Community Standard for Maternal and Newborn Drug Screening

C-SIMI Identification Work Group Recommendations

Purpose:
The purpose of this document is to recommend a community standard and consensus approach for the screening of at-risk pregnant women and newborns for exposure of drugs during pregnancy.

Background:
Infants exposed in utero to substances of abuse are known to be at risk for a variety of problems, including medical conditions, growth problems, developmental delays, and child abuse and neglect. This is widely recognized, including in the 2002 Guidelines for Perinatal Care, 5th Ed. AAP, Elk Grove, IL, published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. Additionally, the federal law entitled Individuals with Disabilities Education Act, Part C, which addresses children age 0-3 years, includes prenatal drug and alcohol exposure as a risk factor for adverse developmental outcomes and therefore qualifies these children for evaluation and developmental services as needed.

Identifying pregnancies complicated by drug use is important for maternal, fetal, and newborn health. Testing for drug use in pregnancy is a complex issue with medical, social, ethical, and legal implications. There should also be a clarification that for these purposes, *screening* refers to a more global assessment for drug or alcohol use or exposure utilizing history-taking and dialogue with the mother and *testing* refers to an actual laboratory tool that identifies the drug in a body substance (i.e. urine or meconium). It should also be noted here that, for many reasons, an individual may be using and/or abusing a drug or alcohol and the testing may be negative. Therefore, this document will attempt to address the utility of both *screening* and *testing*.

There is a great deal of controversy in issues around:

- Which patients are tested (targeting subgroups of women)
- Protection of adult patients' rights to informed consent, privacy, and unreasonable search and seizure
- Protection of vulnerable infants from harm
- Current local and state attempts to legislate solutions to this problem

There are really 3 possible approaches to testing:

- Test all pregnant women and newborns
- Test pregnant women and newborns based on objective, uniform medical criteria
- Test no pregnant women or newborns

In Colorado, there currently appear to be 3 models in use:

- No consent required - all patients are tested according to hospital policy
- Consent required for testing the mother, but not for testing the infant
- Consent required for testing both the infant and the mother

<u>Recommended Standard Approach</u>:
Because of the potentially dangerous consequences of failing to recognize drug or alcohol exposure to infants and abuse in affected families who do not disclose this condition and fail to receive treatment and other supportive services, we propose the following:

Testing of pregnant women or postpartum for drug use:

<u>Consent</u>

- Any policy should allow testing (without consent) of unconscious or intoxicated patients or patients with signs and symptoms of complications of intoxication (i.e. seizure activity)
- Hospital policy may require obtaining written consent from pregnant or postpartum women for drug testing (work group very strongly considered suggesting not requiring consent for testing mothers if Legal Work Group could clarify that general consent for treatment would cover this)
- If written consent for testing is required, hospital policy should clarify who is responsible for getting the consent for testing (i.e. RN or MD)
- Hospital policy should define what happens if the mother refusing to consent to be tested – group recommended:
    - Notification of MD and hospital social worker for evaluation
    - May consider policy that the infant is automatically tested
    - May consider notification of DHS by hospital social worker, RN or MD

<u>Criteria for Testing Mother</u>

- All pregnant or postpartum women should be screened for drug and alcohol abuse using a standard tool (work group to determine recommended tools)
- Hospitals should develop a policy that will clearly delineate which patients will be tested (by urine screen) – recommended criteria are:
    - *Maternal history of:*
        - Admitted or known alcohol or drug use within the past year as identified by maternal report, previous documented intoxication or positive test, or known involvement in a drug/alcohol treatment program
        - Unexplained late, little, or no documented prenatal care
        - Fewer than 3 prenatal visits
        - Previous unexplained fetal demise or repeated spontaneous abortions
        - High risk identification by the Department of Human Services
        - Loss of custody of other child(ren)
        - Parent desirous of fast discharge (< 24 hours) for unexplained reasons
        - Mother evasive about other children's whereabouts
    - *Maternal physical findings:*
        - Physical evidence or behavior associated with the use of alcohol or illegal drugs

        - Signs or symptoms of drug intoxication or withdrawal (i.e. irritability, slurred speech, attention-getting or loud behavior, strong alcohol odor) without other explanation
        - Unexplained mental status changes
        - Skin lesions related to IV drug use
    - *Complications of pregnancy:*
        - Unexplained placental abruption
        - Unexplained severe hypertension
        - Unexplained fetal/intrauterine growth restriction/small for gestational age infant
        - Unexplained premature labor +/- premature birth, premature rupture of membranes or precipitous delivery

Testing of infants for drug exposure:

<u>Consent</u>

- Because of the medical management implications, consent for testing of the infant based on identified risk factors is not needed
- Parents should be notified of the need for testing of the infant based on hospital policy
- Parents should be notified of the results of the drug testing

<u>Criteria for Testing Infant</u>

- It is preferable that both a urine toxicology screen and a meconium screen be done on an infant that is deemed to require testing.
    - *History*
        - Mother refuses to consent her own testing
        - Mother tests positive
        - Any of the criteria for testing mother are positive
    - *Infant physical findings*
        - Unexplained intrauterine growth restriction
        - Unexplained microcephaly
        - Signs or symptoms of drug withdrawal (i.e. CNS dysfunction such as lethargy, jitteriness, irritability, difficult to console, high-pitched cry, hypersensitivity to noise and external stimuli, tremors, seizures or excessive crying; Autonomic dysfunction such as sneezing, sweating, hyperthermia, hypertension or mottling; Respiratory issues such as apnea, yawning or tachypnea; or GI disturbances such as ineffective feeding, diarrhea, excessive sucking or hyperphagia)
        - Infant displays physical stigmata or fetal alcohol syndrome (i.e. craniofacial anomalies such as short eyelid opening, flat midface or upper lip groove, thin upper lip)

Reporting:

- Hospital policies should identify the need for reporting positive tests and other concerning situations to the Department of Human Services – policies can note the desire to work in the best interest of the child and the child's family
- Hospital policy should address the plan for when mother and/or the infant test positive
    - Suggested that hospital policy outlines that the hospital social worker is notified for further evaluation and reported as needed
    - As all hospital personnel are mandated reporters, a positive test can be reported by the MD, RN, or hospital social worker (*Note:* since a positive infant drug test for Schedule I or II drugs is listed in the Civil Code as Child Abuse or Neglect, all mandated reporters are required to report this to the Department of Human Services for further assessment)

Other Recommendations

- The Work Group suggests that a Parent Information Sheet be developed by the hospital:
    - Would outline the hospital policy included what is tested, why the testing is necessary, and how the information will be used
    - Would inform the family of what happens with the results and what happens if the infant tests positive
    - Would give an indication of what to expect in light of a positive test and referral
- Hospital policy should include a procedure in which all pregnant women be asked questions screening for risk of drug use
- Hospitals may want to consider the development of a checklist of the screening criteria fo easy use of hospital staff
- Hospitals may want to consider the use of standing orders for testing of the mothers and/or the infants
- Recommendation of the development of a script to assist hospital staff in negotiating these conversations with families in order to provide consistency
- The Work Group recommended that once these recommendations are accepted, there be a training program developed to include the rest of the C-SIMI program for medical providers