don't have easy access to the appropriate resources.

BH Link Solution: A Triage Center and Hotline provides first responders targeted access and strengthens the state's response to mental health and/or substance use crises.

Current Challenge: Access to treatment can be challenging, and people looking for help often do not know where to begin.

BH Link Solution: BH Link helps people navigate the behavioral healthcare system, making it easier to get people the help they need.

For more information, contact Kristy Moles, Program Manager, Behavioral Health Link Triage Center
(401) 919-1491
kmoles@communitycareri.org

SSTARbirth

"SSTARbirth is a long-term, residential substance abuse treatment program specifically designed forpregnant, postpartum and parenting women. SSTARbirth is the only specialty program of its kind, in the state of Rhode Island. We are a family reunification program and women participate in treatment with their young children. Sstarbirth opened its doors to its first client in January 1994. The program allows for 6 months of treatment and has the capacity for 12 women and 24 children.

The SSTARbirth program provides gender-sensitive services that focus on a woman's sources of strength and resiliency. Using a holistic approach directed toward helping a woman heal her mind, body and spirit, we rely on the principles and traditions of AA/NA to help women become abstinent. The program services include, but are not limited to: individual counseling; psychiatric evaluations and medication management; case management; group therapy; co-occurring disorder education; substance abuse education; relapse prevention; expressive arts; Seeking Safety trauma curriculum; Helping Women Recover curriculum; Nurturing Families parenting program; onsite licensed daycare; transportation; transitional support and continuing care. We collaborate with other agencies in the community to offer specialty psycho-educational groups such as nutrition, health and wellness, domestic violence, HIV education, and Early Intervention services for children under 3 years of age.

SSTARbirth's multidisciplinary team includes; a Program Director, Clinical Supervisor, Mental Health Specialist, Substance Abuse Counselors, Case Manager, Education Coordinator and Head Teacher, as well as other support staff. In addition, SSTARbirth employs a daytime and evening driver to provide safe and timely transportation to appointments and minimize the disruption to treatment.

By providing treatment in a safe and caring environment SSTARbirth allows clients to strengthen their health, find their recovery and nurture their children while helping women learn to integrate their recovery program with their parenting responsibilities."

Moms MATTER

If you are a pregnant or breastfeeding woman who is dealing with an opioid use disorder, you are not alone. Recent research shows that the number of pregnant women who have an opioid use disorder related to prescription pain relievers or heroin has increased in recent years.

Without appropriate treatment, these mothers may be at risk of relapse or increasing use of illicit substances. This can have long-term, negative effects on the relationship between mother and baby.

But help is available. Medication Assisted Treatment (MAT) in pregnancy has been shown to improve birth outcomes among women who have substance use disorders and are pregnant.

MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals. MAT provides a more comprehensive, individually tailored program of medication and behavioral therapy. MAT also includes support services that address the needs of most patients.

The ultimate goal of MAT is full recovery, including the ability to live a self-directed life. This treatment approach has been shown to:

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant

Women & Infants offers office-based buprenorphine maintenance treatment for opioid use disorder during pregnancy and the postpartum period. The Moms MATTER (Medication Assisted Treatment to Enhance Recovery) clinic is a unique model of care that provides a safe place for pregnant and breastfeeding women to seek compassionate, non-judgmental care.

Moms MATTER provides integrated, comprehensive services. Women can be referred from their obstetric provider during pregnancy or the postpartum period. They will then be screened by our team over the phone. If appropriate for an outpatient level of care for medication assisted treatment of opioid use disorder, they will be scheduled for an appointment at the clinic.

Our services include:

- Treatment of acute withdrawal as an inpatient at Women & Infants Hospital.
- Medication assisted treatment with buprenorphine for opioid use disorder.
- Assistance in caring for babies with neonatal abstinence syndrome (NAS) in collaboration with pediatricians at Women & Infants Hospital.
- Pain management for opioid-dependent women as an inpatient at Women & Infants Hospital.

Patients are seen on Thursdays between 12 noon and 4 p.m. at the Center for Obstetric and Consultative Medicine, 100 Dudley Street, Third Floor, Providence, RI (401) 430-2700.

"Discover the Power of Choice!"™

SMART Recovery's 4-Point Program® helps people recover from all types of addictive behaviors, including: alcoholism, drug abuse, substance abuse, drug addiction, alcohol abuse, gambling addiction, cocaine addiction, and addiction to other substances and activities.

SMART Recovery (Self-Management And Recovery Training) is not a 12-step group, like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

Our Purpose

To support individuals who have chosen to abstain, or are considering abstinence from any type of addictive behaviors (substances or activities), by teaching how to change self-defeating thinking, emotions, and actions; and to work towards long-term satisfactions and quality of life.

Our Approach

* Teaches self-empowerment and self-reliance.
* Encourages individuals to recover and live satisfying lives.
* Teaches tools and techniques for self-directed change.
* Meetings are educational and include open discussions.
* Advocates the appropriate use of prescribed medications and psychological treatments.
* Evolves as scientific knowledge of addiction recovery evolves.

SMART Recovery 4-Point Program

SMART Recovery (Self Management And Recovery Training) helps individuals gain independence from addiction (substances or activities). Our efforts are based on scientific knowledge and evolve as scientific knowledge evolves.

The 4-Point Program offers specific tools and techniques for each of the program points:

Point 1: Building and Maintaining Motivation
Point 2: Coping with Urges
Point 3: Managing Thoughts, Feelings and Behaviors
Point 4: Living a Balanced Life

SMART Recovery Groups in Rhode Island

Providence, Rhode Island – Thursday at 7:00 PM to 8:30

Special Directions:

Meeting is held in the Ray Conference Center, room 5 on the 2nd floor.

Butler Hospital
345 Blackstone Blvd. , Providence, Rhode Island 02906, USA
Get Directions

Main Contact:
Mark Leeuwenburgh
Facilitator
(508) 405-7888
smartpvd@gmail.com

Pawtucket, Rhode Island – Saturday at 1:30 PM to 3:00 PM

Pawtucket Public Library
13 Summer Street, Pawtucket, RI 02860, USA
Get Directions
Meeting Tags

Contact Information

Main Contact:
Sam Greenwood
Facilitator
+1 401-680-3339
Sam.SMART.RI@gmail.com

Warwick, Rhode Island – Tuesday at 7:30 PM to 9:00 PM

Anchor Recovery Community Center
890 Centerville Rd., Warwick, Rhode Island, 02886, USA
Get Directions

Contact Information

Main Contact:
Michael DiStefano
Facilitator
(401) 423-1545
mdistefano@cox.net

Substance Abuse Support Groups

Al-Anon

Al-anon is a support group for men and women with a family member, friend, or loved one who struggles with alcohol addiction.
Rhode Island Chapter of Al-Anon
For questions or more information, call (401) 781-0044.

Fridays, 7:30 - 8:30 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center, Room 1

Saturdays, Noon - 1 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center, Room 5

Alcoholics Anonymous

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others recover from alcoholism. To learn more and find other meetings, visit Alcoholics Anonymous on Rhode Island.

Mondays, 7 to 8 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center, Room 5
Questions? Call Ed at (401) 854-8808.

Lesbians Meeting
Thursdays, 6 to 8:30 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center, Room 2
Questions? Call Carol at (774) 212-4481.

Narcotics Anonymous

Narcotics Anonymous is a self-help group for men and women recovering from or wanting to recover from an addiction to drugs.

Rhode Island Chapter of Narcotics Anonymous
For questions or more information, call the Rhode Island Narcotics Anonymous Office at (401) 461-1110.

Sundays, 7 - 8 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center

Alcoholics Anonymous - *Women's Meeting

For women recovering from or wanting to recover from an addiction to alcohol.
Rhode Island Chapter of Alcoholics Anonymous

Saturdays, Noon - 1 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center, Room 2

SMART Recovery (Self-Management and Recovery Training)

SMART Recovery is a support group for men and women recovering from, or considering recovering from, an addiction to substances, addictive behaviors, or both.
SMART Recovery
For questions or more information, call 1-866-951-5357.

Thursdays, 7 - 8 p.m.
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island
Ray Conference Center, Room 3

What They Leave Behind Family & Friends Support Group

A support group for family and friends of those who have lost someone to overdose. The free program is hosted by Project Weber/RENEW in loving memory of Joseph Cintron.

Tuesdays at 6 p.m.
200 Allens Avenue, Second floor
Providence, RI

Patient Resources

Support Groups

Patient and Family Resources (index.cfm)

Amenities (amenities.cfm)

Birth Certificates (birth-announcements-certificates.cfm)

Billing and Insurance (billing-insurance-information.cfm)

Business Office (business-office.cfm)

Financial Assistance (financial-assistance.cfm)

Parking Information (parking-information.cfm)

Visitor Information (visitor-information.cfm)

Spiritual Care (spiritual-care.cfm)

Dining Services (dining-services.cfm)

Patient Rights (patient-rights.cfm)

No Show Policy (no-show-policy.cfm)

Patient and Family Experience (patient-and-family-experience.cfm)

Patient Family Advisory Council (patient-family-advisory-council.cfm)

Bereavement Council (bereavement-council.cfm)

Safety and Security (safety-security.cfm)

When you are experiencing a change in your life with pregnancy or have added stress due to illness, there is nothing more beneficial than meeting other women who are dealing with similar issues. Women & Infants offers a variety of support groups for bereavement, cancer patients, new or expectant parents, and general health to meet the many needs of our community and our patients. For more information on any of the support groups, call the number with the description listed below.

New or Expectant Parents Support Groups:

New Mothers' Group - An informal way to meet with other new mothers to share the new experiences of parenting. Groups meet weekly in the following locations:

- Wednesdays, 10 a.m. - 12 p.m.; Health Education Department, 300 Richmond Street, Suite 102, Providence. Free parking across the street.

Breastfeeding Support Group - In order to provide additional help once breastfeeding moms go home after delivery, Women & Infants offers a weekly Breastfeeding Support Group. Learn more about breastfeeding support services (/women-and-infants-ri/services/pregnancy/feeding-your-baby/breastfeeding-support-services.cfm).

- The group meets on Wednesdays from noon to 1:30 p.m. in the Malcolm and Elizabeth Chace Education Center, South Pavilion, Women & Infants Hospital, 101 Dudley Street, Providence.

Please bring your baby's birth date, birth weight and weight at discharge.

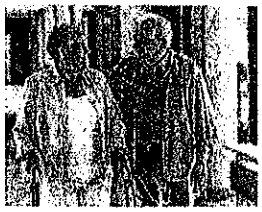
Choices in Family Building - A support group for single women and lesbian couples. The objective of this program is to offer support for women and couples using cryopreserved sperm to share their experiences and build a network of community support.

- Meets the second Wednesday of each month from 6:30 to 8:00 p.m. on the third floor of Women & Infants' Fertility Center, 90 Plain Street, Providence. Facilitated by Lynn Finocchiaro, LICSW, clinical social worker. Please register at (401) 274-1122, ext. 43438.

Pregnancy Loss Support Groups

Miscarriage, Infant Death & Stillbirth (M.I.S.) Group - Meets the first and third Wednesdays of the month at 7:00 p.m. at the Ronald McDonald House, 45 Gay Street, Providence, (401) 274-1122, extension 44049. Click here to view the M.I.S./P.A.L.S. website (http://www.mispals.org/).

Pregnancy After Loss (P.A.L.S.) Support Group - This support group is for women who are pregnant following a loss and would like to share their fears and concerns with other women. The group meets the second Wednesday of each month at 7pm at the Ronald McDonald House, 45 Gay Street, Providence, (401) 274-1122, ext. 44049. Click here to view the M.I.S./P.A.L.S. website (http://www.mispals.org/).



Osteoporosis Risk?

Osteoporosis is a major health issue for women, especially those over age 50. L about common risk factors. (/women-and-infants-ri/services/bone-he

All About Breastfeeding

With the right information, support, and practice, breastfeeding is comfortable ar satisfying for mothers and babies. (/women-and-infants-

WHO IS AN ADDICT?

Most of us do not have to think twice about this question, we know. Our whole life and thinking was centered in drugs in one form or another, the getting and using and finding ways and means to get more. We used to live and lived to use. Very simply, an addict is a man or woman whose life is controlled by drugs. We are people in the grip of a continuing and progressive illness, whose ends are always the same: jails, institutions, and death.

WHAT IS THE NARCOTICS ANONYMOUS PROGRAM?

N.A. is a non-profit fellowship or society of men and women for whom drugs had become a major problem. We are recovering addicts who meet regularly to help each other stay clean. This is a program of complete abstinence from all drugs. There is only one requirement for membership, the desire to stop using. We suggest that you keep an open mind and give yourself a break. Our program is a set of principles written so simply, that we can follow them in our daily lives. The most important thing about them is that they work.

There are no strings attached to N.A. We are not affiliated with any other organizations, we have no initiation fees or dues, no pledges to sign, no promises to keep to anyone. We are not connected with any political, religious, or law enforcement groups, and are under no surveillance at any time. Anyone may join us regardless of age, race, sexual identity, creed, religion, or lack of religion.

We are not interested in what or how much you used, who your connections were, what you have done in the past, how much or how little you have, but only in what you want to do about your problem and how we can help. The newcomer is the most important person at any meeting, because we can only keep what we have by giving it away. We have learned from our group experience that those who keep coming to our meetings regularly, stay clean.

HOW IT WORKS THE TWELVE STEPS OF N.A.

If you want what we to offer, and are willing to make the effort to get it, then you are ready to take certain steps. These are the principles that made our recovery possible.

1. We admitted we were powerless over our addiction, and our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We mad direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory, and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of his will for us, and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts and to practice these principles in all our affairs.

This sounds like a big order, and we can't do it all at once. We didn't become addicted in one day, so remember —*easy does it.*

There is one thing more than anything else that will defeat us in our recovery; this is an attitude of indifference or intolerance toward spiritual principles. Three of these that are indispensable are honesty, open-mindedness, and willingness. With these, we are well on our way.

We feel that our approach to the disease of addiction is completely realistic, for the therapeutic value of one addict helping another is without parallel. We feel that our way is practical, for one addict can best understand and help another addict. We believe that the sooner we face our problems within our society, in everyday living, just that much faster do we become acceptable, responsible, and productive members of that society.

The only way to keep from returning to active addiction is not to take that first drug. If you are like us you know that one is too many and a thousand never enough. We put great emphasis on this, for we know that when we use drugs in any form or substitute one for another, we release our addiction all over again.

Thinking of alcohol as different from other drugs has caused a great many addicts to relapse. Before we came to N.A., many of us viewed alcohol separately, but we cannot afford to be confused about this. Alcohol is a drug. We are people with the disease of addiction who must abstain from all drugs in order to recover.

WHY IT WORKS THE TWELVE TRADITIONS OF N.A.

We keep what we have only with vigilance, and just as freedom for the individual comes from the Twelve Steps, so freedom for the groups springs from our Traditions. As long as the ties that bind us together are stronger than those that would tear us apart, all will be well.

1. Our common welfare should come first; personal recovery depends on N.A. unity.
2. For our group purpose, there is but one ultimate authority – a loving God as He may express Himself in our group conscience; our leaders are but trusted servants, they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous, except in matters affecting other groups or N.A. as a whole.
5. Each group has but one primary purpose – to carry the message to the addict who still suffers.
6. An N.A. group ought never endorse, finance, or lend the N.A. name to any related facility or outside enterprise lest problems of money, property, or prestige divert us from our primary purpose.
7. Every N.A. group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. A., as such, ought never to be organized; but we may create service boards or committees directly responsible to those they serve.
10. A has no opinion on outside issues; hence the N.A. name ought never to be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

Understanding these Traditions comes slowly over a period of time. We pick up information as we talk to members and visit various groups. It usually isn't until we get involved with service that someone points out that "personal recovery depends on NA unity," and that unity depends on how well we follow our Traditions. The Twelve Traditions of NA are not negotiable. They are the guidelines that keep our Fellowship alive and free. By following these guidelines in our dealings with others, and society at large, we avoid many problems. That is not to say that our Traditions eliminate all problems. We still have to face difficulties as they arise: communication problems, differences of opinion, internal controversies, and troubles with individuals and groups outside the Fellowship. However, when we apply these principles, we avoid some of the pitfalls. Many of our problems are like those that our predecessors had to face. Their hard-won experience gave birth to the Traditions and our own experience has shown that these principles are just as valid today as they were when these Traditions were formulated. Our Traditions protect us from the internal and external forces that could destroy us. They are truly the ties that bind us together. It is only through understanding and application that they work.

JUST FOR TODAY LIVING THE PROGRAM

Tell yourself:

JUST FOR TODAY, my thoughts will be on my recovery, living and enjoying life without the use of drugs.

JUST FOR TODAY, I will have faith in someone in N.A. who believes in me and wants to help me in my recovery.

JUST FOR TODAY, I will have a program. I will try to follow it to the best of my ability.

JUST FOR TODAY through N.A. I will try to get a better perspective on my life.

JUST FOR TODAY, I will be unafraid, my thoughts will be on my new associations, people who are not using and who have found a new way of life. So long as I follow that way, I have nothing to fear.

When at the end of the road we find that we can no longer function as a human being, either with or without drugs, we all face the same dilemma. What is there left to do? There seems to be this alternative: either go on as best we can to the bitter ends—jails, institutions or death—or find a new way to live. In years gone by, very few addicts ever had this last choice. Those who are addicted today are more fortunate. For the first time in man's entire history, a simple way has been proving itself in the lives of many addicts. It is available to us all. This is a simple spiritual—not religious—program, known as Narcotics Anonymous.

Basic Text, *page 87*

What is our message?

The message is that an addict, any addict can stop using drugs, lose the desire to use, and find a new way to live. Our message is hope and the promise of freedom.

Basic Text, *page 65*

PHONE NUMBERS

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MAY 2019

GREATER PROVIDENCE AREA Meeting Directory

The lie is dead - We do recover.

NARCOTICS ANONYMOUS

GREATER PROVIDENCE AREA ASC Meeting (Open)

4th Sunday of the month Beneficent Congregational Church 300 Weybosset Street Providence, RI 02903

Send Mail To:

Greater Providence ASC

GPA: P.O. Box 72792 Providence, RI 02907

New England Regional Phoneline

1-866-NA-HELP-U

1-866-624-3578

Visit us on the Web @

www.gpana.org

Any addict is welcome at any meeting, regardless of how it is listed in this directory

Printed on: May 7, 2019

Meeting count: 67

Sunday

10:30A-12:00PM **Sunday Serenity Insanity Group**, Emmanuel House, 239 Public Street, Providence, RI, 02903 **(O, D, S, WC)**

5:00PM-6:30PM **Faith In Recovery Group**, Providence Presbyterian Church, 500 Hope Street, Providence, RI, 02907 **(O, D, S)**

6:00PM-7:15PM **The Meditation Meeting**, Bell Street Chapel, 3 Bell Street, Providence, RI, 02909 **(C, D, ME)**

7:00PM-8:15PM **Dedication**, St Therese Old Catholic Church, 1500 Main Street, West Warwick, RI, 02893 **(O, D, St, Tr, WC, Lit)**

7:00PM-8:00PM **Never Alone Group**, Roger Williams Hospital, 825 Chalkstone Avenue, Providence, RI, 02908 **(O, D, S, WC)**

7:00PM-8:00PM **Recovery Is More Than Abstinence Group**, Butler Hospital, Ray Conference Center, 345 Blackstone Boulevard, Providence, RI, 02906 **(O, D, JT)**

7:00PM-8:00PM **The Message of Hope**, Woodridge Congregational, 30 Jackson Road, Cranston, RI, 02920 **(O, D, S, WC)**

7:00PM-8:15PM **Who's an addict**, Camron Roofing Build, 68 Falmouth Street, Attleboro, MA, 02703 **(O, D, S, Lit)**

7:30PM-9:00PM **Resurrection Group**, Amos House, 460 Pine Street, Providence, RI, 02907 **(O, BT, WC)**

Monday

12:00P-1:00PM **NA In The Day**, St Luke's Episcopal Church, 670 Weeden Street, Pawtucket, RI, 02860 **(O, JT, WC)**

7:00PM-8:15PM **Foundations for Success**, Patterson Creations, 52 Union Street, Attleboro, MA, 02703 **(O, IP, WC)** *Parking lot around back on Crandall Ct*

7:00PM-8:15PM **Learn to Live - Step, Tradition & Concept Lite**, St Peters By the Sea Episcopal Church, Corner of Central and Caswell Street, back lot, 72 Central Street, Narragansett, RI, 02882 **(O, D, St, Tr)**

7:00PM-8:15PM **Smith Hill NA**, Beneficent Congregational Church, 300 Weybosset Street, Providence, RI, 02903 **(O, D, S, WC)**

7:00PM-8:30PM **Step Sisters**, Amos House, 460 Pine Street, Providence, RI, 02907 **(C, St, W)**

7:00PM-8:15PM **Steps To Freedom**, Pilgrim Lutheran Church, 1817 Warwick Avenue, Warwick, RI, 02889 **(O, D, S, St, Tr, WC)**

7:30PM-8:30PM **Dig Deep**, St Theresa, 630 Rathbun Street, Blackstone, MA, 01504 **(C, D, To)**

7:30PM-8:45PM **Grow or Go**, Calvary United Methodist Church, 200 Turner Road, Middletown, RI, 02842 **(O, St, TW)**

7:30PM-9:00PM **New Freedom**, Warwick Central Baptist Church, 3260 Post Road, Warwick, RI, 02886 **(O, D, S)**

Tuesday

8:30AM-9:30AM **Just for Tuesday Morning NA**, Anchor Recovery, 890 Centerville Rd, Warwick, RI, 02886 **(O, D, JT)**

12:00P-1:00PM **NA In The Day**, St Luke's Episcopal Church, 670 Weeden Street, Pawtucket, RI, 02860 **(O, JT, WC)**

Tuesday (cont)

6:00PM-7:00PM **Serenity Plus**, St Vindant DePaul, 6 Street Vincent DePaul Street, Coventry, RI, 02816 **(O, JT)**

7:00PM-8:00PM **Regardless of Sexual Identity**, Brown University-Alumnae Hall, 194 Meeting Street, Providence, RI, 02906 **(O, D, To, BK)**

7:00PM-8:00PM **Serenity Maniacs**, Woodridge United Church, 30 Jackson Road, Cranston, RI, 02920 **(O, D, S)**

7:00PM-8:15PM **Steps In The Chapel**, Chapel Four Corners, 200 Angel Road, Cumberland, RI, 02864 **(C, D, SG, St, BK)**

7:00PM-8:00PM **Why Not Men's Group**, Bridgemark, 2020 Elmwood Avenue, Warwick, RI, 02888 **(C, M)**

7:30PM-9:00PM **Living Free**, First Baptist Church, Lyons St entrance, 91 Cottage Street, Pawtucket, RI, 02860 **(O, D, S)**

7:30PM-9:00PM **Positive Steps**, Wakefield Baptist Church, At Church, 236 Main Street, Wakefield, RI, 02879 **(O, St)**

7:30PM-8:30PM **Recovery In The Beach**, 1st Congregation Church, 715 Oakland Beach Avenue, Warwick, RI, 02889 **(O, D, St, Tr)**

7:30PM-8:30PM **Tuesday Not Use Day**, New England Chapel, 40 Kenwood Circle, Franklin, MA, 02038 **(O, D, S, WC)**

8:00PM-9:00PM **Recovery In The Country**, St Thomas Church, 1 Smith Avenue, Greenville, RI, 02828 **(O, D, S, WC)**

Wednesday

12:00P-1:00PM **NA In The Day**, St Luke's Episcopal Church, 670 Weeden Street, Pawtucket, RI, 02860 **(O, JT, WC)**

7:00PM-8:15PM **Edgewood NA**, Edgewood Congregational Church, 1788 Broad Street, Cranston, RI, 02905 **(O, CS, D, S)**

7:00PM-8:30PM **H.O.P.E (Helping Other People Evolve)**, Amos House, 460 Pine Street, Providence, RI, 02907 **(O, D, BK)**

7:00PM-8:15PM **Steppin Out Wednesday Night**, Advent House, 344 Washington Street., Providence, RI, 02903 **(C, D, St, WC)**

7:00PM-8:00PM **The 107 Club**, St Luke's Church, 99 Pierce Street, East Greenwich, RI, 02818 **(O, BT, D, WC)**

7:30PM-9:00PM **Cookies & Recovery**, St Therese Old Catholic Church, 1500 Main Street, West Warwick, RI, 02893 **(C, D, RF, S, St, TW, WC)**

7:30PM-9:00PM **Loveline Group**, First Unitarian Church, 1 Benevolent Street, Providence, RI, 02906 **(O, BT, D, IP, S)**

7:30PM-9:00PM **Recovery In The Lake Group**, Silver Lake Community Center, 529 Plainfield Street, Providence, RI, 02909 **(O, D, S, WC)**

7:30PM-9:00PM **Straight Today**, Holy Family Parish, 414 South Main Street, Woonsocket, RI, 02895 **(O, D, S)**

7:30PM-8:30PM **The Text Message**, St Augustines, 15 Lower College Road, Kingston, RI, 02881 **(C, BT, RF, WC)**

Thursday

12:00P-1:00PM **NA In The Day**, St Luke's Episcopal Church, 670 Weeden Street, Pawtucket, RI, 02860 **(O, JT, WC)**

Thursday (cont)

7:00PM-8:15PM **IP Time Group**, Providence Youth Services, 640 Broad Street, Providence, RI, 02907 **(O, D, IP, S, WC, BK)**

7:00PM-8:30PM **Men with a Vision**, Providence Presbyterian Church, 500 Hope Street, Providence, RI, 02906 **(O, D)**

7:00PM-8:15PM **NA in NA**, Church on The Hill, 20 Hoppin Hill Ave, North Attleboro, MA, 02760 **(O)**

7:00PM-8:30PM **Why Are We Here**, Riverside Congregational Church, 347 Bullocks Point Avenue, Riverside, RI, 02915 **(O, St, Tr)**

7:30PM-9:00PM **Better Way**, Federated Church (Community Room), 171 Main Street, Franklin, MA, 02038 **(O, BT, D, WC)**

7:30PM-9:00PM **Free at Last**, Baptist Church, Lower Vestry, 582 Putnam Pike, Greenville, RI, 02828 **(O, D, S, St, TW, WC)**

7:30PM-8:30PM **Meeting Street Group**, Brown University (Smith Buano Bldg Rm G012), 195 Cushing Street, Providence, RI, 02906 **(O, D, To)**

7:30PM-8:45PM **Straight Forward**, Amos House, 460 Pine Street, Providence, RI, 02907 **(O, D, WC)**

Friday

12:00P-1:00PM **NA In The Day**, St Luke's Episcopal Church, 670 Weeden Street, Pawtucket, RI, 02860 **(O, JT, WC)**

6:30PM-8:00PM **Gimme Shelter**, Amos House, 460 Pine Street, Providence, RI, 02907 **(O, D, S)**

7:00PM-8:15PM **Clean And Serene**, Pilgrim Lutheran Church, 1817 Warwick Avenue, Warwick, RI, 02889 **(O, D, S, WC)**

7:00PM-8:00PM **Under the Bridge**, Chapel of St John the Divine, At Willett Road, Church Hall, 10 Church Way, Saunderstown, RI, 02874 **(O, BT, CL, D, RF, To, WC)** *Meeting Cancelled on Nov 16th 2018, will Resume Following week. Nov 23rd 2018*

7:30PM-9:00PM **Free at Last**, Calvary United Methodist Church, 200 Turner Road, Middletown, RI, 02842 **(O, D)**

7:30PM-8:45PM **New Life**, Praise Tabernacle, 330 Park Avenue, Cranston, RI, 02905 **(O, BT, D, WC)**

7:30PM-8:45PM **Recovery In The Chapel Group**, Chapel Four Corners, 200 Angell Road, Cumberland, RI, 02864 **(O, D, S)**

7:30PM-9:00PM **The Lie Is Dead Group**, The King's Tabernacle Church, 500 Greenville Ave, Johnston, RI, 02919 **(O, D, S, WC, BK)**

10:00P-11:15PM **Late Nite NA**, St Robert Bellarmine, 1804 Atwood Avenue, Johnston, RI, 02919 **(O, D, JT)**

Saturday

10:00A-11:15AM **Serenity Seekers**, Christ the King church, Parish Building, 130 Legris Avenue, West Warwick, RI, 02893 **(O, To)**

10:30A-12:00PM **Breakfast Club**, Epworth Methodist Church, 915 Newport Avenue, Pawtucket, RI, 02861 **(O, D, S, St)**

12:00P-1:00PM **I Can't We Can**, New England Chapel, 40 Kenwood Circle, Franklin, MA, 02038 **(O, CS, RP, So, WC)**

Saturday (cont)

1:00PM-3:00PM **Keep It Simple Saturday Group**, St Patrick's School, 244 Smith Street, Providence, RI, 02908 **(O, D, S)**

6:30PM-7:45PM **Start your night right**, Camron Roofing Build, 68 Falmouth Street, Attleboro, MA, 02703 **(O, D, S)**

7:00PM-8:00PM **Recovery And Beyond**, St Mathews, 15 Frances Avenue, Cranston, RI, 02910 **(C, JT, M, To, W, WC)**

7:30PM-8:45PM **Opt For Life**, St Peter's By The Sea (Central & Caswell), 72 Central Street, Narragansett, RI, 02882 **(O, D, BK)**

7:30PM-9:00PM **Surrender Or Die Group**, Gerry House, Behind RI Hospital, 142 Borden Street, Providence, RI, 02903 **(O, D, S, WC)**

8:00PM-9:30PM **Hardcore Recovery Group**, Second Presbyterian Church, 500 Hope Street, Providence, RI, 02906 **(O, D, St)**

MEETING FORMAT LEGEND

BK	Book Study	BT	Basic Text
C	Closed	CL	Candlelight
CS	Children under Supervision	D	Discussion
IP	Informational Pamphlet	JT	Just for Today
Lit	Literature Study	M	Men
ME	Meditation	O	Open
RF	Rotating Format	S	Speaker
SG	Step Working Guide	So	Speaker Only
St	Step	TW	Traditions Workshop
To	Topic	Tr	Tradition
W	Women	WC	Wheelchair

Alcoholics anonymous meetings

	TOWN	TIME	MEETING	TYPE	LOCATION
SUN	Providence	07:00 - 08:00AM	Breakfast with Bill	OLS	Our Lady Of the Rosary 463 Benefit St
SUN	Providence	09:00 - 11:00AM	Grupo Despartar Latino	O	Oficina Intergrupal Hispana De AA 273 Pocassett Ave.
SUN	Providence	10:00 - 11:00AM	Day At A Time	O	Roger Williams Hospital(a) 825 Chalkstone Avenue
SUN	Providence	10:00 - 11:00AM	Room To Grow (Women)	ODBG	Alumnae Hall 194 Meeting Street
SUN	Providence	12:15 - 01:15PM	Never Better (Young People	OB	Alumnae Hall 194 Meeting Street
SUN	Providence	03:00 - 04:15PM	Sunday Serenity	OD	Providence Presbyterian Church 500 Hope Street
SUN	Providence	07:00 - 08:00PM	Breathing Easy	OD	First Unitarian Church 1 Benevolent Street
SUN	Providence	08:30 - 09:30PM	Breathing Easy II	OD	First Unitarian Church 1 Benevolent Street
MON	Providence	07:00 - 08:00AM	Breakfast with Bill	OS	Our Lady Of the Rosary 463 Benefit St
MON	Providence	08:00 - 09:00AM	It's A Good Day To Be Sober	OD	Central Congregational Church (a) 296 Angel Street
MON	Providence	12:00 - 01:00PM	United In Sobriety	OBS	Saint Martins Church 50 Orchard Avenue
MON	Providence	05:00 - 06:30PM	Common Bond	CD	Alumnae Hall 194 Meeting Street
MON	Providence	07:00 - 08:00PM	The Magnificent Reality	OS	Providence Presbyterian Church 500 Hope Street

Alcoholics anonymous meetings

MON	Providence	07:00 - 09:00PM	Grupo Despartar Latino	O	Oficina Intergrupal Hispana De AA 273 Pocassett Ave.
MON	Providence	07:00 - 08:00PM	The Gift II	OBS	Butler Hospital 345 Blackstone Boulevard
MON	Providence	07:30 - 08:30PM	AA at the VA	OD	Providence V. A. Hospital 830 Chalkstone Avenue
MON	Providence	07:30 - 08:30PM	Saint Pius	O	Saint Pius Church 55 Elmhurst Ave
MON	Providence	08:00 - 09:00PM	Basic Young Peoples	OD	W. B. N. A. Building 1560 Westminster Street
TUE	Providence	07:00 - 08:00AM	Breakfast with Bill	OB	Our Lady Of the Rosary 463 Benefit St
TUE	Providence	08:00 - 09:00AM	It's A Good Day To Be Sober	OD	Central Congregational Church (a) 296 Angel Street
TUE	Providence	12:00 - 01:00PM	United In Sobriety	OBS	Saint Martins Church 50 Orchard Avenue
TUE	Providence	12:15 - 01:15PM	Out to Lunch Bunch	OD	Matthewson Street United Methodist Church 134 Matthewson Street
TUE	Providence	05:30 - 06:30PM	Insight & Opening	ESM	Alumnae Hall 194 Meeting Street
TUE	Providence	07:00 - 08:30PM	Tuesday Night Step	OST	Saint Patricks School 244 Smith Street
TUE	Providence	07:00 - 08:00PM	The Miracle	OD	Amos House 415 Friendship Street
TUE	Providence	07:00 - 08:00PM	Tuesday Night Men (Men)	CD	Central Congregational Church 296 Angell Street
TUE	Providence	07:00 - 09:00PM	Grupo Un Neuve Despartar	O	Manton Avenue(233) 233 Manton Avenue
TUE	Providence	07:00 - 08:00PM	R.I. L.G.B.T Group	OD	Bell Street Chapel 5 Bell St
TUE	Providence	07:00 - 08:00PM	Willingness to Change	O	Roger Williams Hospital 825 Chalkstone Avenue

Alcoholics anonymous meetings

WED	Providence	07:00 - 08:00AM	Breakfast with Bill	OLS	Our Lady Of the Rosary 463 Benefit St
WED	Providence	08:00 - 09:00AM	It's A Good Day To Be Sober	OD	Central Congregational Church (a) 296 Angel Street
WED	Providence	12:00 - 01:00PM	United In Sobriety	OBS	Saint Martins Church 50 Orchard Avenue
WED	Providence	12:15 - 01:15PM	Out to Lunch Bunch	OS	Matthewson Street United Methodist Church 134 Matthewson Street
WED	Providence	12:15 - 01:15PM	Mustard Seed	OD	First Unitarian Church 1 Benevolent Street
WED	Providence	06:00 - 07:00PM	As Women See It (Women)	CS	Central Congregational Church 296 Angell Street
WED	Providence	07:00 - 09:00PM	Grupo Despartar Latino	O	Oficina Intergrupal Hispana De AA 273 Pocassett Ave.
WED	Providence	07:00 - 09:00PM	Grupo Un Neuve Despartar	O	Manton Avenue(233) 233 Manton Avenue
WED	Providence	07:00 - 08:00PM	Staying Stopped	OD	Salvation Army 386 Broad St.
WED	Providence	07:30 - 08:45PM	Wednesday Night Men (Men)	CS	Central Congregational Church 296 Angell Street
WED	Providence	07:30 - 08:30PM	YPTQ (Young People Queer ,Trans)	OD	Alumnae Hall 194 Meeting Street
THU	Providence	07:00 - 08:00AM	Breakfast with Bill	OB	Our Lady Of the Rosary 463 Benefit St
THU	Providence	08:00 - 09:00AM	It's A Good Day To Be Sober	OD	Central Congregational Church (a) 296 Angel Street
THU	Providence	12:00 - 01:00PM	United In Sobriety	OBS	Saint Martins Church 50 Orchard Avenue
THU	Providence	12:15 - 01:15PM	Out to Lunch Bunch	OD	Matthewson Street United Methodist Church 134 Matthewson Street

Alcoholics anonymous meetings

THU	Providence	05:30 - 06:30PM	Common Bond	CS	Alumnae Hall 194 Meeting Street
THU	Providence	07:00 - 08:00PM	SOBER SISTERS (Lesbian)	OD	Butler Hospital 345 Blackstone Boulevard
THU	Providence	07:00 - 08:00PM	West Side Topic	CD	W. B. N. A. Building 1560 Westminster Street
THU	Providence	07:30 - 08:30PM	You Don't Have To Be Irish	OD	Church of the Redeemer 655 Hope Street
FRI	Providence	07:00 - 08:00AM	Breakfast with Bill	OR	Our Lady Of the Rosary 463 Benefit St
FRI	Providence	08:00 - 09:00AM	It's A Good Day To Be Sober	OD	Central Congregational Church (a) 296 Angel Street
FRI	Providence	12:00 - 01:00PM	United In Sobriety	OBS	Saint Martins Church 50 Orchard Avenue
FRI	Providence	12:15 - 01:15PM	Agape	OS	First Unitarian Church 1 Benevolent Street
FRI	Providence	12:15 - 01:15PM	Out to Lunch Bunch	OLS	Matthewson Street United Methodist Church 134 Matthewson Street
FRI	Providence	06:00 - 07:00PM	An Act of Providence	CD	Central Congregational Church 296 Angell Street
FRI	Providence	07:00 - 09:00PM	Grupo Un Neuve Despartar	O	Manton Avenue(233) 233 Manton Avenue
FRI	Providence	07:00 - 08:00PM	Tick-A-Topic	OD	Church of the Redeemer 655 Hope Street
FRI	Providence	07:00 - 09:00PM	Grupo Despartar Latino	O	Oficina Intergrupal Hispana De AA 273 Pocassett Ave.
SAT	Providence	07:00 - 08:00AM	Breakfast with Bill (11th Step)	OS	Our Lady Of the Rosary 463 Benefit St
SAT	Providence	08:00 - 09:00AM	It's A Good Day To Be Sober	OD	Central Congregational Church (a) 296 Angel Street

Alcoholics anonymous meetings

SAT	Providence	10:00 - 11:00AM	Day At A Time	O	Roger Williams Hospital(a) 825 Chalkstone Avenue
SAT	Providence	12:00 - 01:00PM	No Frills Sobriety(Women)	OD	Butler Hospital 345 Blackstone Boulevard
SAT	Providence	05:30 - 06:30PM	Road Of Happy Destiny	OB	Providence Presbyterian Church 500 Hope Street
SAT	Providence	06:00 - 07:00PM	ticket2sobriety	OD	Church of the Redeemer 655 Hope Street
SAT	Providence	07:00 - 09:00PM	Grupo Despartar Latino	O	Oficina Intergrupal Hispana De AA 273 Pocassett Ave.
SAT	Providence	07:00 - 09:00PM	Grupo Un Neuve Despartar	O	Manton Avenue(233) 233 Manton Avenue
SAT	Providence	07:30 - 08:30PM	Brothers in Sobriety (Gay Men)	OD	Central Congregational Church 296 Angell Street
SAT	Providence	08:00 - 09:00PM	Booze Busters	OD	Saint Augustine Church 635 Mount Pleasant Avenue
SAT	Providence	10:30 - 11:45PM	Saturday Night Live	OD	Providence Presbyterian Church 500 Hope Street

Peer-to-peer support programs

Places where you can get support from other people in recovery, including support from a Certified Peer Recovery Specialist.

East Bay Recovery Center (St. Michael's Parish)

378 Hope St, Bristol, RI 02809

(401) 302-6231

Hours: Mon 1:00PM–4:00PM | Tues 9:00AM–Noon | Wed 1:00PM–4:00PM| Thurs 5:00PM–8:00PM

The Serenity Center

245 Main St, Woonsocket, RI 02895

(401) 332-6478

Hours: Sat and Sun: Noon–5:00PM | Thurs and Fri: 4:00PM–8:00PM

Anchor Recovery Community Center

1280 N. Main St, Providence, RI

(401) 721-5100

Hours: Mon–Sat 9:00AM–4:00PM

890 Centerville Rd, Warwick, RI

(401) 615-9945

Hours: Mon–Fri 9:00AM–4:00PM

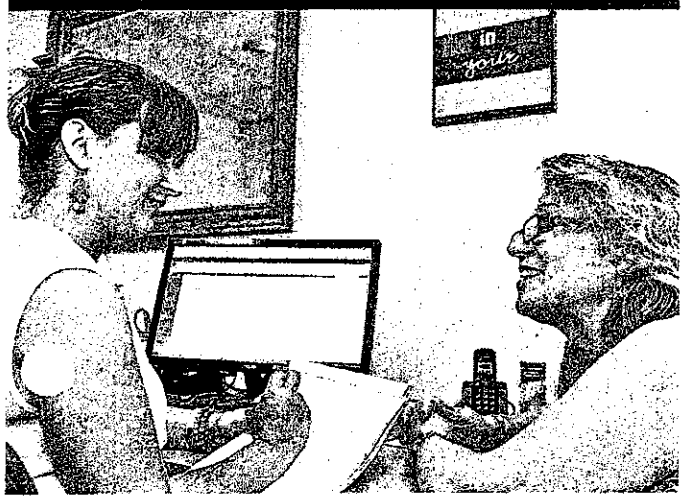
Parent Support Network (PSN) Hope Recovery Center of Newport County

50 Washington Sq, Newport, RI

(401) 619-1343

Hours: Mon–Fri 9:00AM–5:00PM

Connecting overdose survivors with the support they need



Anchor ED

AnchorED has helped connect hundreds of overdose survivors with the support they need to begin the road to recovery.

Recovery specialists are called in when individuals are transported to a hospital's emergency department after having survived an opiate overdose. In the ED, our specialized coaches provide Narcan training, referrals to treatment and recovery support to patients and families.

AnchorED's recovery coaches are on-call at the following hospitals: Kent, Memorial, Rhode Island, Miriam, Newport, Hasbro, Fatima, Roger Williams, Landmark, Westerly and South County.

c ⅞ of patients approached in the ER by AnchorED coaches sought further treatment after being released from the hospital.

Anchor

Recovery Community Center

peer-to-peer support services

Anchor Pawtucket

249 Main St, Pawtucket, RI 02860

(401) 721-5100

Anchor Warwick

890 Centerville Rd, Warwick, RI 02886

(401) 615-9945

www.anchorrecovery.org

info@anchorrecovery.org

Anchor Recovery is a program of The Providence Center, providing adults children and families community based mental health and substance abuse services.

Anchor Recovery Community Center

The Providence CENTER

PR-80.06 (4-2017)

Anchor

Recovery Community Center

peer-to-peer support services

Leading the way to recovery with peer-to-peer support services.

The Providence CENTER

Healthy minds for healthy lives

www.anchorrecovery.org

Anchor

Recovery Community Center

peer-to-peer support services

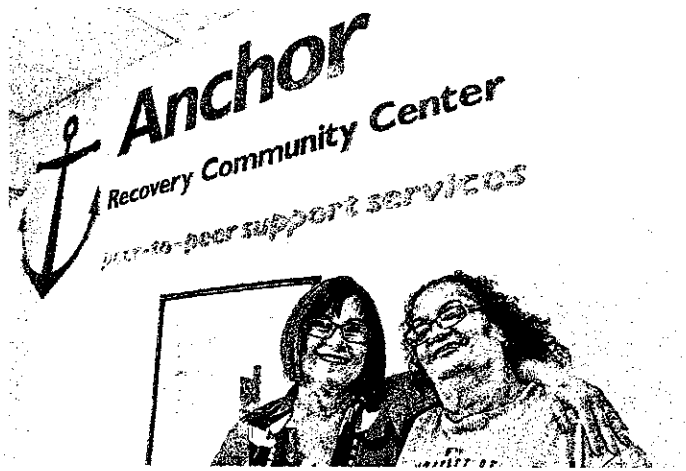
About us

Anchor Recovery Community Center is a supportive community of individuals dedicated to providing addiction recovery assistance where ·d when they are needed most.

At any Anchor location, you will find people who have changed their lives for the better and want to help others do the same.

Anchor members encourage each other to find new ways of living through meaningful relationships, health and wellness activities, social events and a sense of community.

With programs in Pawtucket, Warwick, the DOC and in hospitals across Rhode Island, Anchor has recovery coaches, support groups and access to resources available for people in all stages in recovery.



Anchor Pawtucket

[illegible] Main St, Pawtucket, RI 02860

Anchor Pawtucket is a peer-led recovery community center offering members access to: employment counselors, peer recovery specialists and health and wellness educators all in a safe and supportive environment.

The Pawtucket location holds a variety of support groups including:

- *Alcoholics Anonymous*
- *Narcotics Anonymous*
- *12 Step groups*
  All Recovery groups
- *Specialized groups for LGBT, veterans, Latinos and women*

Anchor Warwick

890 Centerville Rd, Warwick, RI 02886

Anchor Warwick is a wellness-focused program in partnership with the Kent County YMCA. The goal of this program is to promote overall health and wellness for people in recovery. The Y offers reduced-fee membership to Anchor Warwick members.

Through this partnership, members are connected to the YMCA's Health Navigators who help them learn about wellness programs options. Anchor Warwick also offers support groups that address the specific needs of women and veterans.

Anchor Consulting Services

[illegible]hor also offers consulting packages to assist colleagues around the country in developing recovery services. Our expertise can help you take your ideas for recovery solutions in your area from the drawing board to reality.

Recovery Coaches

Recovery coaches play a vital role in connecting individuals to positive resources in the commun to ensure continued recovery. Our coaches have lived experience and have chosen to support positive change, build community support and help their peers focus on life goals that will lea to a strong foundation for a substance free life.

Anchor Pawtucket is the hub for recovery coach training in Rhode Island. Through the Anchor Recovery Coach Academy training program, pee may become state-certified recovery coaches.

Anchor MORE

Anchor MORE (Mobile Outreach Recovery Ef is Anchor's new statewide outreach initiative which peer recovery specialists go out into the community and talk with individuals who suffer from the disease of addiction. Interactions often lead to treatment and recovery support services such as 12 step meetings, detox, recovery housin recovery coaching and Anchor. This mobile effo reaches all 38 towns of Rhode Island.

AnchorMORE staff visit places like soup kitchens shelters, bus stations and needle exchanges, and these efforts result in over 500 conversations in the community each month. AnchorMORE also provides distribution of naloxone (Narcan) and education of overdose prevention strategies.

Anchor Recovery Community Center hosts a wide range of social events including craft making, commu nity service projects and support rallies.

Centers of Excellence

for the treatment of opioid use disorder

Rhode Island Centers of Excellence (COE) —A Center of Excellence (COE) is a specialty center that uses evidence-based practices and is responsible for providing treatment to and the coordination of care to individuals with moderate to severe opioid use disorder.

The goal is to ensure timely access to appropriate, high-quality Medication-Assisted Treatment (MAT) such as Buprenorphine, Methadone or Naltrexone. Locations:

CODAC: Call Line (401) 490-0716 ~ 7:00 am -7:00 pm

CODAC hours are: Monday, Tuesday, Thursday 5:30am - 830pm; Wednesday 5:30am - 8pm; Friday 5:30am - 5pm
COE at Eleanor Slater Hospital hours are listed below

- **CODAC Cranston**– 1052 Park Avenue, Cranston, RI 02910
- **CODAC Providence**– 349 Huntington Avenue, Providence, RI 02909
- **CODAC Newport**– 93 Thames Street, Newport, RI 02840
- **CODAC East Bay**– 850 Waterman Avenue, East Providence, RI 02914
- **CODAC North Main**– 528 North Main Street, Providence, RI 02904
- **CODAC South County**– 350 Columbia Street, Wakefield, RI 02879
- **CODAC at Eleanor Slater Hospital**– 111 Howard Avenue, Cranston, RI 02920 ~ Open Mon. — Fri. 8:00 am – 12 noon

Community Care Alliance: Call Line (401) 235-7120 ~ 24/7

Main Address: 800 Clinton St., Woonsocket, RI 02895 – Walk-in Assessments 8:00-2:00 pm

Mon - Fri: 8:00 AM - 2:30 PM (Assessment/Intake)

Mon - Fri: 8:00 AM - 4:30 PM (Program Hours)

Care New England Recovery Stabilization Center: Call line (844) 401-0111 ~ 24/7

Main Address: 345 Blackstone Blvd, Providence, RI

Butler Campus Providence & North Kingstown Out-Patient Center

RECOVERY & HOPE HOTLINE NUMBER: 401-942-STOP 24/ 7

Individual & Family Support- English/Spanish

For more information go to : www.preventoverdoseri.org

Project Link

Project Link is an outpatient treatment program that specializes in improving the health and well-being of pregnant women and women with young children who are impacted by substance abuse and mental health issues.

Services include:

- Intensive outpatient treatment
- Outpatient treatment
- Group and individual therapy
- Case management
- Parenting and self-care education

On-site child care is provided.

To request an appointment, please call our Intake Department at 401-276-4020

Project Link provides specialized outpatient treatment for pregnant women and women with young children who are working to overcome substance use and mental health issues. Intensive outpatient and non-intensive outpatient services help improve the health and well-being of new moms. Services include individual and group therapy, case management, and parenting and self-care education. On-site child care is also available to remove barriers to treatment.

The program joins The Providence Center's comprehensive continuum of recovery-focused mental health and substance use treatment services and expands the service offerings for women in recovery. "Adding Project Link to our service offerings allows us to expand our services for a population in our community that has a unique set of needs," said Holly Fitting, associate vice president for recovery and residential services at The Providence Center. "Women in recovery have been the focus of our of Women's Day Treatment program for many years and we are eager to support more women and moms as they overcome the challenges of addiction."

"Project Link was found in 1991 specifically to provide care for a very vulnerable population, and the impact that this program and our providers has had is immeasurable," said Margaret Howard, Ph.D., director of the Division of Women's Behavioral Health at Women & Infants Hospital. "As the services are transitioned to our Care New England colleagues at The Providence Center, we are confident that existing and new patients in need of the specialized services will continue to receive the same level of compassion and care that has been the hallmark of Project Link."

2019

8. RI Family Support Program Resources

SBIRT/OB RESOURCE GUIDE

First Connections

We can help

- **Get** answers to questions about your child's growth and development
- **Prepare** for the demands of parenthood
- **Plan** for a healthy delivery
- **Get** support with the challenges of breastfeeding
- **Connect** you and your baby to health services
- **Set** healthy sleep patterns
- **Cope** with feeling down, depressed or hopeless
- **Help** your baby grow and learn
- **Find** good childcare
- **Meet** your everyday needs and reach your parenting goals
- **Connect** you with resources and serices to give you and your child every possible advantage

How this works

We reach out soon after your child is born. Our nurses and trained specialists are available to meet with you at your home or in another place in the community. Interpreting services are available.

Who we help

Pregnant women, mothers, families, and caregivers with children up to age three.

Cost

Free

Where to get First Connections

- Barrington: Visiting Nurse Home and Hospice
- Bristol: Visiting Nurse Home and Hospice
- Burrillville: Community Care Alliance
- Central Falls: Children's Friend
- Charlestown: South County Home Health
- Coventry: South County Home Health
- Cranston: Family Service of RI

- Cumberland: Community Care Alliance
- East Greenwich: South County Home Health
- East Providence: Children's Friend
- Exeter: South County Home Health
- Foster: Community Care Alliance
- Glocester: Community Care Alliance
- Hopkinton: South County Home Health
- Jamestown: Visiting Nurse Home and Hospice
- Johnston: Community Care Alliance
- Lincoln: Community Care Alliance
- Little Compton: Visiting Nurse Home and Hospice
- Middletown: Visiting Nurse Home and Hospice
- Narragansett: South County Home Health
- New Shoreham: South County Home Health
- Newport: Visiting Nurse Home and Hospice
- North Kingstown: South County Home Health
- North Providence: Community Care Alliance
- North Smithfield: Community Care Alliance
- Pawtucket: Children's Friend
- Portsmouth: Visiting Nurse Home and Hospice
- Providence: Family Service of RI
- Richmond: South County Home Health
- Scituate: Community Care Alliance
- Smithfield: Community Care Alliance
- South Kingstown: South County Home Health
- Tiverton: Visiting Nurse Home and Hospice
- Warren: Visiting Nurse Home and Hospice
- Warwick: South County Home Health
- West Greenwich: South County Home Health
- West Warwick: South County Home Health

- Westerly: South County Home Health
- Woonsocket: Community Care Alliance

Healthy Families America

We can help

-
- **Strengthen** your family and your parenting skills

How this works

Family visitors listen and respond to family needs and goals; encourage and offer support to parents to create a home environment that promotes their child's healthy growth and development; and link parents and families to community resources and supports.

Who we help

Pregnant women and families with infants or young children (up to age 4)

Cost

Free

Where to get Healthy Families America

- Barrington: East Bay Community Action Program
- Bristol: East Bay Community Action Program
- Burrillville: Community Care Alliance
- Central Falls: Blackstone Valley Community Action Program
- Central Falls: Children's Friend
- Charlestown: South County Home Health
- Coventry: Comprehensive Community Action Program
- Cranston: Comprehensive Community Action Program
- Cumberland: Blackstone Valley Community Action Program
- East Greenwich: South County Home Health
- East Providence: East Bay Community Action Program
- Exeter: South County Home Health
- Foster: Community Care Alliance
- Glocester: Community Care Alliance
- Hopkinton: South County Home Health

- Jamestown: East Bay Community Action Program
- Johnston: Community Care Alliance
- Lincoln: Blackstone Valley Community Action Program
- Little Compton: East Bay Community Action Program
- Middletown: East Bay Community Action Program
- Narragansett: South County Home Health
- New Shoreham: South County Home Health
- Newport: East Bay Community Action Program
- North Kingstown: South County Home Health
- North Providence: Community Care Alliance
- North Smithfield: Community Care Alliance
- Pawtucket: Blackstone Valley Community Action Program
- Pawtucket: Children's Friend
- Pawtucket: The Providence Center
- Portsmouth: East Bay Community Action Program
- Providence: Blackstone Valley Community Action Program
- Providence: Children's Friend
- Providence: Family Service of RI
- Providence: Meeting Street
- Providence: The Providence Center
- Richmond: South County Home Health
- Scituate: Community Care Alliance
- Smithfield: Community Care Alliance
- South Kingstown: South County Home Health
- Tiverton: East Bay Community Action Program
- Warren: East Bay Community Action Program
- Warwick: Comprehensive Community Action Program
- West Greenwich: South County Home Health
- West Warwick: Comprehensive Community Action Program
- West Warwick: Family Service of RI

- Westerly: South County Home Health
- Woonsocket: Community Care Alliance

Nurse-Family Partnership

We can help

- **Appreciate** your strengthes as a mom
- **Get** the resources your baby needs

How this works

Assist pregnant women to find prenatal care and become more knowledgeable about pregnancy as well as labor and delivery. Provide knowledge and support around child growth and development and link families with social services and community resources.

Who we help

First-time mom and are less than 28 weeks pregnant up until the child turns 2. Fathers and other family members may join in the visits.

Cost

Free

Where to get Nurse-Family Partnership

- Statewide: Children's Friend

Parents As Teachers

We can help

- **Set** goal and achieve goals for your family, know about fun healthy activities to do with your child, and meet other families with young children,

How this works

Parent Educators listen and respond to family needs and link families with: medical homes to ensure children are receiving well-child visits and health screenings, community resources and social supports, and other families with young children.

Who we help

Pregnant women and parents with children (up to age 4) and (some programs serve families with children up to age 5)

Cost

Free

Where to get Parents As Teachers

- Barrington: East Bay Community Action Program
- Bristol: Bristol Warren Regional School Department
- Central Falls: Blackstone Valley Community Action Program
- Charlestown: Westerly Public Schools, Tower Street School Community Center
- Coventry: Comprehensive Community Action Program
- Cranston: Comprehensive Community Action Program
- Cumberland: Connecting for Children and Families
- East Greenwich: Westerly Public Schools, Tower Street School Community Center
- East Providence: East Bay Community Action Program
- Exeter: Westerly Public Schools, Tower Street School Community Center
- Hopkinton: Westerly Public Schools, Tower Street School Community Center
- Jamestown: East Bay Community Action Program
- Johnston: Connecting for Children and Families
- Lincoln: Connecting for Children and Families
- Little Compton: East Bay Community Action Program

- Middletown: East Bay Community Action Program
- Newport: East Bay Community Action Program
- North Kingstown: North Kingstown School District, Office of Family Learning
- North Providence: Connecting for Children and Families
- North Smithfield: Connecting for Children and Families
- Pawtucket: Blackstone Valley Community Action Program
- Providence: Blackstone Valley Community Action Program
- Providence: Federal Hill House
- Richmond: Westerly Public Schools, Tower Street School Community Center
- Smithfield: Connecting for Children and Families
- South Kingstown: Westerly Public Schools, Tower Street School Community Center
- Tiverton: East Bay Community Action Program
- Warren: Bristol Warren Regional School Department
- Warwick: Warwick Public Schools
- West Greenwich: Westerly Public Schools, Tower Street School Community Center
- West Warwick: Comprehensive Community Action Program
- Westerly: Westerly Public Schools, Tower Street School Community Center
- Woonsocket: Connecting for Children and Families

RI HEAD START & EARLY HEAD START PROGRAMS

RI Head Start & Early Head Start Programs

Early Head Start serves low-income infants and toddlers up to age three and their families. The program is available in some Rhode Island communities. There are not enough spaces to serve everyone who is eligible, so children and families are prioritized for enrollment based on risk factors.

Head Start offers preschool to low-income children who are ages 3 and 4. The program is statewide and is free. There are not enough spaces to serve everyone who is eligible, so children and families are prioritized for enrollment based on risk factors.

Use this list to identify Early Head Start/Head Start programs available in your community. Openings can occur throughout the school year. Contact the Early Head Start/Head Start program that serves your community to apply for enrollment.

Head Start/Early Head Start Programs in Rhode Island

East Bay Head Start

8 John H. Chafee Blvd
Newport, RI 02840
401-367-2001

70 Turner Avenue
East Providence, RI 02915
(401) 649-4233

1048 Stafford Road
Tiverton, RI 02878
401-624-4736

386 Willett Avenue
East Providence, RI 02915
(401) 437-0018

790 Main Street
Warren, RI 02885
(401) 245-2833

740 West Main Road
Middletown, RI 02842
(401) 619-1670

Woonsocket Head Start

Karen G. Bouchard Children's Center
204 Warwick Street
Woonsocket, RI 02895
401.769.1850
(Head Start and State Pre-K)

Cass Park Center
350 Newland Avenue
Woonsocket, RI 02895
401.766.0112
(Head Start only)

Benoit-Brown Children's Center
2390 Mendon Road
Woonsocket, RI 02895
401.765.8730
(Child Care only)

Bourdon Blvd. Center
2 Bourdon Blvd.
Woonsocket, RI 02895
401.767.1018
(Head Start only)

Children's Friend Early Head Start/Head Start

Families participate in weekly scheduled home visits that support parents in their role as their children's first teachers. This service focuses on parents' goals for their own education, job skills, and overall family needs. Parents receive health and nutrition information and services to ensure optimal growth for children and their families.

Families are invited to a weekly play group. After sharing an activity with their children, parents leave them in the care of a teacher and have the opportunity to participate in a discussion group, which focuses on parenting skills and reducing stress.

Who is eligible?

- Families living in Central Falls, Pawtucket and Providence
- Pregnant woman
- Families with a child under age 3
- Families must meet income guidelines

Children with disabilities are welcomed and included in all aspects of Early Head Start. The staff works with parents and specialists to plan a program tailored to each child's needs.

For more information contact Malia Goodwin at 401.752.7500 or mgoodwin@cfsri.org.

Head Start's comprehensive child and family development services promote school readiness in low-income preschool children. Services include education, health, nutrition, social services, and other child and family supports. A number of options are available in order to meet the needs of families and children. Most children participate in a traditional center-based preschool classroom. Some children, whose parents are working, or in school or vocational training, participate in an extended day program at a Children's Friend location or with our Child Care/ Head Start partners.

Who is eligible?

- Families living in Providence, Pawtucket, Central Falls, Cumberland and Lincoln
- Children ages 3 – 5 years of age
- Children with disabilities

- Homeless children
- Families must meet income guidelines

For more information contact Stacy Del Vicario at 401.752.7500 or email headstart@cfsri.org.

The Tri-County Community Action Agency Head Start

Our exceptional team of Head Start educators works with families and children to implement developmental and socialization strategies that work best for you and your child. Our classrooms are bright and inviting and are designed to maximize creativity and learning. Healthy lunches and snacks are provided to children daily. In addition to providing educational and nutritional resources, children will have access to health and dental screenings at no cost, and families will be provided with health referrals and referrals for emergency services whenever needed. We recruit families 12 months per year.

Eligibility Guidelines: The programs service families with income at or below the federal poverty guidelines, children in living in foster care, and families experiencing homelessness. Ten percent of enrollment slots must be filled with children with a diagnosed disability.

Northern Rhode Island:

The Head Start program services 134 children in five classrooms across northern Rhode Island. Children from ages three to five years of age, who reside in the towns of Johnston, North Providence, Smithfield, North Smithfield, Burrillville, Glocester, Foster, and Scituate, are eligible for the northern RI Head Start program. For more information, contact us at 401-519-1979.

Southern Region:

The Tri-County Community Action Agency Head Start Program provides a center-based, comprehensive early childhood education program for 76 children from ages three to five years old, who reside in the towns of North Kingstown, South Kingstown, Narragansett, Hopkinton, Richmond, Exeter, Charlestown, Westerly, and New Shoreham. For more information, contact us at 401-515-2471.

C.H.I.L.D. Inc.

C.H.I.L.D., Inc. operates four centers conveniently located to offer programming through out the Kent County Region. We have two centers in Warwick, along with centers in West Warwick, and Coventry.

160 Draper Avenue
Warwick, RI 02889
401 732-5200
401 737-2302 (Fax)

849 Centerville Road
Warwick, RI 02886
401 823-3777
401 823-5908 (Fax)

28 Payan Street
West Warwick, RI 02888
401 828-2888
401 826-4887 (Fax)

23 Cady Street
Coventry, RI 02816
401 823-3228
401 826-8920 (Fax)

RI EARLY INTERVENTION

RI Early Intervention

RI's Early Intervention Program promotes the growth and development of infants and toddlers who have a developmental delay or disability in one or more areas. Developmental delays can affect a child's speech, physical abilities, or social skills. Children referred to the Early Intervention Program receive a comprehensive developmental evaluation to determine if they are eligible. The program is open to families of all incomes. Services are offered at home or in community-based settings. To request an evaluation, contact an Early Intervention provider serving your area of Rhode Island.

Rhode Island Executive Office of Health and Human Services

Central Directory of Early Intervention Providers

ei
early intervention

Children's Friend & Service
621 Dexter Street
Central Falls, RI 02863-2608
Ph. 721-9200
Fax. 729-0010
Director: Natalie Redfearn Ph. 721-9294
Supervisor: Christine Crehan Ph.721-9229
Supervisor: Kristyn Gontarek Ph. 721-9211
Parent Consultant: Open

Community Care Alliance
(formerly Family Resources Community Action)
245 Main Street
Woonsocket, RI 02895-3123
Referral Line: 235-6029
Ph. 235-7000 , Fax. 766-8737
Director: Darlene Magaw Ph. 767-4078
Program Manager: Marcia Card Ph. 235-6007
Supervisor: Linda Majewski Ph. 235-6026
Supervisor: Jennifer Speaks Ph. 235 6028
Parent Consultant: Denise Bouley Ph. 235-6012

Easter Seals, RI
213 Robinson Street
Wakefield, RI 02879
Ph. 284-1000, Fax. 284-1008
Director: Sue Hawkes x11
Supervisor: Tara McGarty x12
Parent Consultant: Open

Family Service of RI
134 Thurbers Avenue
Providence, RI 02905-4754
Referral line: 519-2307
Referral line for Spanish speaking families: 519-2308
Fax. 277-3388
Director: Jenn Kaufman x3358
Supervisor: Monique DeRoche x3343
Supervisor: Rebecca Collins x3353
Parent Consultant: Open

The Groden Center
30 Livingston Street
Providence, RI 02904
Ph. 525-2380, Fax: 525-2382
Director: Leslie Weidenman Ph. 274-6310 x1008
Supervisor: Carol LaFrance Ph. 525-2380
Parent Consultant: Lynette Kapsinow Ph. 680-3202

All phone numbers are area code (401)

Looking Upwards, Inc.
2874 East Main Road
Portsmouth, RI 02871
Mailing Address: PO Box 838
Portsmouth, RI 02871
Ph. 293-5790, Fax: 293-5796
Director: A. Valory McHugh x330
Supervisor: Carolyn Souza x310
Parent Consultant: Susan Plunkett Ph. 474-4703

Meeting Street
1000 Eddy Street
Providence, RI 02905
Ph. 533-9100, Fax. 533-9105
Referral line: 533-9104
Director: Casey Ferrara Ph. 533-9252
Supervisor: Nicole Constantino Ph. 533-9169
Supervisor: Jennifer Demello Ph. 533-9210
Supervisor: Antonio Martins Ph. 533-9281
Supervisor: Amanda Silva Boisvert Ph. 533-9172
Parent Consultant: Cris Faxas Ph. 533-9244
Parent Consultant: Pamela Doner Ph. 533-9266

Seven Hills Rhode Island
178 Norwood Ave.
Cranston, RI 02905
Ph. 921-1470, Fax: 762- 0837
Director: Laurie Farrell x7206
Supervisor: Lynne Gilpatrick x7213
Supervisor: Amanda Hall x 7214.
Parent Consultant: Michele Daveluy

Seven Hills Rhode Island
30 Cumberland Street
Woonsocket, RI 02895
Ph. 921-1470, Fax: 762- 0837

J. Arthur Trudeau Memorial Center
3445 Post Road
Warwick, RI 02886
Ph. 823-1731, Fax. 823-1849
Director: Pat Maris x 268
Supervisor: Kate Donaldson x 208
Supervisor: Marie Preneta x 370
Supervisor: Susan Quinn x364
Parent Consultant: Jenn Franchetti Ph. 378-2475

RI Early Intervention, Lead Agency
Executive Office of Health and Human Services
Center for Child and Family Health
Hazard Building #74
74 West Road, Cranston, RI 02920
Part C Coordinator and Chief, Family Health Systems: Brenda DuHamel Ph. 462-0318

Rhode Island Executive Office of Health and Human Services

Early Intervention Coverage Areas by City/Town

Families can choose Early Intervention (EI) providers who serve the city/town in which they live. By utilizing one of these providers, familes will work with professionals who have the best knowledge of services, activities and educational opportunities within their community. All of RI's Early Intervention (EI) providers offer the same services to all families.

City/Town	RI Early Intervention Program							
Barrington	Family Service	Looking Upwards	Meeting Street	Seven Hills	Groden Center			
Bristol	Meeting Street	Family Service	Groden Center	Looking Upwards	Seven Hills			
Burrillville	Community Care Alliance	Seven Hills	Looking Upwards	Groden Center				
Central Falls	Children's Friend & Service	Family Service	Groden Center	Looking Upwards	Meeting Street	Seven Hills		
Charlestown	Easter Seals	Looking Upwards	Seven Hills	Trudeau Center				
Coventry	Easter Seals	Trudeau Center	Seven Hills	Looking Upwards	Groden Center			
Cranston	Groden Center	Children's Friend & Service	Easter Seals	Family Service	Looking Upwards	Meeting Street	Seven Hills	Trudeau Center
Cumberland	Meeting Street	Family Service	Children's Friend & Service	Groden Center	Community Care Alliance	Seven Hills	Looking Upwards	
E.Greenwich	Trudeau Center	Easter Seals	Looking Upwards	Family Service	Seven Hills	Groden Center	Meeting Street	
E.Providence	Groden Center	Children's Friend & Service	Seven Hills	Meeting Street	Family Service	Looking Upwards		
Exeter	Easter Seals	Trudeau Center	Seven Hills	Looking Upwards				
Foster	Community Care Alliance	Seven Hills	Looking Upwards	Groden Center				
Glocester	Seven Hills	Community Care Alliance	Looking Upwards	Groden Center				
Hopkinton	Looking Upwards	Trudeau Center	Easter Seals	Seven Hills				
Jamestown	Trudeau Center	Looking Upwards	Easter Seals	Seven Hills				
Johnston	Meeting Street	Children's Friend & Service	Community Care Alliance	Family Service	Seven Hills	Looking Upwards	Groden Center	
Lincoln	Community Care Alliance	Meeting Street	Children's Friend & Service	Family Service	Seven Hills	Groden Center	Looking Upwards	
L.Compton	Looking Upwards	Seven Hills						
Middletown	Looking Upwards	Seven Hills	Easter Seals					

2019

9. State of RI DCYF Infant Plans of Safe Care

SBIRT/OB RESOURCE GUIDE

STATE OF RHODE ISLAND

DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

INFANT PLANS OF SAFE CARE

GUIDANCE DOCUMENT

1.1 PURPOSE

In accordance with federal laws Child Abuse and Prevention Treatment Act (CAPTA, Pub. Law 93-247) and Comprehensive Addiction and Recovery Act (CARA, Pub. Law 114-198), and Rhode Island General Laws § § 40-11-2, 40-11-6, 40-11-7, 42-72-8, the Department of Children, Youth and Families (hereinafter the DCYF) must identify infants at risk of child abuse and neglect as a result of prenatal substance exposure, ensure that a Plan of Safe Care (POSC) is developed for these infants, and ensure the referral of these infants and affected caregivers to appropriate services.

All substance exposed newborns must have a Plan of Safe Care (POSC) at the time of discharge from the birth hospital. Plans of Safe Care are developed at discharge by addressing supports in place for the health needs of the newborn, and substance use disorder treatment needs of the parent and/or caregiver. POSC may include services such as home visitation, early intervention services, and recovery supports.

The Rhode Island Department of Health (RIDOH) is assisting in the State's efforts to implement Plans of Safe Care.

RIDOH is responsible for collecting data on POSC and providing to the DCYF the aggregate data to submit to the federal office of the Administration of Children and Families.

This Guidance Document is intended to describe the responsibilities of the DCYF, RIDOH, healthcare providers, and birth hospitals in accordance with federal and State laws.

1.2 DEFINTIONS

"Affected by Substance Abuse" means the presence of any of the following in the mother:

1. Misuse of a legal substance
2. Use of an illicit substance

"Affected by Withdrawal" means a group of behavioral and physiological features in the infant that follow the abrupt discontinuation of a substance that has the capability of producing physical dependence. No clinical signs of withdrawal in the neonate should be attributed to in utero exposure to alcohol or other drugs without appropriate assessment and diagnostic testing to rule out other causes.

"Fetal Alcohol Spectrum Disorders (FASD)" means the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

"Substance Exposed Newborn" means a newborn who was exposed to alcohol and/or a controlled substance (illicit or prescribed) ingested by the mother in utero. This exposure may be detected at birth through a drug screen or through withdrawal symptoms.

"Neonatal Abstinence Syndrome" means a group of signs and symptoms that sometimes occur in a newborn who was exposed to opiate drugs while in utero.

"Healthcare Provider" means any provider of healthcare services involved in the delivery or care of infants and/or care of children.

"Plan of Safe Care" means the document to be completed by the newborn healthcare provider for each substance exposed newborn at the time of discharge from the birth hospital.

1.3 HOSPITAL ALERTS

A. The DCYF may receive a report to the Child Protective Services (CPS) Hotline alleging drug and/or alcohol abuse by a woman during her pregnancy. An investigation is initiated during pregnancy only if there are specific allegations of abuse and/or neglect of existing children in the home. An investigation may not be initiated during pregnancy if there are no children in the home. However, the DCYF employs a system of alerting hospitals to pregnant women for whom there is a potential for child safety concerns after birth. A hospital alert is issued in the following circumstances:

1. There is a history of chronic substance use by one or both parents.
2. When one or both parents has a history of indicated child abuse/neglect.
3. When one or both parents has a child abuse/neglect conviction.
4. There are concerns about the safety of the child after delivery.

1.4 REQUIRED REPORTING TO THE DCYF CPS HOTLINE

A. A Child Protective Services report must be made to the CPS Hotline for any substance exposed newborn for whom there are concerns for child abuse or neglect as defined in *RIGL 40-11-2 Definitions*.

B. A report to the CPS Hotline is required in the following circumstances:

1. A newborn with a positive toxicology screen for maternal illegal, non-prescribed, and/or misused prescribed controlled substance(s).
2. A newborn with clinical signs or symptoms of drug withdrawal as the result of prenatal exposure to illegal, non-prescribed, or misused prescribed controlled substance(s), and/or due to undetermined substance exposure.
3. A mother of a newborn tests positive for an illegal or non-prescribed controlled substance and/or misused prescribed controlled substance and the infant has not tested positive.
4. A newborn is diagnosed with fetal alcohol spectrum disorder.
5. There are any safety concerns.

1.5 COMPLETION OF A PLAN OF SAFE CARE

A. A Plan of Safe Care (POSC) must be completed by the newborn healthcare team prior to discharge from the birth hospital for each substance exposed newborn.

B. Situations that require a POSC, **but not a CPS report to the Hotline**, include:

1. Mother is engaged in medication-assisted treatment for substance use disorder and there are no safety concerns.
2. Mother is taking opioids as prescribed by her clinician and there are no safety concerns.
3. Mother is taking any medication or combination of medications as prescribed by her clinician and there are no safety concerns.

C. A POSC must include referrals to services and supports for the substance exposed newborn and the caregiver affected by substance use. Examples of such services and supports include, but are not limited to, home visiting programs, early intervention services, and recovery supports.

D. The POSC is provided to the newborn's caregiver at the time of newborn hospital discharge.

E. A copy of the POSC must be documented in the newborn's hospital medical record.

F. A copy of the POSC must be given to the newborn's primary care provider.

G. A copy of the POSC must be given to DCYF for all infants with an open case to DCYF.

H. A parent or guardian may consent to release of a copy of the POSC to other treatment and service providers.

1.6 RIDOH POSC DATA SUBMISSION TO THE DCYF

A. Federal law requires information on POSC to be submitted to the DCYF for data tracking purposes and reporting to the Administration for Children and Families. RIDOH is responsible for collecting information on POSC from Rhode Island birth hospitals and for aggregating and submitting these data to DCYF quarterly.

B. Data submission from RIDOH to DCYF must include the number of SENs, including the number diagnosed with NAS and FASD prior to release from the birthing hospital, the number of POSCs completed, and the number and types of service referrals included on the POSCs.

1.7 POSC ONGOING MONITORING OF STATE IMPLEMENTATION

A. DCYF, RIDOH, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Executive Office of Health and Human Services, with input from birthing hospital staff, will meet regularly to review the aggregate data on SEN and POSC, the POSC process, and opportunities for system improvements to support families and ongoing interagency collaboration.

ADDENDUM I

Report to Hotline* 1-800-RI-CHILD	DO NOT REPORT to Hotline RIDOH to coordinate aggregate data collection with hospitals
• A newborn has a positive toxicology screen for illegal or non-prescribed substance(s) • A newborn is treated for NAS as a result of maternal use of illegal substance(s), non-prescribed medication, or misuse of prescribed medication; or due to undetermined substance exposure • A mother of a newborn tests positive for an illegal or non-prescribed substance or misuse of a prescribed medication and the infant has not tested positive • A newborn is diagnosed with fetal alcohol spectrum disorder • Any case of a substance exposed newborn WITH safety concerns	• Mother is engaged in medication-assisted treatment with methadone or buprenorphine and there are no safety concerns • Mother is taking opioids as prescribed by her clinician and there are no safety concerns • Mother is taking any medication or combination of medications as prescribed by her clinician and there are no safety concerns

*if there are any questions as to whether to call the Hotline, please call 1-800-RI-CHILD

Plan of Safe Care
Family Care Plan

☐ Kent
☐ Landmark
☐ Newport
☐ South County
☐ WIH

Infant Name_____ **DOB**____/____/_____ **MRN**_____

The Plan of Safe Care – Family Care Plan coordinates existing supports and provides referrals to new supports that may be helpful after an infant's birth. The hospital treatment team is responsible for completing this form in consultation with the family.

Check all applicable supports and new referrals for parent(s)

Parent Supports	New Referral	Current	Discussed	N/A	Organization	Contact person (if applicable)
Safe Sleep Education			☐			
Smoking Exposure Education			☐	☐		
Smoking Cessation	☐	☐	☐	☐		
Parenting Support Group	☐	☐	☐	☐		
Family Home Visiting	☐	☐	☐	☐		
Mental Health Counseling	☐	☐	☐	☐		
Substance Use Counseling	☐	☐	☐	☐		
Peer Recovery Coach	☐	☐	☐	☐		
Medication-Assisted Treatment	☐	☐	☐	☐		
Family Treatment Drug Court	☐	☐	☐	☐		
Baby Court	☐	☐	☐	☐		
Basic Needs *(housing, food, safety, etc.)*	☐	☐	☐	☐		
Other *(behavioral health, medical, etc.)*	☐	☐	☐	☐		
Other *(behavioral health, medical, etc.)*	☐	☐	☐	☐		

Check all applicable supports and new referrals for infant (Complete *Plan of Safe Care – Foster Family Care Plan form*, if applicable.)

Infant Supports	New Referral	Current	Discussed	N/A	Organization	Contact person (if applicable)
Pediatrician	☐	☐	☐	☐		
Skilled Nursing	☐	☐	☐	☐		
Early Intervention	☐	☐	☐	☐		
First Connections	☐	☐	☐	☐		
WIC	☐	☐	☐	☐		
Brown Family Care F/U Clinic	☐	☐	☐	☐		
Other	☐	☐	☐	☐		
Other	☐	☐	☐	☐		

Plan of Safe Care was prompted by: ☐ Self-reported prenatal substance exposure ☐ Infant withdrawal signs
☐ Positive toxicology screen (infant/maternal) at, or following delivery ☐ Fetal Alcohol Spectrum Disorder diagnosis

Prenatal Substance Exposure	Prescribed	Not Prescribed	Prenatal Substance Exposure	Prescribed	Not Prescribed
Methadone	☐	☐	Illicit opioids:		☐
Buprenorphine	☐	☐			
Opioids for pain	☐	☐	Other known substance exposure(s):	☐	☐
Nicotine/tobacco		☐			
Nicotine replacement therapy	☐	☐	Suspected exposure(s):	☐	☐
Marijuana	☐	☐			
Alcohol		☐			

Complete the following section with input from family

Family Strengths *(parenting skills, employment, community supports, etc.)*

Family Goals *(breastfeeding, quit smoking, recovery, community supports, etc.)*

Comments

Plan was reviewed with family ☐ YES ☐ NO

Parent Signature **Date** **Attending Physician Signature** **Date**

White – Medical Records Yellow – Primary Care Provider Pink – RIDOH Newborn Screening Program Gold – Parent

2019

10. Resources for Foster Families and Grandparents

SBIRT/OB RESOURCE GUIDE

Fostering Families

Fostering Families provides support services for Kinship and Foster families. The goal is to address the needs of foster and kinship families with foster children who are at risk of experiencing removal during the duration of their time while open to DCYF.

Services are provided in home, and include but are not limited to:

- Linkage to community resources
- Court advocacy and case conferencing
- Intensive case management services
- Parenting and Nursing assessment/intervention/monitoring
- Mental health assessment and monitoring
- Recreational and group interventions

Eligibility requirements are:

- Children ages 0-10 years old in Foster or Kinship homes
- Pregnant or Parenting youth in Foster or Kinship homes
- Children at risk for removal due to developmental, behavioral, or medical needs

Fostering Families provides weekly to bi-weekly visits based on the need of the family and/or child. Services are statewide and can be active for up to 15 months.

For more information and/or referrals, please contact Regina Clement at 401.276.4350 or rclement@cfsri.org.

GRANDS FLOURISH™

http://www.grandsflourish.org/

Imagine, you are sitting in your living room, munching cookies, cuddled in a fuzzy blanket and a news story grabs your attention. You say to yourself: wow am I glad that's not me. And then days later you realize.. it's not a movie or a news story. **It's MY life!**

I discovered that **Rhode Island had 13,000 and 2.5 million children across the country** being cared for by grandparents or grandfamilies; mostly due to the opioid crisis .I was now part of this fuzzy demographic of caregivers. I felt like I just entered a *'child welfare twilight zone where pretty much time stood still'*. I began researching, googling and calling.

Suddenly, with little notice I was parenting again; navigating the child welfare system, juggling childcare, work, learning about substance use disorder while assimilating to new family dynamics was challenging. There were few resources; that was my 'aha' moment and where the vision for 'Grands Flourish' was born.

I envisioned a grandparent's hub, a place where grandparents can connect to community, share their stories, engage in support groups, learn about resources and celebrate successes.

Talk about connecting... just he other day I randomly selected a florist in Florida and the individual I was speaking said "you know, I was raised by my grandmother she actually owns this flower store" WOW ! Warmly – Magdalena-

Programs available:

A Grand Space Workshop

Grands Flourish Inc., is a Rhode Island nonprofit organization. Our mission is to inspire and empower grandparents raising grandchildren impacted by substance use to navigate systems, reduce barriers and foster success in their roles as caregivers.

Our 8-week complimentary sessions include informational topics, success tools and peer-led support groups where you can share your story and meet other grandparents.

Lite snacks | On-site case worker | Child watch provided * (child-watch pre-registration required).

Grandma's Closet

Grandma's Closet™ is connecting with local consignment shops, thrift stores and civic groups to help grandparents gain access to gently used clothing, backpacks, shoes and furniture for little to no cost.

In most cases, children are placed suddenly with little notice so grandparents have no time to plan for clothing needs, cribs or diapers.

Join our tribe: Grandma's Closet, Workshops, Support Groups and Fun Events.

Superhero Home Helpers

Grands Flourish is connecting with home improvement suppliers and volunteers to help with small household tasks that are too big for Wonder Woman and Spiderman.

It's a dark and scary world where evil power tools,unassembled child's beds, bicycles, dusty ceiling fans, leaky faucets and jungle lawns lurk behind every corner.

Programs That Can Help foster/kinship grandparents

Local programs that provide support, resources and assistance to grandfamilies can often be found by contacting your local school, area agency on aging, community center, faith-based organization or children's services office.

Key Programs in Rhode Island:

Foster Forward Website: www.fosterforward.net Phone: 401-438-3900 Warm Line: 1-800-655-7787 (toll-free) Service area: Statewide Description: Peer-led monthly support groups, kinship/foster parent mentor program, special events throughout the year, holiday gift campaign, and clothing closet.

Rhode Island Parent Information Network (RIPIN) Website: www.ripin.org Phone: 401-270-0101 or 1-800-464-3399 (toll-free) Email: info@ripin.org Service area: Statewide Description: Information and referral to community resources for health, education and socio-economic well-being.

The Village for RI Foster & Adoptive Families Website: www.rivillage.org Phone: 401-481-5483 Email: info@rivillage.org Service area: Statewide Description: Monthly support groups, foster parent coaching, family activities, peer mentoring and a clothing and equipment closet for free, gently used kids clothing, toys and baby equipment

2019

11. MotherToBaby Fact Sheets

SBIRT/OB RESOURCE GUIDE

MotherToBaby
Medications & More During Pregnancy & Breastfeeding
Ask The Experts

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Marijuana

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to marijuana may increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your health care provider.

What is marijuana?

Marijuana, also called pot, weed, or cannabis, is a drug that comes from the hemp plant. Parts of the plant are dried and smoked in pipes or cigarettes (joints) or sometimes eaten. It is an illegal substance in parts of the United States; however, some states allow marijuana use by prescription for medical purposes, and some states allow the sale of marijuana for recreational use.

The main active chemical in marijuana is delta-9-tetrahydrocannabinol (THC). Another component of marijuana is cannabidiol (CBD). Both THC and CBD are known to cross the placenta during pregnancy and reach the baby's system.

How much is known about the effects of marijuana on a pregnancy?

It is difficult to accurately study marijuana use during pregnancy. Marijuana contains about 400 different chemicals, and some marijuana cigarettes may contain contaminants, such as other drugs, pesticides, or fungi. Some women who use marijuana may also use alcohol, tobacco, or other drugs at the same time. Women who use marijuana during pregnancy may also have other factors that can increase pregnancy complications, such as lack of prenatal care or an unbalanced diet. In addition, marijuana has become more potent (stronger), particularly in THC content over the past years. Many growers are focusing on sinsemilla. Sinsemilla refers to growing marijuana a certain way to get a more potent (stronger) marijuana product. Therefore, studies done years ago would, in theory, be looking at marijuana that was less strong than currently being used. Finally, information on the amount, frequency, and timing of marijuana use can be difficult to accurately collect. All of these factors explain why studies looking at marijuana use during pregnancy sometimes find different results.

I am trying to become pregnant. If I or my partner uses marijuana, do I have a lower chance of becoming pregnant?

In women, long-term use of marijuana may affect the menstrual cycle and lead to a reduction in hormones involved in reproduction and fertility. In men, an association with reduced sperm count has been seen. These side effects might make it harder to get pregnant. The effects on fertility appear to go away when marijuana use is stopped.

Will smoking or eating marijuana cause birth defects in my baby?

Most studies have not found an increase in the chance for birth defects among babies prenatally exposed to "occasional" marijuana use. A few studies have suggested a small increase in the chance for gastroschisis (a rare birth defect in which the infants' intestines stick out of an opening in the abdominal wall), and one study reported an increased chance for heart defects among babies prenatally exposed to marijuana. It can be difficult to draw conclusions from these studies because most of the women who used marijuana also used other substances at the same time or had other factors that may have increased their chance for these defects. Also, the term "occasional" use is hard to quantify and might be different from person to person.

While most studies are reassuring regarding birth defects, without good studies among heavy marijuana users, and because of other potential pregnancy complications it is best to avoid marijuana during pregnancy.

Can marijuana harm the baby in any other way?

Some studies have suggested that among women who smoke marijuana cigarettes regularly, there is an increased chance for pregnancy complications such as: premature birth, low birth weight, stillbirth and small length, small head size, and death in the newborn period. Babies that are born prematurely or with low birth weight can have higher rates of learning problems or other disabilities.

Similar to what is seen with cigarette smoking, smoking marijuana may increase carbon monoxide levels in the blood, which can decrease the amount of oxygen the baby receives, and this can also affect the growth of the baby. Some studies have suggested that lower birth weight is more likely to occur among women who also smoke cigarettes in addition to their marijuana.

If I smoke marijuana in the third trimester, can it cause my baby to go through withdrawal after birth?

Some newborns exposed to marijuana have been reported to have temporary withdrawal-like symptoms, such as increased tremors and crying. These symptoms usually go away within a few days.

Can my marijuana smoking affect the brain development of the baby?

Differences in brain activity, behavior, and sleeping patterns of infants and children exposed to marijuana in pregnancy have been reported in some studies. It is believed that these children might have more problems with attention, impulsive behavior, short term memory, academic performance and difficulty at work as an adult. These problems have been seen more often in children whose mothers were "heavy" marijuana users (smoked one or more marijuana cigarettes per day). The evidence is not conclusive and some studies report conflicting results.

What happens if I use marijuana when I'm breastfeeding?

Marijuana can be passed to infants through their mother's breast milk. Marijuana may also affect the quality and quantity of breast milk that you make. There are no good studies on how marijuana in breast milk might affect a nursing baby. Although no consistent effects have been noticed in infants exposed to marijuana through breast milk, the American Academy of Pediatrics and the Academy of Breastfeeding Medicine advise that breastfeeding mothers avoid using marijuana. Be sure to talk to your health care provider about all your breastfeeding questions.

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Alcohol

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to alcohol may increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your healthcare provider.

What is alcohol?

Alcohol, ethanol and ethyl alcohol are all names for the ingredient in beer, wine, or hard liquor that gives an intoxicating effect to the drinker. The same amount of alcohol is found in a standard serving of beer, wine, or hard liquor. A standard serving is considered to be 12 ounces of beer, 4-5 ounces of wine, or 1.5 ounces of hard liquor.

Is there a safe amount of alcohol that I can drink during pregnancy?

No, there is no safe level. Alcohol crosses the placenta easily and reaches the developing baby. Differences in genetics and metabolism of alcohol by both the mother and the developing baby lead to a wide range of risks. The risk may be different even in the same mother in different pregnancies.

Can drinking alcohol make it harder for me to get pregnant?

Yes. Some studies have shown an increase in fertility problems among women with heavy alcohol exposure. It is best to avoid alcohol while trying to get pregnant.

Can drinking alcohol cause a miscarriage or pregnancy loss?

Yes. Some studies reported higher rates of miscarriage and stillbirth with alcohol use during pregnancy.

Can drinking alcohol during my pregnancy cause a birth defect?

Yes. Drinking alcohol in pregnancy is a leading cause of intellectual disability. Drinking alcohol in pregnancy puts the developing baby at risk for Fetal Alcohol Syndrome (FAS). The features of FAS include a pattern of certain birth defects: small head and body size, specific facial features, and learning and behavioral problems. FAS is the most severe outcome of alcohol use during pregnancy. When a child has some but not all of the findings of FAS, health care providers may use other terms, such as Fetal Alcohol Spectrum Disorder (FASD). The risks from heavy alcohol use (5 or more drinks a days) and binge drinking (around 5 or more drinks on an occasion) have been well established. The risks for occasional use of lower amounts of alcohol are less clear.

Are there long term issues with FAS, FASD, and FAE?

Yes. These cause lifelong challenges, such as problems with learning and poor memory. People with FAS, FASD, and FEA can have a harder time understanding the consequences of their actions, have poor judgment, and difficulty with social relationships. Higher rates of dropping out of school, mental health problems, and alcohol or drug abuse have also been reported in these individuals.

I just found out I am 6 weeks pregnant and last weekend I had one beer. Will my baby have FASD?

While there is no known safe amount of alcohol, a single drink is unlikely to cause a problem. The best thing you can do for your baby is to avoid further use of alcohol during your pregnancy.

Is binge drinking on only some days of the week as risky as drinking alcohol everyday but at lower amounts?

Yes. Binge drinking exposes the developing baby to the highest alcohol at one time. However, studies on alcohol use during pregnancy often look at weekly averages, so the effects of certain patterns of drinking alcohol are

not well studied.

Is it ok to drink after the first trimester?

No. Alcohol affects brain development. The baby's brain develops throughout the entire pregnancy. Drinking alcohol at any time in pregnancy increases the risk for the baby to have alcohol related brain damage. This means there is no safe period to drink when pregnant.

Can a baby go through withdrawal after birth?

Yes, if the mother has been drinking close to delivery. Symptoms can include tremors, increased muscle tone, restlessness and excessive crying.

How will I know if alcohol has hurt my baby?

If you are worried about the amount of alcohol you have drank during pregnancy, it is important to discuss this with your healthcare provider. Your healthcare provider may offer ultrasounds to look for birth defects and to watch the baby's growth. However, an ultrasound cannot tell if alcohol has caused intellectual disabilities, learning difficulties, or if it will affect future behavior.

Once your baby is born, tell your pediatrician about your alcohol use during pregnancy. Your child can then be evaluated for effects of prenatal alcohol exposure. Some of the problems caused by prenatal alcohol exposure, such as learning difficulties and behavioral problems are more likely to be identified as your child gets older. Your child's health care provider can continue to monitor your child over time.

Is there any hope for a baby who has been exposed to alcohol throughout pregnancy?

Yes. It is always recommended for a pregnant woman to stop her alcohol use, regardless of how far along in her pregnancy she is. The baby will benefit by no longer being exposed to alcohol. Though FAS/FASD cannot be cured, children with FAS/FASD can benefit from an early diagnosis. Being raised in a stable and nurturing home can also lead to better outcomes. Services and support are available for children with alcohol related problems.

Can I drink alcohol while breastfeeding?

This should be avoided. Drinking alcohol can make it harder for your body to make milk. Alcohol easily gets into breast milk. The amount of alcohol in the milk is about the same level of alcohol in the woman's bloodstream. Alcohol can pass back and forth from the bloodstream into the milk. Only time can reduce the amount of alcohol in the milk. Pumping and discarding, drinking water, taking caffeine, or exercising do not help your body to get rid of the alcohol faster. It takes about 2 to 2.5 hours for each standard drink to clear from breast milk. For each additional drink, a woman must wait another 2-2.5 hours per drink.

The infant brain continues to grow after birth. Effects on the baby from alcohol in breast milk are not well studied. However, some reports found that babies whose mothers drink alcohol while breastfeeding may eat less and/or have changes in their sleeping patterns. One study suggested problems with motor development following exposure to alcohol in breast milk, but other studies did not show the same results. Since breastfeeding has benefits for the baby, speak with your pediatrician about your specific alcohol intake before avoiding breastfeeding.

What if the father of the baby drinks alcohol?

There is no evidence to suggest that a father's exposure to alcohol causes birth defects. In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet Paternal Exposures at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

Please click here for references.

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E-cigarettes (Vaping)

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to e-cigarettes may increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your health care professional.

What are e-cigarettes?

Electronic cigarettes, or e-cigarettes are battery operated devices that heat a liquid solution into an aerosol (a fine spray) that you inhale (breath in), like you would inhale tobacco smoke from a traditional cigarette. E-cigarettes are known by many different names. They are sometimes called "e-cigs," "e-hookahs," "mods," "vape pens," "vapes," "tank systems," and "electronic nicotine delivery systems (ENDS)." Using e-cigarettes is sometimes referred to as "vaping."

The solutions in e-cigarettes may include chemicals such as nicotine, propylene glycol, ethylene glycol, polyethylene glycol, diacetyl, and/or glycerol; and heavy metals such as nickel, tin, and/or lead. Artificial flavorings may be added.

How does the nicotine level in e-cigarettes compare to traditional cigarettes?

It is not clear. E-cigarettes are largely unregulated, so the nicotine dose varies widely and may not match what the label says. Nicotine has been found in e-cigarettes labeled as not having nicotine, and some e-cigarettes reported to have nicotine do not. It is possible that someone could receive a higher nicotine dose with e-cigarettes compared to traditional cigarettes.

While e-cigarettes may have less cancer causing contaminants than traditional cigarettes, they may still include a number of contaminants that could pose a risk to both the health of the person using the e-cigarette and a pregnancy.

E-cigarettes are promoted as a quit smoking-aid but studies have not shown them to be effective. For this reason, plus uncertainty about the ingredients, the use of e-cigarettes is not recommended during pregnancy. Our fact sheet on tobacco cigarettes can be found at https://mothertobaby.org/fact-sheets/cigarette-smoking-pregnancy/pdf/.

Can use of e-cigarettes during pregnancy cause a miscarriage?

We do not know because there are no published studies. Studies on traditional cigarettes that include nicotine have found an increase in the chance of miscarriage.

Can use of e-cigarettes during pregnancy cause birth defects?

We do not know because there are no published studies. Traditional cigarettes that include nicotine may pose a small increase in the chance for oral clefts (a split in the lip or roof of the mouth that usually requires surgery).

Can the use of e-cigarettes cause other problems during pregnancy?

We do not know because there are no published studies. However, both animal studies with nicotine and studies with traditional cigarettes with nicotine find poor growth of the developing baby. This is thought to be due to lower amounts of blood and oxygen crossing the placenta.

Can use of e-cigarettes during pregnancy cause later learning problems for the baby?

We do not know because it has not been studied. Some studies have linked traditional cigarettes with nicotine to higher chances for attention deficit disorder and learning disabilities.

Are there any resources or medical treatments available to help me to quit e-cigarettes and tobacco cigarettes during my pregnancy?

Yes. Talk with your healthcare provider about your thoughts on quitting. There is also free advice, support and referrals, with the Smoker's Quitline at 1- 800-QUIT-NOW (1-800-784-8669) from anywhere in the U.S. While these resources focus on tobacco cigarettes, nicotine is the addictive chemical in both e-cigarettes and tobacco cigarettes, so they can still provide help regarding e-cigarettes.

Can I use e-cigarettes when I am breastfeeding?

E-cigarette use during breastfeeding has not been studied. The best and safest approach is to not use e-cigarettes while breastfeeding. Nicotine does pass into breast milk. Studies have shown that infant heart rate and blood pressure changes have been associated with increased nicotine concentrations in milk. Be sure to talk to your healthcare provider about your breastfeeding questions.

Is there a concern if my partner is using e-cigarettes?

There is no information to answer this question. Men who smoke traditional cigarettes with nicotine can have lower sperm counts, as well as abnormal shape and movement of sperm, which may make becoming pregnant more difficult. It is not yet known if second hand exposure to e-cigarettes poses a risk to your pregnancy or the baby after birth. Studies are unclear about the level of exposure using e-cigarettes provides to a nearby person. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

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Heroin

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to heroin might increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your health care provider.

What is heroin?

Heroin is a highly addictive opioid. It is smoked, snorted or injected. Street names for heroin include smack, dope, mud, horse, skag, junk, H, black tar, and skunk among others. In the United States, it is an illegal substance and is not available by prescription. This fact sheet discusses heroin alone, but women who use heroin may also use alcohol, tobacco, and other drugs that can be harmful.

I just found out I am pregnant. Should I stop using heroin?

Treatment is available to help you stop heroin. Talk to your health care provider as soon as possible so that you can start treatment. Stopping heroin suddenly (also called "cold turkey") without proper treatment could cause you to go through withdrawal. Withdrawal symptoms could be harmful to you and may increase the chance of a miscarriage or stillbirth. If you do not have a health care provider, call the national number for drug treatment referral at 800-662-4357. When you call for help, let them know that you are pregnant so that you can get routed to the best facility to meet your needs.

I use heroin. Can it make it harder for me to get pregnant?

Heroin has not been studied in women to see if using heroin could make it harder to get pregnant.

Does using heroin during my pregnancy increase the chance of miscarriage?

There are no published studies looking at whether heroin increases the chance of miscarriage. This does not mean there is an increased chance or that there is no increased chance. It only means that this question has not been answered.

Can using heroin in pregnancy cause birth defects?

Overall, the studies of heroin do not support an increased risk of birth defects. However, heroin often has other drugs, medications and even chemicals added to it. This makes it difficult to know the actual risks for each woman who uses heroin.

Could heroin cause other pregnancy complications?

Studies involving women who use heroin found an increased chance for poor growth of the baby, stillbirth, premature delivery, and c-section. Use of a heroin close to the time of delivery can result in withdrawal symptoms in the baby (see the section of this fact sheet on neonatal abstinence syndrome).

Will my baby have withdrawal (neonatal abstinence syndrome) if I continue to take heroin?

Most likely, yes. Studies have reported a risk for neonatal abstinence syndrome (NAS) with heroin use during the third trimester of pregnancy.

NAS is the term used to describe withdrawal symptoms in newborns from medicines that a mother takes during pregnancy. Most often, symptoms of NAS appear two days after birth and may last more than 2 weeks. The most common symptoms of NAS include irritability, poor feeding, tremors, and rigid or loose muscle tone. Most babies can be treated successfully for NAS while in the hospital. If you use heroin or other opioid drugs during pregnancy, it is

important that your baby's doctors know to check for symptoms of NAS so your newborn can get the best possible care.

What do we know about abuse of heroin?

Studies find that pregnant women who abuse opioids have an increased risk for pregnancy problems. These include poor growth of the baby, stillbirth, premature delivery, low birth weight and c-section. Some women who abuse opioids also have unhealthy and risky lifestyles that can result in health problems for both the mother and the baby. For example, poor diet choices can lead to mothers not having enough nutrients to support a healthy pregnancy and could increase the chance of miscarriage and premature birth. Sharing needles to inject opioids increases the risk of getting diseases like hepatitis and HIV, which can cross the placenta and infect the baby.

Will using heroin during pregnancy affect my baby's behavior or cause learning problems?

This is unknown. The results from studies about behavioral or learning problems in children whose mother's used heroin during pregnancy are unclear.

Can I take heroin while I am breastfeeding?

No. While there are very few studies on heroin and breastfeeding, heroin easily passes into the breastmilk. Babies that are exposed to heroin could have difficulty breathing, apnea (stop breathing), and cyanosis (not enough oxygen in the blood causing the baby's skin to turn bluish). The baby's health care provider should be contacted right away if your baby has any problems. Be sure to talk to your health care provider about all your breastfeeding questions.

What if the baby's father takes heroin?

Heroin use in men may affect the sperm, making it difficult to become pregnant. Also, if the father has an infection such as hepatitis C or HIV, it can be passed on from the semen to the mother and then to the baby. In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

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Buprenorphine

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to buprenorphine may increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your healthcare provider.

What is buprenorphine?

Buprenorphine is an opioid medication used to treat addiction to opioid drugs such as heroin and other narcotic painkillers. It has also been used to treat pain. A brand name for buprenorphine is Subutex®. When combined with the medication naloxone, it is also known as Suboxone®, Zubsolv®, or Bunavil®. Buprenorphine may be taken as a tablet, film (placed under the tongue or in the cheek), patch, implant, injection or given intravenously (through a vein).

I am taking buprenorphine, but I would like to stop taking it before becoming pregnant. How long does the medication stay in my body?

Talk with your healthcare provider before making any changes to your medications. People get rid of medications from their bodies at different rates. In healthy, non-pregnant adults, it takes up to 9 days for most of the buprenorphine to be gone from the body.

I just found out I am pregnant. Should I stop taking buprenorphine?

No. If you have been taking buprenorphine regularly you should not stop suddenly (also called "cold turkey"). Stopping an opioid medication suddenly could cause you to go into withdrawal. More research is needed to know how going through withdrawal might affect a pregnancy. Talk with your healthcare providers before making any changes to your medications. Changes to your buprenorphine treatment during pregnancy or while breastfeeding should be done only under the care of an experienced healthcare provider.

I take buprenorphine. Can it make it harder for me to get pregnant?

Studies in women have not been done to see if taking buprenorphine could make it harder for you to get pregnant.

Does taking buprenorphine during my pregnancy increase the chance of miscarriage?

Limited studies looking at buprenorphine use in pregnant women have not reported higher rates of miscarriage than what is seen in the general population. However, there are no published studies looking at whether buprenorphine increases the chance of miscarriage. This does not mean there is an increased chance or that there is no increased chance. It only means that this question has not been answered.

Can taking buprenorphine increase the chance of having a baby with a birth defect?

Limited studies looking at buprenorphine in pregnancy have not reported an increased chance for birth defects.

I need to take buprenorphine throughout my pregnancy. Will it cause withdrawal symptoms (neonatal abstinence syndrome) in my baby after birth?

Possibly. Studies have reported between 22-67% of babies will experience neonatal abstinence syndrome (NAS) when buprenorphine is used up to the time of delivery. NAS is the term used to describe withdrawal symptoms in newborns from medicines that a mother takes during pregnancy. For any opioid, symptoms can include difficulty breathing, extreme drowsiness (sleepiness), poor feeding, irritability, sweating, tremors, vomiting and diarrhea. NAS

symptoms from buprenorphine may not appear for 36-60 hours after birth and may last more than two weeks. If needed, babies can be treated for withdrawal while in the hospital. If you use an opioid in your pregnancy, it is important that your baby's healthcare providers know and check for symptoms of NAS, so your newborn gets the best possible care.

Could buprenorphine cause other pregnancy problems?

Studies involving women who regularly use opioids during their pregnancy have found an increased chance for poor pregnancy outcomes such as poor growth of the baby, stillbirth, premature delivery, and C-section. This is more commonly reported in women who are taking heroin or who are using opioids in higher doses or for longer than recommended by their healthcare provider. When taken as prescribed, buprenorphine does not seem to increase the chance for pregnancy problems. Studies comparing buprenorphine and methadone in pregnancy found lower rates of problems with buprenorphine.

Will taking buprenorphine during pregnancy affect my child's behavior or cause learning problems?

There are not enough studies on buprenorphine to know if there is a chance for long-term problems.

What do we know about misuse of opioid medications in pregnancy?

Studies find that pregnant women who take opioids in higher doses or for longer than recommended by their healthcare providers (i.e. "misuse" or "abuse" opioids) have an increased chance for pregnancy problems. Some women who misuse opioids also have other habits that can result in health problems for both the mother and the baby. For example, a poor diet can lead to mothers not having enough nutrients to support a healthy pregnancy and could increase the chance of miscarriage and premature birth. Sharing needles to inject opioids increases the chance of getting diseases like hepatitis C and/or HIV which can cross the placenta and infect the baby.

Can I breastfeed my baby if I am taking buprenorphine?

Yes. The amount of buprenorphine in breast milk is expected to be too low to pose a problem for the nursing baby. While problems are not expected, a nursing infant can be watched for sleepiness and for proper weight gain. The baby's healthcare provider should be contacted right away if you suspect the baby has symptoms related to buprenorphine. Abruptly stopping breastfeeding while taking buprenorphine is not recommended because it may result in withdrawal symptoms in the baby. Be sure to talk to your healthcare provider about all your breastfeeding questions.

What if the father of the baby uses buprenorphine?

There are no studies looking at possible risks to a pregnancy when the father takes buprenorphine. In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/

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Methadone

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What is methadone?

Methadone belongs to a group of medications called opioids. Opioids are sometimes called narcotics. Methadone is often used to help treat withdrawal symptoms in people addicted to heroin or other opioid medications. Methadone is sometimes used to treat pain.

I am taking methadone, but I would like to stop taking it before becoming pregnant. How long does the medication stay in my body?

Talk with your healthcare provider before making any changes to your medications. People get rid of medications from their bodies at different rates. In healthy, non-pregnant adults, it can take up to two weeks for methadone to be gone from the body.

I take methadone. Can it make it harder for me to get pregnant?

Methadone has not been studied to see if using methadone could make it harder to get pregnant.

I just found out that I am pregnant. Should I stop taking methadone?

No. If you have been taking methadone regularly you should not stop suddenly (also called "cold turkey"). Stopping an opioid medication suddenly could cause you to go into withdrawal. More research is needed to know how going through withdrawal might affect a pregnancy. Talk with your healthcare providers before making any changes to your medications. Withdrawing from methadone during pregnancy or while breastfeeding should be done only under the care of an experienced healthcare provider.

Does taking methadone during my pregnancy increase the chance of miscarriage?

There are no published studies looking at whether methadone increases the chance of miscarriage. This does not mean there is an increased chance or that there is no increased chance. It only means that this question has not been answered.

Does taking methadone increase the chance of having a baby with a birth defect?

Probably not. Most studies of methadone do not find a higher chance of birth defects than the background risk. Two small studies of pregnant women using methadone reported birth defects, but there was no pattern of defects. Based on the available information, using methadone is unlikely to increase the chance of birth defects.

I need to take methadone throughout my entire pregnancy. Will it cause withdrawal symptoms (neonatal abstinence syndrome) in my baby after birth?

Studies have reported a chance for neonatal abstinence syndrome (NAS) with methadone use during the last 3 to 4 weeks of pregnancy. NAS is the term used to describe withdrawal symptoms in newborns from medicines that a mother takes during pregnancy. For any opioid, symptoms can include difficulty breathing, extreme drowsiness (sleepiness), poor feeding, irritability, sweating, tremors, vomiting and diarrhea. Symptoms of NAS may appear at birth and may last more than two weeks. If needed, babies can be treated for withdrawal while in the hospital. If you use an opioid in your pregnancy, it is important that your baby's doctors know and check for symptoms of NAS, so your

newborn gets the best possible care.

Could methadone cause other pregnancy complications?

Some studies have found higher chances of low birth weight and premature delivery when methadone is used during pregnancy.

Will taking methadone during pregnancy affect my child's behavior or cause learning problems?

There are not enough studies on methadone to know if there is a chance for long-term problems.

What do we know about misuse of opioid medications in pregnancy?

Studies find that pregnant women who take opioids in higher doses or for longer than recommended by their health care providers (i.e. "misuse" or "abuse" opioids) have an increased risk for pregnancy problems. These include poor growth of the baby, stillbirth, premature delivery, and C-section. Some women who misuse opioids also have other habits that can result in health problems for both the mother and the baby. For example, a poor diet can lead to mothers not having enough nutrients to support a healthy pregnancy and could increase the chance of miscarriage and premature birth. Sharing needles to inject opioids increases the risk of getting diseases like hepatitis C and/or HIV which can cross the placenta and infect the baby.

Can I breastfeed my baby if I am taking methadone?

Probably. Very small amounts of methadone get into breast milk. Taking methadone, up to 100 mg per day, is usually not a problem for healthy, full-term breastfed babies if their mothers were taking the drug during pregnancy. In addition, breastfeeding might help with neonatal withdrawal symptoms in babies who were exposed during pregnancy. Some studies have found shorter hospital stays, less need of neonatal abstinence treatment and shorter lengths of treatment among breastfed babies.

Use of some opioids in breastfeeding may cause babies to be very sleepy and have trouble latching on. Some medications may cause difficulty with breathing, apnea and cyanosis (not enough oxygen in the blood causing the baby's skin to turn bluish). The baby's doctor should be contacted immediately if your baby has any of these problems. Be sure to talk to your healthcare provider about all your breastfeeding questions.

What if the baby's father takes methadone?

In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

References Available Upon Request

November, 2017

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Cocaine

This sheet talks about exposure to the illicit use of cocaine in a pregnancy or while breastfeeding. This information should not take the place of medical care and advice from your healthcare provider.

What is cocaine?

Cocaine is a local anesthetic (pain killer) and a powerful stimulant of the central nervous system (brain and spinal cord). Cocaine can be inhaled, injected or smoked (crack).

I have heard that cocaine can cause a miscarriage. Is this true?

Yes. In the early months of pregnancy, cocaine can increase the chance for miscarriage. The chance of this happening may be related to the amount the woman uses during pregnancy.

When I use cocaine, does it get into my baby's body too?

Yes. Cocaine crosses the placenta and enters the developing baby. Cocaine can be found in the urine, meconium (stool), umbilical cord and hair of newborns who were exposed during pregnancy. Cocaine is cleared more slowly from the developing baby in a pregnancy and as a newborn than it does in an adult. Therefore, cocaine stays in the baby's body for a longer time.

Does cocaine cause birth defects?

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. Studies do not agree as to whether cocaine increases the chance for birth defects. Birth defects that have been reported with maternal cocaine use include abnormalities of the brain, skull, face, eyes, heart, limbs, intestines, genitals, and urinary tract. Most babies exposed to cocaine during pregnancy do not have a birth defect. The risk for a birth defect may be more likely when the mother has used cocaine frequently during the pregnancy.

Can cocaine cause other problems for my baby?

Yes. Cocaine can lower the supply of food and oxygen that need to reach the developing baby. The babies of mothers who use cocaine during pregnancy tend to have poor growth (weigh less, be shorter in length, and have smaller heads) than babies born without exposure to cocaine. Babies with low birth weight are more likely to die in their first month of life than are normal weight babies. They are also more likely to have life-long disabilities, including learning, visual, and hearing problems.

Cocaine use can cause the placenta to pull away from the wall of the uterus before labor starts. This condition, called placental abruption, can lead to heavy bleeding and can be fatal for both the mother and baby. Cocaine can also increase the risk for premature delivery (delivery before week 37). Babies who are born prematurely often start life with serious health problems, especially breathing difficulties. These babies may also have an intracranial hemorrhage (bleeding in the brain) before or soon after birth, and this can cause permanent brain damage and other disabilities.

Cocaine can cause significant central nervous system problems that may not be seen until the child is older. These effects may include problems with attention and behavioral self-control. Delays in learning, slower growth rate, language difficulties and an increased need for special education in school have been reported.

If I can't stop using cocaine during my pregnancy, will my baby be born addicted?

It is unknown if the use of cocaine through delivery causes withdrawal in the newborn baby. The late term use of cocaine has been reported with symptoms of toxicity in the newborn baby. Symptoms include increased irritability, tremors, muscle stiffness, poor feeding, sleeplessness, and hyperactivity or, in some cases, tiredness. Less commonly,

vomiting, diarrhea, and seizures have also been reported. Symptoms usually start at 1 to 2 days after birth. Symptoms are most severe on days 2 and 3. Some of these problems may last 8 to 10 weeks after birth or even longer. As soon as you know that you are pregnant, and start prenatal care, tell your healthcare provider about your cocaine use and ask for help. If the pregnant woman is not using at the end of her pregnancy, then no increased risk for these symptoms would be expected for the newborn.

What about using cocaine and other drugs at the same time?

Using other drugs, including alcohol or cigarettes, can also harm the baby. The combined effect of cocaine and other drugs may be worse for the developing baby than with cocaine alone.

Is there any way to know if my baby has been harmed before delivery?

If you are worried that your baby may have a birth defect or other problem due to cocaine use, speak to your healthcare provider. He/she can discuss with you any available tests. An ultrasound can be used to screen for birth defects, growth of the baby and location of the placenta. However, there are no tests that can be done prenatally to see if a developmental disability will be present. The pediatrician who will care for your baby should also be told about any concerns you have.

Can I use cocaine while I breastfeed?

No. When a mother uses cocaine in any form, the drug can get in the breast milk. Exposure to breastmilk with cocaine is serious and can be dangerous for a baby. A newborn does not have the ability to inactivate cocaine and infants can have cocaine intoxication following nursing. Symptoms include difficulty breathing and seizures in the infant. Never put cocaine on your nipples to treat soreness. This is extremely dangerous for the baby and is known to cause seizures. Talk to your healthcare provider about all your question related to breastfeeding.

Is it a problem if the baby's father is using cocaine when I get pregnant?

Cocaine appears in the semen and may reduce the number of sperm, and increase the number of abnormal sperm. This can make it harder for a woman to get pregnant. Cocaine can attach to sperm. This has led to the suggestion that sperm could deliver cocaine directly to the egg, causing developmental problems. However, no birth defects have been identified as a direct result of paternal exposure to cocaine. The safest approach is for a man to avoid cocaine use three months prior to conception (when pregnancy occurs) when sperm are developing. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

Please click here for references.

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Ketamine (Ketalar®)

This sheet talks about exposure to ketamine in pregnancy and while breastfeeding. This information should not take the place of medical care and advice from your healthcare provider.

What is ketamine?

Ketamine (Ketalar®) is an anesthetic medication. An anesthetic is used with medical procedures, such as surgery, to help lower a person's ability to feel pain and to make them less aware of what is happening. MothertoBaby has a fact sheet on general anesthesia at: https://mothertobaby.org/fact-sheets/general-anesthesia-pregnancy/pdf/.

Ketamine has also been used to treat pain and for other medical conditions, such as asthma and major depressive disorder. MothertoBaby has fact sheets on asthma and depression at: https://mothertobaby.org/fact-sheets/asthma-and-pregnancy/pdf/ and https://mothertobaby.org/fact-sheets/depression-pregnancy/pdf/.

Ketamine has been misused as an illicit drug. Street names for illicit ketamine use include K, K-Hole, Super K and Special K.

Can ketamine make it harder for me to get pregnant?

Studies in women have not been done to learn
if ketamine exposure could make it harder to get pregnant. However, an experimental animal study did not find that ketamine exposure affected fertility.

I just found out that I am pregnant and I misuse ketamine. Should I tell my healthcare provider?

Yes. If you have been taking ketamine regularly you should not stop suddenly (also called "cold turkey"); as this could cause you to go into withdrawal. Talk with your healthcare providers for advice on how to slowly stop taking ketamine. You can also contact the National Drug Helpline at http://drughelpline.org/ or 1-888-633-3239.

Can exposure to ketamine increase the chance for miscarriage?

Miscarriage can occur in any pregnancy. It is not known if ketamine would increase the chance for miscarriage. A few studies suggest a small increase in the chance for a miscarriage in women who had surgery with general anesthesia in the first half of pregnancy. However, it is unclear if this is due to the anesthesia, or a response of the body to surgery, illness in the mother or another reason.

Does ketamine exposure increase the chance of having a baby with a birth defect?

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. It is not known if ketamine exposure would increase this background risk. Experimental animal studies have shown that ongoing or high dose exposure could affect the brain and liver in a developing baby.

Will ketamine exposure during pregnancy affect my baby's behavior or cause learning problems?

Experimental animal studies have reported that ketamine exposure can affect brain development, which might affect learning and behavior. Women who are pregnant and need surgery, especially for life-threatening conditions, should not be discouraged from the use of general anesthesia. Talk with your healthcare providers about the benefits, risks, and appropriate timing of surgery or procedures requiring general anesthesia.

Could ketamine cause other pregnancy complications?

When used as an anesthetic at the time of delivery, there may be changes in fetal heart rate or breathing

difficulties in the newborn. However, there are also reports of births without these findings. It may depend on the dose used and the amount of time the anesthesia is used.

There is a case report of a baby born with low muscle tone (called hypotonia or "floppy baby syndrome") whose mother misused ketamine throughout the pregnancy. The baby's hypotonia improved over the first month of life. There are no other reports on the misuse of long-term use of ketamine in human pregnancies.

Can I breastfeed my baby if I was given ketamine during labor and delivery?

Ketamine has not been well studied for use while breastfeeding. There are four case reports of infants who did not have side effects from breastfeeding after their mothers were given ketamine during labor. It is not known how much ketamine would get into breastmilk. Talk to your healthcare provider about all of your breastfeeding questions.

What if the baby's father has been given ketamine?

Ketamine has not been well studied for use in men who are trying to get a partner pregnant. In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

Please click here for references.

March, 2019

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Lysergic Acid Diethylamide (LSD)

This sheet talks about exposure to Lysergic Acid Diethylamide (LSD) in pregnancy or while breastfeeding. This information should not take the place of medical care and advice from your healthcare provider.

What is LSD?

Lysergic acid diethylamide (commonly known as LSD) is a drug that causes an altered state of mind (hallucinations/delusions). Some physical effects of LSD on the body can include increased blood pressure, fast heart rate, and dilated pupils. This drug is usually taken by mouth, but can also be taken by injection (using a needle) or by inhalation (breathing it into lungs). "Acid", "Kool-Aid", and "Blotter Paper" are examples of slang or street names for LSD.

I took LSD. How long should I wait to become pregnant?

LSD breaks down differently in each person. How LSD leaves the body is complicated and probably depends on the dose taken along with health and other characteristics of the person using the drug. On average, it is thought that most of the LSD is gone from the blood stream in one or two days.

Can use of LSD make it harder for me to get pregnant?

This has not been well studied.

Can use of LSD during pregnancy cause miscarriage?

The chance of having a miscarriage from using LSD is not yet known. There are some data that suggest the use of LSD might increase the chance to have a miscarriage.

Can use of LSD during pregnancy cause birth defects?

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk.

Many of the studies on LSD are very old and have different results. There are reports of babies being born with birth defects, and reports of babies born without birth defects following LSD use during pregnancy. One study of pregnant women given LSD for medical reasons did not show a link with causing birth defects. No pattern of birth defects has been reported with LSD use during pregnancy.

Can use of LSD during pregnancy cause other pregnancy complications?

This is not well studied, but it is possible. It is difficult to study how the use of LSD might affect a pregnancy. This is because people who use LSD might also have unhealthy and risky lifestyles that can result in a variety of health problems for both the mother and a pregnancy. For example, poor diet choices can lead to mothers not having enough nutrients to support a healthy pregnancy, and could increase the chance of miscarriage and premature birth. Some people who use LSD also use other drugs, such as alcohol or marijuana. These can also affect a mother's health and a pregnancy.

Can use of LSD during pregnancy cause learning or behavioral problems for the child?

Long term studies have not been done to follow pregnancies with exposure to LSD to see if using LSD during pregnancy causes learning or behavioral problems for the child.

Can I breastfeed while taking LSD?

There is little information on the safety of using LSD while breastfeeding. Based on the molecular size of this drug, it will probably get into the breast milk. LSD should be avoided while breastfeeding for a number of reasons, including the concern that women caring for young children should not be on mind-altering drugs. Be sure to talk with your healthcare provider about all of your breastfeeding questions.

What if the father of the baby takes LSD?

There are no confirmed reports that prior use of LSD by anyone would increase the chance of having a baby with a birth defect. In general, exposures that fathers have are unlikely to increase the risks for babies to have a birth defect or to cause other negative pregnancy outcomes. For more information, please see the MotherToBaby fact sheet on Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

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MDMA (Molly, Ecstasy)

This sheet talks about exposure to MDMA in a pregnancy and while breastfeeding. This information should not take the place of medical care and advice from your healthcare provider.

What Is MDMA?

MDMA is short for 3,4 methylenedioxymethamphetamine. This is a man-made drug that causes people who use it to experience psychedelic and hallucinogenic effects, meaning they see or hear things that are not really there. Common or street names for MDMA are Molly, ecstasy, E, X, XTC and Mandy. MDMA can be swallowed as a pill or capsule, or snorted/inhaled as a powder.

Can using MDMA make it harder for me to get pregnant?

Studies on women have not been done to see if MDMA use could make it harder for a woman to get pregnant.

Does taking MDMA increase the chance for miscarriage?

Miscarriage can occur in any pregnancy. Studies have not been done to see if MDMA could increase the chance for a woman to have a miscarriage.

Will MDMA use during pregnancy cause birth defects?

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. It is unclear if MDMA use during pregnancy increases the chance for birth defects. There is very little published data on MDMA use during pregnancy. One small study in humans reported an increase in heart defects and/or club foot (when the foot is twisted). As with other illicit drugs, MDMA may come in a form that is mixed with several other drugs such as cocaine or caffeine. This means that it is hard to know for sure whether it's the MDMA or something else that is added. Since the effects of MDMA on a baby during pregnancy are unknown, the healthiest choice is to avoid MDMA during pregnancy.

I used MDMA later during pregnancy. How will this affect the baby?

Studies are very limited. One study that followed a small group of children exposed one month prior to pregnancy and in the first and second trimester, suggested that babies exposed to MDMA might be delayed in their development up to two years of age. The women also reported exposure to alcohol as well as other recreational drugs.

I have already used MDMA during my pregnancy. What can I do to find out if the baby has a birth defect?

If you have used MDMA in pregnancy, talk with your healthcare provider. They can discuss screening options, such as an ultrasound.

After the baby is born, is it safe to use MDMA while I breastfeed?

Studies have found MDMA in the breast milk of mothers who used this drug. Amphetamine drugs (like MDMA) are concentrated in the breast milk, meaning they are found at higher levels in breastmilk than in the mother's blood. The effect of MDMA on a breastfeeding infant is not known. However, the use of MDMA in breastfeeding is strongly discouraged. If MDMA has already been taken, it has been recommended to not breastfeed for 48 hours. During this time breast milk should be expressed and discarded. Be sure to discuss your breastfeeding questions with your healthcare provider.

What if the father of the baby uses MDMA?

Some animal studies have found MDMA can damage the DNA in sperm. However, no decrease in the ability to father a pregnancy was seen. At this time there is no evidence that paternal use of MDMA increases the risk for birth defects or other problems. For more information about paternal exposures, please see please see the MotherToBaby fact sheet on Paternal Exposures and Pregnancy at http://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

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Methamphetamine

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to methamphetamine may increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your healthcare provider.

What is methamphetamine?

Methamphetamine is also known as metamfetamine, methylamphetamine, and desoxyephedrine. Methamphetamine is sometimes prescribed by a healthcare provider for attention deficit hyperactivity disorder (ADHD). A brand name for this use is Desoxyn®. However, methamphetamine is highly addictive and is more commonly used illegally for recreation. Methamphetamine has also been called "meth," "crystal meth," "crank," "speed" or "ice." Methamphetamine can be smoked, snorted, swallowed, injected, inhaled, taken rectally, or dissolved under the tongue.

Methamphetamine is a psychoactive drug, meaning it changes brain function by exciting the brain with chemicals that can make people "feel good." The drug acts as a stimulant, causing a fast heart rate, sweating, loss of appetite, hallucinations, anxiety, paranoia, trouble sleeping and dizziness. Methamphetamine overdoses can cause death or brain damage. Long term use can cause many health problems.

Will taking methamphetamine make it harder for me to get pregnant?

>Methamphetamine has not been studied in women to see if using it could make it harder to get pregnant.

Should I stop taking methamphetamine if I find out that I am pregnant?

Methamphetamine misuse (used when not prescribed, or used at doses higher than prescribed) should be avoided during pregnancy. However, stopping methamphetamine suddenly could cause you to go into withdrawal. There are no studies on withdrawal during pregnancy.

If your healthcare provider prescribed methamphetamine, call the healthcare provider and let them know about your pregnancy. Your healthcare provider can help you wean off of the medication, if needed.

If you are misusing methamphetamine and live in the U.S. and want to stop, there is help available. You can also dial 211 confidentially if you are in the U.S. or Canada to get a referral to drug treatment near you. Your healthcare providers can also help. You can also contact a MotherToBaby specialist for information.

Some women who abuse methamphetamine may have other habits that can result in health problems that could be harmful for both the mother and a pregnancy. For example, a poor diet can lead to mothers not having enough nutrients to support a healthy pregnancy. Sharing needles to inject methamphetamine increases the risk of getting diseases like hepatitis C and/or HIV, which can affect the baby.

Does taking methamphetamine increase the chance of miscarriage?

Some studies have suggested that methamphetamine use could increase the chance for pregnancy loss.

Does taking methamphetamine increase the chance of having a baby with a birth defect?

There is mixed information on whether methamphetamine increases the chance of birth defects. However, most studies do not find an increased chance for major birth defects. Some women who misuse / abuse methamphetamine could have other lifestyle factors, such as other drug or alcohol use, that can make it difficult to study methamphetamine use in pregnancy.

Could methamphetamine use cause other pregnancy complications?

Yes. Methamphetamine abuse has been associated with a greater chance for premature delivery (delivery before 37 weeks of pregnancy), poor growth (babies born too small and/or with a small head size), and low birth weight. Some, but not all studies, have also suggested that methamphetamine abuse in pregnancy can increase the chance for high blood pressure, placental abruption (the placenta pulls away from the uterus) and for sudden infant death syndrome (SIDS). Pregnancy complications are more likely to occur when methamphetamine is misused throughout a pregnancy or when taken at high doses.

Will my baby have withdrawal if I continue to take methamphetamine?

Possibly. When mothers use methamphetamines near the end of their pregnancy, babies could show signs of withdrawal after they are born. Symptoms for the newborn may include trouble eating, sleeping too little or sleeping too much, having floppy (poor) muscle control or tight muscles, being jittery, and / or having a hard time breathing. Withdrawal symptoms usually go away within a few weeks, but can last for a few months. The baby might need to be admitted to the special care nursery.

Will taking methamphetamine during pregnancy affect my baby's behavior or cause learning problems?

Possibly. Studies have suggested that children who were exposed to methamphetamine during pregnancy could have a higher chance for learning difficulties and behavior problems later in life.

What if I use other drugs besides methamphetamine?

Many women who misuse methamphetamine also use other drugs, alcohol, and / or cigarettes, which can increase the chance of having a baby with problems.

How can I know if methamphetamine may have hurt my baby?

It is important to tell your healthcare provider what you have taken during your pregnancy. They can offer you a detailed ultrasound to screen for some birth defects and can also help you find treatment or support. There is no test in pregnancy that can look for learning problems. Once your baby is born, you should also tell your child's doctor who can look for early warning signs of problems and give your child extra help, if needed.

Can I use methamphetamine while I breastfeed?

Methamphetamine should not be abused while breastfeeding. Methamphetamine can pass into breast milk. Methamphetamine has been detected in the blood and urine of breastfeeding babies. Prescription methamphetamine use has not been studied in nursing infants. Be sure to talk to your health care provider about your breastfeeding questions.

What if my baby's father was using methamphetamine when I got pregnant?

There are no studies on this topic. In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

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Opioids | Narcotics

MotherToBaby has developed fact sheets for a number of different opioids/narcotics. Please visit the fact sheets below for information on the effects of these agents during pregnancy and while breastfeeding.

- Buprenorphine: https://mothertobaby.org/fact-sheets/buprenorphine/pdf/
- Codeine: https://mothertobaby.org/fact-sheets/codeine/pdf/
- Fentanyl: https://mothertobaby.org/fact-sheets/fentanyl/pdf/
- Heroin: https://mothertobaby.org/fact-sheets/heroin/pdf/
- Hydrocodone: https://mothertobaby.org/fact-sheets/hydrocodone/pdf/
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- Methadone: https://mothertobaby.org/fact-sheets/methadone/pdf/
- Morphine: https://mothertobaby.org/fact-sheets/morphine/pdf/
- Oxycodone: https://mothertobaby.org/fact-sheets/oxycodone/pdf/
- Tramadol: https://mothertobaby.org/fact-sheets/tramadol/pdf/

If you have questions about an opioid that is not included in the above list, please contact our experts for free, confidential, up-to-date information.

CALL
(toll-free): (866) 626-2847

TEXT
(std messaging rates may apply): (855) 999-3525

EMAIL & LIVE CHAT:
https://mothertobaby.org/contact-expert/

June, 2018

MotherToBaby
Medications & More During Pregnancy & Breastfeeding
Ask The Experts

Fact Sheet
by the Organization of Teratology Information Specialists (OTIS)
For more information about us or to find a service in your area, call (866) 626-6847. Visit us online at www.MotherToBaby.org.
Find us! Facebook.com/MotherToBaby or @MotherToBaby on Twitter

Fentanyl

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. This sheet talks about whether exposure to fentanyl might increase the risk for birth defects over that background risk. This information should not take the place of medical care and advice from your healthcare provider.

What is fentanyl?

Fentanyl belongs to a class of medications known as opioids. An opioid is sometimes called a narcotic. Fentanyl is often given during surgery. It is used to treat pain. Fentanyl can be given in different ways, such as IV, injection, epidural (space around the spinal cord), transdermal (patch applied to skin), nasal spray, or buccal (pill in mouth next to cheek).

I am taking fentanyl, but I would like to stop taking it before becoming pregnant. How long does the medication stay in my body?

People break down medications at different rates. The time it takes to clear from your body also depends on how the fentanyl is being given. IV fentanyl only stays in your body for a few hours, while the patch version can last 3 or 4 days, even once the patch is removed. Be sure to talk with your healthcare providers before making any changes to your medications.

Can taking fentanyl make it harder for me to get pregnant?

Studies on women have not been done specifically on fentanyl to see if it makes it harder to get pregnant. However, it is known that long term use of opioids can affect hormones important in getting pregnant.

I just found out I am pregnant. Should I stop taking fentanyl?

No. If you are pregnant and using fentanyl regularly, talk to your healthcare provider about options that will allow you to either gradually wean off or stay on a carefully controlled dose of an opioid medication during your pregnancy. If you have been taking fentanyl regularly you should not just stop suddenly (also called "cold turkey"). Stopping an opioid medication suddenly could cause you to go into withdrawal. More research is needed to know how going through withdrawal might hurt a pregnancy. Talk with your healthcare provider about the risks and benefits of continuing or stopping your medication. Any reduction in your codeine needs to be done slowly, and under the direction of your healthcare provider.

Does taking fentanyl during my pregnancy increase the chance of miscarriage?

There are no published studies looking at whether fentanyl increases the chance of miscarriage. This does not mean there is an increased chance or that there is no increased chance, it only means that this question has not been answered. Miscarriage is one of the risks of surgery during pregnancy, and it is hard to tell if miscarriage is due to the underlying condition, the procedure, or the medications being used.

I took fentanyl in the beginning of my pregnancy. Is there a greater chance for birth defects?

Some studies have suggested that opioids may be associated with birth defects, while other studies did not find an increased risk for birth defects. There are no human studies looking specifically at fentanyl and birth defects. Studies in laboratory animals did not find an increased risk for birth defects. Based on the available information, using fentanyl is not expected to increase the chance of birth defects.

Could fentanyl cause other pregnancy complications?

Possibly. Studies involving women who chronically use some opioids during their pregnancy have found an increased risk for adverse outcomes including poor growth of the baby, stillbirth, premature delivery, and c-section. This is more commonly reported in women who are taking heroin or who are using prescribed pain medications in greater amounts or for longer than recommended by their health provider. Use of an opioid close to the time of delivery can result in withdrawal symptoms in the baby (see the section on withdrawal).

Will taking fentanyl during pregnancy affect my baby's behavior or cause learning problems?

There are not enough studies on fentanyl to know whether there is a chance for long-term problems. Brief use of fentanyl during surgery or for post-surgical pain is not likely to cause learning or behavior problems.

I need to take fentanyl throughout my entire pregnancy. Will it cause withdrawal symptoms (neonatal abstinence syndrome) in my baby after birth?

Possibly. Studies have reported a risk for neonatal abstinence syndrome (NAS) with some opioid medicines; however, not all medications have been studied. Based on what we know about the risk of NAS with other opioids, it is likely that fentanyl also has a risk for NAS. Because there are few studies, we do not know if the risk is higher or lower than with other opioids.

NAS is the term used to describe withdrawal symptoms in newborns from medicines that a mother takes during pregnancy. For any opioid, symptoms can include difficulty breathing, extreme drowsiness (sleepiness), poor feeding, irritability, sweating, tremors (shivers), vomiting and diarrhea. Symptoms of NAS may appear at birth and may last more than two weeks. If needed, babies can be treated for NAS in the hospital. If you use an opioid in your pregnancy, it is important that your baby's doctors know and check for symptoms of NAS, so your newborn gets the best possible care.

Can I take fentanyl while I am breastfeeding?

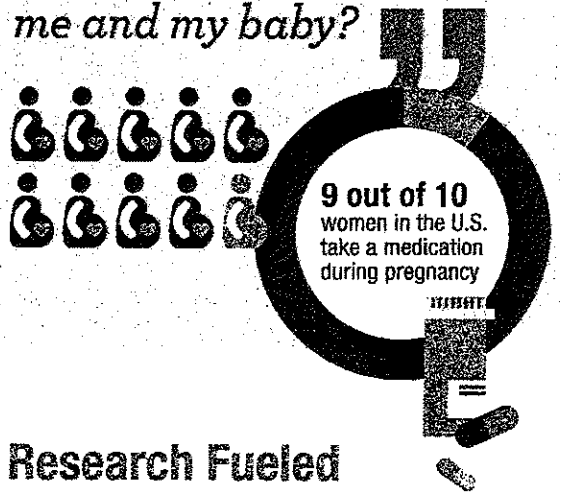
Possibly, depending on how it is given to you. Small amounts of fentanyl get into breast milk. Newborns are not fully developed and might have problems with the amounts from breast milk. If you have had a very brief exposure (example: IV use in surgery) then the amount in your milk is likely to be very low after 12 hours. If you take an opioid, such as fentanyl, on a daily basis, there may be concerns about your baby being very sleepy and not feeding well. Other opioids have been reported to cause difficulty with breathing, and in a few cases have even resulted in death of the baby. If you are using any opioid, your baby can be watched carefully for excessive sleepiness or poor feeding. The baby's healthcare provider should be contacted right away if your baby has any problems. Speak to your healthcare provider about your pain and medications that can be used while you are breastfeeding.

What if the father of the baby takes fentanyl?

There are no studies looking at how fentanyl use in a man might affect his ability to get his partner pregnant or how it might affect a partner's pregnancy. In general, exposures that fathers have are unlikely to increase risks to a pregnancy. For more information, please see the MotherToBaby fact sheet Paternal Exposures and Pregnancy at https://mothertobaby.org/fact-sheets/paternal-exposures-pregnancy/pdf/.

References Available By Request

Is this medication safe for me and my baby?



Research Fueled by Moms, for Moms

Our observational pregnancy research aims to find answers to whether mom's health conditions and treatments affect her pregnancy.

PARTICIPATION IS EASY!

- 1 to 3 phone interviews during pregnancy with at least 1 interview after delivery
- Releasing medical records for your pregnancy and for your baby
- May include a free specialized pediatric exam and developmental testing for your baby
- No travel or changes to your medication use or healthcare routine

To share your pregnancy or learn more

mothertobaby.org/studies

877-311-8972

mothertobaby@ucsd.edu

MotherToBaby

MotherToBaby is the nation's most trusted source of evidence-based information on the safety of medications and other exposures during pregnancy and while breastfeeding.

Join the conversation
@MotherToBaby

MotherToBaby is a service of the non-profit Organization of Teratology Information Specialists (OTIS), and is recommended by the FDA Office of Women's Health and the Centers for Disease Control and Prevention (CDC).

PATBR082017

When your bundle of joy comes with a bundle of questions

– Ask the experts –

MotherToBaby
PREGNANCY STUDIES

Critical periods of your baby's development

What are structural birth defects?

Structural birth defects are abnormalities in the structure of body parts. Examples include cleft palate, heart defects and spina bifida.

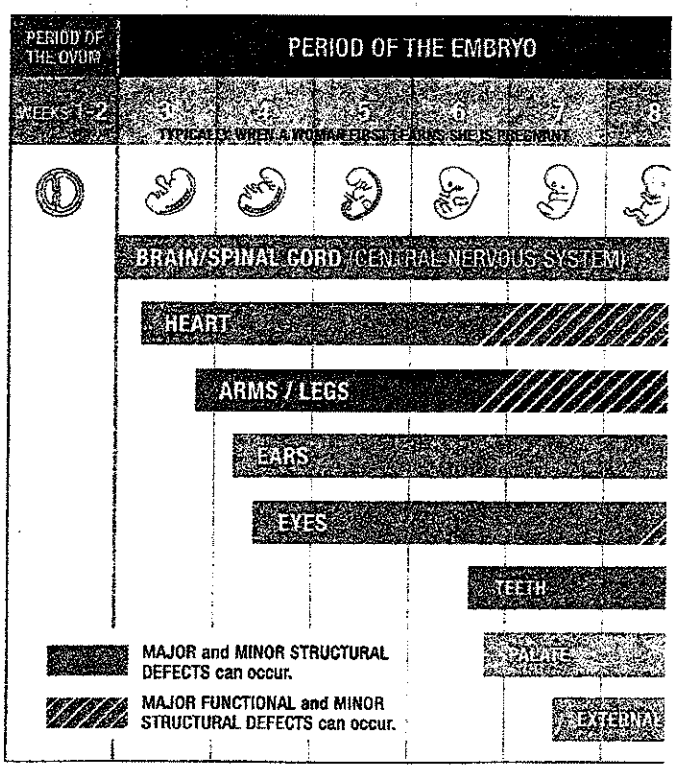
What are functional birth defects?

Functional birth defects are problems in how a body system works. Examples include hearing and vision loss.

What causes birth defects?

Birth defects can be caused by genetic, nutritional, environmental factors. Teratogens. Examples of teratogens include alcohol, certain medications and certain infections.

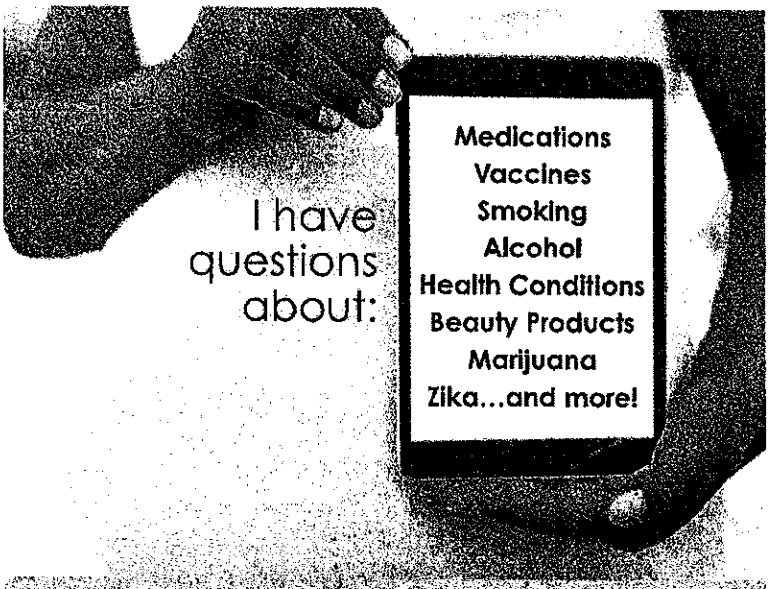
This chart shows the most sensitive times of a **baby's development** during the 38 weeks of pregnancy*



*This fetal chart shows the 38 weeks of pregnancy. Since it is difficult to know exactly when conception occurs, health care providers calculate a woman's due date 40 weeks from the start of her last menstrual cycle.

ASK THE EXPERTS
about the safety of medications and other exposures during pregnancy.
Call **877.311.8972**
Visit **mothertobaby.org**
Hablamos Español

What's safe during pregnancy or breastfeeding?



FREE – CONFIDENTIAL – CONVENIENT

CALL **(866) 626-6847**

TEXT **(855) 999-3525**

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NEW! "MotherToBaby" app for iOS & Android

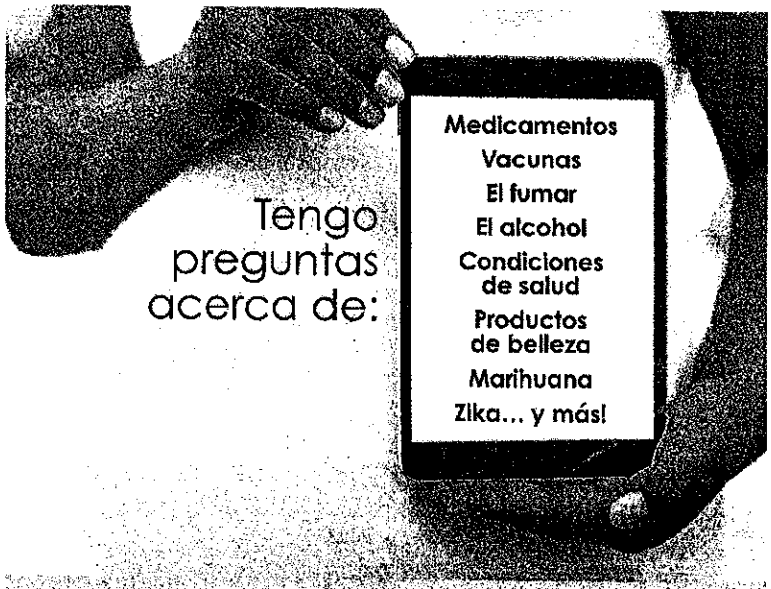
MotherToBaby

Medications & More During Pregnancy & Breastfeeding
Ask The Experts

MotherToBaby is a service of the non-profit Organization of Teratology Information Specialists (OTIS) and is a suggested resource by agencies like the Centers for Disease Control and Prevention (CDC). Learn about sharing your pregnancy in an important pregnancy study on **MotherToBaby.org**.

Find @MotherToBaby

¿Qué es lo seguro durante el embarazo o la lactancia?



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CHAT EN VIVO **MotherToBaby.org**

¡NUEVO! Aplicación de "MotherToBaby" para iOS y Android

MotherToBaby
Medicamentos y Más Durante el Embarazo y la Lactancia
Pregunte a los Expertos

MotherToBaby es un servicio de la organización sin fines de lucro OTIS (Organización de Especialistas en Información de Teratología). Somos un recurso sugerido por agencias como los Centros para el Control y la Prevención de Enfermedades (CDC). Aprenda cómo puede compartir su embarazo en un estudio importante en **MotherToBaby.org**.

Encuentre @MotherToBaby

2019

12. Patient Handouts Regarding Substance Use and Pregnancy

SBIRT/OB RESOURCE GUIDE

Alcohol and Pregnancy

If you drink alcohol during pregnancy, your baby may be at risk of lifelong birth defects.

Moderate Drinking: What's the Risk?

There is no safe amount or type of alcohol use during pregnancy. Even moderate drinking (one drink a day) can cause lifelong problems for your baby. These problems may be less obvious than those caused by heavy drinking. They may include problems with

- coordination
- behavior
- attention
- learning
- understanding consequences

Heavy Drinking: What's the Risk?

Heavy drinking is having more than three drinks per occasion or more than seven drinks per week. The most severe result of heavy drinking during pregnancy is called fetal alcohol syndrome (FAS). FAS can cause serious birth defects for your baby, including

- problems with brain development
- lower-than-average height and weight
- smaller-than-normal head size
- abnormal facial features

DID YOU KNOW

- **No drinks are safe. One beer, one shot of liquor, one mixed drink, and one glass of wine all contain about the same amount of alcohol.**
- **If you are trying to get pregnant, you should not drink alcohol.**
- **Didn't know you were pregnant? While no amount or type of alcohol is safe during pregnancy, serious harm is unlikely if you drank before you knew you were pregnant. The most important thing is to stop drinking alcohol when you find out you are pregnant.**

Alcohol-related birth defects are completely preventable.

Do not drink alcohol during pregnancy.

If it is hard for you to stop drinking, talk with your obstetrician–gynecologist (ob-gyn) or other health care professional about getting help. You also can visit the Alcoholics Anonymous website at www.aa.org or call the Substance Abuse and Mental Health Services Administration's treatment referral line at 800-662-HELP (4357).

During your first prenatal visit, or at any time throughout your pregnancy, your ob-gyn or other health care professional can offer advice about avoiding alcohol while pregnant.

The American College of Obstetricians and Gynecologists believes that pregnant women who are dependent on alcohol should receive counseling and medical support to help them stop drinking.

The American College of Obstetricians and Gynecologists
[illegible]
409 12th Street SW, PO Box 96920
Washington, DC 20090-6920
www.acog.org

Alcohol Use in Pregnancy

Women who are pregnant or who may be pregnant should not drink alcohol. This includes women who are trying to get pregnant and women who are at risk of becoming pregnant because they do not use effective contraception (birth control).

Alcohol use during pregnancy is dangerous

Drinking alcohol during pregnancy can cause lifelong physical, behavioral, and intellectual disabilities.

Alcohol in the mother's blood passes to the baby through the umbilical cord. Drinking alcohol during pregnancy can cause miscarriage, stillbirth, and a range of lifelong physical, behavioral, and intellectual disabilities. These disabilities are known as fetal alcohol spectrum disorders (FASDs).

Fetal alcohol syndrome (FAS) is the most involved condition among the range of FASDs. A baby born with FAS has a small head, weighs less than other babies, and has distinctive facial features.

Some of the behavioral and intellectual disabilities of people with FASDs include:

- Difficulty with learning or memory
- Higher than normal level of activity (hyperactivity)
- Difficulty with attention
- Speech and language delays
- Low IQ
- Poor reasoning and judgment skills

FASDs are completely preventable if a woman does not drink alcohol during pregnancy.

Why take the risk?

People born with FASDs can also have problems with their organs, including the heart and kidneys.

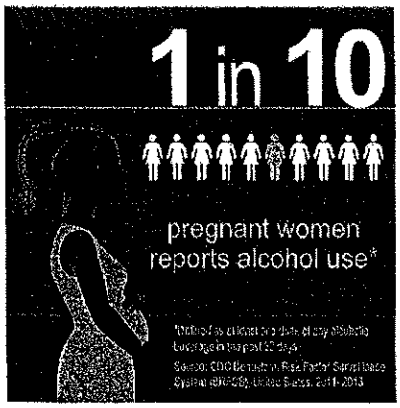
Any amount of alcohol during pregnancy is harmful

There is no known safe amount of alcohol use during pregnancy or when trying to get pregnant.

All types of alcohol are dangerous during pregnancy

Drinking any type of alcohol can affect the baby's growth and development and cause FASDs. This includes all types of wine, beer, and mixed drinks.

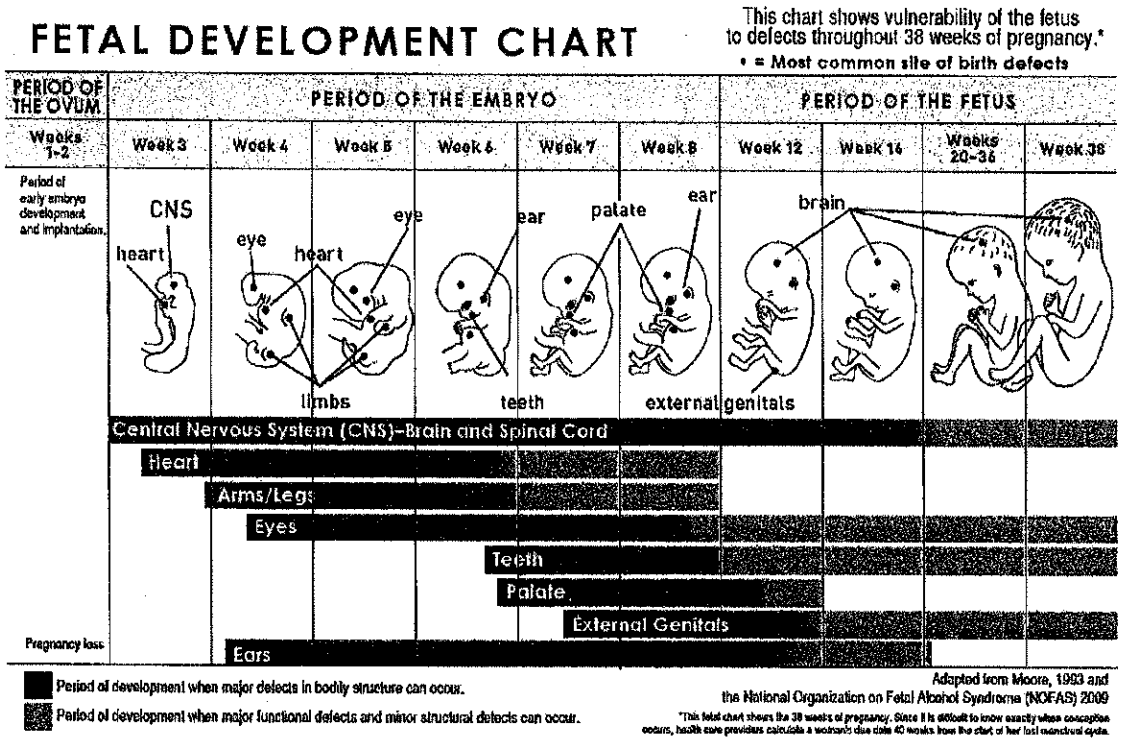
A 5-ounce glass of red or white wine (12% alcohol) has the same amount of alcohol as a 12-ounce can of beer (5% alcohol) or a 1.5 ounce shot of hard liquor (40% alcohol).



There is no safe time for alcohol use during pregnancy

Alcohol can cause problems for a developing baby throughout pregnancy, including before a woman knows she is pregnant.

The chart below shows important times during pregnancy when birth defects can happen.



Alcohol use while trying to get pregnant is risky

If a woman is trying to get pregnant, she might already be pregnant. A woman could get pregnant and not know it for up to 4 to 6 weeks. This means she might be drinking and exposing her developing baby to alcohol. The best advice is for women to stop drinking alcohol when they start trying to get pregnant.

Even if a woman is not trying to get pregnant...

A woman should not drink alcohol if she is sexually active and does not use effective contraception (birth control). This is because a woman might get pregnant and expose her baby to alcohol before she knows she is pregnant. Nearly half of all pregnancies in the United States are unplanned. Most women who get pregnant will not know they are pregnant for up to 4 to 6 weeks.

For More Information

The organizations and resources below can provide more information on alcohol use during pregnancy and FASDs:

- Centers for Disease Control and Prevention www.cdc.gov/fasd or call 800–CDC–INFO
- Substance Abuse and Mental Health Services Administration (SAMHSA) FASD Center for Excellence www.fasdcenter.samhsa.gov
- National Institute on Alcohol Abuse and Alcoholism www.niaaa.nih.gov

If you are pregnant or trying to get pregnant and cannot stop drinking, the following organizations and resources can help:

- National Organization on Fetal Alcohol Syndrome (NOFAS) www.nofas.org or call 800–66–NOFAS (66327)
- Substance Abuse Treatment Facility Locator www.findtreatment.samhsa.gov or call 800–622–HELP (4357)
- Alcoholics Anonymous www.aa.org
- National Council on Alcoholism and Drug Dependencies, Inc. (NCAAD) www.ncadd.org/get-help

HEALTH ADVISORY FROM THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

No alcohol during pregnancy **is the safest choice.**

Take Action for Healthier Moms & Babies

Massachusetts ranks among the top 5 states in terms of the proportion of women aged 18–44 who drink alcohol.[1] The most recent data indicates that 64.1% of women of childbearing age reported they'd used alcohol in the last month. Almost 1 in 5 had engaged in binge drinking.

According to the American Congress of Obstetricians and Gynecologists (ACOG), **no amount of alcohol is safe in pregnancy.** Because many pregnancies are unplanned, and because critical aspects of fetal development occur before women know they are pregnant, health care providers can help avoid the devastating effects of Fetal Alcohol Spectrum Disorders (FASD) through direct communication with **all** women of child-bearing age. This means that medical providers in all specialties who work with women have an opportunity to make a difference, by doing the following:

- Encourage all patients of childbearing age to avoid alcohol at any time they could become pregnant.
- Reinforce that using reliable birth control and condoms is a priority for all those who use alcohol, especially during times when they could become pregnant.
- Help women who want to become pregnant to create a plan to stay alcohol-free, before they try to conceive.

[1] *Centers for Disease Control and Prevention [CDC]. State-Specific Alcohol Consumption Rates for 2010. www.cdc.gov/ncbddd/fasd/monitor_table.html. Accessed January 31, 2014.*

BSAS
Bureau of Substance Abuse Services
Prevent • Treat • Recover • For Life

Alcohol & Pregnancy: The Facts

Massachusetts babies are at high risk.

- Most Massachusetts mothers (61.5%) report drinking in the three months before becoming pregnant.[2] And over a quarter (26.7%) of mothers report binge drinking in the three months prior to becoming pregnant.[3]
- Media reports, friends, family and others may not have all of the factual information. But the science is clear: The safest choice is to abstain from drinking alcohol throughout the entire pregnancy.

Alcohol is a teratogen that inflicts serious, lifelong harm to a fetus.

- Alcohol readily crosses the placenta and may cause neurobehavioral effects quite early in pregnancy.
- Alcohol use during pregnancy is the most common cause of preventable intellectual disabilities.
- Babies impacted by alcohol suffer from a range of serious, lifelong problems from Fetal Alcohol Spectrum Disorder, which can include physical abnormalities, mental impairments and behavioral issues.[4] Many of these problems may not be noticed until children enter school, or later. Even at lower levels of alcohol use, children still may have problems with focusing, memory and organization.[5, 6]
- About 50% of women report their pregnancy was unintended.[7] Since most women of childbearing age drink alcohol, many inadvertently drink early in pregnancy.
- **Thus, according to ACOG, the Centers for Disease Control and Prevention (CDC) and the Massachusetts Department of Public Health (MDPH), the healthiest advice for women of child-bearing age is: "do not drink alcohol" when pregnancy may be possible.**

[2] *Massachusetts Department of Public Health [MDPH]. (2013). Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS) 2009/2010 Surveillance Report, p. 89.*

[3] *MDPH. p. 89.*

[4] *American College of Obstetricians and Gynecologists. (2006). Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Tool Kit, p. 4.*

[5] *Kearney, M.H., Murphy, S., Rosenbaum, M. (1994). Mothering on crack cocaine: A grounded theory analysis. Soc Sci Med., 38, 351-361.*

[6] *Lewis S.J., Zuccolo, L., Davey Smith, G., Macleod, J., Rodriguez, S., Draper, E.S., Barrow, M., Alati, R., Sayal, K., Ring, S., Golding, J., Gray, R. (2012). Fetal Alcohol Exposure and IQ at Age 8: Evidence from a Population-Based Birth-Cohort Study. PLoS ONE, 7(11):e49407.*

[7] *American College of Obstetricians and Gynecologists. p. 9.*

Health care providers should screen and discuss alcohol with all patients who could become pregnant.

- Because many women have unintended pregnancies or may not be aware they are pregnant for several weeks, intervention with **all** women of childbearing age will help prevent alcohol-exposed pregnancies.
- In one multicenter project, nearly 70% of women reduced their risk of an alcohol-exposed pregnancy within six months after brief interventions.[8]
- **The U.S. Preventive Services Task Force (USPSTF) recommends that all providers screen all patients for alcohol use. Click on one of these tools T-ACE, CRAFFT (for younger women) or find other screening tools on the web.**

Women Welcome Information about Alcohol

- At least two studies have shown that women who are pregnant welcome information on alcohol or other drugs.[9,10]
- The more comfortable providers are with discussing alcohol use, the more likely women will be forthcoming with their alcohol use patterns.
- Motivational Interviewing (MI) is an evidence-based approach in which providers ask pros and cons of substance use, provide feedback, help establish a goal, and summarize the interaction. Visit **http://www.masbirt.org** for more details and information on training.

A Few Minutes Help Prevent a Lifetime of Health Issues

A short conversation with women who may be, or become, pregnant can help avoid a lifetime of challenges for unborn babies and their families. It's critical to talk with patients *before* they conceive. Providers can help prevent FASD by explicitly discouraging the use of any alcohol when women are at risk of pregnancy, or by encouraging effective contraception. As always, the developmental level of younger women will shape your approach.

Here are some examples of what you can say:

- ***"No alcohol during pregnancy is the safest choice, I recommend you to stop before you start trying to become pregnant."***
- ***"Your baby could be harmed by alcohol before you even realize you're pregnant. Alcohol can have harmful effects when your embryo is still small enough to fit inside of the zero on a penny's date."*** [11]

- ***"No alcohol during pregnancy is the safest choice; if you drink, use condoms and effective protection."***

Discuss Alcohol with Women Who Are Already Pregnant

If a woman uses alcohol and then finds she is pregnant, it is never too late to stop. The screening results can put her use into perspective. A healthy lifestyle without alcohol for the rest of her pregnancy is essential.

[8] *Ingersoll K, Floyd L, Sobell M, Velasquez MM. Reducing the risk of alcohol-exposed pregnancies: a study of a motivational intervention in community settings. Project CHOICES Intervention Research Group. Pediatrics 2003; 111:1131–5.*

[9] *Kearney M.H. et al.*

[10] *Murphy, S., Rosenbaum, M. (1999). Pregnant women on drugs: Combating stereotypes and stigma. New Brunswick (NJ): Rutgers University Press.*

[11] *Collaborative Initiative on FASD [CIFASD]. (2012). Fetal Alcohol Spectrum Disorders, slide 8. http://cifasd.org/. Downloaded February 3, 2014. CIFASD Funded by National Institutes of Health/National Institute on Alcohol Abuse and Alcoholism.*

You can say:

- ***"If you have been drinking alcohol, you can still benefit your child by stopping now."***
- ***"Try a festive mocktail."*** Having something fun to drink can make it easier to avoid alcohol in social situations. Websites offer mocktail recipes you can drink from a cocktail glass.
- ***"If you are having trouble stopping alcohol use, I can help you find the support you need."*** Pregnant women are a priority for the Massachusetts Department of Public Health Bureau of Substance Abuse Services. Women who have trouble avoiding alcohol during pregnancy may need a referral to an outpatient or residential program. The Institute for Health and Recovery staffs the Central Access Line for pregnant women seeking treatment for substance use issues and those who serve them. Call **617-661-3991** or **866-705-2807/TTY 617-661-9051.** Professionals or patients can also call **(800) 327-5050/TTY (888) 448-8321** or visit **http://www.helpline-online.com** 7 days a week. Health plans can give you counseling referral information. In Massachusetts state-funded and private programs address alcohol and other drug issues.

Begin the Conversation. Get the Tools You Need.

For more information for patients on how alcohol and drugs affect birth, please download or order the following informative pamphlets from **http://mass.gov/maclearinghouse** at no charge:

- When You're Pregnant Your Baby Drinks What You Drink (English & Spanish) **http://massclearinghouse.ehs.state.ma.us/product/SA3501kit.html**
- Would We Give Our Baby Alcohol? No Way. (English & Spanish) **http://massclearinghouse.ehs.state.ma.us/product/SA3503kit.html**
- It's the Same Risk for Every Pregnant Woman Everywhere (English & Spanish) **http://massclearinghouse.ehs.state.ma.us/product/SA3507kit.html**

To protect children from the well-documented danger of prenatal alcohol exposure, be clear and consistent with pregnant women *"No alcohol during pregnancy is the safest choice."*

Thank you for your leadership in keeping Massachusetts women and babies healthier.

Alcohol Use and Your Health

Drinking too much can harm your health. Excessive alcohol use leads to about 88,000 deaths in the United States each year, and shortens the life of those who die by almost 30 years. Further, excessive drinking cost the economy $249 billion in 2010. Most excessive drinkers are not alcohol dependent.

What is considered a "drink"?

U.S. Standard Drink Sizes

12 ounces 5% ABV beer | **8 ounces** 7% ABV malt liquor | **5 ounces** 12% ABV wine | **1.5 ounces** 40% ABV (80 proof) distilled spirits

Excessive alcohol use includes:

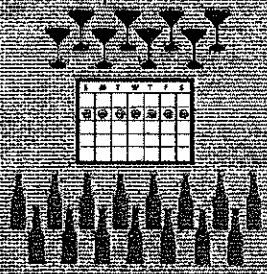
Binge Drinking

For women, 4 or more drinks consumed on one occasion

For men, 5 or more drinks consumed on one occasion

Heavy Drinking

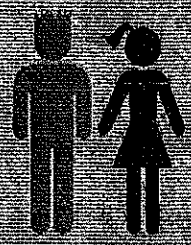
For women, 8 or more drinks per week



For men, 15 or more drinks per week

Any alcohol used by pregnant women

Any alcohol used by those under the age of 21 years



If you choose to drink, do so in moderation:

DON'T DRINK AT ALL if you are under the age of 21, or if you are or may be pregnant, or have health problems that could be made worse by drinking.

FOR WOMEN, up to 1 drink a day

FOR MEN, up to 2 drinks a day

NO ONE should begin drinking or drink more frequently based on potential health benefits.

National Center for Chronic Disease Prevention and Health Promotion
Division of Population Health

CDC

CS246270

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Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions. These are most often the result of binge drinking. Over time, excessive alcohol use can lead to the development of chronic diseases and other serious problems.

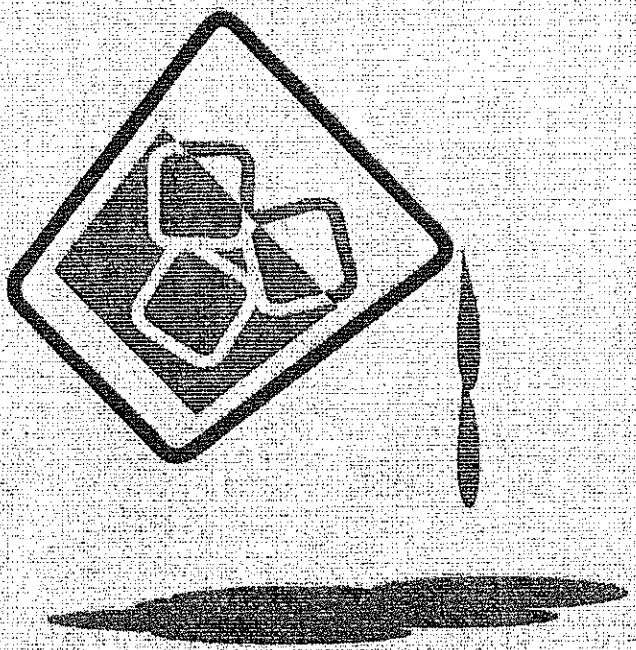
Short-Term Health Risks

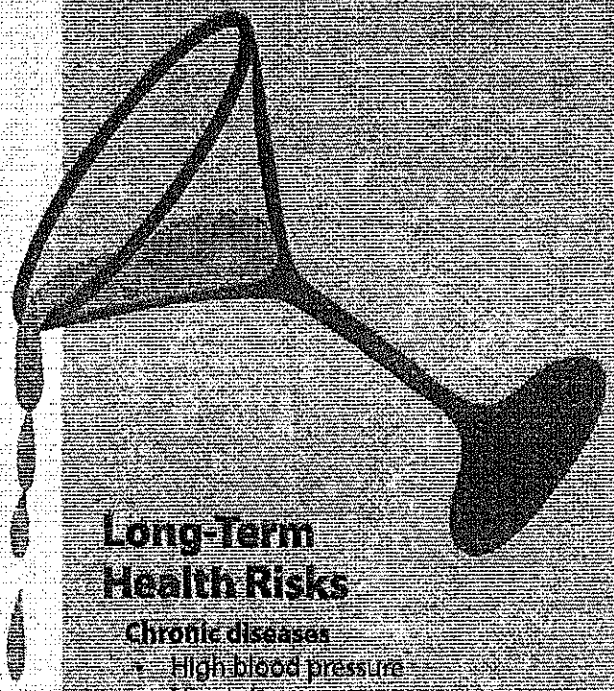
Injuries
- Motor vehicle crashes
- Falls
- Drownings
- Burns

Violence
- Homicide
- Suicide
- Sexual assault
- Intimate partner violence

Alcohol poisoning

Reproductive health
- Risky sexual behaviors
- Unintended pregnancy
- Sexually transmitted diseases, including HIV
- Miscarriage
- Stillbirth
- Fetal alcohol spectrum disorders (FASDs)





Long-Term Health Risks

Chronic diseases
- High blood pressure
- Heart disease
- Stroke
- Liver disease
- Digestive problems

Cancers
- Breast
- Mouth and throat
- Liver
- Colon

Learning and memory problems
- Dementia
- Poor school performance

Mental health
- Depression
- Anxiety

Social problems
- Lost productivity
- Family problems
- Unemployment

Alcohol dependence

http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

Marijuana Fact Sheet

What You Need to Know About Marijuana Use and Pregnancy

Marijuana use during pregnancy can be harmful to your baby's health. The chemicals in marijuana (in particular, tetrahydrocannabinol or THC) pass through your system to your baby and can harm your baby's development.[1-7]

Although more research is needed to better understand how marijuana may affect you and your baby during pregnancy, it is recommended that pregnant women do not use marijuana.[17]

What are the potential health effects of using marijuana during my pregnancy?

- Some research shows that using marijuana while you are pregnant can cause health problems in newborns— including low birth weight.[10,11]
- Breathing marijuana smoke can also be bad for you and your baby. Marijuana smoke has many of the same chemicals as tobacco smoke and may increase the chances for developmental problems in your baby.[12,13]

Can using marijuana during my pregnancy negatively impact my baby after birth?

- Some research shows marijuana use during pregnancy may make it hard for your child to pay attention or to learn; these issues may only become noticeable as your child grows older.[1-7]
- Separate from the direct, chemical effects of marijuana on a baby, use of marijuana may affect a mother's ability to be able to properly care for her baby.

Does using marijuana affect breastfeeding?

- Chemicals from marijuana can be passed to your baby through breast milk. THC is stored in fat and is slowly released over time, meaning your baby could still be exposed even after you stop using marijuana.
- However, data on the effects of marijuana exposure to your baby through breastfeeding are limited and conflicting. To limit potential risk to the infant, breastfeeding mothers should avoid marijuana use.[11, 14-16]

Fast Facts

- Using marijuana during pregnancy may impact your baby's development.[1-7]

- About 1 in 20 women in the United States reports using marijuana while pregnant.[8]

1 IN 20
use marijuana while pregnant

- The chemicals in any form of marijuana may be bad for your baby – this includes eating or drinking, creams or lotions applied to skin, smoking, vaping and dabbing.[9]
- If you're using marijuana and are pregnant or are planning to become pregnant, talk to your doctor.

For more information, visit:

- Smoking During Pregnancy: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm
- Treating for Two: https://www.cdc.gov/pregnancy/meds/treatingfortwo/index.html

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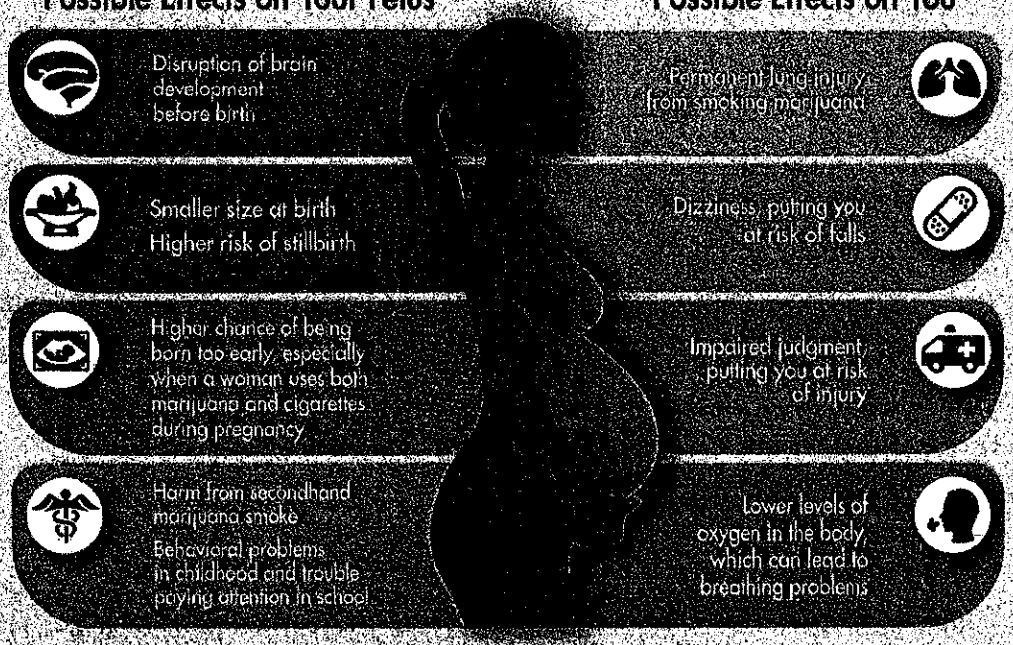
Marijuana AND Pregnancy

If you use marijuana during pregnancy, you may be putting your health and your fetus's health at risk.



Did you know?

- Medical marijuana is not safer than recreational marijuana. Recreational and medical marijuana may be legal in some states, but both are illegal under federal law.
- There's no evidence that marijuana helps morning sickness (ask your obstetrician–gynecologist [ob-gyn] about safer treatments).
- You also should avoid marijuana before pregnancy and while breastfeeding.

Marijuana and pregnancy don't mix. If you're pregnant or thinking about getting pregnant, don't use marijuana.

If you need help quitting marijuana, talk with your ob-gyn or other health care professional.

Research is limited on the harms of marijuana use for a pregnant woman and her fetus. Because all of the possible harms are not fully known, the American College of Obstetricians and Gynecologists (ACOG) recommends that women who are pregnant, planning to get pregnant, or breastfeeding not use marijuana. ACOG believes women who have a marijuana use problem should receive medical care and counseling services to help them quit.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS
409 12th Street SW, PO Box 96920
Washington, DC 20090-6920
www.acog.org

PFS1645. This information was designed to be educational aid to patients and may help you understand information and questions related to women's health. It is not intended as a statement of the standard of care, nor does it constitute all proper treatments or methods of care. If you're unable to find a treating clinician's independent professional judgment. Please seek the guidance of your doctor or other qualified clinician.

12345/21098

MARIJUANA AND YOUR BABY

Marijuana is now legal for adults over 21 but this doesn't mean it is safe for pregnant or breastfeeding moms or babies. You should not use marijuana while you are pregnant, just like you should not use alcohol and tobacco.

KNOW THE FACTS

Marijuana and Pregnancy:

- Using marijuana while pregnant may harm your baby. Marijuana that passes to your baby during pregnancy may make it hard for your child to pay attention and learn, especially as your child grows older. This would make it harder for your child to do well in school.
- Tetrahydrocannabinol (THC) is the chemical in marijuana that makes you feel "high." Using marijuana while you are pregnant passes THC to your baby.
- Some hospitals test babies after birth for drugs. If your baby tests positive for THC at birth, Colorado law says child protective services must be notified. Talk to your doctor early in your pregnancy about any marijuana use.

Marijuana and Breastfeeding:

- The American Academy of Pediatrics says that mothers who are breastfeeding their babies should not use marijuana.
- Breastfeeding has many health benefits for both the baby and the mother. But THC in marijuana gets into breast milk and may affect your baby.
- Because THC is stored in body fat, it stays in your body for a long time. A baby's brain and body are made with a lot of fat. Since your baby's brain and body may store THC for a long time, you should not use marijuana while you are pregnant or breastfeeding.
- Breast milk also contains a lot of fat. This means that "pumping and dumping" your breast milk may not work the same way it does with alcohol. Alcohol is not stored in fat so it leaves your body faster.

Talk to your doctor if you are pregnant or breastfeeding and need help to stop using marijuana. Or call 1-800-CHILDREN for help.

MYTHS ABOUT MARIJUANA

Marijuana is not safe to use while pregnant or breastfeeding.

You cannot eat or use some foods and medicines while pregnant or breastfeeding. This is because they might harm the baby. This includes marijuana.

Even though marijuana is legal, it is not safe.

Using marijuana during pregnancy may harm your baby, just like alcohol or tobacco. Being legal does not make it safe.

Although marijuana is natural, it is not safe.

Not all natural substances or plants are safe. Tobacco and poisonous berries are great examples. Marijuana contains THC, which may harm a baby.

Although some people use marijuana as medicine, it is not safe.

Marijuana can be recommended by a doctor in special cases. A doctor decides whether the benefits are greater than the risks. It is unsafe to use any medicines while pregnant or breastfeeding that are not recommended by a doctor. This includes marijuana. Talk to your doctor about safer choices that do not risk harming your baby.

THINGS YOU SHOULD KNOW

Is smoking marijuana bad for my baby?

Yes. Breathing marijuana smoke is bad for you and your baby. Marijuana smoke has many of the same chemicals as tobacco smoke. Some of these chemicals can cause cancer. Do not allow anyone to smoke in your home or around your baby.

What if I use marijuana without smoking it?

THC in any form of marijuana may be bad for your baby. Some people think that using a vape pen or eating marijuana (like cookies or brownies) is safer than smoking marijuana. Even though these forms do not have harmful smoke, they still contain THC.

How can I store marijuana safely?

Store all marijuana products in a locked area. Make sure your children cannot see or reach the locked area. Keep marijuana in the child-resistant packaging from the store.

What happens if my child eats or drinks marijuana by accident?

- Marijuana can make children very sick. Look for problems walking or sitting up, starting to be sleepy or having a hard time breathing.
- If you are worried, call the poison control hotline as soon as possible. Calling is free and you will be helped quickly: 1-800-222-1222.
- If symptoms seem bad, call 911 or go to an emergency room right away

What else should I know to keep my baby safe?

- Being high or buzzed while doing some activities can be risky.
- Being high while caring for a baby is not safe. Do not let anyone who is high take care of your baby.
- Some marijuana can make people feel very sleepy when they are high. It is not safe for your baby to sleep with you, especially if you are high.
- If you plan to use marijuana, make sure there is another person who can safely care for your baby.
- It is not safe to drive a car while high. Do not let your baby ride in a car if the driver is high.
- All marijuana products must use the universal symbol on packaging and edible products. Be sure to teach your kids not to eat or drink anything with this symbol.

REFERENCES: All information on the health effects of marijuana comes from the Monitoring Health Concerns Related to Marijuana in Colorado: 2016 *Report. Colorado.gov/pacific/cdphe/retail-marijuana-public-health-advisory-committee*

COLORADO
Department of Public Health & Environment

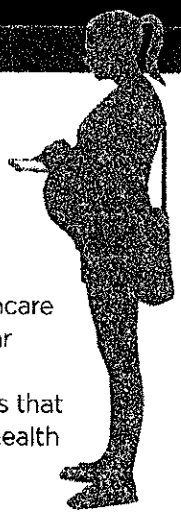
JUNE 2017

Pregnancy Planning for Women Being Treated for Opioid Use Disorder

How does opioid use disorder (OUD) treatment affect pregnancy?

- Your chances of becoming pregnant increase as your OUD treatment becomes more effective.
- An unplanned pregnancy can impact your recovery because it can add complications to your life when you are already dealing with many changes.
- If you want to wait until you are better prepared to become pregnant, your care team can help you find out about your family planning options.
- You will need to start taking 1 milligram of folic acid or a prenatal vitamin with 1 milligram of folic acid daily:
  - Before you become pregnant.
  - If you are pregnant.

- Babies exposed to opioids before birth may develop withdrawal signs called neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS). Longer term effects of OUD medicine on the infant are possible, but more research needs to be done to understand these longer term effects.
- Your OUD medicine dose may change during your pregnancy.
  - Your dose may need to be temporarily increased during your third trimester when your body changes the most.
  - You should never change your medicine routine unless you have talked to your care team first.
  - Changing your dose will NOT change the severity of NAS/NOWS for your baby.
- Your pregnancy will be safest if:
  - You are living in a calm, stable place.
  - You know you can maintain your recovery.
  - You take care of yourself and are ready to be a mother.



What should you do if you become pregnant while being treated for OUD?

- Talk to your care team about questions you may have.
- Begin prenatal care with your healthcare provider as soon as possible. Regular medical prenatal visits can provide pregnancy screenings for conditions that should be treated to ensure good health for you and your baby.
- Don't assume that your treatment medicines like methadone or buprenorphine are dangerous. They can be used safely during pregnancy.
- Discuss your treatment options with your care team. The risk for relapse is high when people stop taking their treatment medicines, so it is important for many women to continue taking them. Any decisions about OUD medicine should be made carefully with you and your provider.

What should you consider when planning a pregnancy?

- Discuss how to prepare for pregnancy with your care team.
  - They can help you quit smoking and drinking alcohol and offer other suggestions to help you.
  - If you don't have an OB/GYN provider, your care team can recommend one.
- At your first appointment with your OB/GYN provider, discuss all your medicines, including those you are taking for OUD.
- Talk to your care team about safe options for treating pain during or shortly after delivery.
- Think about seeking additional counseling or another form of support.
  - Pregnancy and parenting can be stressful and overwhelming.
  - Counseling can help you make good decisions about your health.
- Your care team can work with you to stay on track with your recovery.

Planning for Pregnancy While Being Treated for Opioid Use Disorder

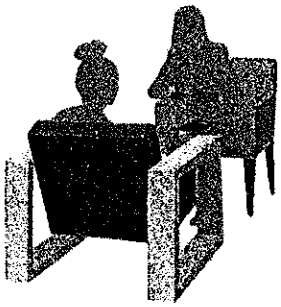
What do you need to do when you are pregnant?

As soon as you find out you are pregnant

- Contact your OUD care team immediately to let them know of your pregnancy.
  - They will advise you about any potential changes in your treatment.
  - They can help you find an OB/GYN provider if you don't have one.

- Make your first medical appointment with an OB/GYN provider for prenatal care and follow the schedule of visits that your OB/GYN provider recommends.
- Talk with your OB/GYN provider about your medical history, especially if you suffer from anxiety, depression, bipolar disorder, attention deficit hyperactivity disorder, hypertension, or diabetes.
- Ask your care team about which medicines are safe to use during pregnancy and which are not safe; you might need to make some changes.
- Stop using alcohol and tobacco and drugs that are harmful to pregnancy.
  - Quitting smoking and drinking while in (or getting into) treatment may improve your chances of recovery from other substances.
  - Smoke-free environments and abstaining from drinking alcohol during pregnancy are best for your child's lifelong health.

During your pregnancy



- Learn about NAS/NOWS.
  - Find out what you can expect during your pregnancy and after delivery to reduce NAS/NOWS severity.
  - Ask your care team about breastfeeding, safe sleep practices, and other ways to comfort your baby and keep your baby healthy.
- Participate in childbirth classes before the baby is born and parenting classes during and after pregnancy.
- Learn as much as you can about how to provide a safe and healthy home for your baby.
- Remember that help is available to you and your baby after birth.

  - Your pediatric provider can answer your questions about your baby's development.
  - Early childhood programs (e.g., State Pre-K, Head Start, Early Head Start, Model Early Childhood Programs, Nurse Home Visiting) are available for all family members.

Identify people you can count on before and after your baby is born

- Think about who is in your circle of friends and family now.
  - Will people in your circle help you during the pregnancy and after your baby arrives?
  - Will they help you provide a safe environment to raise your baby?
- If you answer no to either of these questions, talk with your care team about finding support before, during, and after your baby arrives.
- Ask for help whenever you need it.
  - Pregnancy can add a lot of stress to your life and may impact your ability to stay in recovery.
  - Your group or individual therapy classes can help you while you are pregnant and afterward.
  - Counseling or other types of support can keep you on track with recovery and prepare you for the rewards and challenges of being a mother.

- Stay connected and ask your care team for help when you feel sad or depressed.

Take care of yourself. A healthy mother means a healthy baby!

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
HHS Publication No. (SMA) 19-5094-FS

SAMHSA
Substance Abuse and Mental Health Services Administration

Opioid Use Disorder and Pregnancy

Taking helpful steps for a healthy pregnancy

Introduction

If you have an opioid use disorder (OUD) and are pregnant, you can take helpful steps now to ensure you have a healthy pregnancy and a healthy baby. During pregnancy, OUD should be treated with medicines, counseling, and recovery support. Good prenatal care is also very important. Ongoing contact between the healthcare professionals treating your OUD and those supporting your pregnancy is very important.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know, about OUD and pregnancy, as well as the Do's and Don'ts for making sure you have a healthy pregnancy and a healthy baby.

Things to know

- OUD is a treatable illness like diabetes or high blood pressure.
- You should not try to stop opioid use on your own. Suddenly stopping the use of opioids can lead to withdrawal for you and your baby. You may be more likely to start using drugs again and even experience overdoses.
- For pregnant women, OUD is best treated with the medicines called methadone or buprenorphine along with counseling and recovery support services. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- Tobacco, alcohol, and benzodiazepines may harm your baby, so make sure your treatment includes steps to stop using these substances.
- Depression and anxiety are common in women with OUD, and new mothers may also experience depression and anxiety after giving birth. Your healthcare professionals should check for these conditions regularly and, if you have them, help you get treatment for them.
- Mothers with OUD are at risk for hepatitis and HIV. Your healthcare professionals should do regular lab tests to make sure you are not infected and, if you are infected, provide treatment.
- Babies exposed to opioids and other substances before birth may develop neonatal abstinence syndrome (NAS) after birth. NAS is a group of withdrawal signs. Babies need to be watched for NAS in the hospital and may need treatment for a little while to help them sleep and eat.

About OUD

People with OUD typically feel a **strong craving for opioids** and find it hard to cut back or stop using them. Over time, many people **build up a tolerance** to opioids and need larger amounts. They also spend more time looking for and using opioids and less time on everyday tasks and relationships. Those who suddenly reduce or stop opioid use may suffer **withdrawal symptoms** such as nausea or vomiting, muscle aches, diarrhea, fever, and trouble sleeping.

If you are concerned about your opioid use or have any of these symptoms, please check with your **healthcare professionals** about treatment or tapering or find a provider at this website: **www.samhsa.gov/find-help.**

☑ Do

Do talk with your healthcare professionals about the right treatment plan for you.

Do begin good prenatal care and continue it throughout your pregnancy. These two websites give helpful information on planning for your pregnancy: **http://bit.ly/ACOGprenatal** and **http://bit.ly/CDCprenatal**.

Do stop tobacco and alcohol use. Call your state's Tobacco Quit Line at 800-QUIT-NOW (800-784-8669).

Do talk to your healthcare professionals before starting or stopping any medicines.

Do get tested for hepatitis B and C and for HIV.

Do ask your healthcare professionals to talk to each other on a regular basis.

☒ Don't

Don't hide your substance use or pregnancy from healthcare professionals.

Don't attempt to stop using opioids or other substances on your own.

Don't let fear or feeling embarrassed keep you from getting the care and help you need.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy

The healthcare professionals who are treating your OUD and providing your prenatal care need a complete picture of your overall health. Together, they will make sure you are tested for hepatitis B and C and for HIV. They will ask you about any symptoms of depression or other feelings. You should be ready to answer questions about all substances you have used. They need this information to plan the best possible treatment for you and to help you prepare for your baby. These issues may be hard to talk about, but do the best you can to answer their questions completely and honestly. Expect them to treat you with respect and to answer any questions you may have.

Remember: Pregnancy is a time for you to feel **engaged** and **supported**. Work with your healthcare professionals to gain a better understanding of what you need for a healthy future for you and your baby.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

_____

_____

_____

_____

Next Appointment Date: _____ Time: _____ Location: _____

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HHS Publication No. SMA-18-5071FS1

SAMHSA
Substance Abuse and Mental Health Services Administration

OPIOID USE DISORDER AND PREGNANCY

- Are you using more opioids than prescribed?
- Do you feel a strong urge to use opioids?
- Does your opioid use cause work, school, or family problems?
- Do you need more opioids to get the same effect?

If you answered YES to any of these questions, you may have an opioid addiction, also called opioid use disorder.

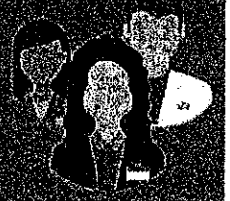
Opioid use disorder during pregnancy can harm you and your fetus.
If you are pregnant and addicted to opioids, you need medical treatment.

How Treatment Works

The recommended treatment for opioid addiction involves the following:

Taking medication that reduces your cravings (methadone or buprenorphine)

Getting behavioral therapy and counseling



Why Treatment Matters

In the right doses, methadone or buprenorphine can

- prevent withdrawal symptoms, cravings, and unhealthy use of opioids
- help prevent overdose
- make it more likely that your fetus will grow normally
- help prevent an early birth

Counseling and good prenatal care can

- help you avoid and cope with situations that might lead to relapse
- help you have a healthier baby
- help you regain control of your health and life

Did You Know?

- If you are prescribed an opioid during pregnancy, you should discuss the risks and benefits with your obstetrician–gynecologist (ob-gyn) or other health care professional.
- When taken under a doctor's care, prescription opioids can be safe for both you and your fetus.
- It is important to take the medication only as prescribed.

Treatment and Your Newborn

Babies born to women taking methadone or buprenorphine can have short-term withdrawal symptoms. Swaddling, breastfeeding, skin-to-skin contact, and sometimes medications can help make babies feel better.

REMEMBER, if you are addicted to opioids, ask your ob-gyn or other health care professional about safe treatments.

The American College of Obstetricians and Gynecologists believes that pregnant women who have an opioid use disorder should receive medical care and counseling services, not punishment. Many states have created treatment programs for pregnant women. Seeking help is the first step in recovering from addiction and making a better life for you and your family.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS
409 12th Street SW, PO Box 96920
Washington, DC 20090-6920
www.acog.org

PREVENTING FASD: HEALTHY WOMEN, HEALTHY BABIES

WHAT YOU NEED TO KNOW

Alcohol abuse is a serious public health concern. Did you know that alcohol can harm a fetus at any point in its development, often before a woman knows she's pregnant?

"Fetal alcohol spectrum disorders" (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD).

If women do not drink alcohol during pregnancy, FASD is 100 percent preventable. The Surgeon General issued an advisory in February 2005 to help share this important message and to urge health professionals to identify and assist women who are drinking or at risk of drinking during pregnancy.

WHO IS AT RISK?

Any pregnant woman who drinks alcohol is at risk of having a child with an FASD, regardless of her education, income, or ethnicity. Women who are at particularly high risk of drinking during pregnancy and having a child with an FASD include:

- Women with substance abuse or mental health problems
- Women who have already had a child with an FASD[1,2]
- Recent drug users
- Smokers
- Women who have multiple sex partners
- Recent victims of abuse and violence

Alcohol is a potent teratogen, a substance that can damage a developing fetus. There is no known safe level of alcohol use during pregnancy, so pregnant women or women who may become pregnant should not drink any alcohol from conception to birth.

Surgeon General's Advisory on Alcohol Use in Pregnancy

- A pregnant woman should not drink alcohol during pregnancy.
- A pregnant woman who has already consumed alcohol during her pregnancy should stop in order to minimize further risk.
- A woman who is considering becoming pregnant should abstain from alcohol.
- Recognizing that nearly half of all births in the United States are unplanned, women of childbearing age should consult their physician and take steps to reduce the possibility of prenatal alcohol exposure.
- Health professionals should inquire routinely about alcohol consumption by women of childbearing age, inform them of the risks of alcohol consumption during pregnancy, and advise them not to drink alcoholic beverages during pregnancy.

—Surgeon General Richard Carmona, February 2005

TREATMENT FOR WOMEN

Many women who need alcohol treatment may not receive it due to lack of money or child care, fear of losing custody of their children, or other barriers. For successful recovery, women often need a continuum of care for an extended period of time, including:

- Comprehensive inpatient or outpatient treatment for alcohol and other drugs
- Case management
- Counseling and other mental health treatment
- Medical and prenatal care
- Child care
- Transportation
- Followup pediatric and early intervention services for children
- Services that respond to women's needs regarding reproductive health, sexuality, relationships, and victimization

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

- Other support services, such as housing, education and job training, financial support services, parenting education, legal services, and aftercare[3]

Research shows that residential substance abuse treatment designed specifically for pregnant women and women with children can have substantial benefits in terms of recovery, pregnancy outcomes, parenting skills, and women's ability to maintain or regain custody of their children.[4]

Three Ways To Prevent FASD

There are three main approaches to preventing FASD:[5]

- Increase public knowledge about FASD through general education, public service announcements, media attention, alcohol warning labels, posters, pamphlets, and billboards.
- Target women at risk by screening pregnant women and women of childbearing age for alcohol use, and by providing interventions with pregnant women who drink and with women who drink and do not use birth control. Brief interventions such as motivational interviewing may be effective at reducing risk.[6]
- Target women at highest risk through treatment of alcohol problems and strategies to encourage pregnancy prevention. Women at risk include those who abuse alcohol while pregnant or who are at risk of becoming pregnant, particularly women who have already given birth to a child with an FASD.

All three strategies are important, but targeting women at increased or highest risk may be more effective in reducing alcohol use during pregnancy. Primary care providers, such as obstetricians/gynecologists and family doctors, play a key role in preventing FASD. They should:

- Talk to their patients about the dangers of drinking alcohol during pregnancy
- Identify women who are at risk by using screening tools such as T-ACE and TWEAK, which ask specific questions about drinking habits[7,8]
- Refer to treatment and other support services women with drinking problems, pregnant women who drink, and women who are at risk of an alcohol-exposed pregnancy

A woman's partner, other family members, and friends can also help prevent FASD by:

- Sharing information with her about FASD and the importance of not drinking during pregnancy
- Modeling safe behavior by not drinking themselves
- Encouraging her to talk about problems in her life that may lead her to drink
- Helping her find treatment if she cannot stop drinking

Conclusion

Drinking during pregnancy can cause permanent damage to a fetus. However, FASD is 100 percent preventable. The only cause of FASD is prenatal exposure to alcohol. If a woman does not drink alcohol while she is pregnant, her baby will not have an FASD. Health care providers, families, friends, and other community members all have a role in addressing FASD.

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Stop and think. If you're pregnant, don't drink.

For more information, visit **fasdcenter.samhsa.gov** or call 866-STOPFAS.

www.stopalcoholabuse.gov

Substance Abuse and Mental Health Services Administration
A Life in the Community for Everyone
U.S. Department of Health and Human Services

SAMHSA
Fetal Alcohol Spectrum Disorders Center for Excellence

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Fetal Alcohol Spectrum Disorder (FASD) Supplement: *Screening*

Who to screen? *All women of childbearing age.*

1) preconception; 2) during pregnancy; 3) at the time of delivery; 4) in postnatal period - especially if breastfeeding; 5) at all GYN and health visits. Rescreen every year or following life changes or increase in stressors. Parental screening by pediatric providers is recommended by the American Academy of Pediatrics.

Why screen?

- Fetal Alcohol Spectrum Disorders (FASD) are completely preventable.
- Fetal Alcohol Syndrome (FAS) is the leading preventable cause of mental retardation.
- FASD occurs in approx. 10/1,000 births: in Colorado that equals ~700 cases/yr. This outranks Down syndrome and autism in prevalence.
- 50% of pregnancies are unplanned.
- A woman can expose a pregnancy to alcohol even before she knows she is pregnant.
- **There is no known time or amount of alcohol that is safe during pregnancy.**

Definition/Problem:

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term that describes the range of effects that can occur to an individual whose mother drank during pregnancy. These include physical, mental, behavioral, and learning disabilities. Fetal Alcohol Syndrome (FAS) is on the severe end of the spectrum and characterized by facial dysmorphia, growth restriction, and CNS abnormalities. However, most individuals affected by prenatal exposure do not display the facial dysmorphia or growth deficits of FAS.

- **Alcohol is a teratogen.** Adverse effects of alcohol on the fetus may be exacerbated by other teratogens.
- Maternal factors such as nutrition and mental illness may mitigate or exacerbate effects of alcohol.

1. Assess alcohol use + 2. Assess risk for pregnancy = 3. Alcohol Exposed Pregnancy (AEP) Risk

Use SBIRT Guideline at www.healthteamworks.org.

Brief Screen for Alcohol:

1. When was the last time you had more than 3 drinks in one day?
   ***Positive** = in past 3 months*
2. How many drinks do you have per week?
   ***Positive** = more than 7*
   ***Recommendation**: verify quantity and frequency of usual alcohol intake - do the math!*

Any alcohol use is a positive screen for a pregnant woman, a woman trying to become pregnant, or an adolescent.

For positive Brief Screen, do further screening using a Brief Assessment Instrument such as the AUDIT.

- Able to get pregnant? (no = hysterectomy or permanent sterilization)
- Sexually active with a male or planning pregnancy by other method?
- Non-use or incorrect use of contraception?
- Use of non-effective method of contraception?

Ask (can be self-administered):

- Are you pregnant? ☐ Yes ☐ No ☐ Don't Know
- Are you able to get pregnant? ☐ Yes ☐ No ☐ Don't Know
- In the last year have you had sex with a male? ☐ Yes ☐ No
- When you have sex do you use something to prevent pregnancy:
  ☐ all the time
  ☐ most of the time
  ☐ sometimes
  ☐ not at all
- What method(s) do you use to prevent pregnancy?

- Did the patient use an effective method of pregnancy prevention? ☐ Yes ☐ No
- Was the method used 100% correctly? ☐ Yes ☐ No
  - If no, was a backup method used every time? ☐ Yes ☐ No
- Is the patient planning to become pregnant in the next year? ☐ Yes ☐ No
- Is the patient at risk for unintended sexual contact due to alcohol and/or drug use? ☐ Yes ☐ No

Negative AEP Risk:

- *Correctly using an effective contraceptive method, not planning a pregnancy in the next year and not at risk for unintended sex* ***-or-*** *Unable to get pregnant*

-and-

- *Negative alcohol screen* ***-or-*** *No alcohol use in a pregnant woman*

Do a brief intervention to:

- Address hazardous or harmful use of alcohol and refer to treatment, if indicated.
- Address pregnancy prevention.

COUNSEL: ***No amount of alcohol is considered safe during pregnancy. Pregnancy should be delayed until individuals are alcohol free.***

Myths about alcohol and pregnancy

- **Science is unclear about the effects of alcohol on the developing fetus: FALSE.**
  3,000+ research studies since 1973 describe the risks of alcohol during pregnancy. The conclusion is overwhelming and clear. Since 1982 the United States Surgeon General has advised women to abstain from alcohol during pregnancy to prevent birth defects. (NOFAS, 2010)
- **Only heavy or binge drinking can harm the fetus: FALSE.**
  Effects of prenatal alcohol exposure occur on a continuum. Rather than a threshold, there is a dose-response effect. Also, harm may occur at all stages of pregnancy. (NOFAS, 2010)
- **Only hard liquor is harmful. Beer and wine are okay: FALSE.**
  All alcohol acts as teratogen. Since some individuals and cultures do not view beer as alcohol, it is important to specify all forms of alcoholic drinks when screening patients. (NOFAS, 2010)
- **Health professionals infrequently see patients with Fetal Alcohol Syndrome and FASD is no longer a significant health issue: FALSE.**
  Individuals with FASD are in every system of care. As of 2008, only ~6 medical schools offered training on FASD. Many practitioners have not been educated on addiction medicine or trained to diagnose FASD in children or adults. (NOFAS, 2010)

This supplement is designed to assist clinicians in alcohol screening and management. It is not intended to replace a clinician's judgment or establish a protocol for all patients with a particular condition.
For references, important updates and copies of the supplement go to www.healthteamworks.org or call 720-297-1681 or 1-866-401-2092. Funding for this supplement was provided by SAMHSA. Completed on August 26, 2010.

Fetal Alcohol Spectrum Disorder (FASD) Supplement: *Intervention*

GOAL:
To encourage behavior change(s) to decrease risk of alcohol exposed pregnancy.

- ***» Ask permission before providing feedback.***
- ***» Remain neutral and factual.***
- ***» Elicit reaction before and after each step.***

A. Provide feedback about screening results

Alcohol Use +
Review moderate and risky drinking levels.

Feedback (2002 BRFSS):
- ~47% of women 18-44 yrs drink at moderate levels
- ~ 13% of women 18-44 yrs drink at risky levels

Pregnancy Risk =
Review effectiveness of current contraception and effectiveness of use.

Feedback, in the United States:
- 50% of all pregnancies in the are unplanned
- 82% of pregnancies in the 15-19 yr. old age group are unplanned

Risk for an Alcohol Exposed Pregnancy (AEP)
Feedback:
- Because you are at risk for pregnancy and using alcohol you are at risk of an AEP
- Many women do not find out they are pregnant until the 6th-8th week
- No known safe time /no known safe amount of alcohol during pregnancy

Offer brochures/fact sheets on AEP and FASD.

B. Discuss options to decrease risk; Patient chooses behavior(s)

****Decrease risk of AEP by changing alcohol use, increasing effective contraception used correctly, or both.***

Options: Pregnant patient
- *Stop drinking*
- Improve nutrition
- Decrease stress
- Stop other drug use
- Stop tobacco use
- Maintain pre-natal care

Options: Not pregnant/not wanting pregnancy
- *Use effective contraception correctly*
- Drink below risk levels
- Stop other drug use
- Stop tobacco use

Options: Not pregnant/wanting pregnancy
- *Stop drinking*
- Stop tobacco
- Stop other drug use
- Improve nutrition
- Decrease stress
- *Use effective contraception correctly until pre-conceptual health achieved*

C. Assess motivation; Set goals and plan

1. **Assess Motivation to change:** use 0-10 ruler to assess Importance, Readiness for identified targeted behavior(s), and Confidence. (If pregnant, choose a behavior other than birth control.)
   > Ask patient "Why this number and not a lower or higher number?"
   > Listen for change talk:
   D *(desire)* **A** *(ability)* **R** *(reason)* **N** *(need)* **C** *(commitment)* **A** *(activation)* **T** *(taking steps).*
   > Respond to change talk:
   E *(elaborate)* **A** *(affirm)* **R** *(reflect)* **S** *(summarize).* Probe for anything else.

2. **Set Goals and Develop a Plan**
   Consider referral to treatment if patient is motivated or having difficulty setting/achieving goals.

D. Follow up at every visit for women at risk for an AEP

All patients:
- Assess urges, cravings, high risk situations, and alcohol use
- Develop and review emergency plan for high risk situations.
- Monitor stressful life events and significant life changes
- Assess motivation for treatment or engagement in treatment
- Designate support person

Pregnant patient:
- Monitor need to add other behaviors to the plan
- Engage in activities and information to increase bond with the baby
- Consider need for more frequent visits

Not pregnant/not wanting pregnancy:
- Encourage contraception compatible with lifestyle
- Monitor for correct use, side effects, difficulty in use
- Include back up plan
- Consider whether alcohol/drugs are interfering with plan
- Monitor contraception use monthly until stable

Not pregnant/wanting pregnancy:
- Evaluate importance, readiness, confidence for healthy pregnancy
- Encourage contraception compatible with life style until pre-conceptual health achieved, and alcohol/drug free
- Monitor for correct use, side effects, difficulty in use
- Include back-up plan

Substance Abuse Services for Women

1. **Regional Managed Service Organizations (MSOs):** Can assist with locating an appropriate treatment agency or with referral to a Division of Behavioral Health (DBH) accredited treatment program:
   - Region 1: Northeast region of the state: Signal Behavioral Health Network, Inc. 1-888-607-4462
   - Region 2: Denver Metropolitan Area: Signal Behavioral Health Network, Inc. 1-888-607-4462
   - Region 2: Boulder County: Boulder County Health Department 303-441-1292
   - Region 3: Colorado Springs Service Area: Connect Care 1-719-572-6133 or 1-888-845-2881
   - Region 5 & 6: Central Mountain and Western Slope Services: West Slope CASA 1-800-804-5008

2. **Personal DECISIONS:** Resource for providers and women in the community who are drinking and want to change their behavior. A woman who calls will be assessed for AEP risk and other concerns and then sent a packet of information with resources, referral information, and self-guided change information. Once the woman completes the packet she may share it with her provider for a more focused brief intervention. 1-888-724-3273. The message is in both English and Spanish.

3. **Specialized Women's Services (SWS):** To learn about funding and services set aside for women in CO who use or abuse substances:
   http://www.cdhs.state.co.us/adad/PDFs/ItemsfortheWomenstreatmentWebsite.pdf

Legal and Confidentiality Considerations

1. Pregnant women have priority status for treatment in Colorado.
2. Confidentiality regulations for substance use/abuse are different than HIPAA, know the law.
3. Drinking during pregnancy in and of itself is not a violation of the law. Women need treatment for substance abuse.
4. Separate and specific release of information is required for alcohol and drugs.

Assessment and Diagnosis of FASD

Colorado FASD Diagnostic Clinics:
- Sewall Child Development Center: Diagnostic & Evaluation (up to age 10): 303-399-1800
- The Children's Hospital Child Development Unit: 720-777-6630

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TOBACCO and Pregnancy

Smoking during pregnancy is dangerous for you and your fetus. If you use cigarettes or e-cigarettes, now is the time to quit.

RISKS FOR YOUR FETUS

- Delayed growth
- Higher chance of being born too early
- Permanent brain and lung damage
- Higher risk of stillbirth

RISKS FOR YOUR NEWBORN

- Smaller size at birth
- Colic with uncontrollable crying
- Sudden infant death syndrome (SIDS)
- Development of obesity and asthma during childhood

RISKS FOR YOU

- Ectopic pregnancy (a pregnancy outside of the uterus)
- Problems with the placenta
- Problems with your thyroid
- Water breaking too early

QUITTING SMOKING

will help you have a healthy pregnancy and a healthy baby.

Did You Know ?

- Nicotine is only one of 4,000 toxic chemicals in cigarettes.
- Using e-cigarettes (vaping) is not a safe substitute for smoking cigarettes.
- Other smokeless tobacco products, like snuff and gel strips, also are not safe.
- Secondhand smoke can cause growth problems for your fetus and increase your baby's risk of SIDS.

If you need help quitting, talk with your obstetrician–gynecologist (ob-gyn) or other health care professional. Or call the national smoker's quit line at 1-800-QUIT-NOW.

The American College of Obstetricians and Gynecologists believes that pregnant women who use tobacco should receive counseling to help them quit. Your ob-gyn or other health care professional can offer advice about quitting at your first prenatal visit or at any time throughout your pregnancy.

The American College of Obstetricians and Gynecologists
www.acog.org
409 12th Street SW, PO Box 96920
Washington, DC 20090-6920
www.acog.org

Smoking and Pregnancy

Smoking can cause problems for a woman trying to become pregnant or who is already pregnant, and for her baby before and after birth.

Effects on Women

- Difficulty getting pregnant
- Placenta separates from the womb too early, causing bleeding
- Placenta covers the cervix, causing complications
- Water breaks too early
- Pregnancy occurs outside of the womb

Smoking causes these health effects.

Smoking could cause these health effects, but more studies are needed to be sure.

Effects on Babies

- Baby born too small
- Baby born too early
- Sudden Infant Death Syndrome
- Stillbirth
- Infant death
- Cleft lip/palate
- Certain birth defects, such as:
  - Clubfoot
  - Gastroschisis
  - Some heart defects
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Miscarriage

Quitting Smoking Can Be Hard, But It Is One of the Best Ways a Woman Can Protect Herself and Her Baby's Health

If you or someone you know wants to quit smoking, talk to your healthcare provider about strategies. For support in quitting, including free quit coaching, a free quit plan, free educational materials, and referrals to local resources, please call 1-800-QUIT-NOW (1-800-784-8669); TTY 1-800-332-8615.

For additional resources to help quit smoking, visit www.cdc.gov/reproductivehealth/TobaccoUsePregnancy/Resources.htm

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Updated based on 2014 Surgeon General's Report

CS245221

2019

13. Patient Handouts on Naloxone, Suboxone, and Subutex

SBIRT/OB RESOURCE GUIDE

PATIENT HANDOUT: HOW TO USE NALOXONE

What are opioids?

Opioids are generally used to **treat pain** and include both prescription painkillers and heroin.

What is an opioid emergency or overdose?

Opioids can cause a person's **breathing to slow or even stop**—this is considered an overdose. **All opioids put people at risk.**

What is naloxone?

Naloxone temporarily **blocks the effects** of opioids, and can reverse overdose. Naloxone only works if **opioids** are in the body and has no effects on alcohol or other drugs. It takes **2-5 minutes** to start working, and may require more than one dose. The effects of naloxone last for between **30-90 minutes**.

Naloxone may cause an opioid dependent person to go into **withdrawal** (e.g. *nausea, vomiting, agitation, muscle aches*). These symptoms **will go away** as the naloxone wears off.

Signs of an opioid emergency or overdose:

- A person is **unresponsive** and won't wake up even if you shake them or say their name loudly
  Try to wake the person by vigorously rubbing knuckles up and down the front of their rib cage (sternal rub)
- Breathing slows or even stops
- Lips and/or fingernails turn blue, pale or gray

IN CASE OF OVERDOSE:

1. **Call 911**
   Follow dispatcher instructions.
2. **Give naloxone.**
   See reverse for instructions. If no reaction in 3 minutes, give second dose.
3. **After naloxone**
   Stay with the person for 3 hours (as long as you can) or until help arrives. Make sure the person **does not take more opioids** even if they don't feel well. **If the person is still unresponsive,** lay them on their side, wait for help.
4. **If you know how, do rescue breathing and/or CPR**
   See reverse for instructions or follow 911 dispatcher instructions.

Opioids include:

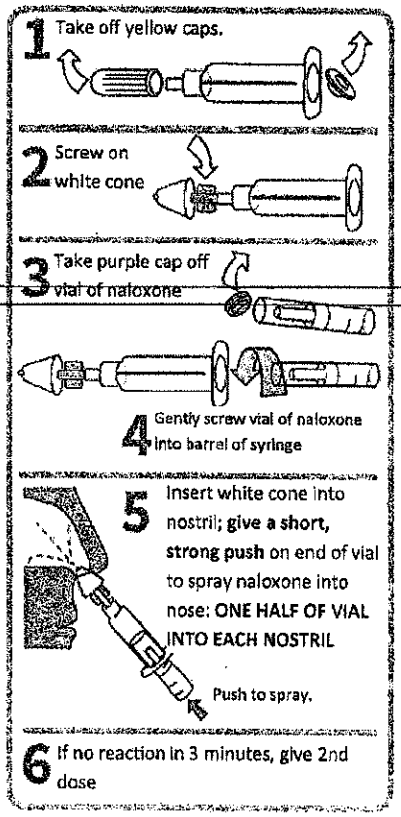
GENERIC	BRAND NAME
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morphine	MSContin, Kadian, Embeda, Avinza
Codeine	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans
Heroin	

It is important to **share this information** with family and friends. Create a plan of action so others are prepared to respond in case of emergency. Tell people **where your naloxone is** so it is easily accessible in case of emergency.

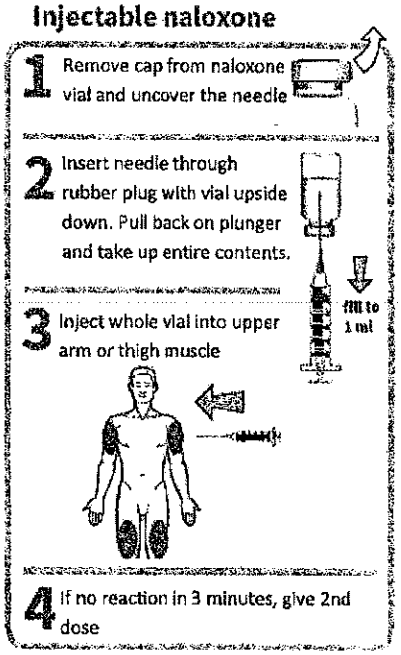
NOTE: The New York State 911 Good Samaritan Law provides substantial protection to anyone calling 911 to save a life, even if drugs are present.

Administering naloxone:

Nasal spray naloxone



Injectable naloxone



Auto-injector

The naloxone auto-injector is FDA approved for use by anyone in the community. It contains a speaker that provides instructions to inject naloxone into the outer thigh, through clothing if needed.

REDUCE RISK

Certain factors can increase risk of opioid emergency or overdose:

- **Changes in tolerance** *(how much of the drug your body can handle)*: Resuming opioid use after a period of abstinence and changing medicines can increase risk.
- **Mixing other drugs or medications** – such as alcohol, benzodiazepines (e.g. Xanax® or Valium®), or cocaine – with opioids can increase risk of overdose.
- **Taking opioids by yourself** increases the chance that if anything happens, you will not get help.

Resuscitation

- If you are trained in CPR you may do this.
- If you only know rescue breathing or chest compressions do one of those
- Follow the instructions of the 911 dispatcher

When to get a refill:

Please get a refill if:

- One of more doses of naloxone are used
- Naloxone or any piece of the applicator is lost or damaged
- Naloxone is nearing expiration date or is expired

If possible, store naloxone at room temperature, away from direct light.

For a list of New York State registered Opioid Overdose Prevention Programs where you can access free naloxone, please visit: http://www.health.ny.gov/overdose

For information on treatment options call the OASAS HOPEline: 1-877-8-HOPENY (877-846-7369) or visit http://www.oasas.ny.gov/

harm reduction COALITION

www.harmreduction.org

MEDICATION GUIDE

SUBOXONE® (Sub-OX-own)
(buprenorphine and naloxone)
Sublingual Tablets (CIII)

IMPORTANT:

Keep SUBOXONE in a secure place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally uses SUBOXONE, get emergency help right away.

Read this Medication Guide that comes with SUBOXONE before you start taking it and each time you get a refill. There may be new information. This Medication Guide does not take the place of talking to your doctor. Talk to your doctor or pharmacist if you have questions about SUBOXONE.

Share the important information in this Medication Guide with members of your household.

What is the most important information I should know about SUBOXONE?

- SUBOXONE can cause serious and life-threatening breathing problems. Call your doctor right away or get emergency help if:
  - You feel faint, dizzy, or confused
  - Your breathing gets much slower than is normal for you

  These can be signs of an overdose or other serious problems.
- Do not switch from SUBOXONE to other medicines that contain buprenorphine without talking with your doctor. The amount of buprenorphine in a dose of SUBOXONE may not be the same as the amount of buprenorphine in other medicines that contain buprenorphine. Your doctor will prescribe a starting dose of SUBOXONE that may be different than other buprenorphine containing medicines you may have been taking.
- SUBOXONE contains an opioid that can cause physical dependence.
  - Do not stop taking SUBOXONE without talking to your doctor. You could become sick with uncomfortable withdrawal signs and symptoms because your body has become used to this medicine
  - Physical dependence is not the same as drug addiction
  - SUBOXONE is not for occasional or "as needed" use
- An overdose, and even death, can happen if you take benzodiazepines, sedatives, tranquilizers, antidepressants, or alcohol while using SUBOXONE. Ask your doctor what you should do if you are taking one of these.
- Call a doctor or get emergency help right away if you:
  - Feel sleepy and uncoordinated

- Have blurred vision
- Have slurred speech
- Cannot think well or clearly
- Have slowed reflexes and breathing

- Do not inject ("shoot-up") SUBOXONE.
  - Injecting SUBOXONE may cause life-threatening infections and other serious health problems.
  - Injecting SUBOXONE may cause serious withdrawal symptoms such as pain, cramps, vomiting, diarrhea, anxiety, sleep problems, and cravings.

- In an emergency, have family members tell the emergency department staff that you are physically dependent on an opioid and are being treated with SUBOXONE.

What is SUBOXONE?

- SUBOXONE is a prescription medicine used to treat adults who are addicted to (dependent on) opioid drugs (either prescription or illegal) as part of a complete treatment program that also includes counseling and behavioral therapy.

SUBOXONE is a controlled substance (CIII) because it contains buprenorphine, which can be a target for people who abuse prescription medicines or street drugs. Keep your SUBOXONE in a safe place to protect it from theft. Never give your SUBOXONE to anyone else; it can cause death or harm them. Selling or giving away this medicine is against the law.

- It is not known if SUBOXONE is safe or effective in children.

Who should not take SUBOXONE?

Do not take SUBOXONE if you are allergic to buprenorphine or naloxone.

What should I tell my doctor before taking SUBOXONE?

SUBOXONE may not be right for you. Before taking SUBOXONE, tell your doctor if you:

- Have liver or kidney problems
- Have trouble breathing or lung problems
- Have an enlarged prostate gland (men)
- Have a head injury or brain problem
- Have problems urinating
- Have a curve in your spine that affects your breathing
- Have gallbladder problems
- Have adrenal gland problems
- Have Addison's disease

- Have low thyroid (hypothyroidism)
- Have a history of alcoholism
- Have mental problems such as hallucinations (seeing or hearing things that are not there)
- Have any other medical condition
- Are pregnant or plan to become pregnant. If you take SUBOXONE while pregnant, your baby may have symptoms of opioid withdrawal or respiratory depression at birth. Talk to your doctor if you are pregnant or plan to become pregnant.
- Are breastfeeding or plan to breastfeed. SUBOXONE can pass into your milk and may harm your baby. Talk to your doctor about the best way to feed your baby if you take SUBOXONE. Monitor your baby for increased sleepiness and breathing problems.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins and herbal supplements. SUBOXONE may affect the way other medicines work and other medicines may affect how SUBOXONE works. Some medicines may cause serious or life-threatening medical problems when taken with SUBOXONE.

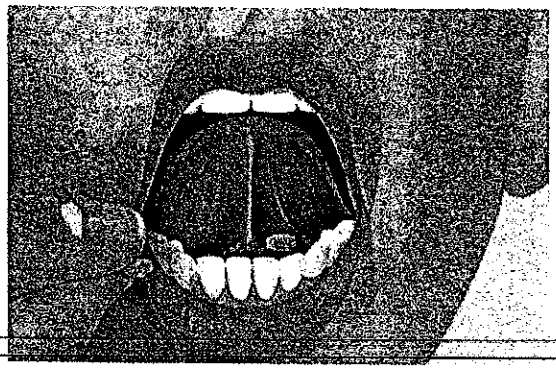
Sometimes the doses of certain medicines and SUBOXONE may need to be changed if used together. Do not take any medicine while using SUBOXONE until you have talked with your doctor. Your doctor will tell you if it is safe to take other medicines while you are taking SUBOXONE.

Be especially careful about taking other medicines that may make you sleepy, such as pain medicines, tranquilizers, antidepressant medicines, sleeping pills, anxiety medicines or antihistamines.

Know the medicines you take. Keep a list of them to show your doctor or pharmacist each time you get a new medicine.

How should I take SUBOXONE?

- Always take SUBOXONE exactly as your doctor tells you. Your doctor may change your dose after seeing how it affects you. Do not change your dose unless your doctor tells you to change it.
- Do not take SUBOXONE more often than prescribed by your doctor.
- If you are prescribed a dose of 2 or more SUBOXONE tablets at the same time:
  - Ask your doctor for instructions on the right way to take SUBOXONE tablets
  - Follow the same instructions every time you take a dose of SUBOXONE tablet
- Put the tablets under your tongue. Let them dissolve completely.



- While SUBOXONE is dissolving, do not chew or swallow the tablet because the medicine will not work as well.
- Talking while the tablet is dissolving can affect how well the medicine in SUBOXONE is absorbed.
- If you miss a dose of SUBOXONE, take your medicine when you remember. If it is almost time for your next dose, skip the missed dose and take the next dose at your regular time. Do not take 2 doses at the same time unless your doctor tells you to. If you are not sure about your dosing, call your doctor.
- Do not stop taking SUBOXONE suddenly. You could become sick and have withdrawal symptoms because your body has become used to the medicine. Physical dependence is not the same as drug addiction. Your doctor can tell you more about the differences between physical dependence and drug addiction. To have fewer withdrawal symptoms, ask your doctor how to stop using SUBOXONE the right way.
- **If you take too much SUBOXONE or overdose, call Poison Control or get emergency medical help right away.**

What should I avoid while taking SUBOXONE?

- **Do not drive, operate heavy machinery, or perform any other dangerous activities until you know how this medication affects you.** Buprenorphine can cause drowsiness and slow reaction times. This may happen more often in the first few weeks of treatment when your dose is being changed, but can also happen if you drink alcohol or take other sedative drugs when you take SUBOXONE.
- **You should not drink alcohol** while using SUBOXONE, as this can lead to loss of consciousness or even death.

What are the possible side effects of SUBOXONE?

SUBOXONE can cause serious side effects including:

- **See "What is the most important information I should know about SUBOXONE?"**
- **Respiratory problems.** You have a higher risk of death and coma if you take SUBOXONE with other medicines, such as benzodiazepines.

- **Sleepiness, dizziness, and problems with coordination**
- **Dependency or abuse**
- **Liver problems.** Call your doctor right away if you notice any of these signs of liver problems: Your skin or the white part of your eyes turning yellow (jaundice), urine turning dark, stools turning light in color, you have less of an appetite, or you have stomach (abdominal) pain or nausea. Your doctor should do tests before you start taking and while you take SUBOXONE.
- **Allergic reaction.** You may have a rash, hives, swelling of the face, wheezing, or a loss of blood pressure and consciousness. Call a doctor or get emergency help right away.
- **Opioid withdrawal.** This can include: shaking, sweating more than normal, feeling hot or cold more than normal, runny nose, watery eyes, goose bumps, diarrhea, vomiting and muscle aches. Tell your doctor if you develop any of these symptoms.
- **Decrease in blood pressure.** You may feel dizzy if you get up too fast from sitting or lying down.

Common side effects of SUBOXONE include:

- Nausea
- Vomiting
- Drug withdrawal syndrome
- Headache
- Sweating
- Numb mouth
- Constipation
- Swollen and/or painful tongue
- The inside of your mouth is more red than normal
- Intoxication (feeling lightheaded or drunk)
- Disturbance in attention
- Irregular heart beat (palpitations)
- Decrease in sleep (insomnia)
- Blurred vision
- Back pain
- Fainting
- Dizziness
- Sleepiness

Tell your doctor about any side effect that bothers you or that does not go away.

These are not all the possible side effects of SUBOXONE. For more information, ask your doctor or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store SUBOXONE?

- Store SUBOXONE at room temperature between 68°F and 77°F (20°C to 25°C).

- **Keep SUBOXONE in a safe place, out of the sight and reach of children**

How should I dispose of unused SUBOXONE?

- Dispose of unused SUBOXONE as soon as you no longer need them.
- Unused tablets should be flushed down the toilet.
  If you need help with disposal of SUBOXONE, call 1-877-782-6966.

General information about the safe and effective use of SUBOXONE.

~~Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide.~~
Do not take SUBOXONE for a condition for which it was not prescribed. Do not give SUBOXONE to other people, even if they have the same symptoms you have. It may harm them and it is against the law.

This Medication Guide summarizes the most important information about SUBOXONE. If you would like more information, talk to your doctor or pharmacist. You can ask your doctor or pharmacist for information that is written for health professionals. For more information call 1-877-SUBOXONE (1-877-782-6966).

What are the ingredients in SUBOXONE sublingual tablets?

Active Ingredients: buprenorphine and naloxone
Inactive Ingredients: lactose, mannitol, cornstarch, povidone K30, citric acid, sodium citrate, FD&C yellow No. 6 color, magnesium stearate, acesulfame K sweetener and a lemon-lime flavor

Manufactured for Indivior Inc.

North Chesterfield, VA 23235

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Revised: February 2018
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Printed in USA

MEDICATION GUIDE

SUBUTEX® (Sub-u-tex)
(buprenorphine)
Sublingual Tablet (CIII)

IMPORTANT:

Keep SUBUTEX in a secure place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally uses SUBUTEX, get emergency help right away.

Read this Medication Guide that comes with SUBUTEX before you start taking it and each time you get a refill. There may be new information. This Medication Guide does not take the place of talking to your doctor. Talk to your doctor or pharmacist if you have questions about SUBUTEX.

Share the important information in this Medication Guide with members of your household.

What is the most important information I should know about SUBUTEX?

- SUBUTEX can cause serious and life-threatening breathing problems. Call your doctor right away or get emergency help if:
  - You feel faint, dizzy or confused
  - Your breathing gets much slower than is normal for you

  These can be signs of an overdose or other serious problems.
- Do not switch from SUBUTEX to other medicines that contain buprenorphine without talking with your doctor. The amount of buprenorphine in a dose of SUBUTEX may not be the same as the amount of buprenorphine in other medicines that contain buprenorphine. Your doctor will prescribe a starting dose of SUBUTEX that may be different than other buprenorphine containing medicines you may have been taking.
- SUBUTEX contains an opioid that can cause physical dependence.
  - Do not stop taking SUBUTEX without talking to your doctor. You could become sick with uncomfortable withdrawal signs and symptoms because your body has become used to this medicine
  - Physical dependence is not the same as drug addiction
  - SUBUTEX is not for occasional or "as needed" use
- An overdose, and even death, can happen if you take benzodiazepines, sedatives, tranquilizers, antidepressants, or alcohol while using SUBUTEX. Ask your doctor what you should do if you are taking one of these.
- Call a doctor or get emergency help right away if you:
  - Feel sleepy and uncoordinated

- Have blurred vision
- Have slurred speech
- Cannot think well or clearly
- Have slowed reflexes and breathing

- Do not inject ("shoot-up") SUBUTEX.
  - Injecting SUBUTEX may cause life-threatening infections and other serious health problems.
  - Injecting SUBUTEX may cause serious withdrawal symptoms such as pain, cramps, vomiting, diarrhea, anxiety, sleep problems, and cravings.

- In an emergency, have family members tell the emergency department staff that you are physically dependent on an opioid and are being treated with SUBUTEX.

What is SUBUTEX?

- SUBUTEX is a prescription medicine used to begin treatment in adults who are addicted to (dependent on) opioid drugs (either prescription or illegal drugs), as part of a complete treatment program that also includes counseling and behavioral therapy.
- SUBUTEX is most often used for the first 1 or 2 days to help you start with treatment.

SUBUTEX is a controlled substance (CIII) because it contains buprenorphine, which can be a target for people who abuse prescription medicines or street drugs. Keep your SUBUTEX in a safe place to protect it from theft. Never give your SUBUTEX to anyone else; it can cause death or harm them. Selling or giving away this medicine is against the law.

- It is not known if SUBUTEX is safe or effective in children.

Who should not take SUBUTEX?

Do not take SUBUTEX if you are allergic to buprenorphine.

What should I tell my doctor before taking SUBUTEX?

SUBUTEX may not be right for you. Before taking SUBUTEX, tell your doctor if you:

- Have liver or kidney problems
- Have trouble breathing or lung problems
- Have an enlarged prostate gland (men)
- Have a head injury or brain problem
- Have problems urinating
- Have a curve in your spine that affects your breathing
- Have gallbladder problems
- Have adrenal gland problems

- Have Addison's disease
- Have low thyroid (hypothyroidism)
- Have a history of alcoholism
- Have mental problems such as hallucinations (seeing or hearing things that are not there)
- Have any other medical condition
- Are pregnant or plan to become pregnant. If you take SUBUTEX while pregnant, your baby may have symptoms of opioid withdrawal or respiratory depression at birth. Talk to your doctor if you are pregnant or plan to become pregnant.
- Are breastfeeding or plan to breastfeed. SUBUTEX can pass into your milk and may harm your baby. Talk to your doctor about the best way to feed your baby if you take SUBUTEX. Monitor your baby for increased sleepiness and breathing problems.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. SUBUTEX may affect the way other medicines work, and other medicines may affect how SUBUTEX works. Some medicines may cause serious or life-threatening medical problems when taken with SUBUTEX.

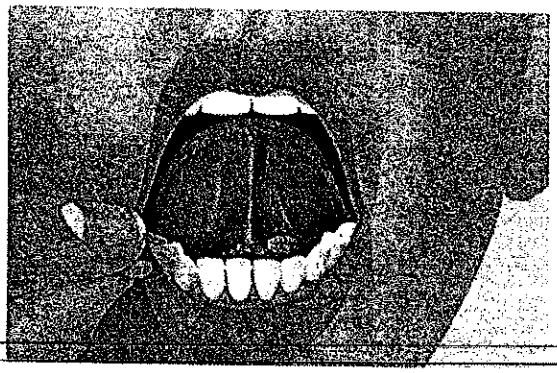
Sometimes the doses of certain medicines and SUBUTEX may need to be changed if used together. Do not take any medicine while using SUBUTEX until you have talked with your doctor. Your doctor will tell you if it is safe to take other medicines while you are taking SUBUTEX.

Be especially careful about taking other medicines that may make you sleepy, such as pain medicines, tranquilizers, sleeping pills, anxiety medicines or antihistamines.

Know the medicines you take. Keep a list of them to show your doctor and pharmacist each time you get a new medicine.

How should I take SUBUTEX?

- Always take SUBUTEX exactly as your doctor tells you. Your doctor may change your dose after seeing how it affects you. Do not change your dose unless your doctor tells you to change it.
- Do not take SUBUTEX more often than prescribed by your doctor.
- If you are prescribed a dose of 2 or more SUBUTEX tablets at the same time:
  - Ask your doctor for instructions on the right way to take SUBUTEX tablets
  - Follow the same instructions every time you take a dose of SUBUTEX tablet
- Put the tablets under your tongue. Let them dissolve completely.



- While SUBUTEX is dissolving, do not chew or swallow the tablet because the medicine will not work as well.
- Talking while the tablet is dissolving can affect how well the medicine in SUBUTEX is absorbed.
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- Sleepiness

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