

INDICATIONS FOR TOXICOLOGY TESTING in Colorado Birthing Facilities



**SuPPoRT
Colorado**

Supporting Perinatal substance use Prevention,
Recovery, and Treatment in Colorado

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Title: INDICATIONS FOR TOXICOLOGY TESTING in Colorado Birthing Facilities

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How to use this document:

The following document is intended to serve as best practice guidance for Colorado birthing facilities on clinical best practice principles related to toxicology testing. This template should be used to inform development of a clear and transparent toxicology testing policy at a birthing facility or health system, and can be adopted and/or adapted to meet an individual facility's needs.

Purpose of Best Practice Guidance

1. Through standardization of criteria, this guidance is intended to minimize bias, discrimination, and variability in the use of toxicology testing for pregnant/birthing persons and their infants.
2. Describe limitations of and appropriate clinical indications for toxicology testing in the care of birthing people and infants affected by substance use during pregnancy.
3. This policy is not intended to be overly prescriptive or replace the clinical judgment of providers or the multidisciplinary care team.

Statement of Policy

Systemic social, economic and environmental inequities impact experiences and outcomes related to substance use, pregnancy and/or parenting. Substance use is strongly correlated with individual, historical, and intergenerational trauma, as well as mental health conditions, toxic stress, sexual violence and/or intimate partner violence²⁶. Thus, substance use during pregnancy and/or parenting must be understood in this broader context. To decrease inequities, the systems, services, and policies that shape perinatal care must be trauma-informed, culturally-responsive, and serve individuals and families with dignity and respect.

Because of generational anti-Black racism and other forms of bias and discrimination, toxicology testing has criminalized people cared for by our healthcare institutions, and regardless of intention, has resulted in structural and social stigma that has influenced toxicology testing policies^{23, 24}. Toxicology policies that are punitive, non-transparent, "risk" based, or rely on indications for testing that are conflated with poverty, have caused harm and have been shown to disincentivize pregnant people from seeking prenatal care and/or substance use treatment, even when desired²⁵. Concerning examples of risk-based indications for automatic toxicology testing include: Medicaid insurance, late entry to prenatal care, teen pregnancy, previous child welfare involvement, person in recovery from substance use disorder, history of incarceration, medical conditions that are more prevalent among minoritized birthing individuals such as preterm birth or low birthweight, etc.

It is essential that medical care team, administrators, and policy makeup alike, work together to understand how such policies, as well as explicit or implicit bias, may impact decisions to perform biological toxicology testing on pregnant or laboring individuals and their infants. Research shows that even in the setting of equal application of toxicology testing criteria across populations, Black individuals are tested at higher rates and experience more referrals to child welfare agencies⁴. In an effort to address this harm, toxicology testing is not to be used as a proxy for fitness for parenting nor as a sole data point in decision-making regarding [Plans of Safe Care](#). See [Appendix B](#) for more information on Plans of Safe Care.

The criteria mentioned below apply to all birthing people and infants, regardless of age, race, ethnicity, gender, country of origin, language spoken, income level, religion, housing status, etc. Care should be taken to not disclose suspicion of substance use to anyone not directly involved in care planning for families, because substance use disclosures are protected by federal law.

Relevant Research

Per clinical guidelines from ACOG², all patients should be universally screened for behavioral health concerns, including substance use, with a validated screening tool.³ Unless there is a medical emergency where the patient is unable to answer questions, toxicology testing should never precede screening. Of note, separation of a newborn from the birthing person can be harmful even in cases where drug use is confirmed.⁴ The benefits of bonding, skin-to-skin contact, and chest/breastfeeding can outweigh the risks of harm depending on the case. Finally, due to structural racism and social stigma, toxicology testing results are weighed heavily in the legal system and can supersede even expert opinion from addiction medicine specialists.

Screening vs Testing

While the terms screening and testing are at times used interchangeably, screening refers to the process of gathering more information from patients about their substance use, through the use of a self-administered or clinician-administered validated verbal or written screening tool. Toxicology testing refers to the collection of a biological sample looking for the presence of a drug or its metabolite.

Screening

Universal verbal screening (preferably with a validated tool⁵) is the gold standard for assessing and identifying families affected by substance use⁶. All pregnant birthing people should be verbally screened for substance use. Education should be provided about the impact of substance exposure and use during pregnancy, birth, and chest/breastfeeding and about how this information will be used to help in care planning.

Indications for Toxicology Testing

If screening for substance use is positive, toxicology testing is not automatically indicated and warrants further conversation with the patient. This is an opportunity to strengthen the therapeutic relationship and collaboratively determine if toxicology testing is indicated. Toxicology testing results could be helpful in identifying additional exposures, known or unknown, that would change the course of medical care for the birthing parent and/or infant during birth hospitalization and/or the postpartum period. This is an important consideration for the patient/provider team given the current prevalence of fentanyl in Colorado. Simultaneously, providers must be aware that toxicology testing, and the way testing is carried out, has the potential to cause harm and decrease trust between patients and providers. There is significant physiologic and psychological vulnerability during labor and in the early hours/days postpartum, when many toxicology conversations take place. Care must be taken to have these conversations in a way that is trauma-informed, strengths-based, and includes [informed consent](#). See trauma-informed care section below for more guidance.

Before ordering a toxicology test for the birthing person or newborn, the reason for obtaining the test, how it will change medical management, and how it may impact discharge and disposition should be clearly identified and documented. In addition, a multidisciplinary discussion with pediatrics and obstetric/midwifery providers, nursing, and the family should take place prior to administration of toxicology testing. Care teams should be familiar with the type of toxicology testing available at their facility, the limitations and advantages to each type, and the possibility of false positives/ negatives prior to moving forward with ordering the test to ensure it has clinical utility for their question/concern. Providers are not to order a test without knowing why and how the results will guide clinical management and care of the birthing parent and/or infant.

Birthing Parent Toxicology Testing Indications (must obtain consent)

1. Signs and symptoms of intoxication, withdrawal, or altered mental status which could include: Unexplained disorientation, psychosis, manic symptoms, ataxia, hallucinations, internal preoccupation, severe psychomotor agitation, confusion, and or somnolence where a toxicology test would dictate medical management. There are many conditions that present in a similar fashion to intoxication and/or withdrawal; differentials should be broad and include trauma responses.
2. If desired by the birthing person (e.g., to demonstrate substance use disorder recovery, identify

unintended exposure to substances, and/or safety of chest/breastfeeding).

3. If a birthing person desires to chest/breastfeed, toxicology would be indicated if one or more of the following conditions exist:
 - a. Report of substance use or positive urine toxicology test during last trimester of pregnancy.
 - b. Birthing person has an active substance use disorder and is not engaged in treatment. **Note:** If birthing person is involved in treatment, it is strongly recommended to consult with providers who have an ongoing relationship with the birthing person to assess the level of engagement with recovery (e.g. prenatal provider, SUD treatment providers, etc). See [Lactation Considerations](#) section for more information on lactation guidance.

Newborn Toxicology Testing Indications:

1. If a newborn exhibits symptoms consistent with intoxication (somnolence, jitteriness/irritability, depressed respiratory and/or cardiovascular status) or withdrawal (inconsolability, poor sleeping, and/or poor feeding) that are otherwise unexplained.
2. If the newborn's birthing parent meets criteria for toxicology testing and results would alter medical management of the newborn.
3. Newborn with physical stigmata of fetal alcohol syndrome.

Informed Consent & Procedure

Informed consent is best practice in all cases. If toxicology testing is indicated for the birthing person or infant based on the above criteria, the primary care team should engage in a thorough informed consent conversation with the birthing person and/or legal guardian. Informed consent requires a clear explanation of why testing is indicated, potential benefits of testing, such as understanding all known or unknown exposures and guiding medical management of the dyad, and potential risks of testing, including the possible legal, criminal, or child welfare consequences. Informed consent should also include the risks and benefits of refusing consent for testing. If consent for testing the birthing person's sample is not obtained, the toxicology test can only be sent if the patient is deemed to lack capacity. This rationale must be clearly documented and supported by history and physical exam findings.

If toxicology testing is indicated for the newborn, but consent is not obtained from the birthing person or guardian, testing should only occur when there is a compelling medical need. Consent should clarify that umbilical cord testing is the most common form of infant toxicology testing requested and is non-invasive for the infant.

Team response

If toxicology testing is requested by the provider team for the birthing person or newborn, the reason for obtaining the test, how it will change medical management, and how it may impact discharge and disposition should be clearly identified in a multidisciplinary discussion with pediatrics and obstetric/midwifery providers, nursing, and the family. The rationale and plans need to be clearly documented in the medical record. It is best practice to obtain consent.

All positive substance use screens and/or positive toxicology tests should be followed by an interdisciplinary team check in or "time out" to ensure alignment between care teams, gather context, and ensure consistent information is communicated to patients in a trauma-informed manner. This includes positive verbal screening for substance use. It is best practice to use team decision making whenever possible at key decision points that could have life altering impacts for the infant-birthing parent dyad. Key decision points include ordering toxicology tests, response after a positive toxicology test, chest/breastfeeding, rooming-in, discharge planning, and before reporting child safety concerns to Child Welfare. The team should include the patient or patient's caregivers, alongside the providers who are managing care for the dyad. See [Appendix A](#) for suggested structured "check-in."

Interpretation

A toxicology test gives information about the presence or absence of various substances or their metabolites, but doesn't necessarily provide information about the amount, recency, route or possible impairment related to any potential substance use. For example, urine immunoassay testing for amphetamines is typically only

positive for 1-3 days after last use, in part because the threshold for positivity for amphetamine immunoassays is 500 ng/mL. Other analytical methods such as high performance liquid chromatography/tandem mass spectrometry (LC-MS/MS) have a lower threshold for positivity (250 ng/mL per SAMHSA workplace cutoffs, though some reference labs use reporting limits as low as 50 ng/mL), and as such can detect amphetamines for a longer period of time after last use. Similarly, due to inter-individual variability in drug use patterns, drug deposition characteristics and drug metabolism, testing for cannabinoids cannot provide specific information regarding the timing of the most recent exposure; some individuals have no detectable cannabinoids in urine one day after last exposure while others have positive testing for many weeks. There is no threshold or cutoff for these analytical methods that can determine if a patient was toxic or impaired; toxicity and impairment are clinically determined.

Toxicology testing via urine immunoassay (a typical “urine drug screen”) may be valuable in some situations as it provides rapid results, however it is limited by frequent false positive and false negative results. Confirmatory testing techniques such as gas or liquid chromatography coupled with mass spectrometry are highly accurate, however this often takes a longer time to result compared to standard urine immunoassay testing as most hospitals rely on reference laboratories to perform confirmatory tests. Synthetic opioids, such as fentanyl and methadone, will not produce a positive result on most opiate immunoassays. Similarly, semisynthetic opioids such as buprenorphine and oxycodone produce variable results on most opiate immunoassays and will not reliably produce a positive result.

False positives for stimulants occur frequently. The timing of last use, dosage, potential interactions with other medications and personal metabolic rate all affect the result of the urine test. It is critical that the provider caring for the birthing person check if the birthing person was prescribed and taking medications, including over-the-counter medications or supplements, that can result in false positive or false negative tests.

There are multiple considerations and nuances when interpreting toxicology tests– unfortunately a “quick guide” to aid in interpretation is not recommended. Every facility or hospital has its own clinical laboratories and each lab is able to choose different assays. The cross reactivities across assays are *not* translatable from one assay to another. Even for an individual facility, there are many caveats to interpreting toxicology tests. Additionally, hospital labs can change assays any time (due to cost, availability of reagents etc).

Best practice in high-risk situations, such as when interpreting toxicology results during the birth episode, is to have all birthing parent test results reviewed by a Medical Review Officer (MRO). An MRO is a physician who is specifically trained in the above nuances and interprets the results, taking into account medical history, co-administered medications, type of test used, etc. Similarly, newborn toxicology test results should be interpreted by someone with such training and expertise in interpretation of newborn toxicology tests.

If an MRO is not available, providers can contact Rocky Mountain Poison and Drug Safety (our state’s poison control center) and speak with a toxicologist for assistance with interpretation (800-222-1222). Another option is for providers to call the lab at their facility to ask about known “interference” (false positives/negatives) and for assistance in result interpretation.

***Most umbilical cord toxicology tests assess for a greater number of substances (relative to most urine immunoassays) and evaluate a greater time frame of substance exposure (approximately the last trimester of pregnancy, although data on drug detection windows for most substances in umbilical cord tissue is lacking). Note that testing for certain drugs or metabolites in umbilical cord tissue (such as testing for cannabinoids or ethyl glucuronide testing for ethanol exposure) must be ordered separately, as they are often not included in many reference labs’ “drug panels” for umbilical cord tissue. Most umbilical cord toxicology tests will identify synthetic and/or prescribed opiates. A result is listed as positive in the umbilical cord tissue if it is present above a specified threshold (thresholds can vary between labs). Technique of collection of umbilical cord tissue for toxicology testing can influence the results of the test (both false positives and false negatives). Similar to confirmatory urine testing, the umbilical cord testing can take several days to result.

Lactation Considerations

Chest/breastfeeding is an established, evidence-based practice that serves as a significant protective factor against numerous acute and chronic diseases, including childhood obesity.²⁸ Generally speaking, birthing parents with active non-prescribed or illegal substance use and/or misuse of legal substances in the 30 days prior to delivery should be engaged by the multidisciplinary care team (maternity, pediatric, lactation, etc) in a discussion to determine appropriate and individualized chest/breastfeeding advice. Providers should be aware that there are longstanding racial, socioeconomic and geographic disparities in rates of chest/breastfeeding initiation and continuation⁹ that are perpetuated by systemic barriers and implicit biases. It is critical that administrators, maternity, pediatric, and lactation care teams work to identify and remedy these systemic barriers, while simultaneously creating a team culture that internally challenges preconceived notions or beliefs about a birthing person's capacity, appropriateness, or desire to chest/breastfeed.

The Academy of Breastfeeding Medicine states that “infants of women with substance use disorders, at risk for multiple health and developmental difficulties, stand to benefit substantially from breastfeeding and human milk, as do their mothers,”¹⁰ and outlines criteria and circumstances in which lactation would be contraindicated due to the risk of substances passing on to the newborn via human milk. For more information, see the full guidance from the American Breastfeeding Medicine’s clinical protocol on [Guidelines for Breastfeeding and Substance Use or Substance Use Disorder](#).

Cannabis and Lactation

Major medical organizations recommend that lactating people abstain from using cannabis as THC/metabolites are secreted into and can remain in human milk after use. However, lactation is not necessarily contraindicated if a person is currently using or has used in the past. To limit potential risk to the infant, individuals should be advised not to use cannabis or products containing cannabis in any form while breastfeeding. Individuals choosing to feed their child(ren) human milk should be provided lactation care, education, and support.

The potential health risks to the infant, the known benefits of breastfeeding to the child and parent, as well as the parent’s desires, must all be carefully considered when counseling patients about the risks and benefits of lactation in the setting of cannabis use. It is ideal to speak with patients about cannabis use as early as possible (prenatally or early postpartum) and encourage abstinence or reduction of use.

Mandated Child Welfare Reporting Considerations

Reports to child welfare are at times a critical component of ensuring an infant’s safety and well-being. It’s important to acknowledge that there could be safety concerns unrelated to substance use that may result in a child welfare report. For the purposes of this document, the following focuses on the nuances of child welfare reporting as it relates to perinatal substance exposure and to infants affected by perinatal substance use.

[Colorado statute](#) defining “child abuse and neglect” as it relates to a substance exposed newborn changed in 2020. Per Colorado statute 19-1-103(1)(a)(VII), child abuse and/or neglect as it relates to substance exposed newborns is defined as a child:

born *affected* by alcohol or substance exposure (except when taken as prescribed or recommended and monitored by a licensed health care provider), AND the newborn child’s health or welfare is *threatened* by substance use. A child is born affected by alcohol or substance exposure when it impacts the child’s physical, developmental, and/or behavioral response. The newborn child’s health or welfare is threatened by substance use when the medical, physical, and/or developmental needs of the newborn child are likely to be inadequately met or likely unable to be met by parents and/or caregiver.

The recent change in statute gives mandated reporters additional discretion in whether or not to make a report, encouraging mandated reporters to consider if an infant is both affected AND threatened by a birthing person's substance use. A positive substance use screen and/or toxicology result as a stand-alone, is not indicative of child abuse or neglect. The severity of perinatal substance exposure is an important consideration, and should be coupled with observations related to a caregiver's interactions with, and ability to safely care for the newborn.

It is important to remember that over-reporting to child welfare has the potential to cause unintended harm to infants and families.¹⁹ It is critical to consider cultural lenses and internal bias before making a report, as race and poverty-related disparities and disproportionality are reflected in the Child Welfare System due to longstanding systemic and structural racism. Care should be taken to ensure that policy and practice which delineate criteria for toxicology testing and child welfare reporting do not directly or indirectly target low-income families or families of color.

Case examples that likely wouldn't meet criteria for further investigation of child abuse and neglect:

1. Provider reports that the child does not appear affected by exposure. There are no withdrawals; the child is able to eat, sleep, and be consoled. There are no apparent physical, developmental, and/or behavioral concerns for the child.
2. Birthing parent and infant are impacted by substance use, but parent(s) or caregiver(s) are able to meet the medical, physical, and developmental needs of the child. Examples include:
 - a. Live-in sober responsible caregiver who has demonstrated the ability to care for the child in the hospital.
 - b. Primary caregiver is currently in or enters into treatment and the child may discharge to that or another caregiver who has shown they can provide safe care for the child.
 - c. Caregiver may have demonstrated they have a high level of support to care for the child.
3. Birthing parent has a previous history of substance use and/or child welfare involvement. There are no current concerns. Each pregnancy should be considered on its own merit.

Case examples that likely would meet criteria for further investigation for child abuse and neglect:

1. If a caregiver has shown they cannot meet the needs of their infant in the hospital (lack of responsiveness to infant's cries, lack of capacity to respond to infant-specific needs for food, sleep, comfort).
2. Caregiver is intoxicated or in active withdrawal.
3. Caregiver leaves the infant unattended.
4. Caregiver does not have a plan for discharge to meet the newborn's needs.

Trauma-Responsive Care

Hospitals must ensure that the multidisciplinary team caring for birthing individuals and newborns completes [trauma-informed care training](#) and gains competency in the principles of trauma-responsive care, so that they do not inadvertently retraumatize patients and cause harm. Though trauma affects people of all ages, races, ethnicities, genders and socioeconomic backgrounds, those in power have upheld systems and practices that disproportionately traumatize some populations at higher rates and greater frequencies than others, resulting in the perpetuation of historical and generational trauma. Trauma is not necessarily the "event" that happens to a person, but rather the enduring impact that harmful events, circumstances and socio-political conditions can have on a person's internal stress-response system. The way a person's nervous system responds in the face of traumatic events is involuntary, often unconscious, and outside of a person's control.

Because the prevalence of trauma is so high, and because one cannot look at a person and determine if they have experienced trauma, best practice is to treat all patients (and staff) as if they might be trauma-survivors.

A trauma-informed approach to care is strengths-based and reflects an understanding of and responsiveness to the impacts of trauma. This approach recognizes the significance of power differentials, the historical diminishing of a person's voice and choice in past coercive encounters, and as a result, offers patients the choice to be actively involved in all decision-making regarding their care.²⁰ Trauma-informed care emphasizes physical, emotional and psychological safety for patients, and creates opportunities for survivors to rebuild a sense of control and empowerment.²¹ When care is not provided in a trauma informed manner, trauma survivors can find themselves re-traumatized by well intentioned members of their care team. This leaves patients vulnerable to destabilization of mental health, misuse of substances/return to use, and can seed distrust in the healthcare system.

Healthcare practitioners should become familiar with the trauma-informed model of care and strive to universally implement a trauma-informed approach across all levels and aspects of maternity and pediatric care. SAMHSA outlines the following four key assumptions of any program, organization or system that is trauma-informed, known as the "4 R's":

- **Realizes** the widespread prevalence of trauma and takes universal precautions.
- **Recognizes** the signs and symptoms of trauma in patients, families and staff.
- **Responds** by integrating knowledge about trauma into policies, procedures, and practices.
- **Resists** re-traumatization of patients, families and staff.²² From a patient's perspective, many things in a medical encounter (physical exam, personal questions, power differential, labor/delivery, etc.) can trigger implicit/explicit memories of trauma and feelings of helplessness and powerlessness.

It is important for healthcare providers to know that past trauma often resurfaces during the perinatal period and that a history of trauma can have a profound effect on attitudes toward and outcomes of medical care. The medical model highlights pathology and inadvertently gives the impression that there is something wrong with a person rather than that something wrong happened to that person. To counteract this, trauma-informed practitioners need to collaborate with patients and families to create an environment where the patient experiences themselves as safe, in control, and empowered to make choices. This looks like:

- Partnership between the patient and provider- goals are mutual and the treatment plan is co-created. Power with, not power over.
- Inform the patient about what is going to be done and why, before doing it.
- Always get permission. Continue to explain what is happening throughout processes and procedures.
- Ask the patient if there's anything you can do to help them feel safer or more comfortable.
- Provider is trained in, and aware of, signs and symptoms of trauma reactions and somatic issues that may be related to trauma and responds appropriately.

Resources to Support Families

There are many resources available to families who face psychosocial stressors, and care should be taken to partner with families in determining appropriate referrals. Each facility needs to identify resources and interventions within their region to include in their facility-specific policy. For examples of real Colorado resources and interventions that are designed to improve outcomes for pregnant and parenting families, see [Appendix C](#). It is not required to have a toxicology test to mobilize these resources.

Plans of Safe Care

The Plan of Safe Care (POSC) project is available to help care team members craft and implement safe care plans for birthing people and their newborns affected by substance use and mental illness. See [Appendix B](#) for more information about the POSC. Care providers should take care in differentiating a concern for neglect, which is primarily a failure of the community to support people to parent, and abuse.

Things to consider when creating a Plan of Safe Care:

A Plan of Safe Care (POSC) is a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following his or her release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver.

Ideally, a POSC is initiated prenatally by the primary health care provider caring for the family impacted by SUD, and is developed over time. If this is the case, ideally birthing hospital teams should collaborate with the prenatal care team and develop a POSC in collaboration with the birthing parent and the birthing parent's support persons, other healthcare providers involved in caring for the family (including prenatal providers, addiction medicine specialists, pediatricians, neonatologists, and/or family medicine providers), social workers, mental health specialists, and other professionals and agencies involved in serving the affected infant and family.

Support & services for infant: The plan will address the safety, health, and substance use disorder treatment needs of the infant and affected family members or caregivers. Best practices indicate this should be done through the interdisciplinary coordination of services to enhance the overall well-being of the infant and their parents or caregivers.

- Developmental screening and assessment
- Linkage to early intervention services
- Medical services needed to meet the ongoing health needs of the newborn
- Home visiting programs

Support & services for adult caregivers: Best practice tells us that a POSC should be designed to meet both the short- and long term needs of the family, with the goal of strengthening the family and keeping the child safely in the home. A POSC could include the following components, depending on the needs of the family.

The following is a list of suggested components:

- Substance use assessment and services
- Medical services needed to meet the ongoing health needs of the parents and other caregivers
- Mental health services
- Assistance with obtaining safe housing
- Instruction on the special care needs of the infant
- Provision of infant safe-sleep information and ensuring safe-sleep arrangements in the home
- Child care or respite care
- Vocational training for parents seeking entry to the job market
- Comprehensive and coordinated social services, including family therapy groups, parent-child therapy, and residential support groups

Technical assistance & next steps

For technical assistance and training on developing an equitable toxicology testing policy at your place of practice, please contact Illuminate Colorado's Strategic Initiatives Manager, Kelli Sutton:

ksutton@illuminatecolorado.org

Appendix A: Framework for Interdisciplinary Team “Time Out” for Families affected by Substance Use

Interdisciplinary Team “Time Out” for Families Affected by Substance Use

Birth Person:
Birth Person MRN:

Infant’s Name:
Infant’s MRN:

Pertinent patient-care team members should be alerted by Charge RN

Meeting involves:

- Social Worker:
- Primary OB provider:
- Primary Pediatric provider:
- Primary RN:
- Charge RN:
- Behavioral Health (Perinatal Pathways) provider:
- Anesthesia (if applicable)

Best practice (if possible and when applicable) to also reach out to:

- Lactation consultant:
- Patient PCP and/or prenatal care provider:
- Outpatient Social Worker:
- Addiction Medicine provider:
- Case worker/counselor from outside program:

Substance(s) used by birth parent this pregnancy (check all that apply and provide specifics when applicable):

- Medication Assisted Treatment = ***
- Opioids (other than MOUD) = ***
- Methamphetamines
- Marijuana
- Benzodiazepines
- Cocaine
- Alcohol
- Tobacco/Nicotine
- Other:

Appendix B: Plan of Safe Care

SuPPoRT Colorado is in the process of finalizing a Best Practice Recommendation Guide on implementation of Plans of Safe Care for Colorado healthcare providers and child welfare professionals. The guide is currently in draft form and this appendix will be updated with the final materials.

Plan of Safe Care (coloradocwts.com)

[Draft SuPPoRT Colorado Best Practice Recommendations for: Collaboration and Integration of Plans of Safe Care Implementation in Colorado.](#)

Appendix C: Examples of Colorado Resources/ Interventions for Families Affected by Substance Use

Prior to discharge and/or during initial outpatient visits, consider the following resources (referrals should include discussion with birth parent/caregivers regarding access and parent/caregiver preferences; follow up with resources to provide connection and warm hand off is encouraged):

Consider Speech Language Pathology, Occupational Therapy , and/or Physical Therapy consultation to address any feeding difficulties or motor/sensory concerns (both in hospital and post-discharge).

- [2-1-1 Colorado \(211colorado.org\)](http://211colorado.org)
- [Prenatal Plus](#) (integrated prenatal care, including behavioral health, care coordination and nutrition support)
- [Early Intervention](#)
- Early Childhood Mental Health Consultants
- [Elephant Circle](#) (Doula services)
- [Fussy Baby Network](#)
- [Colorado Home Visiting Programs](#)
- **Public health nursing services:**
 - [Nurse-Family Partnership](#) (first time parents only)
 - [Nurse Support Program \(NSP\)](#)
 - Insurance based nurse visitation
 - Public Health Nurse Visitors (including CYSHCN)
 - [Recovery Nurse Advocates](#) (nurse home visits + doula support for pregnant/postpartum individuals impacted by substance use disorder, Denver)
- **Home visiting programs (local availability and family eligibility will vary):**
 - [Safe Care](#)
 - [Child First](#) (children 0-5)
 - [Healthy Families America](#)
 - [Parents As Teachers](#)
 - [Early Head Start](#)
 - [Family Connects](#)
 - [Great Expectations](#)
- **Family Resource Centers**
- **Parenting Support Groups**
 - [Circle of Parents](#) (General groups and Recovery groups)
 - [Healthy Expectations](#)
 - [Incredible Years](#) (evidence based parenting group)
 - [Mothers of Multiples](#)
 - [Motherwise](#)
- **Parent Mental Health and Substance Use Disorder Support/Treatment**
 - [The CUB clinic at University of Denver](#)
 - [ARTS](#) (Addiction Research and Treatment Services)

- [Connections Program for High Risk infants](#)
- [Postpartum Support International](#)
- [Tough as a Mother](#)
- [Special Connections](#)
- [Parentline](#) (statewide telehealth for perinatal families w/ behavioral health struggles)
- [Parents Thrive](#)
 - [Cultura Cura Belly](#)

Endnotes

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