SECTION 2:

SCREENING AND ASSESSMENT

Section 2: Screening and Assessment

The Northern New England Perinatal Quality Improvement Network (NNEPQIN) promotes the recommendations of organizations like the World Health Organization, the American College of Obstetricians and Gynecologists, the American Society of Addiction Medicine, and the American College of Nurse Midwives to screen all pregnant patients for use of alcohol, Choo, R. E., Huestis, M. A., Schroeder, J. R., Shin, A. S., & Jones, H. E. (2004). Neonatal abstinence syndrome in methadone-exposed infants is altered by level of prenatal tobacco exposure. Drug and alcohol dependence, 75(3), 253-260., and other substances at entry to obstetric care, during the third trimester and at delivery. Screening should be conducted using a validated instrument, and a screening, brief intervention, and referral for treatment (SBIRT) framework. This section provides an overview of the SBIRT framework along with examples of validated screening tools and other helpful templates.

In addition, this section references resources to screen for other social determinants, including intimate partner violence. Identifying other needs and linking pregnant patients with substance use disorder (SUD) to available resources can enhance overall care and improve outcomes.

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Note: This section is designed to be used as a companion to the NNEPQIN guideline: Screening for Alcohol, Tobacco & Drug Use During Pregnancy

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 birthing people and their infants. Universal screening for drug and alcohol use is an essential first step in identifying birthing people 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). Screening should always include illicit drug, tobacco, and alcohol use.

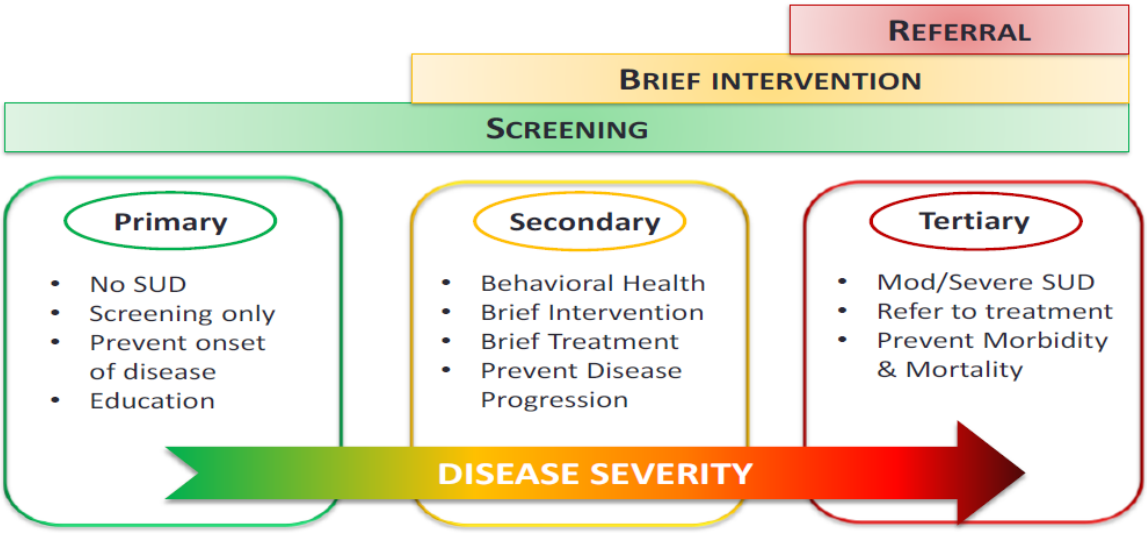
Perinatal substance use exists across all sociodemographic groups. (National Survey on Drug Use and Health, 2015) NNEPQIN recommends a population based approach, in which all pregnant people are screened at entry to maternity care and again in the third trimester and at delivery. It is the responsibility of all maternity care providers to ensure that pregnant people 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:

- Substance Use Risk Profile
- Alcohol Use Disorders Identification Test-Concise (AUDIT-C)
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT for women under age 26)
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Parents, Partner, Past, and Present (4 Ps) Plus

(Bush, et al, 1998; Chang, et al 2011; Chasnoff, et al, 2005; Hotham, et al, 2013; Yonkers, et al, 2011)

NNEPQIN along with other national organizations 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 pregnant and parenting people who use drugs or alcohol, to provide counseling about harm reduction, support decreasing and eliminating use, 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 PROCESS: SCREENING

- All pregnant people should be screened using a validated instrument.
- All pregnant people 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 1.2.1 under Patient Resources)
- Screening for substance use should be conducted while a person is alone or accompanied only by young children
- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as reproductive health history, and to safely screen pregnant and postpartum people for domestic violence
    - If a person 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 diagnosis of a substance use disorder, but rather to the need for further exploration about risk of substance exposure during pregnancy

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 pregnant person or fetus. For example, a pregnant person 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 people 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 person has discontinued substance use due to pregnancy, brief advice should consist of congratulating them, and explore strategies to avoid return to risky use during pregnancy and 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. Providing a brief intervention does not require extensive training in Motivational Interviewing skills.
- The obstetric provider performing the brief intervention should provide information to a pregnant person about and document discussion regarding:

- Potential harm of identified substance(s) to the fetus and newborn
- Discuss specific risks of identified substances used with breastfeeding and while parenting (e.g., sleepiness increasing risk for unsafe sleep, Sudden Infant Death Syndrome (SIDS), not able to attend fully to baby's needs)
- Explore indications 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 maternal and newborn urine and newborn umbilical cord, and/or meconium toxicology testing.
- Advise patients regarding Federal and State requirements for mandated reporting and development of a Plan of Safe Care/ Family Care Plan for newborns who have been exposed to substances
- Offer referral to case management/social worker if available at institution to address social determinants of health needs

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 person in need of treatment for substance use disorders. Most people 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 Section 1 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.

Treatment for substance use disorders are available at different levels of intensity and duration. Access to treatment specific for pregnant people varies widely by region. Some programs do not have specific programming for pregnant people, and many do not allow children to accompany their parents.

Medication Assisted Treatment (MAT)

Medications used to help with withdrawal symptoms, cravings and to prevent the use of alcohol, tobacco, opioids, and other drugs. These medications may be prescribed in combination with counseling services.

Medication for Opioid Use Disorder (MOUD)

Medications used to reduce withdrawal symptoms, cravings, and prevent use of non-prescribed opioids. Methadone, buprenorphine, and naltrexone are commonly prescribed as MOUD. Both methadone and buprenorphine are commonly used to treat prenatal OUD, but data is lacking on the safety and efficacy of naltrexone during pregnancy.

Considerations for Detoxification:

Outpatient: Symptoms of withdrawal may be managed in an outpatient setting if an individuals' withdrawal symptoms are not life threatening (e.g. severe-level physiologic dependence on alcohol or benzodiazepines) and supports are available to help manage their symptoms without the need of a supervised setting. Withdrawal symptoms are managed by medical staff with medications prescribed as needed.

Residential (non-hospital): Symptoms of withdrawal may be managed in a residential, non-hospital setting if an individuals' withdrawal symptoms are not life threatening but a supervised setting is needed to control their access to alcohol and other drugs. Individuals must be cleared medically to seek care in a residential setting due to medical staff not being available on site. Staff may hold prescribed medication and observe self-administration.

Inpatient: Symptoms of withdrawal must be managed in an inpatient, hospital setting if an individuals' withdrawal symptoms are potentially life threatening (e.g. severe alcohol withdrawal) and require 24 hour medial care. Medical staff monitor withdrawal symptoms and medications are used to manage symptoms and reduce risk.

*Source: New Hampshire Bureau of Drug and Alcohol Services

Intensive outpatient programs (IOP)

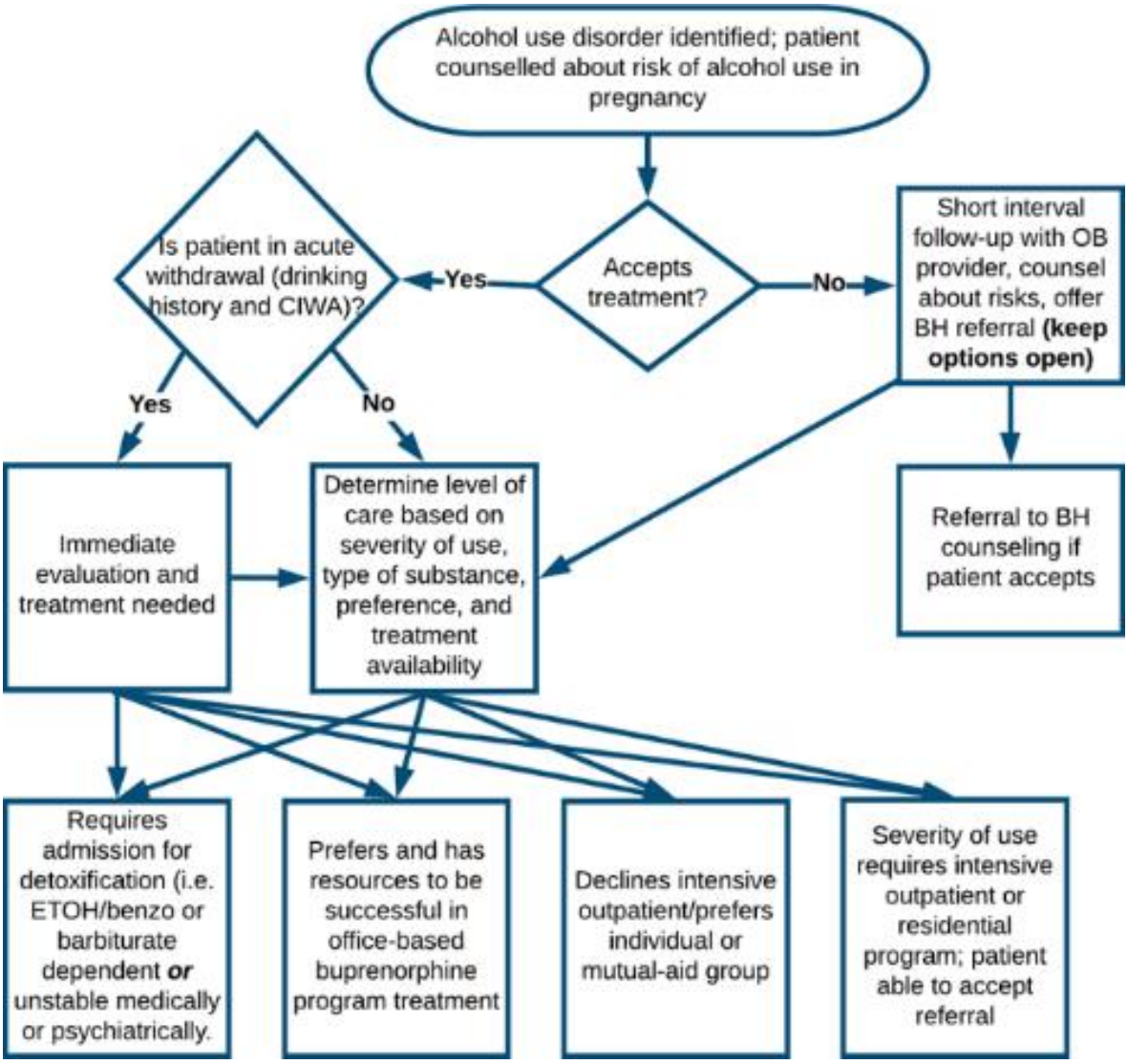
This service may involve structured individual, group, and family counseling, education, case management, and psychiatric services. Services for adults are provided at least nine hours per week and services for adolescents are provided at least six hours per week.

Residential Services

Onsite full-time programs for individuals who are unable to achieve their goals in their current environment. Services may involve structured individual, group, and family counseling, education, case management, and psychiatric services. The length of the program should be based on the needs of the individual but is often driven by reimbursement, bed demand, etc.

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)



DEVELOPING AN SBIRT PROCESS IN THE MATERNITY CARE CONTEXT

SBIRT implementation requires modification of existing clinic workflows. Each context is different. Incorporating SBIRT into the existing intake process for new obstetrics (OB) patients, which includes screening for other medical risks is recommended.

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:

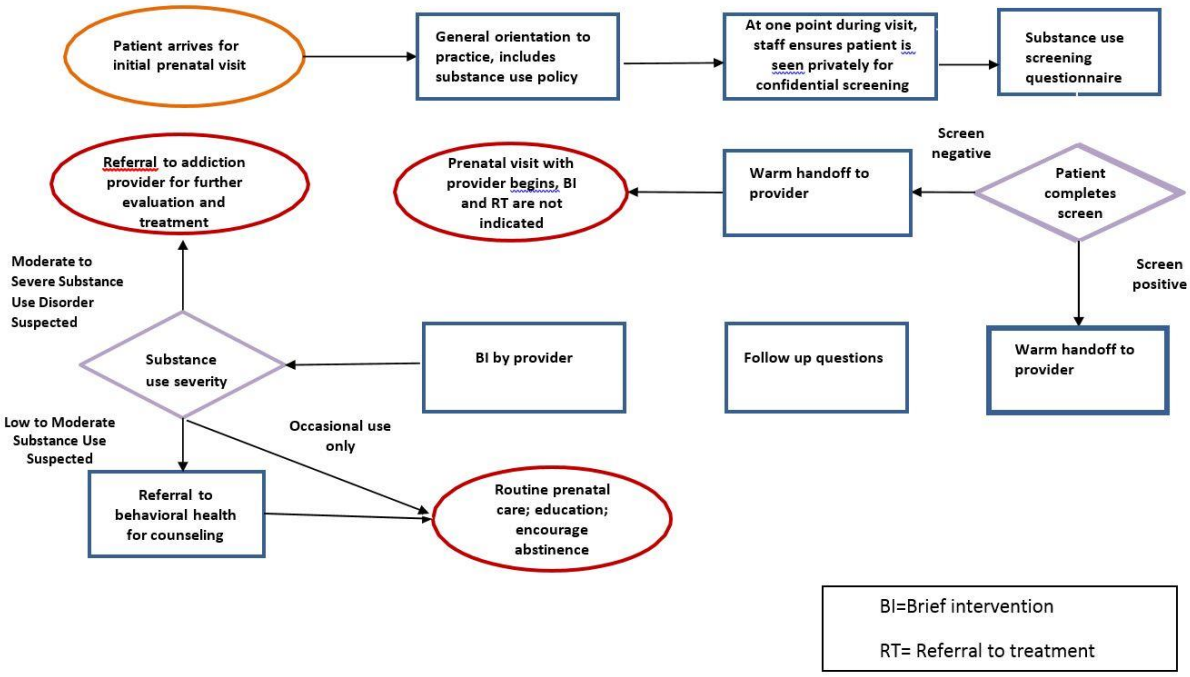
- Implement workflow modification to include confidential screening and response
- Provide information about institutional substance use policy as part of new patient orientation
- Screen using a validated questionnaire on paper, or the electronic equivalent
- Ensure a warm handoff occurs from staff 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 Advanced Practice Registered Nurse (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 person discloses an 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



1.1. Provider Materials

1.1.1. BRIEF NEGOTIATED INTERVIEW (BNI) DURING PREGNANCY: MODIFIED FROM THE BNI-ART INSTITUTE BY CAITLIN BARTHELMES, MPH *(USED WITH PERMISSION)*

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 Ask about lower #	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.

www.nnepqin.org/clinical-guidelines/

1.1.2. 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.

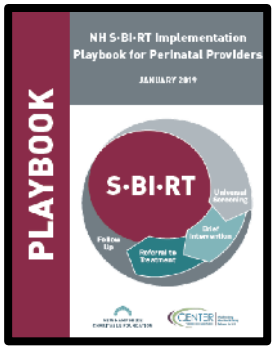
1. **SBIRT**
   - Routine screening without brief intervention: can be performed periodically, must reference use of a validated screening tool.
   - Billing code: 96160
   - If brief intervention is required, may bill for screening and brief intervention as "additional E&M (evaluation and management) 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

1.1.3 NH SBIRT IMPLEMENTATION PLAYBOOK FOR PROVIDERS

Provides a compendium of actions and/or strategies to support implementation of SBIRT in obstetric settings. The Playbook is organized by actions/strategies called "Plays" as they are meant to be put into action at the right time, in the right place, and in the right sequence of SBIRT implementation based on the unique context of each organization and site.



https://sbirtnh.org/wp-content/uploads/2019/02/perinatal-playbookFINALdig-2.pdf

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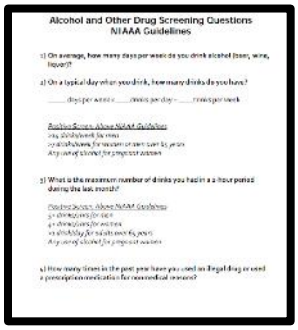
1.1.4. BOSTON UNIVERSITY BNI AND EXAMPLE SCREENING TOOL

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

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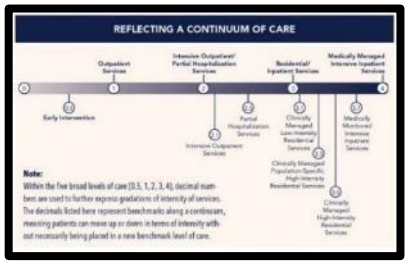
1.1.5. BNI TRAINING VIDEO

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 people* [included with permission]).

http://cahsmedia2.uc.edu/host/PregnancyModule/story.html

1.1.6. AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) LEVELS OF CARE

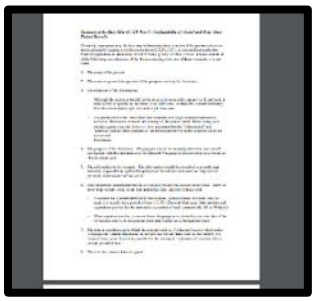
Additional information about the levels of care for the treatment of substance use disorders.



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

1.1.7. CONSENT TO SHARE INFORMATION WITH TREATMENT PROVIDERS

Once a substance use disorder has been diagnosed and a patient is referred for treatment, 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 the Providers Clinical Support System (https://pcssnow.org/) and the American Osteopathic Academy of Addiction Medicine.



https://aoaam.org/resources/Documents/ClinicalTools/Sample_Consent_for_release_o.pdf

1.2. Patient Materials

1.2.1. 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.

If you are a smoker and have been unable to quit, please let us know if you would like a nicotine replacement (patches, gum or lozenges) while you are at our tobacco free campus.
Some 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, fentanyl, 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 newborn baby

Federal law requires healthcare providers to develop a Plan of Safe Care/Family Care Plan when a baby is born affected by drug or alcohol use, including treatment medication that may cause withdrawal. This is intended to get people the help they need, and is not the same as a report to Child Protection Services. Our team would be happy to talk more with you about the information shared here! We are here to help.
Thank you for choosing to partner with us and including us in your pregnancy journey.

[Your Ob/Gyn Team]

1.2.2. STATE AND LOCAL TREATMENT RESOURCES TEMPLATE

(Name of Provider)

(Address)

(Contact phone number)

STATE TREATMENT RESOURCES

NH Treatment Locator: www.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

2-1-1 - 211 is New Hampshire's statewide, comprehensive, information and referral service. New Hampshire residents need **only dial 211** to be connected, at no cost, with trained Information and Referral Specialists who can provide them with the health and human service information they need to get help, give help or discover options.

NH Doorway - https://thedoorway.nh.gov/home - New Hampshire has 9 "Doorways" across the state through which people can ask for help for substance use- whether that be treatment, recovery, or local resources.

Plan of Safe Care (POSC) Materials (ask your provider if a POSC is right for you):
POSC (English), POSC (Spanish)
POSC Brochure (English), POSC Brochure (Spanish)

Note: A warm handoff is key when connecting patients to services. Providers should make referrals to the services and supports the patient may want and provide contact information. This may include medications for the treatment of opioid or alcohol use disorder, SUD treatment services, etc.

Below is a blank template that providers can fill out with local resources for the patient.

LOCAL TREATMENT PROVIDERS:

Office-based Buprenorphine Treatment Programs:

Program Name:

Contact:

Program Name:

Contact:

Program Name

Contact:

Recovery Centers/Recovery Coaches:

Program Name:

Contact:

Licensed Alcohol and Drug Counselors (LADC)

Program Name:

Contact:

Narcotics Anonymous:

Contact:

Methadone Maintenance programs

Program Name:

Contact:

Program Name:

Contact:

Intensive Outpatient Program

Program Name:

Contact:

Program Name:

Contact:

Residential Treatment Program (*Program Accepts Pregnant people)*

Program Name:

Contact:

2. Screening for Social Determinants of Health

> "Health workers providing care for [people] with substance use disorders during pregnancy need to understand the complexity of the [person's] social, mental and physical problems in order to provide appropriate advice and support throughout pregnancy and the postpartum period."
>
> *(World Health Organization, 2014)*

The World Health Organization recommends that all pregnant people with opioid use disorders receive a full assessment for psychosocial needs which may create barriers to care. Ideally, this should be performed by a clinical social worker or other care management specialist. However, many practices do not have access to case management or other support services. A validated screening instrument for social determinants of health can be administered by any member of the care team; it is recommended in this context to help identify patient needs.

A statement by the American College of Obstetricians and Gynecologists, calling for integrating screening for social determinants of health in routine pregnant and parenting people's health care, can be accessed at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health- Care-for-Underserved-Women/Importance-of-Social-Determinants-of-Health-and-Cultural-Awareness- in-the-Delivery-of-Reproductive

In 2021, revised E&M rules were released which allow providers to be reimbursed for medical decision making complicated by social determinants of health, with appropriate documentation. We recommend consulting the coding and compliance advisor at your institution for details (https://www.cms.gov/files/document/zcodes-infographic.pdf). .

Some example diagnostic codes for common SDOH concerns:

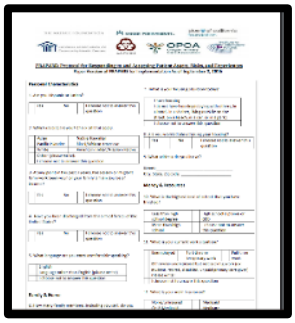
- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances

2.1. Provider Materials

2.1.1. PRAPARE

This toolkit was developed and is owned by the National Association of Community Health Centers (NACHC) in partnership with the Association of Asian Pacific Community Health Organization (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF). PRAPARE can be downloaded and used without charge.

Additional background on the development and validation of PRAPARE, as well as information on incorporating the tool in a variety of electronic health records systems is available from: http://nachc.org/research-and-data/prapare/ (PRAPARE is protected by copyright)



http://nachc.org/wp-content/uploads/2016/09/PRAPARE_One_Pager_Sept_2016.pdf

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2.1.2. SCREENING TECHNICAL ASSISTANCE AND RESOURCE (STAR) CENTER TOOLKITS

The American Academy of Pediatrics' Screening Technical Assistance and Resource (STAR) Center offers various toolkits for screening for Social Determinants of Health. These resources are available without charge from:

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx

3. Screening for and Responding to Disclosures of Intimate Partner Violence

WHAT IS INTIMATE PARTNER VIOLENCE?

Intimate partner violence (IPV) is a preventable public health problem that affects millions of people regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. IPV is defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, depravation of personal needs, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.

Reproductive and sexual coercion and IPV are health issues that disproportionately affect women, although they affect people of all genders. Women are at significantly higher risk than men of experiencing IPV, of sustaining serious injuries, and being killed by an intimate partner. Human trafficking and substance use coercion are closely associated.

- Approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner.
- Nearly half (45.9%) of women experiencing physical abuse in a relationship also disclose forced sex by their intimate partner. In a nationally representative sample, and 1 in 4 women reported lifetime coerced sex.
- Among women reporting coerced sex, more than one-third were 15 years old or younger at the time of their first coerced sexual experience.
- Childhood sexual trauma is strongly associated with adult substance use in women.

WHY SHOULD THIS BE INCLUDED IN HEALTHCARE?

IPV has serious implications for health and wellbeing of its survivors:

- Leading cause of female homicides and injury-related deaths during pregnancy
- Accounts for a significant proportion of injuries and emergency room visits for women
- May lead to lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and death.
- People who have been victimized by an intimate partner and children raised in violent households are more likely to experience a wide array of physical and mental health conditions including headaches, gastrointestinal problems, depression, anxiety, sleep problems, post-traumatic stress disorder (PTSD), and substance use disorders.

There is a substantial body of research describing the dynamics and effects of IPV on health. Abusive and controlling behaviors range from sexual assault and forced sex, to more hidden forms of victimization that interfere with a partner's choices about sexual activities, contraception, safer sex practices, and pregnancy. IPV is often a barrier to accessing reproductive health care.

SCREENING FOR IPV:

- All birthing people should be screened for interpersonal violence before, during, and after pregnancy. Although optimal timing of screening has not been determined, repeated screening is recommended.
- Creating space for confidential screening allows providers to safely ask questions about IPV and other sensitive topics such as reproductive health history, infectious disease history.
- When a birthing person cannot be confidentially screened, screening should be deferred

IF MY PATIENT SCREENS POSITIVE, WHAT SHOULD I DO?

It is important to validate the patient's experience and to thank them for sharing this very personal information with you. Some helpful, scripted responses are included below. If a person declines an offer of resources, that's okay. It's important to validate their experience and to meet them where they are today.

- *"I am glad you told me. We see many patients here with similar situations, and there are services in the area that can be of help. Can I give you some more information?"*
- *"Would you be interested in talking further about this with one of us [social worker, behavioral health clinician, domestic violence advocate] today?"*

Always offer referral: Domestic violence advocacy programs are available 24/7. During clinic hours, they may be available to come to the clinic for a warm referral if the patient has time, so it's good to offer this whenever possible. This can also be planned for a future date as it may be safer for a person to come to a medical appointment than to make other arrangements.

If a person does not have time or is not sure about accepting a referral, provide them with local and/or national contact information. It's important that every clinic has this information readily available.

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233)

(TTY) 1-800-787-3224

www.thehotline.org

For patients who screen negative: It's important to know why screening for IPV is necessary. Normalizing the discussion of IPV and providing reassurance that the practice is a safe place to disclose may encourage survivors who are afraid to disclose in the future. It may also help them counsel a friend or family member who is in an abusive relationship. Normalizing these conversations is valuable.

DOCUMENTATION FOLLOWING A POSITIVE SCREEN:

- Provider notes, especially with objective findings related to trauma may be helpful evidence in custody or divorce proceedings. However, including a diagnosis of adult physical abuse or other documentation in your note can increase risk if the abusive partner has access to your patient's electronic medical records.

3.1. Provider Materials

3.1.1. PARTNER VIOLENCE SCREEN (PVS)
The 3 question PVS is a short screening tool for interpersonal violence that may be used as a follow up tool to screen a pregnant or parenting MIHP beneficiary. It may not be used in place of the Maternal Risk Identifier (MRI) or Infant Risk Identifier (IRI) which ask additional questions.

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF.(2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. Journal of Trauma, 54, 352-55.

If a pregnant or parenting person answers the PVS screen affirmatively. Please pull the POC2 for Abuse/Violence.

3.1.2. WOMAN ABUSE SCREENING TOOL* (WAST)

1. In general, how would you describe your relationship?
   - ☐ a lot of tension
   - ☐ some tension
   - ☐ no tension

2. Do you and your partner work out arguments with:
   - ☐ great difficulty
   - ☐ some difficulty
   - ☐ no difficulty

3. Do arguments ever result in you feeling down or bad about yourself?
   - ☐ often
   - ☐ sometimes
   - ☐ never

4. Do arguments ever result in hitting, kicking or pushing?
   - ☐ often
   - ☐ sometimes
   - ☐ never

5. Do you ever feel frightened by what your partner says or does?
   - ☐ often
   - ☐ sometimes
   - ☐ never

6. Has your partner ever abused you physically?
   - ☐ often
   - ☐ sometimes
   - ☐ never

7. Has your partner ever abused you emotionally?
   - ☐ often
   - ☐ sometimes
   - ☐ never

8. Has your partner ever abused you sexually?
   - ☐ often
   - ☐ sometimes
   - ☐ never

Source: Brown, J., Lent, B., Schmidt, G., & Sas, S. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice, 49,* 896-903.

*his tool is validated for use with pregnant people

3.1.3. ICD DIAGNOSIS CODES

- **2018 ICD-10-CM Diagnosis Code T74.11XA: Adult physical abuse, confirmed, initial encounter**
- **2018 ICD-10-CM Diagnosis Code Z91.410: Personal history of adult physical and sexual abuse**
    - Some EHR systems have the option of hiding documentation to protect highly confidential information, this is recommended if available.

3.1.4. MENTAL HEALTH AND SUBSTANCE USE COERCION SURVEYS-REPORT FROM THE NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH AND THE NATIONAL DOMESTIC VIOLENCE HOTLINE

http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf

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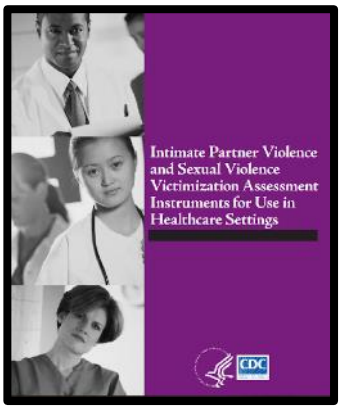
3.1.5. CDC INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE VICTIMIZATION ASSESSMENT INSTRUMENTS FOR USE IN HEALTHCARE SETTINGS



https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf

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3.1.6. IPVHEALTH.ORG
Contains various resources on IPV for healthcare providers from the National Resource Center on Domestic Violence

www.ipvhealth.org

4. Screening for Co-Occurring Psychiatric Conditions

All pregnant people with substance use disorders should be screened for depression and anxiety at the first and subsequent prenatal visits. Screening should be done with empathy, using validated screening instruments. Positive screens should be followed up by a healthcare provider to ensure that clients receive follow-up care and, if needed, referral to behavioral health clinicians, primary care provider, or psychiatrist.

Ideally all people with substance use disorders should receive a psychiatric evaluation to ensure that untreated psychiatric needs are met. However, many substance use treatment providers do not include other mental health needs in their initial evaluation, and access to behavioral health and psychiatry is often limited. Therefore, initial screening and consultation should be accomplished in the obstetric or primary care setting. Healthcare providers should be sensitive that trauma history is particularly prevalent among women with substance use disorders, and care should be informed by the assumption that any woman with active SUD is likely to have experienced sexual and/or physical violence in her lifetime.

Screening instruments for depression and anxiety which have been validated for use during pregnancy and postpartum include the Patient Health Questionnaire (PHQ-9), the Center for Epidemiologic Studies Depression Scale (CES-D), the Edinburgh Postnatal Depression Scale (EPDS), and the Generalized Anxiety Disorders Scale (GAD-7). If post-traumatic stress disorder (PTSD) is suspected, the Abbreviated PCL-C is a brief, validated screening tool which can be used in the primary care setting (SAMHSA, 2017). The Mood Disorders Questionnaire (MDQ) is a brief screening tool to help clinicians differentiate symptoms of depression from bipolar affective disorder. Links to these non-proprietary screening tools are included below.

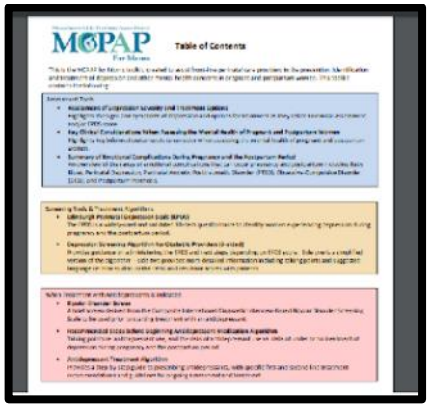
Maternity care providers who are comfortable treating uncomplicated depression, anxiety, and PTSD during pregnancy and postpartum should be aware of potential drug-drug interactions between methadone and antidepressant medications (SSRIs or tricyclics) (SAMHSA, 2018). Benzodiazepines are not indicated for the long term treatment of anxiety or PTSD symptoms, are associated with a neonatal benzodiazepine withdrawal syndrome, and may cause life-threatening respiratory depression for mothers when combined with opioids. Exposure to SSRIs for the treatment of co-occurring depression and anxiety disorders in addition to treatment with buprenorphine or methadone may increase symptoms of NAS/NOWs. However, not treating mental health disorders during pregnancy and postpartum can have serious consequences for both birthing person and baby, and therefore benefits often outweigh risks. Supporting evidence and clinical considerations regarding these decisions can be found in Factsheet 5 of SAMHSA'S *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018, pp 42-44).

4.1 Provider Materials

4.1.1 MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT (MCPAP) TOOLKIT

MCPAP provides a publicly available toolkit for assessment and management of uncomplicated perinatal mood disorders. Resources include:

- Scoring and follow up for Edinburgh Postnatal Depression Scale
- Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women
- Complications during Pregnancy and the Postpartum Period

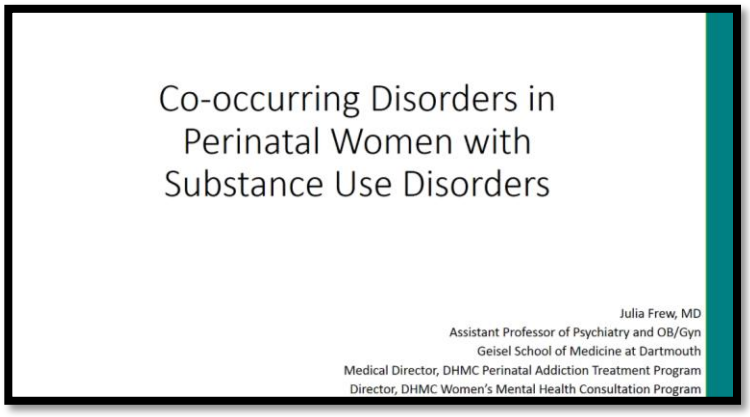


https://www.mcpapformoms.org/Docs/Adult%20Toolkit.pdf

4.1.2 LEARNING COLLABORATIVE SESSION ON TREATMENT OF CO-OCCURRING MENTAL HEALTH DISORDERS

Dr. Julia Frew, Assistant Professor, Geisel School of Medicine and Medical Director of the Dartmouth-Hitchcock Perinatal Addiction Treatment Program

May 11, 2017



https://dhvideo.webex.com/dhvideo/ldr.php?RCID=41ad25307bbc0b6a3333885938808c22

4.1.3 MGH WOMEN'S MENTAL HEALTH PROGRAM

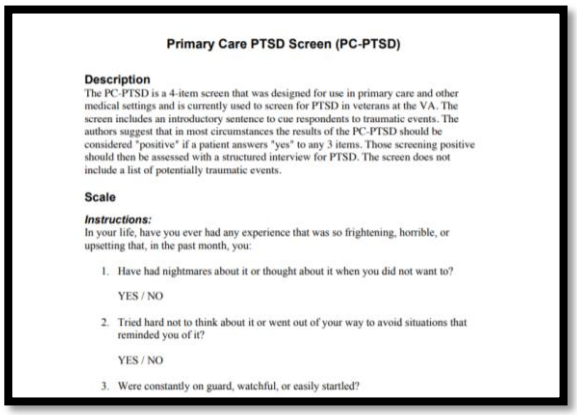
https://womensmentalhealth.org/

4.1.4 MOTHERTOBABY

Organization of Teratology Information Specialists. Useful info on psychiatric medications in pregnancy, including patient handouts

https://mothertobaby.org/

4.1.5 PRIMARY CARE POSTTRAUMATIC STRESS DISORDER (PTSD) SCREENER



Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

https://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

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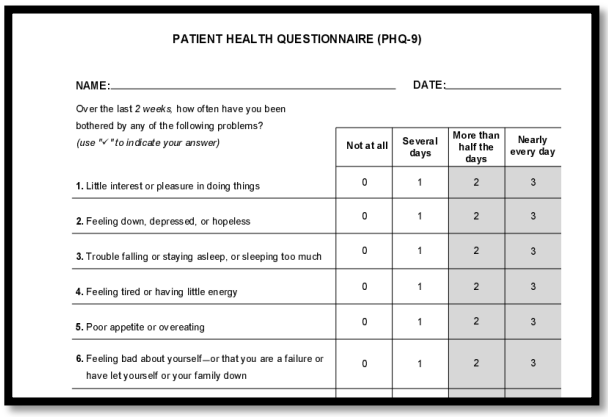
4.1.6 PHQ-9 PATIENT DEPRESSION QUESTIONNAIRE



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

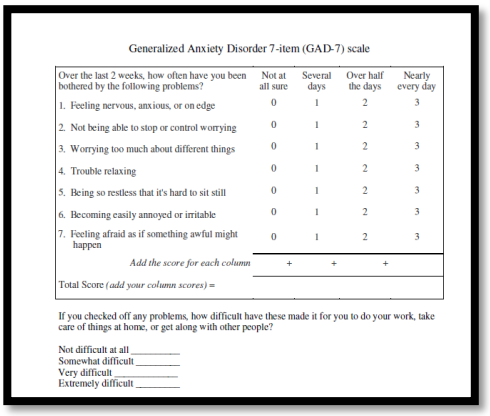
NAME:_____ DATE:_____

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

https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218

4.1.7 GAD-7 GENERALIZED ANXIETY DISORDER 7-ITEM SCALE



Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

https://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

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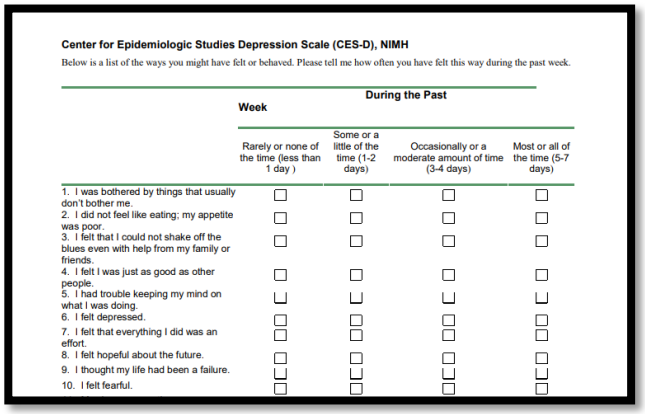
4.1.8 CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE (CES-D)



Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

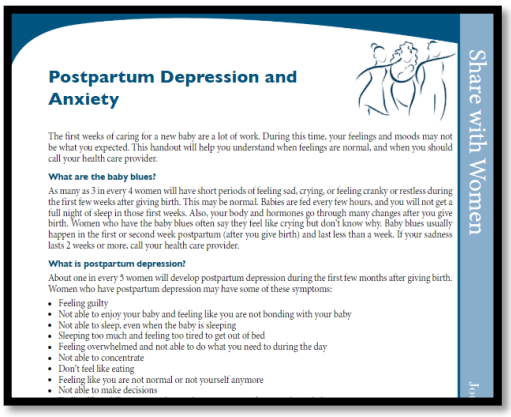
Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐

http://www.chcr.brown.edu/pcoc/cesdscale.pdf

4.2 Patient Materials

4.2.1 POSTPARTUM DEPRESSION AND ANXIETY HANDOUT
American College of Nurse Midwives. Postpartum Depression. J Midwifery and Women's Health 2014; 58; 6

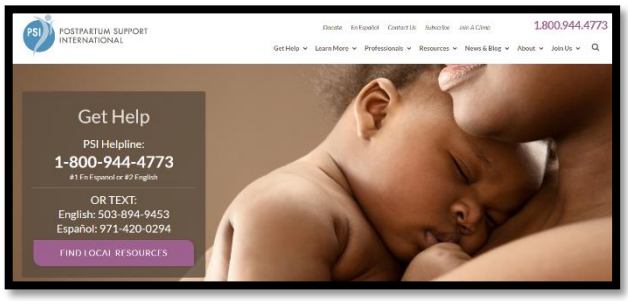


https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.12949

4.2.2 INFORMATION ON POSTPARTUM DEPRESSION
American College of Obstetricians and Gynecologists

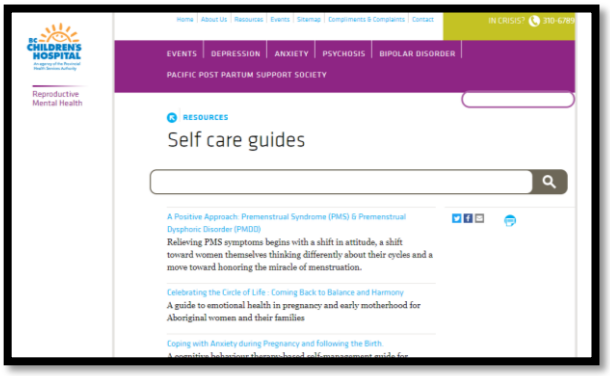
https://www.acog.org/Patients/FAQs/Postpartum-Depression

4.2.3 POSTPARTUM SUPPORT INTERNATIONAL



www.postpartum.net

4.2.4 MENTAL HEALTH SELF-CARE GUIDES FOR REPRODUCTIVE MENTAL DISORDERS
Cognitive Behavior Therapy



https://reproductivementalhealth.ca/resources/self-care-guides