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Ethics and Substance Use Disorder

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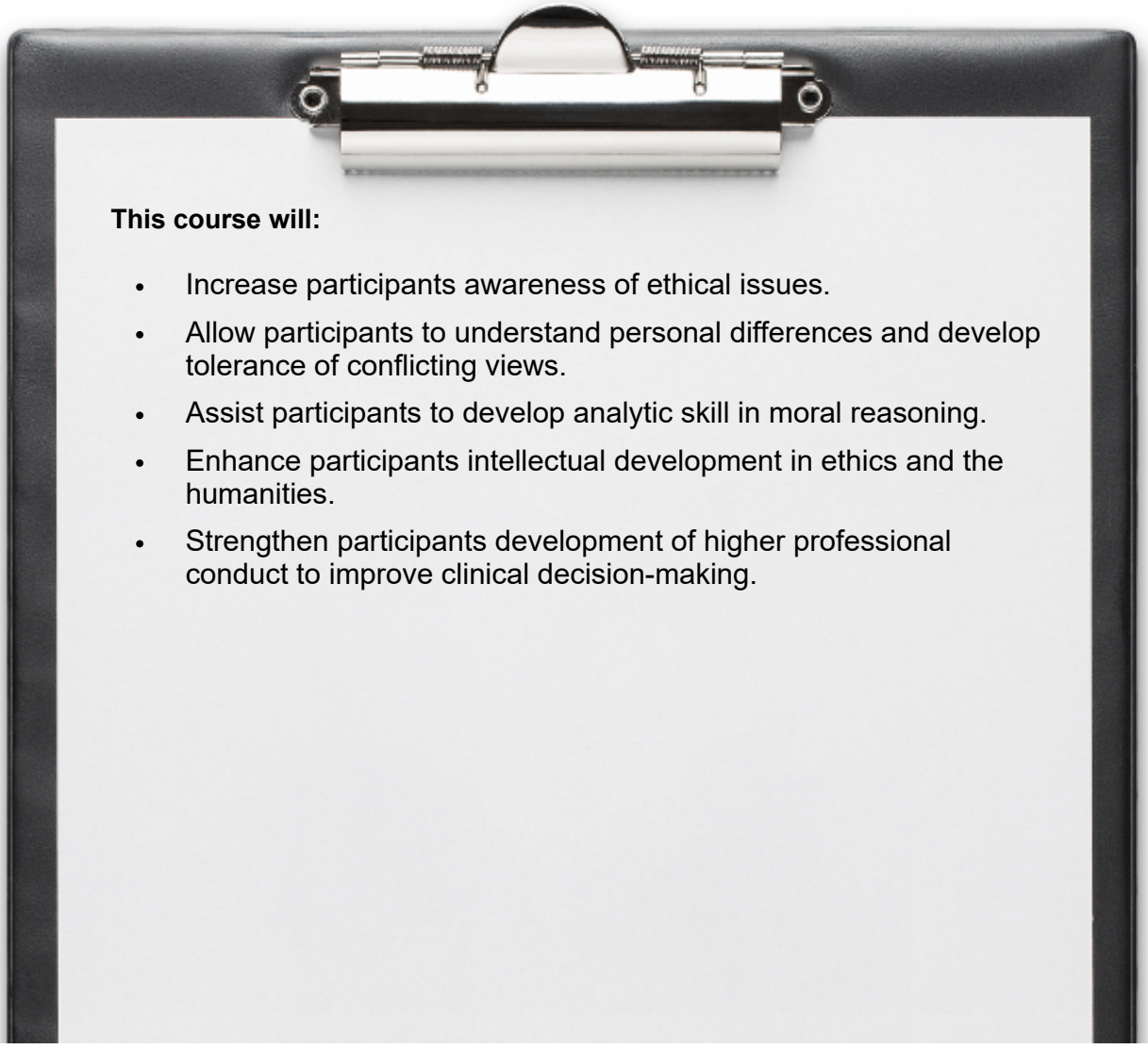
Course Description:

- This course on ethics in pregnancy will evaluate situations that require the health care professional to put his or her personal values and beliefs aside and come to an understanding of what the patient desires.
- Disagreements between the health care provider and the patient, on the choice of therapy, can be a tremendous challenge in medical practice and cause tension in the patient and health care provider relationship.
- This course will help the provider work through situations when the patient does not accept the recommended treatment or requests treatment that is deemed unsafe for her and/or her unborn fetus.

Approximate Time to Complete: 60 minutes

Click here to download a print version of this course.

Introduction

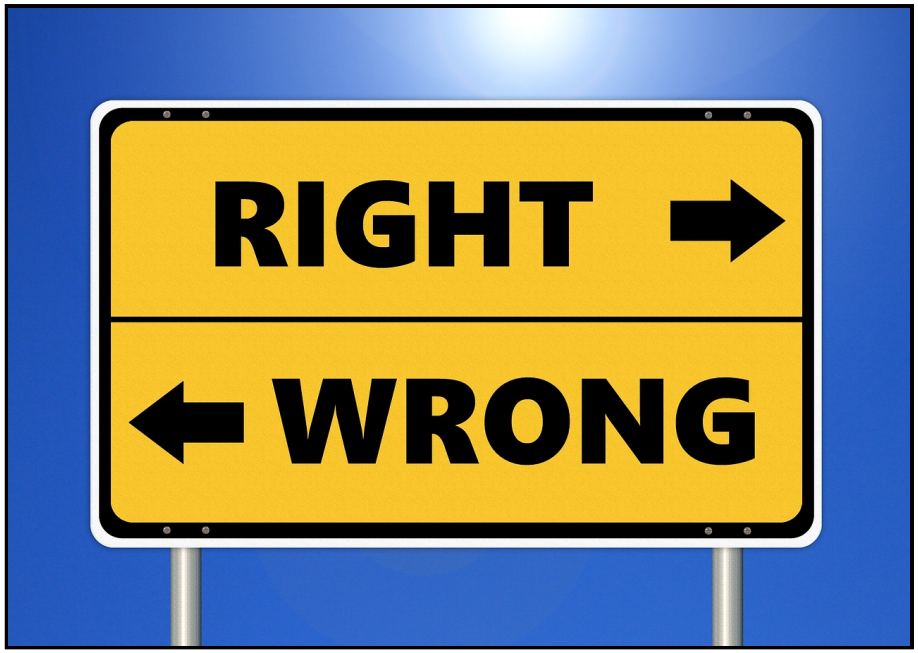


This course will:

- Increase participants awareness of ethical issues.
- Allow participants to understand personal differences and develop tolerance of conflicting views.
- Assist participants to develop analytic skill in moral reasoning.
- Enhance participants intellectual development in ethics and the humanities.
- Strengthen participants development of higher professional conduct to improve clinical decision-making.

Definition of Ethics

Ethics is a discipline of systematizing, defending and recommending concepts of right and wrong behavior.



Bioethics

Bioethics -- also known as medical ethics -- applies the core principles of autonomy, beneficence, non-maleficence and justice, to medical and health care decisions. It is a multidisciplinary lens through which to view complex issues and make recommendations regarding a course of action.

Ethical concerns arise frequently in all health care settings, but there can be particular challenges when a woman is pregnant.

Obstetric Ethical Challenges

Obstetrical complications are difficult to predict and can quickly threaten the life of the patient and her unborn baby.

- If there is no assigned medical decision maker and an emergent situation arises, medical decision making defaults to next of kin and subsequently follows a specified hierarchy.
- Difficulties arise if there is disagreement regarding medical decisions among family members.

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Principles of Bioethics

- Autonomy
- Justice
- Beneficence
- Non-maleficence

Principles of Bioethics

Click each picture for more information.

Conflicts of Value, Beneficence and Non-Maleficence

Beneficence

- Patients should be treated in an ethical manner by respecting their decisions and protecting them from harm
- Physicians also have a duty to act for the benefit of the patient and to promote their welfare

Non-maleficence

- The obligation of a physician to do no harm

Autonomy

- The right for patients to make decisions regarding their healthcare, even when decisions contradict the recommendations of the healthcare team

Medical Futility

Two reasons to address futility:

- To conserve resources.
- To protect clinician integrity.
- Medical futility is the judged futility of medical care, used as a reason to limit care.

There are two types of futility:

Click each picture for more information.

Normative futility is a judgement that a treatment exists that has a physiologic effect, but is believed to have no benefit by the healthcare team.

- An example of normative futility would be to maintain life in a patient who is in a permanent vegetative state - the treatment sustains life, but does not improve the quality of life for the patient

Physiologic futility is a judgement that a proposed treatment cannot physiologically achieve a desired effect

- An example of physiologic futility is taking an antibiotic for an uncomplicated viral infection

Just Culture

- A **just culture** recognizes that many individuals represent predictable interactions between human operators and the system in which they work.
- A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.

Click the picture for more information.

Just Culture

- It's a culture that holds organizations accountable for the systems they design and for how they respond to staff behaviors fairly and justly. The premise is instead of hospitals punishing people for making mistakes, they should concentrate on fixing the systemic problems causing mistakes to be made.
- Just culture requires a change in focus from individual errors and outcomes to system-wide design and management of the individual behavioral choices of all employees [1].

Decision Making

The principle of autonomy holds that patients have the right to accept or reject health care recommendations made by health care providers [2]:

- This does not mean the patient has the right to demand interventions which are not medically indicated.

Decision Making

The principle of autonomy holds that patients have the right to accept or reject health care recommendations made by health care providers [2]:

- Good decision-making and patient-centered care is knowing what is important to the patient and their families [3]. Knowing what is important will assist in avoiding disagreements between the health care provider, patient and family members [4].

Medical Decision Making

Decision making requires suggestions or recommendations by the health care provider and/or allowing a family member to verbalize what would be in the patient's best interest. Criteria frequently used to determine a patient's best interests include:

Click each checkbox for more information.

- Considering what the patient's description of acceptable care would be.
- Evaluating the benefits and risks of each reasonable intervention as well as short and long term outcomes.
- Determining what the patient's description of acceptable or stable quality of life was, or what the patient would described as sufficient decrease in quality of life if affected by the decisions that are made.
- Defining the risk and degree of pain and/or suffering associated with an intervention, plus the health care providers' ability to decrease any suffering encountered.
- Explaining the expected outcome and/or prognosis with or without treatment in terms of survival and long term consequences.

When patients cannot verbalize their desires or wishes, a **surrogate** is used.

- A surrogate is an individual in the patient's life who can provide guidance based on actual knowledge of the patient's wishes or their understanding of what is in the patient's best interest.

Common issues faced by health care providers when a surrogate is used:

- The surrogate may not know the patient's preferences.
- The health care provider knows or believes the surrogate is not acting in accordance with the patient's wishes.
- The surrogate has difficulty or is unable to make an informed decision based on the best interest of the patient.
- The surrogate's decision may be in conflict with other family members [5,6].
- The surrogate lacks decision-making capacity themselves.

Acting as a Surrogate

If there is no assigned medical decision maker and an emergent situation arises, medical decision making defaults to next of kin and subsequently follows a specified hierarchy

- The hierarchy typically follows:
- Legal guardian or durable power of attorney
- Spouse
- Adult child
- Parent
- Sibling [7-9]

Stressors associated with a surrogate decision maker :

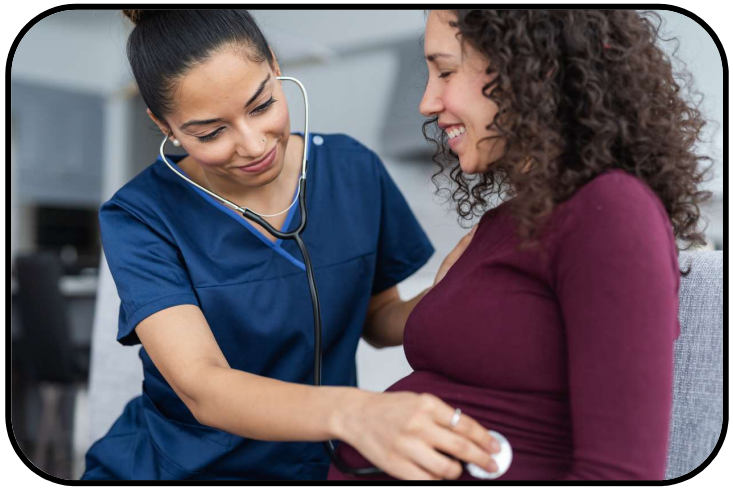
- Unawareness of what the patient's preferences would be
- Uncertain prognosis
- Hospital environment
- Communication difficulties with the health care providers
- Time frame allowed to make a decision
- Conflict between health care providers and family
- Logistics of the process of decision making
- Feelings of uncertainty or guilt over the decisions

Decision Hierarchy During Pregnancy

Members who may be involved in the hierarchy are:

In obstetrics, if the woman is not able to verbalize her decision, hierarchy will be implemented for decisions in health care. This can become complicated if she is not married, not in a relationship, or if her unmarried partner and family disagree on medical decisions. This can occur any time from conception through postpartum.

Preventive Ethics



Click the picture for more information.

There is an advantage in obstetrics as the woman who is receiving prenatal care can receive informed consent prior to the time when a decision needs to be made. This situation:

- Promotes an understanding of the issue and opportunity for discussion.
- Reduces the risk of miscommunication.
- Allows time to resolve disagreements between the health care provider and patient [10].

Preventive Ethics

Intrapartum decision making can be difficult due to unanticipated complications and emergent issues [10].

Examples of Preventive Ethics

Click the pictures for more information.

Women with underlying health conditions need to be educated regarding management of the condition during pregnancy; including typical course, medication management and potential impact on the pregnancy. This can include many preexisting conditions, including but not limited to hypertension, diabetes, mood disorder, substance abuse and cancer treatment.

During preconception counseling or the first antenatal appointment, pregnant women should receive education, including the understanding that 2 to 3% of all pregnancies are affected by fetal anomalies [11].

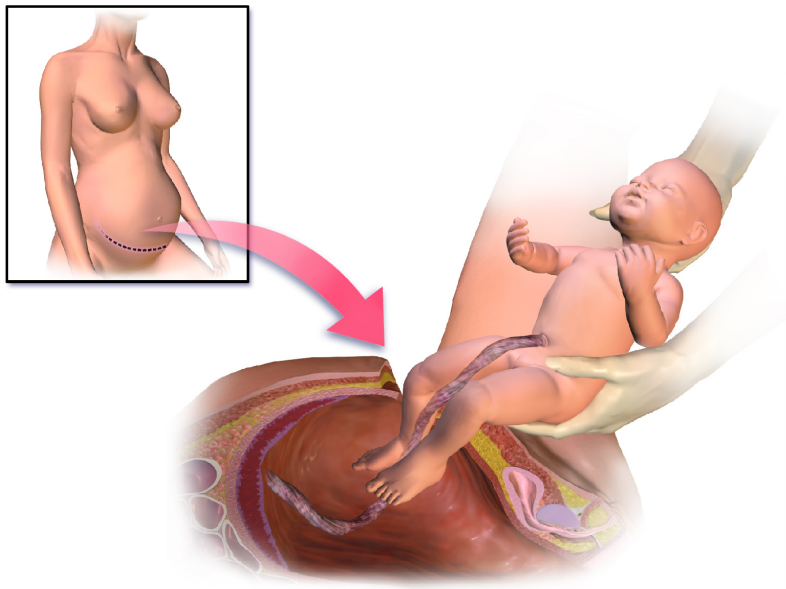
- The woman needs to understand an anomaly can occur with no fault of her or the health care provider.
- When an anomaly occurs, the health care provider needs to discuss options for risk assessment, diagnosis and management of fetal anomalies.

Obstetric Ethical Issues

Click each button for more content.

- Maternal refusal of blood
- Alcohol or other substance use disorder
- Maternal request for inappropriate management
- Maternal health care emergency
- Maternal request elective cesarean delivery
- Intimate partner violence
- Maternal mood disorder
- Pregnant and homelessness

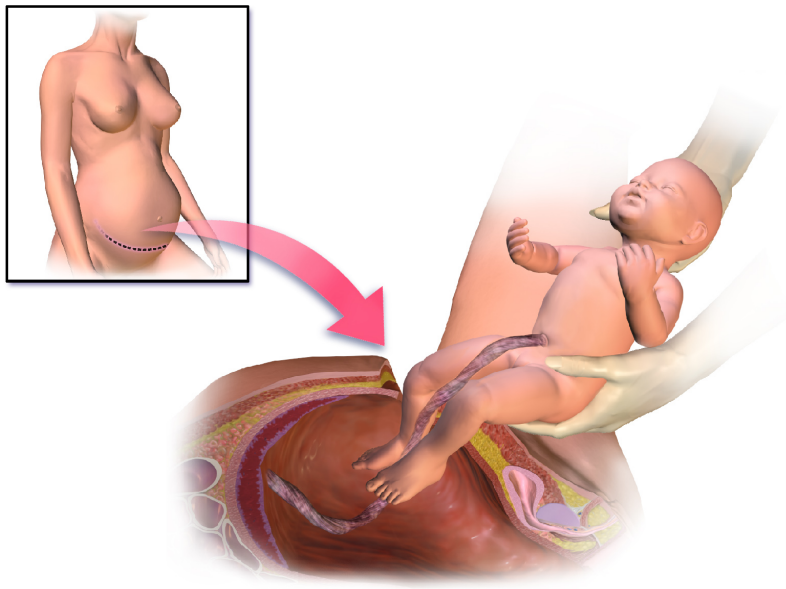
Maternal Request for Cesarean Delivery



When asked about cesarean delivery on maternal request, the health care practitioner should determine the reasons for the woman's request:

- Evaluate her values and emotional and social needs.
- Discuss her concerns about labor and vaginal birth and any misinformation contributing to those concerns.
- Over a number of clinic visits, involve her and her support person(s) if she desires in a discussion about the risks and benefits [18].

Maternal Request for Cesarean Delivery



- The American College of Obstetricians and Gynecologists (ACOG) committee opinion states that — in the absence of maternal or fetal indications for cesarean delivery — vaginal delivery is safe and appropriate, and should be recommended [14,15].
- If, after appropriate counseling, the patient continues to desire an elective cesarean section, it is an acceptable mode of delivery.

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Maternal Request for Elective Cesarean Delivery

Maternal Request for Inappropriate Management

Inappropriate requests may be defined as requests for clinical management that are not medically reasonable, because they are incompatible with evidence-based clinical judgment.
Examples include:

- Request for vaginal delivery in the setting of a complete placenta previa.
- Request for vaginal delivery in the setting of Category III fetal heart tones remote from delivery.

Maternal Request for Inappropriate Management

When situations such as this arise, it is the provider's responsibility to review risks and benefits of management options and how each choice could affect both the patient and her baby.

- It is important to thoroughly document these conversations, but, due to patient autonomy, the decision for management is ultimately up to the patient.
- If the patient continues to contradict medical advice, the conversations should continue throughout the course of prenatal care and delivery [12].

2 of 3

Maternal Request for Inappropriate Management

It is important to start discussions early in pregnancy, provide risks and benefits to care selected, and educate patients on the standard of care

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Alcohol and Other Substance Use Disorders

- Use and abuse of substances by pregnant women is a global problem.
- There is no exact dose-response relationship between the amount of alcohol consumed during the prenatal period and the extent of damage in the fetus [16].
  - Alcohol use is widespread and women who drink come from all socio-economic strata, ages and races [17].
  - Alcohol use prior to and during pregnancy is a common activity and women need to be aware of the potential harms of this exposure to the developing fetus.

Alcohol and Other Substance Use Disorders

- In a national survey from the U.S., 87% of women who drank alcohol before pregnancy quit drinking during pregnancy, 6.6% reduced their alcohol intake and approximately 6.4% reported no reduction [18].
- In a survey from the Centers for Disease Control and Prevention (CDC) from 2015-2017, 4% of pregnant women admitted to binge drinking and 12% reported some alcohol consumption.
  - In this study, non-married status was the demographic factor most consistently associated with binge drinking [19].

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Alcohol and Other Substance Use Disorders

- Identifying women who are using and abusing substances provides the healthcare team an opportunity to intervene, which may help in reduction or cessation of use.
- There are many screening tools that may be used to evaluate alcohol use in the pregnant woman:

Click for screening tools to evaluate alcohol use in pregnant women

Click for a list of WHO measures

- The T-ACE [44]
- TWEAK [45-47]
- AUDIT-C

T-ACE Screening Tool

T-ACE is a measurement tool of four questions that are significant identifiers of risk drinking (i.e., alcohol intake sufficient to potentially damage the embryo/fetus).

The T-ACE is completed at intake. The T-ACE score has a range of 0-5. The value of each answer to the four questions is totaled to determine the final T-ACE score.

Note:
1 Drink
= 12 oz beer
= 12 oz cooler
= 5 oz wine
= 1 mixed drink (1.5 oz. hard liquor)

Binge (drinking) = consuming 5 or more alcoholic drinks on an occasion

A total score of 2 or greater indicates potential risk for the purposes of Pregnancy Outreach Program identification of prenatal risk.

1. How many drinks does it take to make you feel high? 0. less than or equal to 2 drinks 1. more than 2 drinks	**Tolerance**
2. Have people annoyed you by criticizing your drinking? 0. No 1. Yes	**Annoyance**
3. Have you felt you ought to cut down on your drinking? 0. No 1. Yes	**Cut Down**
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? 0. No 1. Yes	**Eye Opener**
Total Score = _____	

Sokol, Robert J., "Finding the Risk Drinker in Your Clinical Practice" in G. Robinson and R. Armstrong (eds), Alcohol and Child/Family Health: Proceedings of a Conference with Particular Reference to the Prevention of Alcohol-Related Birth Defects. Vancouver, BC., December, 1988.

TWEAK

(**T**olerance, **W**orried, **E**ye-opener, **A**mnesia, **K**-Cut Down)

Description: The TWEAK screening test consists of five questions designed to screen pregnant women for harmful drinking habits. The tool consists of questions from the CAGE as well as the MAST, regarding tolerance and amnesia.

The TWEAK:

QUESTION	ANSWER	POINTS
1. How many drinks does it take to make you feel high? (3 or more drinks = 2 points)		
2. Have close friends or relatives worried or complained about your drinking in the past year? (Yes = 1 point)		
3. Do you sometimes take a drink in the morning when you first get up? (Yes = 1 point)		
4. Are there times when you drink and afterwards can't remember what you said or did? (Yes = 1 point)		
5. Do you sometimes feel the need to cut down on your drinking? (Yes = 1 point)		
TOTAL SCORE		

Scoring: The TWEAK is scored on a 7-point scale. On the tolerance question (#1), 2 points are given if a woman reports that she can consume more than five drinks without falling asleep or passing out. A positive response to the worry question (#2) yields 2 points, and positive responses to the last three questions yield 1 point each. A woman who has a total score of 2 or more points is likely to be an at-risk drinker (Chang, 2001).

Source: Russell, M (1994). New Assessment tools for risk drinking during pregnancy: T-ACE, TWEAK and others. Alcohol Health and Research World.

CHAN, A. K.; PRISTACH, E. A.; WELTE, J. W.; AND RUSSELL, M. The TWEAK test in screening for alcoholism/ heavy drinking in three populations. *Alcoholism: Clinical and Experimental Research* 6: 1188 1192, 1993.

AUDIT-C ASSESSMENT TOOL

The AUDIT-C assessment tool[i] can be used to provide a quick assessment of how much and often a woman is drinking alcohol. AUDIT-C is the first three questions of the longer AUDIT tool, which is a more comprehensive assessment of problem drinking. Both tools are internationally recognised and widely used.

Questions	**0**	**1**	**2**	**3**	**4**	**Score**
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	
					Total	

Scoring and interpreting AUDIT-C

Add the scores (shown in the top line) for each of the three questions for a total score out of 12. The following total scores provide an indication of whether to advise no alcohol use and/or refer the woman to a specialist addiction treatment service. They are a guide only.

0-3 Low-risk drinking (advise no use)

4-5 Moderate-risk drinking (advise no use and use professional judgement to consider referral to a specialist addiction service)

≥ High-risk drinking (definite referral to a specialist addiction service)

There is no known safe level of alcohol use at any stage of pregnancy.

Acknowledgement: This reproduction of the AUDIT-C assessment tool has been extracted from the Ministry of Health's 2010 publication *Alcohol and Pregnancy: A practical guide for health professionals*.

[i] World Health Organization (2001). AUDIT: *The Alcohol Use Disorders Identification Test: Guidelines for use in primary care*. Geneva: World Health Organization.

- The Substance Use Risk Profile-Pregnancy Scale (SURP-P)
  - SURP-P assesses the amount of alcohol consumed in the month prior to pregnancy and if the individual has ever felt the need to reduce alcohol or drug use.
- The Proprietary 4P's Plus Plan
  - The 4P's screen for substance use in pregnancy and consist of questions about substance use by the Patient (past or current), Partner, Peers, or Parent(s). One limitation is that this is a copyrighted screening instrument that must be purchased for use.
- The National Institute on Drug Abuse (NIDA) Quick Screen Modified Alcohol, Smoking and Substance Involved Screening Test (ASSIST)
  - The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.

Alcohol and Other Substance Use Disorders

ACOG advises universal screening for all pregnant individuals using [24]:

- The 4P's:
  - The 4P's screen for substance use in pregnancy and consist of questions about substance use by the Patient (past or current), Partner, Peers or Parent(s). One limitation is that this is a copyrighted screening instrument that must be purchased for use.
- NIDA Quick Screen
- CRAFFT

NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/ activities/assist_v3_english.pdf).*

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should not indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.**
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST 2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using alcohol or drugs?
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 or **ALONE**?
F	Do you ever **FORGET** things you did while using alcohol or drugs
F	Do **FAMILY** or **FRIENDS** ever tell you to cut down on your drinking or drug use?
T	Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?

CRAFFT

Alcohol and Other Substance Use Disorders

- Difficulty arises when there is:
  - Lack of screening tools that allow for communication to all cultures and languages.
  - Barriers to patient disclosure of substance use.
  - Limited resources for intervention.
- The health care team must develop ways to discuss substance use, develop screening tools, and explain the impact substance use has on her health and her fetus.

Maternal Alcohol Abuse and Other Substance Abuse Disorders

Maternal Alcohol Abuse and Other Substance Abuse Disorders

- Universal laboratory testing for drug use is not recommended because of the limitations of these tests.
- Being alert to possible clinical indication or drug testing after informed consent:
  - Previous positive drug test
  - Monitoring compliance with methadone or buprenorphine
  - Unexplained abruptio placenta
  - Unexplained fetal demise
- Health care providers must be aware of their state's requirements for testing and reporting of drug test results.
  - Some states feel a pregnant woman abusing substances constitutes child abuse and a few consider it a reason for involuntary commitment to a treatment facility [49].

Maternal Alcohol Abuse and Other Substance Abuse Disorders

Maternal Alcohol Abuse and Other Substance Abuse Disorders

Giving the pregnant woman and unborn fetus priority treatment, the health care team must remain non-judgmental, compassionate and recognize this as an illness for the woman.

Comprehensive prenatal care to improve maternal and fetal outcomes may include:

Click this button for more information

- Screening pregnant women for alcohol use.
- Counseling pregnant women regarding the risks of alcohol and drug use for herself and her unborn fetus.
- Building a multidisciplinary team of health care providers — including the pediatrician and social service providers — to work with pregnant women who abuse alcohol or other substances. The pediatrician will monitor for neonatal withdrawal if she has continued abuse.
- The pregnant woman will have more frequent prenatal visits to monitor her and the fetus' status, provide education, and offer support.
- An early ultrasound examination to confirm gestational age and monitor fetal growth.
- Establishing antenatal testing to monitor for growth restriction, 3rd trimester bleeding and maternal withdrawal.
- Discouraging breastfeeding in women who continue to consume alcohol or drugs.

Alcohol and Other Substance Use Disorders

Alcohol and Other Substance Use Disorders

- Universal laboratory testing for drug use is not recommended because of the limitations of these tests.
- Indications to consider urine drug screening:
  - Previous positive drug test
  - Monitoring compliance with methadone or buprenorphine
  - Unexplained placental abruption
  - Unexplained fetal demise
- Health care providers must be aware of state requirements for testing and reporting of drug test results.
  - Some states feel a pregnant woman abusing substances constitutes child abuse and a few consider it a reason for involuntary commitment to a treatment facility [25].

- Pregnant women who consume alcohol but who do not drink heavily may need a brief intervention with education sessions and counseling.
- Pregnant women who consume moderate alcohol and who are unlikely to reduce their consumption should be referred to a professional alcohol treatment.
- Pregnant women with a substance abuse disorder may need a multi-disciplinary team of obstetric, medical, pediatric, psychiatric, addiction medicine and social service providers.
- Pregnant women who have alcohol or substance abuse disorders and are homeless, poorly nourished or incarcerated will also require assistance with food, shelter and transportation.
- Women with a substance abuse disorder may need consultation with pain management or anesthesia specialists prior to labor or surgical delivery to discuss management of pain prior to the event.

Alcohol and Other Substance Use Disorders

If screening tests are positive, the healthcare team much approach the patient in a non-judgemental, compassionate manner.

Click this button for more information

Alcohol and Other Substance Use Disorders

- Pregnant women who consume alcohol but who do not drink heavily should still be counseled on adverse effects of alcohol use in pregnancy.
- Pregnant women who consume moderate alcohol and who are unlikely to reduce their consumption should be referred for professional alcohol treatment [42].

Click this button for more on components of care

Maternal Refusal of Blood

- One of the most common obstetric complications is hemorrhage. For this reason, it is important to discuss willingness to accept blood products during the course of prenatal care.
  - Women who identify as Jehovah's Witnesses commonly will not accept blood transfusions, even in life threatening situations
  - This group of patients has been identified as having 44-130x higher risk of maternal mortality from hemorrhage than women who are accepting of blood products [26].
- Not all Jehovah's Witnesses are the same in what blood products they will and will not accept. It is important to develop a checklist and review all blood products during the prenatal course.

Click for more information

Maternal Refusal of Blood

- Educating women about the possibility of antepartum, intrapartum and postpartum hemorrhage is an important discussion during prenatal care so she has knowledge that refusal could result in her and/or the fetus' death.
  - Risks of refusal should be clearly communicated and documented.
- For women who plan to refuse blood products, it is important to be proactive regarding management of antepartum anemia
- At the time of delivery, it is important to consider hemodilution techniques and to be proactive with management of hemorrhage including administration of medication and surgical techniques

Click for information on why Jehovah's Witnesses don't accept blood transfusions?

https://www.jw.org/en/jehovahs-witnesses/faq/jehovahs-witnesses-why-no-blood-transfusions

Maternal Care Emergency

- As previously mentioned, all pregnant women should be informed that obstetric complications can arise quickly and can be unpredictable [10].
- Heath care providers have a legal and ethical responsibility to provide the woman with information that they can process and use to make decisions.
- Examples include:
  - Discussing risk factors for cesarean section
  - Discussing risks and benefits of vaginal birth after cesarean section versus repeat cesarean section in women with a prior cesarean section
  - Discussing risk factors for hemorrhage at the time of delivery

Click the next arrow above for more information.

MATERNAL911®

Maternal Care Emergency

Educating the pregnant woman on situations that could possibly happen at any time antenatal, intrapartum or postpartum may create a trusting relationship, allow the opportunity for questions and ensure her understanding.

Click this button for a list of high-acuity, low occuring events

- Preterm labor (PTL)
- Premature preterm rupture of membranes (PPROM)
- Hypertension in pregnancy
- Gestational diabetes
- Umbilical cord prolapse
- Shoulder dystocia
- Intrahepatic cholestasis of pregnancy (ICP)
- Amniotic Fluid Embolism (AFE)
- Imminent birth
- Induction of Labor (IOL)
- Operative vaginal birth
- Postpartum hemorrhage (PPH)
- Intrapartum hemorrhage
- Venous thromboembolism (VTE)
- Sepsis in pregnancy
- Cardiomyopathy

Many of these topics are included in the other Maternal 911 modules.

Pregnancy and Homelessness

Homelessness is defined by the United States Department of Health and Human Services (HHS) as “an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or nonpermanent situation [27].”

Click the next arrows to read more information.

Pregnancy and Homelessness

- Pregnant women who are homeless have a history of family disruption and are generally younger than non-pregnant homeless women [28].
- Teenagers who are homeless and pregnant typically have previously lived in environments of poverty and domestic instability [29].
- 20 to 50% of all homeless women and children become homeless as a direct result of trying to escape domestic violence [30].
- It can be difficult for some pregnant women to find places in shelters due to liability related to pregnancy. [31].

Click the next arrows to read more information.

Pregnancy and Homelessness

- Screening for homelessness is an important part of initial prenatal care.
- Screening for homelessness is very important due to the high incidence of additional issues such as:
  - Substance abuse
  - Intimate partner violence
  - Mental illness
- Homeless women should be evaluated to ensure there is no concern for compromised decision making capacity.
  - If decision making capacity is in question, the patient should undergo neurocognitive testing
  - If decision making capacity is not present, a durable power of attorney should be established
  - This is important because homeless women may be estranged from family and family may be not be aware of the patient's wishes

Click the next arrows to read more information.

Pregnancy and Homelessness

- Prenatal care is encouraged and recommended for homeless women.
  - Homeless pregnant women, like all pregnant women, need to be prepared for labor and delivery, postpartum issues, care of the newborn and parenting.
  - Establishing access to social workers and ongoing assessment of basic needs including food, clothing and shelter is vital for continued prenatal care.

Click the next arrows to read more information.

Pregnancy and Homelessness

- Few studies have examined pregnancy outcomes in the homeless.
- The risk of adverse maternal and fetal outcomes is increased in homeless pregnant women due to poor access to health care, poor nutrition, lack of housing, substance use, exposure to violence, a high prevalence of infection and medical comorbidities [31,32-36].
  - When possible, education on the most common complications in pregnant homeless women when compared to non-homeless pregnant women should be discussed:
    - Preterm delivery (PTD)
    - Low birth weigh fetus
    - Hemorrhage
    - Hypertensive disorders of pregnancy

Click the next arrows to read more information.

Pregnancy and Homelessness

- Healthcare professionals should evaluate each case and involve the social worker and case manager. The multidisciplinary team approach should evaluate the safety of the woman's environment.
- If there are concerns for welfare, appropriate legal services should be contacted.
- If there are any concerns for the welfare of the child, the case should be reported to Children's Protective Services (CPS).
- Some cases may be so complicated that the hospital's ethics committee and legal department may become involved.
- Info to assist with discharge planning is available from the National Health Care for the Homeless Council [27].

Intimate Partner Violence

- Intimate partner violence (IPV) affects over 32 million Americans [37].
- In countries around the world, 10 to 69% of women report physical assault by an intimate partner at some time in their life [38].
  - IPV is an actual or threatened harmful event which can be:
    - Psychological
    - Physical
    - Sexual
    - Experienced by a current or former partner or spouse
- IPV can occur among people with any sexual orientation or gender identity, and does not require sexual intimacy.

Click the next arrows to read more information.

Intimate Partner Violence

- IPV screening should be a routine part of prenatal care.
- ACOG recommends screening at the first prenatal visit, at least once per trimester and at the postpartum visit [39].
  - Women may be asked to complete a questionnaire detailing their psychosocial, medical, obstetric and family history.
  - Women for whom IPV is suspected but not acknowledged should be asked again at subsequent visits.

Click the next arrows to read more information.

Intimate Partner Violence

- Healthcare professionals should be aware that domestic violence often begins or increases during pregnancy and the postpartum period [40-42].
- Women with an unintended pregnancy have a 3 times greater risk of physical abuse compared with those whose pregnancy was planned [43].
- Pregnant women who are abused have a 3 times higher risk of being victims of attempted or completed homicide than non-abused people with similar demographic characteristics [44].

Click the next arrows to read more information.

MATERNAL911®

Intimate Partner Violence

- Intermittent screening throughout pregnancy increases the detection of IPV
- When violence is identified, the following steps are important [45]:

Click this button for more information

Click the next arrows to read more information.

- Non-judgmental and compassionate health care professionals
- Confidentiality maintenance
- Understand the complexities of violence and the difficulty of a quick resolution
- Not ‘medicalizing’ the issue
- Communication that is neither rushed nor hurried
- Affirmation that the violence is undeserved
- Supportive listening and feedback
- Allowing her to progress at her own pace
- Not pressuring her to disclose, leave the relationship or press legal charges
- Shared decision-making
- Respect for her decisions

Intimate Partner Violence

- The immediate expression of empathy, acknowledgement and continued ability to support and assist the woman are the most important components of care after a patient has disclosed abuse.
- The healthcare professional must remain ethical in assisting her with decision-making and not allow personal values into the discussion.
- If IPV is recognized, the healthcare provider should offer continued support, and review with her available prevention and referral options.
  - Availability may vary across the nation but a local domestic hotline, a hospital or community domestic violence advocate, or a hospital social worker may provide advice about community programs.
- If the woman declines services at an appointment, she should be offered these services at subsequent appointments and told she can contact the clinic at any time.

Click this button to close the window

Maternal Mood Disorders

All pregnant women should be screened for mood disorders during the pregnancy and postpartum period.

- Antenatal depression is associated with an increased risk of poor obstetrical outcomes, including spontaneous abortion, bleeding, operative deliveries and preterm birth [46,47].
- Mood disorders can also affect a woman's ability to understand information provided to her and make health care decisions.

Maternal Mood Disorders

Depressive disorders:

- Major depression is common in pregnant women and is a condition which often goes untreated [48].
- Untreated mental health conditions increase the risk for [49, 50]:

Click this button for more information

Maternal Mood Disorders

- Poor nutrition
- Substance use disorders
- Minimal prenatal care
- Increased risk of postpartum depression
- Impaired family relationships
- Increased risk of suicide

Maternal Mood Disorders

Patients with psychotic or schizoaffective disorders, bipolar mood episodes with psychotic features and unipolar major depression with psychotic features, may be at risk for impaired capacity.

There are four generally accepted decision-making abilities that constitute capacity:

- Understanding
- Expressing a choice
- Appreciation
- Reasoning

Decision making capacity is determined by formal neurocognitive testing.

Maternal Mood Disorders

Maternal Mood Disorders

Anxiety Disorders

- Anxiety is common in pregnancy due to the uncertainty regarding the prenatal course and the potential for unforeseen complications
  - Anxiety disorders are also common in pregnancy
  - Anxiety disorders increase the risk of pregnancy complications and increase the risk for postpartum depression

Click to learn more about treatment for mood disorders

Maternal Mood Disorders

When a mood disorder is identified, for treatment should be considered. This can include counseling, cognitive behavioral therapy (CBT) and psychopharmacology therapy.

Maternal Mood Disorders

Mood disorders during pregnancy are usually treated by primary care clinicians (PCP) in collaboration with perinatal or general psychiatrists [49, 51-54].

Referral may be needed if this is not the health care provider's expertise; however, the obstetrician should continue to address the mood disorder at all prenatal visits.

Maternal Mood Disorders

Barriers to treatment during pregnancy may include:

- Cost
- Maternal fear of exposing the fetus to antidepressant medication
- Refusal of psychotherapy
- Psychotherapy is unavailable
- Stigma associated with mental health disorders [49,50].
- Health care providers who lack expertise in prescribing medication to pregnant women [55].

Click for more on barriers to treatment

Maternal Mood Disorders

- In cases of mild depression, the patient should be recommended to seek counseling and consideration should be given for initiation of medical treatment
- The patient should be asked if she has ever been on pharmacologic treatment for depression or anxiety in the past and the perceived efficacy of prior medication should be reviewed
  - If safe in pregnancy, consider resumption of prior therapy
  - In pregnancy, therapy with SSRIs, including Zoloft, Prozac, Lexapro and Celexa, is considered safe

Maternal Mood Disorders

Treatment for Severe Depression

- Mental health treatment is provided in an appropriate setting for her condition [56-58].
  - Inpatient hospitalization may be needed to maintain her safety and stabilize her, especially when suicidal ideation with a plan or intent is in place.
  - Perinatal psychiatric inpatient units are preferable, however, these facilities are typically not available [59].
  - Partial hospitalization, also known as day therapy, may be implemented when she has moderate symptoms — such as when suicidal ideations are nebulous or no plan exists and she is deemed not at imminent risk.
  - Outpatient therapy may be implemented when there is no acute threat present. She may have thoughts, such as that her family would be better off if she were dead, but has no plan or preoccupied thoughts to commit suicide.

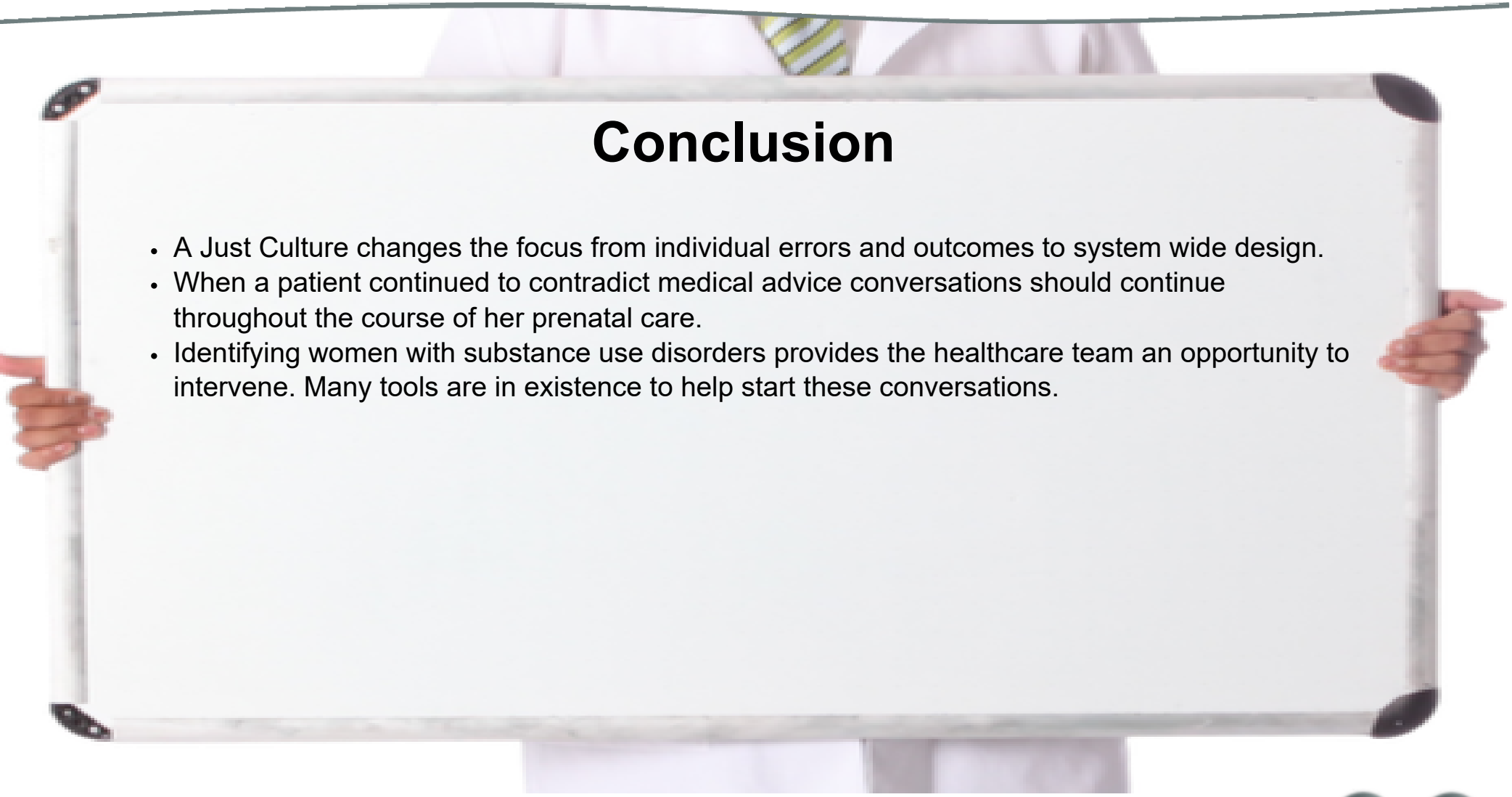
Click for more on barriers to treatment

Maternal Mood Disorders

Maternal Mood Disorders

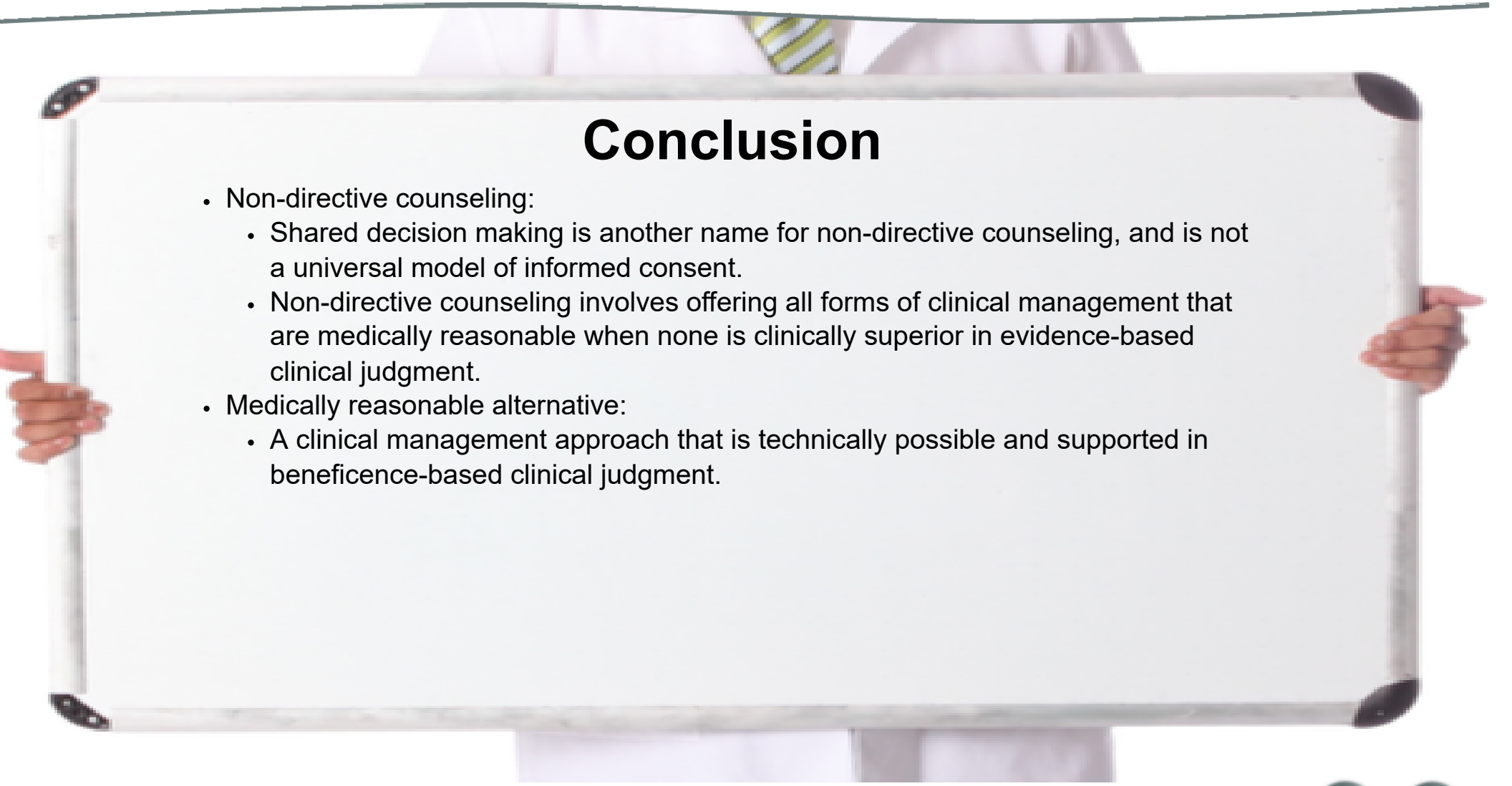
- If she is unwilling or does not recognize the need for either pharmacologic and/or therapy, the hierarchy of decision making may be needed to keep her safe.
- At times court ordered treatment may be necessary to ensure her safety and the safety of her unborn child.
- Ongoing monitoring and therapy will be needed through the pregnancy, the postpartum period and beyond by her health care team of PCP, Psychiatrist, Counselor, and Obstetrician.
- Considering various issues involved in psychiatric disorders and research, ethics plays a crucial role in protecting the rights of individuals with mental illness and simultaneously safeguarding them.

Click this button the close the window



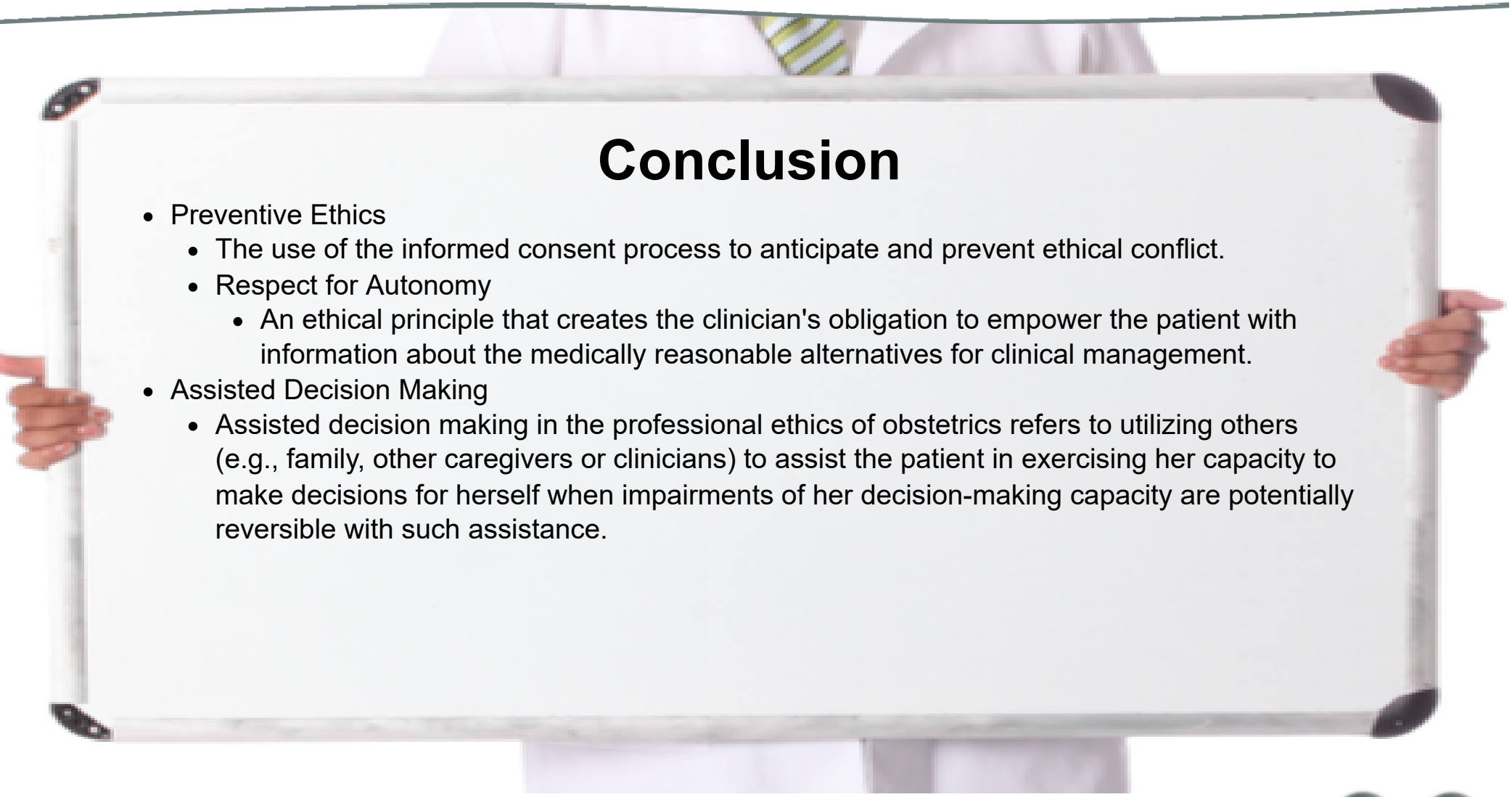
Conclusion

- A Just Culture changes the focus from individual errors and outcomes to system wide design.
- When a patient continued to contradict medical advice conversations should continue throughout the course of her prenatal care.
- Identifying women with substance use disorders provides the healthcare team an opportunity to intervene. Many tools are in existence to help start these conversations.



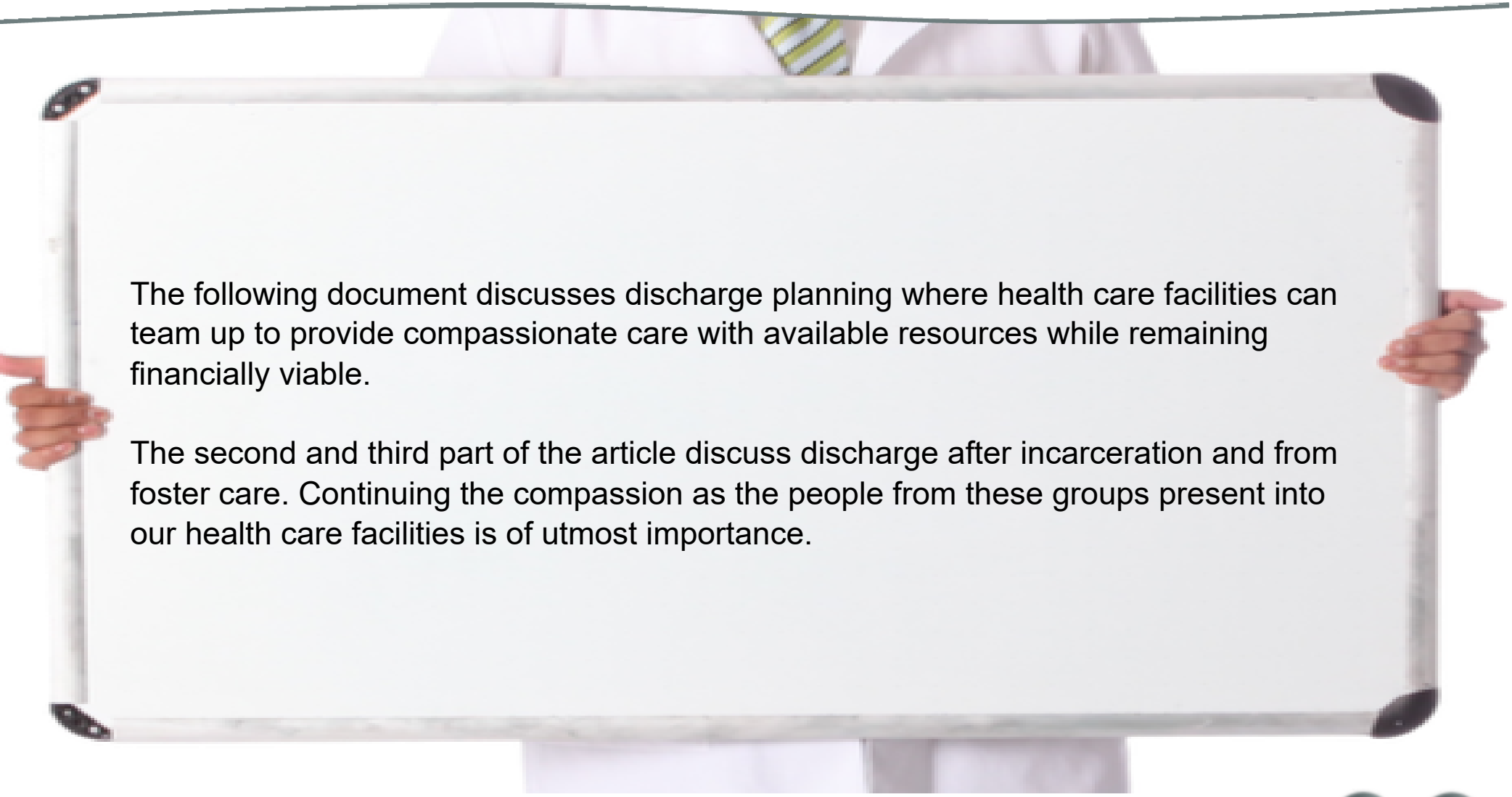
Conclusion

- Non-directive counseling:
  - Shared decision making is another name for non-directive counseling, and is not a universal model of informed consent.
  - Non-directive counseling involves offering all forms of clinical management that are medically reasonable when none is clinically superior in evidence-based clinical judgment.
- Medically reasonable alternative:
  - A clinical management approach that is technically possible and supported in beneficence-based clinical judgment.



Conclusion

- Preventive Ethics
  - The use of the informed consent process to anticipate and prevent ethical conflict.
  - Respect for Autonomy
    - An ethical principle that creates the clinician's obligation to empower the patient with information about the medically reasonable alternatives for clinical management.
- Assisted Decision Making
  - Assisted decision making in the professional ethics of obstetrics refers to utilizing others (e.g., family, other caregivers or clinicians) to assist the patient in exercising her capacity to make decisions for herself when impairments of her decision-making capacity are potentially reversible with such assistance.



The following document discusses discharge planning where health care facilities can team up to provide compassionate care with available resources while remaining financially viable.

The second and third part of the article discuss discharge after incarceration and from foster care. Continuing the compassion as the people from these groups present into our health care facilities is of utmost importance.

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HEALING HANDS

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Tools to Help Clinicians Achieve Effective Discharge Planning

Too many people without financial resources and social supports cycle among hospitals, mental health facilities, foster care or group homes, correctional institutions, shelters, and the streets. These insidious "revolving doors" exacerbate homelessness and call for clinicians and communities to find coordinated solutions that are humane and cost effective. First steps often involve creative adaptation of existing interventions. The following articles discuss discharge planning strategies and focus on individuals who are leaving health care institutions, jails and prisons, protective youth services, or the armed forces.

In 2006–2007, one in five homeless individuals admitted to shelter programs came from either in-patient medical facilities (12%) or correctional institutions (9%).[1] Those figures do not include unsheltered individuals or those living in domestic violence shelters or doubled up with family members or friends.

Discharge Planning: The process—beginning on admission—to prepare a person in an institution for return into the community and the linkage of the individual to essential community services and supports.

— *Massachusetts Housing and Shelter Alliance*

Regardless of which institution an individual may be leaving, some form of discharge planning is imperative to assure a successful transition to independent or assisted living. Without a stable home environment and family or peer support, people recovering from illness, surgery or physical injury; those without health insurance and income; and those newly emancipated from protective or correctional institutions are especially vulnerable to the harsh realities of homelessness. Many homeless shelters provide a place to sleep at night but close their doors in the morning, leaving residents to depend on soup kitchens, drop-in centers or public places, or to walk the streets without a safe place to rest or heal.[2]

Poignant case histories illustrate what can happen without adequate discharge planning. **Brooke Doyle**, Vice President of Homeless Services and Intensive Addiction Services at Community Heathlink's HOAP project in Worcester, MA, oversees facilities that provide medical and mental health case management at multiple service sites. Recently, she relates, "One of our clients was released from prison to an emergency shelter where our staff provides health care services. He had an open wound from recent surgery for a spinal cyst. His health risk was too high for shelter living, and he was unable to manage on the streets during daytime hours." In addition, as a former sexual offender, he was barred from subsidized housing and nursing homes.

HOAP has two respite beds that are staffed 24/7 at its primary site. The staff was able to establish wound care through their hospital partner; but this patient will occupy 50% of the center's medical respite capacity for an extended period of time—perhaps 12 months—before he is sufficiently healed to be discharged to a shelter. "Clearly, this case illustrates a lack of coordinated and humane planning," observes Doyle. "It is understandable that when an inmate's sentence has been completed, he or she needs to be released. But individuals with no income and no family don't have a lot of choices."

Ted Amann, MPH, RN, Director of Healthcare and Improvement at Central City Concern in Portland, OR, reminds us that "adapting to the changing fiscal and healthcare landscape while maintaining essential social benefits requires foresight, innovation, and new sources of revenue. Together, hospitals, states, the broader health care community, insurers, and patients must craft solutions that are financially viable and compassionate so that medically underserved populations, including rural communities, receive adequate healthcare now and far into the future."[3] That means hospitals, substance abuse treatment facilities, medical respite care providers, prisons, jails, and protective programs for youth all need to be skilled in the principles and practice of discharge planning.

Discharge Planning Guidelines for Health Care Institutions[4]

- Provide physical and mental/cognitive assessment at intake.
- Work with the patient on treatment adherence issues.
- Ensure patient stability prior to discharge.
- Base the decision to discharge on medical, not financial considerations.
- Encourage the patient (or surrogate) to participate in discharge planning.
- Give the patient (or surrogate) written notice of the intent to discharge and allow for an appeal of the discharge determination.
- Involve social work, pastoral care, legal counsel, ombudsman, ethicist, and a multidisciplinary care team in discharge planning.
- Provide information about community resources to clinicians and patients.
- Dedicate a clinical social worker to all homeless discharges.

The Health Care Link in Discharge Planning

On July 14, 2008, representatives of major homeless continuums of care in Cook County, IL met with county, state and federal officials to discuss how discharge policies of health, mental health, youth services, and correctional institutions were impacting homelessness. This Countywide Forum on Discharge Planning and Homelessness resulted in the formation of seven subcommittees representing agencies and subpopulations affected by discharge planning: Veterans Affairs, Health Care, Mental Health Care, Substance Abuse Treatment, the Cook County Jail, Youth Protective Services, and the Illinois Department of Corrections.

Kathleen Kelleghan, Associate Director of Health Outreach Services for Heartland Health Outreach in Chicago, chairs the Health Care subcommittee. "The forum inspired hope that this collaborative effort will engender necessary systems change to assure better care for vulnerable people," said Kelleghan, who has already seen how important it will be for her group to interact with the other six.

Nancy Radner, Chief Executive Officer of the Chicago Alliance to End Homelessness, told forum participants: "We are finding that people who leave the mental health, corrections, or child welfare systems can end up in the homeless [service] system. [It is important to] highlight how effective planning and coordination among these systems [can be] the key to preventing homelessness for so many people."

REVOLVING DOORS In the mid-1980s, caregivers nationwide began to notice the often cyclical inter-relationships among institutions that provide medical or behavioral health care, child protective services, and correctional facilities, and to realize their collective impact on homelessness. Clients tended to move from one institution to another without careful screening or resources, as if through revolving doors.[5,6] As more and more homeless individuals were caught in this vortex, financial burdens for institutions increased, public budgets inflated, and pressure was exerted on clinicians, administrators, and government agencies to look for creative solutions.

The U.S. Department of Housing and Urban Development (HUD) published a bibliography on discharge planning in 2005, noting that "good discharge planning is the lynchpin of a comprehensive homelessness prevention strategy."[7] Ensuring an individual's successful transition from institutions to the community "requires continuity of care and linkages to appropriate housing and community treatment and support" following discharge.[5-7] Research emphasizes that without permanent housing options even the most effective discharge planning will fall short.[5,8,9]

The National Health Care for the Homeless Council finds the linkage between ineffective discharge planning and homelessness unacceptable and recommends:[10]

- Development of explicit discharge planning policies;
- Prohibition of institutional discharge into homelessness from all publicly funded institutions including hospitals, treatment facilities, jails, prisons, and the foster care system;
- Effective discharge into stable housing as an imperative outcome measure for any residential program; and
- Requirement that publicly funded institutions help residents secure all available entitlements prior to discharge.

ZERO TOLERANCE In 1994, the State of Massachusetts mandated zero tolerance for discharge to homelessness in response to pressure generated by the Massachusetts Housing and Shelter Alliance (MHSA). Research conducted by MHSA identified state systems that were discharging clients without stable housing options.[11] As a result, state agencies eventually adopted common discharge planning procedures.

With the assistance of its 87 member agencies, including the Boston HCH Program, MHSA introduced innovative procedures to prevent homelessness through better discharge planning.[11] MHSA contends that discharge planning

- must be tailored to meet different needs of different consumers;
- should be comprehensive;
- must create a system that is continuous and coordinated;
- must prevent consumers from falling into homelessness; and
- should begin at admission.

The HUD McKinney Act requires states, counties, and city governments that apply for continuum of care funds to certify that their communities have policies and protocols in place to prevent the discharge of individuals into homelessness. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has required hospitals to practice discharge planning since 2003.[5] Nevertheless, discharge planning processes are far from uniform, ranging from minimalist to comprehensive practices. It is hoped that emerging evidence-based practices will validate preventive models and encourage their adoption by service organizations nationwide.

TRAINING FOR CLINICIANS There are 79,000 homeless people and 5,240 emergency shelter beds in Los Angeles County. Inappropriate hospital discharges to the streets have increased dramatically and documented cases have been prosecuted, resulting in large monetary settlements. Homeless Health Care Los Angeles (HHCLA) conducted a detailed survey about the experiences of clients discharged from area hospitals and follow-up practices, with support from the Kaiser Permanente Foundation. In response to survey results, HHCLA developed an innovative training model that is designed to help clinicians improve their skills. The training targets social workers, discharge planners, nurse case managers, and selected emergency department personnel.

Director of Discharge Planning Services **Linda Rodriguez, MSW**, explains that HHCLA's training curriculum focuses on

- Clinicians' roles in discharge planning and legal and regulatory responsibilities;
- Community resources including social services;
- Values inherent in the delivery of discharge planning services;

- Assessment as a continuous process on which planning criteria are based; and
- Strategies to reduce avoidable inpatient days through better discharge planning.[4]

HOSPITAL CONSULT SERVICE
Operation Safety Net in Pittsburgh, PA, has implemented a hospital consult service for homeless people. "The consult program serves both clients and hospitals by providing ongoing clinical communication and filling the reality gap that exists when the client leaves the hospital," explains Medical Director **Jim Withers, MD**. "We are called to visit clients at admission, which allows us to share background information with hospital staff and facilitates inpatient assessment. The patient sees a familiar face, and we know how to follow up with client care after discharge. This enables us to remain in the care loop."

MEDICAL RESPITE CARE Some urban areas including Washington, DC, and Boston have operated medical respite care facilities for homeless people since the 1980s.[12] Others are seeing the need to begin or expand such programs in the face of shorter hospital stays and a growing need for recuperative services and continuity of care after clients move back into the community. There are currently over 40 medical respite centers in the U.S. and Canada (http://www.nhchc.org/Respite/2008-2009RespiteCareProgramDirectory100708.pdf).

Homeless people are known to experience higher rates of physical and mental illness than the general population. A study by the Stroger Hospital of Cook County in Chicago suggests that medical respite care improves health outcomes and reduces health care costs. The cost of respite care provided to the study cohort was approximately half the per diem rate for hospital care and resulted in a 36% decrease in emergency department (ED) usage.[13]

"Interfaith House, a 64-bed facility in Chicago established in 1994, often fills an essential gap between a homeless person's hospital discharge and complete recovery," says Kathleen Kelleghan. "But there just aren't enough beds—3 of every 4 patients must be turned away. One of our needs is to find alternatives for medical respite care, perhaps by using established clinic sites."

During the 2008 National HCH Pre-conference Institute on Respite Care and Hospitals, **Adele O'Sullivan, MD**, Medical Director of the Maricopa County Public Health Department's HCH project, spoke passionately about the drive to build a homeless respite center in Phoenix, AZ that will open with 25 beds. What had been a dream for the future became a front-burner issue for Phoenix after an egregious example of a hospital discharge to the streets was caught on the homeless center's security videotape. People from across the community have contributed time, talent, skills, and money to bring the new facility closer to reality.

Benefits of Medical Respite Care[2]

- Stabilization of acute health conditions and a care plan to address chronic conditions
- Help getting required documentation to qualify for public benefits: Food Stamps, SSI/SSDI, Medicaid
- Help getting stable housing and employment
- Linkage to community service agencies offering ongoing support
- Better self-management of health following discharge from respite care

These initiatives are important because acute and chronic illnesses can be extremely difficult to treat when patients do not have a stable living situation in which to receive recuperative or convalescent services. Mental illness, substance dependence, HIV, and tuberculosis require regular, uninterrupted treatment and are exacerbated by exposure to the elements, poor diet, lack of health insurance, and irregular access to primary care. Medical respite programs can:[2]

- Prevent patient readmission to the hospital by providing a clean living area where wounds can heal;
- Provide patient referrals for medical evaluations;
- Initiate case management services that facilitate documentation of eligibility for health insurance or other disability benefits; and
- Protect existing relationships with case managers while building patients' readiness to address mental health issues and seek more permanent housing.

PARTNERING WITH HOSPITALS
Across the country, many tertiary care hospitals affiliated with universities are finding the economics of health care unmanageable. Oregon Health & Science University Hospital (OHSU) in Portland serves some of the state's most vulnerable citizens who are unable to pay for their care. In 2007, the hospital sustained uncompensated costs totaling $53 million.[3]

Central City Concern (CCC) in Portland, which operates a continuum of affordable housing integrated with health care, addictions treatment, recovery support, and employment services, is partnering with OHSU to help reduce some of these costs. CCC's medical respite care program, which is supported by a grant from OHSU, serves high utilizers of the hospital's ED whose complex health problems and unstable living conditions often result in longer inpatient stays and frequent readmissions.[3]

This collaboration between CCC and OHSU has resulted in more effective care management. The respite program has:[3]

- Reduced the length of homeless patients' hospital stays;
- Improved patient flow and capacity management;
- Provided cost-effective care of high quality by trained staff familiar with the needs of homeless people; and
- Managed other care functions such as utilization review, discharge planning, and social services.

This partnership has also resulted in better fiscal outcomes and resource management for OHSU:

- Patients moving to the respite program required shorter hospital stays;
- Respite care protected medically stabilized clients and added social stability that helped decrease the likelihood of readmission; and
- Engagement in primary care through the respite program provided client education about how best to use the health care system and discouraged unnecessary dependence on the hospital emergency department.

Discharge Planning for Re-entry after Incarceration

Kushel and colleagues conducted a study of homeless and marginally housed adults in San Francisco that illustrates the bi-directional association between homelessness and imprisonment. Acknowledging that "the intersection of substance abuse, unemployment, imprisonment, and homelessness is potent and lasting," they concluded that "high rates of imprisonment among homeless populations may be the end result of a system that does not provide access to timely services—including access to housing, health care, mental health care, and substance abuse treatment—and systems that have obstacles preventing receipt of these services by people exiting prison." [14]

Jails and prisons are mandated to provide health care, but are allowed to use their own staff, private contractors, or community health centers as providers. Traditional approaches have often been slapdash; many inmates are discharged with even worse medical problems than they had at intake.

Each year, over 9 million people spend hours, days, or months in the United State's 3,300 jails; 80% of inmates are incarcerated less than a month and as many as 60% are awaiting trial or arraignment.[15] Because inmates are generally incarcerated for a limited period, many of these individuals (mostly men) cycle back into their communities, bringing a host of communicable and chronic diseases with them. Over a third of inmates report medical problems more serious than a cold; 17% were homeless before being jailed; and 64% have mental health problems.[15] In addition, most inmates have little education, are poor, and lack social support.

CONTINUITY OF CARE During the 1990s, doctors from a clinic in Hampden County, MA, wanted to track patients with HIV during incarceration. When the Sheriff's Department allowed medical staff into the jails to provide treatment, a new model of care was born. That model resulted in many ex-offenders with medical or mental health problems who after release continued to see providers they had met in jail.

In 2006, the Robert Wood Johnson Foundation allocated $7.5 million to fund a new nonprofit organization, the Community Oriented Correctional Health Services (COCHS), to encourage replication of the Hampden experience nationwide. Since then, in addition to the ongoing project in Hampden County, COCHS has added similar projects in the District of Columbia and Ocala County, FL.

Community-based approaches to ensure continuity of care have often relied on the APIC Model: assess, plan, identify, coordinate.[16] The COCHS approach goes further, allowing inmates to establish a health care "home," to learn about their health conditions and how to keep from infecting others in their communities after release, and to leave jail with prescriptions that can be filled at their community health center. The model uses new computerized systems to produce electronic medical records that can be accessed by community health clinics after discharge.

Diana Lapp, MD, Deputy Chief and Medical Director of Correctional Health Facilities for Unity Health Care, the HCH grantee in Washington, DC, is tremendously proud of her staff's accomplishments. "Unity has 11 discharge planners who begin working with inmates soon after incarceration, often the same day, by developing an individualized plan of care that will connect the inmate back to the community," she says. "All inmates receive primary care in jail from 'half and half providers', who spend half time at the correctional facility and half time at one of Unity's 28 health sites. At discharge, over 95% of those released receive a seven-day supply of medications and are connected to the DC Healthcare Alliance; those infected with HIV receive a 30 day supply of meds funded by the AIDS Drug Assistance Program (ADAP) [which provides free medications for the treatment of HIV/AIDS and opportunistic infections]."

EMR "From intake to discharge, we use electronic medical records (EMR) that can later be viewed by providers outside the correctional health system," explains Lapp. "Corrections officials and court officials see the value of our discharge planning, and everyone is helping to make the process seamless." She attributes the program's success to the person-to-person connection between inmates and discharge planners. The planners give inmates their pager numbers along with a packet of information that includes a pamphlet with resources and referrals to facilitate early access to health care sites. The DC Department of Corrections (DOC) gives every person discharged from jail an ID upon release and tokens for food to help encourage successful reintegration into the community.

The DOC–Unity Health Care program is working so well that in July 2008, the National Commission on Correctional Health Care (NCCHC) recognized this remarkable partnership with the "Program of the Year Award," which is presented annually to only one of its 500 accredited prisons, jails, and juvenile detention facilities.

INFECTION CONTROL Prison terms are longer than jail terms, and imprisoned individuals are often located farther from their home communities. Although longer sentences provide an opportunity to work on treatment adherence, infection control is especially problematic in prisons where people from diverse backgrounds and communities are housed in close proximity.

The Centers for Disease Control and Prevention (CDC) have issued guidelines to correctional and detention facilities for the control of HIV/AIDS, viral hepatitis, STD, and TB prevention.[17] Similar to the COCHS programs, the guidelines call for early assessment and identification of infection, completion of prescribed treatment, appropriate use of isolation and environmental controls to minimize transmission of airborne infection, comprehensive discharge planning, and efficient and thorough contact investigation, as well as continuing education for inmates and facility staff.

DISCHARGE PLANNING GUIDE In New Jersey, the DOC's Office of Transitional Services strives to provide a systemwide continuum of care based on proven practice

while trying to prepare the 14,000 offenders it discharges each year for any eventuality. Director **Darcella Sessomes** has created linkages to resources including health care, employment, housing, and family support services.

The department spearheaded development of *The Smart Book: A Resource Guide for Going Home* for New Jersey counties. Recognized nationally as a top-tier discharge planning guide, these booklets leave nothing to chance.

Topics include:

- Getting Started: ID and Other Documents
- First Steps After Release: Where Do I Go to Find . . .
- Taking Care of Yourself: Getting Support and Health Care Resources
- Finding a Job: Employment Assistance and Training Programs
- Reconnecting with Family
- The Game Plan

(http://liberty.state.nj.us/corrections/OTS/news_ots.html)

"These are vital skills for all ex-offenders," says **James Comstock, MSW**, Senior Social Worker at Project HOPE in Camden, NJ. He recently retired after 25 years as a correctional counselor and knows the difference that the Smart Books make for positive discharge planning. "The step-by-step entries give individuals a guidewire to resources for success."

Discharge Planning for Youth in Foster Care

Statistics that describe youth who are aging out of foster care paint a grim picture. These young people suffer disproportionately from physical and mental health problems, may be involved in illegal activities, are isolated from the community at large, and face a life of poverty. Scared, lonely, and angry, they often act out in response to cumulative trauma, making placement in a supportive environment difficult.

Of the 750,000 young adults estimated to experience homelessness each year, 20,000 have a history of foster care. Four years after emancipation, 46% of these individuals have not finished high school, 42% have become parents, 25% have been homeless, and 20% are still not able to support themselves.[18,19]

Research shows that youngsters leaving foster care are hindered by missing social supports, incomplete education, poor employment opportunities, and the inability to access health care and housing.[18,19] While the 1999 Chafee Foster Care Independence Program was enacted to provide a safety net of programs for youth leaving care systems, states are required to add a 20% match to the federal dollars. Flexible funding allows them to design programs for specific groups as needed. Foundations, government agencies, and clinicians are increasingly aware that available funds are insufficient to provide a comprehensive assistance program.[18]

Foster children whose birth parents were themselves in foster care are particularly disadvantaged, both socially and economically. Conservative estimates indicate that 49% of birth parents of children entering foster care have experienced homelessness.[20]

Best Practices for Young People Aging Out of Foster Care

- Preventive rather than reactive practices
- Adequate dollars to fund consistent programs
- Automatic support systems: a health insurance card that travels with young adults through age 25; employment and housing assistance
- Foster care programs designed at the national level and applied consistently across all states
- Mentors for all youth in foster care
- Educational and peer group support for pre-teens so that they learn preparation skills when they are still receptive

— Cheryl Zlotnick, RN, DrPH

PREPARATION & SUPPORT Although young adults who have episodes of homelessness after emancipation may have more trouble accessing health care than do those without a history of foster care, they do not seem to experience worse health outcomes.[21] The key to successful transitions from foster care to the community is preparation for independent living coupled with strong relationships, education, housing, life skills, identity, youth engagement, and adequate financial support.[22]

ONGOING ASSESSMENT **Cheryl Zlotnick, RN, DrPH**, Project Director of the Center for the Vulnerable Child, an HCH project at Children's Hospital and Research Center in Oakland, CA, says that "for children who have experienced trauma and have mental health problems, ongoing psychological assessments and treatment are very important. More time in care, more placements and trauma lead to more mental health problems in later life." It is well-established that young children living in foster care have higher rates of social and psychological problems, notes Zlotnick. In addition, newly emancipated 18 year olds encounter high rates of unemployment and homelessness.

MENTAL HEALTH SERVICES Because childhood history of foster care appears to be linked to later mental health problems, effective statewide interventions for children in foster care could reduce the development of psychosocial problems in adulthood.[23] "Mental health services are very important for children in foster care," Zlotnick emphasizes. "And a constant adult who cares about the child and can be part of his or her life consistently—even a birth mom who is not living with the child—is wonderful."

MENTORING RELATIONSHIPS Ahrens and coworkers' recently published study demonstrates that youth in foster care engaged in mentoring relationships with nonparental adults during adolescence have significantly better outcomes than do nonmentored youth. The establishment of such relationships within existing social networks seems to promote stronger and longer lasting relationships.[24]

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For more information about Discharge Planning, see
the National Health Care for the Homeless Council's website: www.nhchc.org/dischargeplanning.shtml

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