SUBSTANCE USE DISORDER PERINATAL PRACTICE GUIDELINES

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Community Services Division

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

The Community Services Division, within the California Department of Health Care Services (DHCS), is mandated by State and Federal law to update, disseminate, and implement the Substance Use Disorder (SUD) Perinatal Practice Guidelines (PPG).[1] These guidelines address SUD treatment services for women, specifically pregnant and parenting women seeking or referred to SUD treatment.

The purpose of the SUD PPG is to ensure California providers deliver quality SUD treatment services and adhere to state and federal regulations.[2] The SUD PPG provides guidance on perinatal requirements in accordance with Drug Medi-Cal (DMC)[3], Drug Medi-Cal Organized Delivery Systems (DMC-ODS), California Advancing and Innovating Medi-Cal (CalAIM)[4], and the Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG) Perinatal Set-Aside from the Substance Abuse and Mental Health Services Administration (SAMHSA). The SUBG requires specified funds to be used for perinatal clients, regardless of whether perinatal funds are exchanged for discretionary funds.[5,6] Providers must adhere to the requirements as outlined in the SUD PPG.

Additionally, the SUD PPG outlines best practices for serving pregnant and parenting women. These best practices are based on resources and research published by the National Association of State Alcohol and Drug Abuse Directors[7] and SAMHSA.[8] The best practices also align with California statutes and regulations.[9]

The purpose of the best practices is to supplement the SUD PPG requirements and provide recommendations for the delivery of SUD services to pregnant and parenting women. Providers are encouraged to use the best practices as a reference tool to develop comprehensive, individualized, gender-specific, and family-centered SUD services.

The DHCS, Community Services Division provides training and technical assistance (TTA) to counties, providers, and members of the public regarding services for pregnant and parenting women with SUDs. TTA offered to counties and providers assists them with program development and increases public awareness of the potential impact of SUDs. TTA services may include telephone calls, literature, webinars, and/or other program development resources. TTA can be requested by submitting a request during the annual county monitoring reviews or by contacting DHCS through the following methods:

Email: DHCSPerinatal@dhcs.ca.gov

Webpage: https://www.dhcs.ca.gov/services/MH/Pages/Prevention-and-Youth-Branch.aspx

SERVICE DELIVERY REQUIREMENTS

Priority Population and Coverage Period

The priority population for the SUD PPG is pregnant and parenting women. Due to the harmful effects of substance use on the fetus, pregnant women require more urgent treatment services.[10]

In accordance with SUBG requirements, all SUD treatment providers must treat the family as a unit and admit both women and their child(ren) into treatment services, if appropriate. Treatment providers must serve the following individuals with a SUD:[11,12]

- Women who are pregnant.
- Women with dependent children.
- Women attempting to regain custody of their children.
- Postpartum women and their children.
- Women with substance exposed infants.

Additionally, SUD providers offering services funded by DMC or DMC-ODS shall address specific treatment and recovery needs of pregnant and parenting women.[13,14]

The postpartum coverage period for individuals receiving postpartum care services begins after the last day of pregnancy through the last day of the month in which the 365th day occurs.[15] Individuals will maintain coverage through their pregnancy and the 12-month postpartum coverage period regardless of income changes, citizenship, immigration status, or how the pregnancy ends.[16] Questions concerning the postpartum coverage period should be sent to Pregnancy@dhcs.ca.gov.

Admission Priority

It is required that SUD providers serving women shall provide preference to pregnant women with access to more urgent treatment services due to the harmful effects of substance use on the fetus.[17] Specifically, priority must be given to pregnant women who are seeking or referred to treatment in the following order:[18]

- Pregnant injecting drug users
- Pregnant substance users
- Injection drug users
- All others

Best Practices for Admission Priority

It is encouraged to identify prenatal drug exposure and provide timely care to pregnant women with a SUD as it provides a significant buffer against adverse pregnancy outcomes, including premature births and low birth weight.[19]

Outreach and Engagement

It is required to use outreach and engagement. Effective outreach engages individuals in need of treatment services, making it more likely they will attend treatment, participate in activities, complete the treatment, and participate in recovery support services. Pregnant and parenting women with a SUD are at risk for potential harmful effects to both mother and child.[20] Outreach efforts educate pregnant and parenting women on the harmful effects of drug use and the services available.

SUD treatment providers that serve pregnant and parenting women using injection drugs must use the following research-based outreach efforts:[21]

- Select, train, and supervise outreach workers.
- Contact, communicate, and follow-up with high-risk individuals with SUDs, their associates, and neighborhood residents, within the Federal and State confidentiality requirements.
- Promote awareness among women using injection drugs about the relationship between injection drug use and communicable diseases, such as Human Immunodeficiency Virus (HIV), Hepatitis B, Hepatitis C, and Tuberculosis (TB).
- Recommend steps to ensure that HIV transmission does not occur.
- Encourage entry into treatment.

SUD treatment providers delivering treatment services to pregnant and parenting women must publicize the availability of such services.[22] It is important for women to be aware of the services available to them within their community.

Best Practices for Outreach and Engagement

It is encouraged for providers to use the following methods to publicize the availability of services and engage pregnant and parenting women:[23,24]

- Street outreach programs
- Public services announcements
- Advertisements

- Posters placed in strategic areas
- Notification of treatment availability distributed to the network of community-based organizations, health care providers, and social service agencies
- Clearinghouse/information resource center(s)
- Resource directories
- Media campaigns
- Brochures
- Speaking engagements
- Health fairs/health promotion
- Information lines
- Multidisciplinary coalitions

Partnerships

It is required for SUD providers to coordinate treatment services with other appropriate services, including health, criminal justice, social, educational, and vocational rehabilitation, as well as additional services that are medically necessary to prevent risk to a fetus, infant, or mother. Providers shall also provide or arrange for transportation to ensure access to treatment.[25,26] Refer to transportation section for more information.

Best Practices for Partnerships

It is encouraged to develop partnerships among other local agencies and neighboring communities to share resources to aid in the delivery of services in remote areas. In addition, provide education to bring awareness to the community-based organizations that serve pregnant and parenting women. Cultivating true partnership is important as it can lead to constructive collaboration and ensure pregnant and parenting women receive services wherever they are in the community. Training should include other social healthcare facilities and personnel within the community to enhance awareness, identify women with SUDs, and increase appropriate referrals.[27]

Screening

It is required to conduct an alcohol and drug use screening to identify women who have or are developing SUD. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. APL 21-014 includes a list of validated screening tools. Screening is typically a brief process for identifying whether certain conditions may exist

and usually involves a limited set of questions to establish whether a more thorough evaluation and referral(s) are needed.[28]

Providers are required to implement infection control procedures designed to prevent the transmission of tuberculosis. In doing so, providers must screen pregnant and parenting women and identify those at high risk of becoming infected.

Best Practices for Screening

It is encouraged to regularly screen women to effectively minimize the risk of fetal exposure to alcohol or drugs. When women are screened for SUD during pregnancy, education can be provided about the risks of substance use. In addition, it serves to identify women whose pregnancies are at risk due to their substance use, which allows for pregnant and parenting women to receive early intervention services, or to receive a referral for appropriate treatment services.

Screening often is the initial contact between a woman and the treatment system, and the client forms her first impression of treatment during screening and intake. The screening method can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

Although screening can reveal an outline of a client's involvement with alcohol, drugs, or both, it does not result in a diagnosis or provide details of how substances have affected the client's life. The most important domains to screen for when working with women include:[29]

- Substance use, including the type, frequency, and impact of alcohol or drug consumption.
- Pregnancy considerations, including the stage of pregnancy, potential risks to maternal and fetal health, and the impact of any substance use or medical conditions on the pregnancy.
- Immediate risks related to serious intoxication or withdrawal.
- Immediate risks for self-harm, suicide, and violence.
- Past and present mental disorders, including posttraumatic stress disorder and other anxiety disorders, mood disorders, and eating disorders.
- Past and present history of violence and trauma, including sexual victimization and interpersonal violence.
- Health screenings, including HIV/AIDS, hepatitis, tuberculosis, and sexually transmitted diseases.

Some refer to screening and assessment interchangeably, however, it is significant to understand the difference to determine and ensure the most appropriate treatment services:[30]

- Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.
- Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

Intervention

It is required to provide intervention services to pregnant and parenting women. Intervention services are designed to motivate and encourage individuals with a SUD to seek and/or remain in treatment.

Women have a unique set of needs that are often not addressed in co-ed settings. SUD treatment providers must provide or arrange for gender-specific treatment and other therapeutic interventions for pregnant and parenting women, such as issues of relationships, sexual and physical abuse, and parenting.[31] Child care services must be provided while the women are receiving gender-specific treatment services.[32] SUD treatment providers must also provide or arrange for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's needs.[33]

Best Practices for Intervention

It is encouraged for SUD treatment providers to use brief interventions. SUD treatment providers who identify specific risk factors associated with initiation of use, such as people of introduction, may determine client's potential barriers and specific problem areas, anticipate intervention strategies, and develop compatible individually tailored treatment plans (hereafter referred to as "care plans").[34]

The following is a list of the potential benefits of using brief interventions:[35]

- Reduce no-show rates for the start of treatment.
- Reduce dropout rates after the first session of treatment.
- Increase treatment engagement after intake assessment.
- Increase group participation and a more collaborative treatment environment.
- Increase compliance with outpatient mental health referrals.
- Serve as interim intervention for clients on treatment program waiting lists.

Assessment

It is required to conduct assessments of pregnant and parenting women. Required assessment guidelines and documentation provided are in alignment with DMC and DMC-ODS services. Please reference BHIN No. 23-068 for clinical documentation requirements and BHIN 21-071 for medical necessity and level of care determination requirements.

Assessments may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary.[36]

The intake process begins with assessing the individual's needs to ensure that clients are placed in the most appropriate treatment modality and are provided with a continuum of services that will adequately support recovery.

In addition, Outpatient drug free (ODF), Naltrexone treatment, day care habilitative, and licensed residential SUD providers delivering perinatal services, shall meet the following admission criteria and procedures:[37]

- The provider shall develop and document procedures for the admission of beneficiaries to treatment; and
- The provider shall complete a personal, medical, and substance use history for each beneficiary upon admission to treatment.
- The physician shall review each beneficiary's personal, medical, and substance use history within 30 calendar days of the beneficiary's admission to treatment date.
- The physician shall determine whether substance use disorder services are medically necessary, within 30 calendar days of each beneficiary's admission to treatment date.

All SUD providers should attempt to obtain physical examinations for beneficiaries prior to or during admission.[38] In addition, providers must obtain medical documentation that substantiates the woman's pregnancy.[39]

Physical examination requirements are as follows:[40]

- The physician shall review the beneficiary's most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12-month period prior to admission date.
- Alternatively, the physician, a registered nurse, or a physician's assistant may perform a physical examination for the beneficiary within 30 calendar days of admission. If the physician, or a physician extender, has not reviewed the documentation of the beneficiary's physical examination or the provider does not

perform a physical examination of the beneficiary, then the LPHA or counselor shall include in the beneficiary's initial care plan the goal of obtaining a physical examination, until this goal has been met.[41]

Covered services provided under a county DMC Treatment Program or a DMC-ODS shall use criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of care for SUD treatment services.[42]

The ASAM Criteria is a multidimensional assessment used to determine the appropriate level of care across a continuum.

- DMC treatment programs reference BHIN No. 21-071 for medical necessity and level of care determination requirements.
- DMC-ODS assessment requirements reference BHIN No. 21-075.
- DMC-ODS Waiver counties reference MHSUDS IN No. 18-046 regarding the submission of ASAM level of care data to the Behavioral Health Information System (BHIS).

Best Practices for Assessment

It is encouraged to perform initial and ongoing assessments as it ensures pregnant and parenting women are continuously placed in the appropriate level of care.[43] The assessment process offers pertinent information in determining the types of services and treatment pregnant and parenting women may need. Appropriate placement of care is dependent on the assessment, which considers the nature and severity of a woman's SUD, the presence of co-occurring mental or physical illnesses or disabilities, and the identification of other needs related to her current situation.[44]

Care Planning

It is required to complete a care plan. Care planning is a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions, and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.[45]

Providers shall develop and update individual care plans or problem lists as specified within BHIN 23-068 for pregnant and parenting women with a SUD.[46] The provider shall prepare an individualized care plan or problem list based on the information obtained during the intake and assessment process.[47] SUD treatment providers shall make an effort to engage all beneficiaries, including pregnant and parenting women, to meaningfully participate in the preparation of the initial and updated care plans or problem lists.[48]

In addition, providers offering perinatal services shall address treatment and recovery

issues specific to pregnant and parenting women.[49] Perinatal-specific services shall include the following:[50]

- Mother/child habilitative and rehabilitative services, such as parenting skills and training in child development.
- Access to services, such as arrangement for transportation.
- Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
- Coordination of ancillary services, such as medical/dental, education, social services, and community services.

All SUD providers shall document treatment services, activities, sessions, and assessments.[51] In accordance with BHIN No. 23-068, DHCS removed standalone treatment plan requirements from DMC and DMC-ODS, with the exception of Narcotic Treatment Programs (NTP), and replaced them with these new behavioral health documentation requirements, including problem list and progress notes requirements. NTP are required by Federal law to create care plans for their beneficiaries.[52]

NTP physical examination requirements are as follows:[53]

- An evaluation of the applicant's organ systems for possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction.
- A record of the applicant's vital signs (temperature, pulse, blood pressure, and respiratory rate).
- An examination of the applicant's head, ears, eyes, nose, throat (thyroid), chest (including heart and lungs), abdomen, extremities, skin, and general appearance.
- An assessment of the applicant's neurological system.
- A record of an overall impression that identifies any medical condition or health problem for which treatment is warranted.

Pregnant women who are dependent on opioids and have a documented history of addiction to opioids, may be admitted to maintenance treatment without documentation of a two-year addiction history or two prior treatment failures.[54]

Physicians shall reevaluate the pregnant woman no later than 60 days postpartum to determine whether continued maintenance treatment is appropriate.[55]

Referrals

It is required for a SUD treatment provider to submit a referral when the provider has

insufficient capacity to provide treatment services to a pregnant and/or parenting woman.[56] Providers shall establish, maintain, and update individual patient records for pregnant and parenting women, which shall include referrals.[57]

If no treatment facility has the capacity to provide treatment services, the provider will make available or arrange for interim services within 48 hours of the request, including a referral for prenatal care.[58] Refer to the following sections for more information:

- Interim Services
- Capacity Management
- Waiting List

Best Practices for Referrals

It is encouraged to use SAMHSA's Screening, Brief Intervention, and Referral to Treatment Initiative (SBIRT) to provide opportunities for early intervention with at-risk SUD pregnant and parenting women before more severe consequences occur. Many people with SUDs do not seek specialty addiction treatment but often enter the healthcare system through general medical settings. This is an important but neglected opportunity to screen for substance misuse and provide brief interventions or referrals to specialty care.[59] SBIRT is a comprehensive, integrated, public health approach to address the disconnection that often happens beginning with the lack of identification of substance-related problems of the patient and extending to the failure of appropriate referrals and brief interventions.

Please note that when reporting referrals, do not include referrals to non-treatment services such as medical appointments, twelve-step programs, or other recovery support services.

Interim Services

It is required for SUD treatment providers to make interim services available for pregnant and parenting women awaiting admission into treatment.[60] The purpose of providing interim services is to reduce the adverse health effects of substance use, promote the health of the woman, and reduce the risk of disease transmission.[61]

If a SUD treatment provider has insufficient capacity to provide treatment services to pregnant and parenting women using drugs intravenously, and a referral to treatment has been made, the provider must:

- Admit the woman no later than 14 days of the request;[62] or

- Admit the woman no later than 120 days of the request and provide interim services no later than 48 hours after the request.[63]
- At a minimum, interim services include the following:[64]
  - Counseling and education about the risks and prevention of transmission of HIV and TB.
  - Counseling and education about the risks of needle-sharing.
  - Counseling and education about the risks of transmission to sexual partners and infants.
  - Referral for HIV or TB services.
  - Counseling on the effects of alcohol and drug use on the fetus; and referrals for prenatal for pregnant women.

Referrals based on individual assessments may include, but are not limited to self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, children's services, medical services, and Temporary Assistance to Needy Families (TANF)/Medi-Cal services.

Best Practices for Interim Services

It is encouraged to use these additional methods for providing Interim Services for pregnant and parenting women while they are awaiting admission into treatment:[65]

- Peer mentorship
- Services by telephone or e-mail
- Risk assessment activities
- Drop-in centers

Capacity Management

It is required to maintain a capacity management system to track and manage the flow of clients with SUDs entering treatment. These systems serve to ensure timely placement into the appropriate level of care.[66]

When a SUD treatment provider cannot admit a pregnant and parenting woman because of insufficient capacity, the provider will provide or arrange for interim services within 48 hours of the request, including a referral for prenatal care.[67]

Refer to the following sections for more information:

- Interim Services

- Waiting List
- Referrals

In the event a treatment facility has insufficient capacity to provide treatment services, the provider must refer the woman to DHCS through its capacity management program the DATAR.[68] The DATAR system is used to collect data on SUD treatment capacity and waiting lists.[69] When a SUD treatment provider serving intravenous substance users reaches or exceeds 90 percent of its treatment capacity, the provider must report this information to the DATAR for each month by the 10th of the following month. For more information regarding the DATAR program and technical assistance, visit the DHCS DATAR webpage at https://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx.[1]

Waiting List

It is required to maintain a waiting list to ensure pregnant and parenting women receive timely treatment. Long waiting periods and delayed services serve as a barrier for substance users seeking treatment.[70]

SUD treatment providers must submit waiting list information to DATAR upon reaching capacity.[71] Waiting lists must include a unique patient identifier for each injection substance user seeking treatment and include those receiving interim services while awaiting admission into treatment.[72] SUD treatment providers must also:[73]

- Develop a mechanism for maintaining contact with the women waiting for admission to treatment.
    - As space becomes available, SUD treatment providers will match clients in need of treatment with a SUD treatment provider that renders the appropriate treatment services within a reasonable geographic area.

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[1] The DATAR User Manual is available to authorized users after logging in to the Application Portal at https://portal.dhcs.ca.gov. For questions about the DATAR capacity reporting program, please contact DATAR-CalOMSProgramSupport@dhcs.ca.gov.

- Ensure injection drug users are placed in comprehensive treatment within 14 days.[74]
    - If any individual cannot be placed in comprehensive treatment within 14 days, then the provider must admit the woman no later than 120 days and provide interim services no later than 48 hours after the request.[75]
    - Refer to the Interim Services Section for more information.
- A woman may be removed from the waiting list and not provided treatment within the 120 days if she cannot be located or refuses treatment.[76] It is important to note that:[77]
    - Days waited will only include those days waiting for treatment due to an unavailability of a slot.
    - Circumstances unique to the individual's life are not counted as days on the waiting list.
- If a woman requests treatment at a later date and space is not available, refer to the following sections for more information:
    - Interim Services
    - Capacity Management
    - Referrals

Case Management

It is required that SUD treatment providers provide or arrange for case management to ensure that pregnant and parenting women, and their children, have access to the following services:[78]

- Primary medical care, including referral for prenatal care and, while the women are receiving such services, child care.
- Primary pediatric care, including immunization, for their children.
- Gender-specific treatment and other therapeutic interventions which may address issues of relationships, sexual and physical abuse and parenting, and child care while receiving these services.
- Therapeutic interventions for children in custody of women in treatment, which may, among other things, address developmental needs, sexual and psychological abuse, and neglect.

Best Practices for Case Management

It is encouraged to apply the following case management principles:

- Case management is client-driven and driven by client needs.
  - The aim of case management is to provide the least restrictive level of care necessary so that the client's life is disrupted as little as possible.
- Case management involves advocacy.
  - The paramount goal when dealing with substance use clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests.
- Case management is community-based.
  - All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church.
- Case management is pragmatic.
  - Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care.
- Case management is anticipatory.
  - Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action.
- Case management must be flexible.
  - The need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions.
- Case management is culturally sensitive.
  - Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process.

Transportation

It is required for SUD treatment providers to provide or arrange for transportation to ensure that pregnant and parenting women, and their children, have access to all the

services aforementioned in the case management section.[79]

In addition, SUD treatment providers shall provide or arrange transportation to ensure service access to and from medically necessary treatment for pregnant and parenting women.[80,81]

Medi-Cal offers transportation to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, or SUD appointments, and to pick up prescriptions and medical supplies. The DHCS Transportation webpage provides information on how to schedule transportation services, find approved transportation providers, and other related resources. For additional Medi-Cal Transportation Service questions, please email DHCSNMT@dhcs.ca.gov.

Best Practices for Transportation

It is encouraged to use these additional methods for providing transportation services:

- Provide vouchers and tickets for public transportation.
- Implement contracts with community-based transportation services (i.e., Uber, Lyft, shuttle services, etc.).
- Provide company owned vehicles.

Recovery Support

It is required to provide recovery support services for pregnant and parenting women who have a SUD. Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. SUD Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and the development of parenting skills.[82]

Upon treatment completion and discharge from a treatment provider, pregnant and parenting women shall continue receiving recovery support services to encourage continued health and wellness.

Providers shall complete a discharge summary for pregnant and parenting women being discharged.[83] The discharge summary shall be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the beneficiary.

The discharge summary shall include:

- The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
- The reason for discharge.

- A narrative summary of the treatment episode.
  - The beneficiary's prognosis.[84]
- For narcotic treatment program services, the discharge summary shall meet the requirements of Section 10415, Title 9, CCR.[85]

Best Practices for Recovery Support

It is encouraged to use a variety of recovery support methods as the process of recovery is highly personal. Methods may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.[86]

SAMHSA's Four Major Dimensions of Recovery:

- Health – Overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being.
- Home – Having a stable and safe place to live.
- Purpose – Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- Community – Having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice.

Treatment Modalities

It is required to provide Residential,[87] Outpatient Drug Free Treatment Services,[88] Narcotic Treatment Programs,[89,90] Intensive Outpatient Treatment Services, and Naltrexone Treatment Services[91] to pregnant and parenting women.

Pregnant women who were eligible for Medi-Cal and received Medi-Cal during the last month of pregnancy shall continue to receive the full breadth of medically necessary services through the end of the 365-day postpartum period. Postpartum begins on the last day of pregnancy.[92]

A pregnant or parenting woman can stay in residential treatment longer than the 30 or

60 days if the assessment indicates such a need. Please see the funding table in Appendix A for more information.

Providers must adhere to the following requirements when delivering SUD services in Licensed Residential Facilities or Outpatient Programs that deliver treatment services to pregnant and parenting women:

- Licensed Residential SUD Treatment Services – Providers offering residential SUD services to pregnant and parenting women shall provide a range of activities and services. Supervision and treatment services shall be available day and night, seven days a week.[93]
- Outpatient Programs – Mother and child habilitative services shall be provided to pregnant and parenting women.[94] During Intensive Outpatient Treatment services, group counseling shall be conducted with no less than two and no more than 12 clients at the same time.[95,96]

Parenting Skills

It is required to incorporate parenting skills into a woman's care plan to help the woman and her child(ren) while the woman is in treatment.[97] Parenting skills are defined as a relationship between a woman and her child(ren) that includes identification of feelings, empathy, active listening, and boundary setting.[98,99] The mothers can practice these skills alone or with their children.

Parenting skills can be improved through education in child development, skill-building training, counseling, modeling, and problem-solving in specific instances of parent-child interactions.[100]

Best Practices for Parenting Skills

It is encouraged to match parenting, coaching, and/or other support groups to the women's services that can help improve her ability to cope with new parenting skills. Parents need time to practice their new parenting skills and change patterns of behavior to improve interactions with their children.

Topics for parenting skills and relationship building can include, but are not limited to, the following:[101]

- Developmentally age-appropriate programs for children.
- Parenting education for mothers.
- Strategies to improve nurturing for mothers and children.
- Appropriate parent-child roles, including modeling opportunities.

- Integration of culturally competent parenting practices and expectations.
- Nutrition education for mothers.
- Children's mental health needs.
- Integration of culturally competent parenting practices and expectations.
- Education for mothers about child safety.
- Children's substance use prevention curriculum.
- Children's mental health needs.

Best Practices for Child Care

It is encouraged that SUD treatment providers provide on-site, licensed child care in accordance with child care licensing requirements.[102] Conducting child care within close proximity of the SUD treatment provider may serve as a motivation for the mothers to stay in treatment.[103]

When a SUD treatment provider is unable to provide licensed on-site child care services, the SUD treatment provider should partner with local, licensed child care facilities. Providers can also offer on-site, license-exempt child care through a cooperative arrangement between parents for the care of their children.[104]

All the following conditions must be met in the event of a cooperative arrangement:[105]

- Parents shall combine their efforts, so each parent rotates as the responsible care giver with respect to all the children in the cooperative arrangement.
- Any person caring for the children shall be a parent, legal guardian, stepparent, grandparent, aunt, uncle, or adult sibling of at least one of the children in the cooperative arrangement.
- No monetary compensation, including receipt of in-kind income, may be provided in exchange for the provision of care.
- No more than 12 children can receive care in the same place at the same time.

When possible, it is recommended that women offering child care in the cooperative arrangement be directed under supervision of an experienced staff member with expertise in child development. This staff member can teach the women how to respond appropriately to a child's needs and help women address child-specific issues.[106] NOTE: This staff member should have passed a background check before working in the program's child care.

For women in SUD treatment, access to child care is a critical factor that may serve as a barrier to a woman's participation in treatment. Children born to mothers with SUDs are

at a greater risk of in-utero exposure to substances. As a result, many of these children struggle to achieve basic developmental milestones and they often require child care that extends beyond basic supervision.[107]

In addition, it is recommended that child care services include therapeutic and developmentally appropriate services to help identify a child's developmental delays, including emotional and behavioral health issues.[108,109] When appropriate, child care services should be tailored to each child and support the child's individual developmental needs. This includes considering a child's culture and language to incorporate culturally responsive practices and deliver culturally appropriate services.

Furthermore, if other clinical treatment services for the child are deemed medically necessary, services should be comprehensive and, at a minimum, include intake; screening and assessment of the full range of medical, developmental, emotional-related factors; care planning; residential care; case management; therapeutic child care; substance use education and prevention; medical care and services; developmental services; and mental health and trauma services.[110]

Appendix A: Regulation Requirements Chart

Section Requirements	Regulation	DMC / DMC-ODS	SUBG
Priority Population			
Pregnant women	45 C.F.R. § 96.124(e) HSC § 11757.59(a)		X
Parenting/Postpartum women	45 C.F.R. § 96.124(e) HSC § 11757.59(a)		X
Parenting/Postpartum women (up to365 days)	22 CCR § 51341.1(c)(3)	X	X
Women with dependent children	22 CCR § 50260		X
Women attempting to regain custody of their children	45 C.F.R. § 96.124(e) HSC § 11757.59(a)		X
Admission Priorities			
Pregnant injection drug users	45 C.F.R. § 96.131(a)(1)		X
Pregnant substance users	45 C.F.R. § 96.131(a)(2)		X
Injection drug users	45 C.F.R. § 96.131(a)(3)		X
All others	45 C.F.R. § 96.131(a)(4)		X

*Not exclusive to pregnant and parenting women

Appendix A: Regulation Requirements Chart Continued

Section Requirements	Regulation	DMC / DMC-ODS	SUBG
Outreach and Engagement			
Promote awareness about communicable diseases	45 C.F.R. § 96.126(e)(3)		X
Select, train, and supervise outreach workers	45 C.F.R. § 96.126(e)(1)		X
Contact, communicate, and follow-up with high-risk individuals with SUD	45 C.F.R. § 96.126(e)(2)		X
Recommend steps that can be taken to ensure HIV transmission doesn't occur	45 C.F.R. § 96.126(e)(4)		X
Encourage entry into treatment	45 C.F.R. § 96.126(e)(5)	X*	X
Partnerships			
Coordinate with other systems health care, social services, corrections and criminal justice, education, vocational rehabilitation, and employment services	45 C.F.R. § 96.132(c)		X
Screening			
Implement infection control procedures	45 C.F.R. § 96.127(a)(3)		X

*Not exclusive to pregnant and parenting women

Appendix A: Regulation Requirements Chart Continued

Section Requirements	Regulation	DMC / DMC-ODS	SUBG
Intervention			
Provide/arrange for gender-specific treatment services	45 C.F.R. § 96.124(e)(3)		X
Provide/arrange for child care services	45 C.F.R. § 96.124(e)(3)		X
Provide/arrange for therapeutic interventions for children of clients	45 C.F.R. § 96.124(e)(4)		X
Assessment and Placement			
Perform/acquire physical examinations	22 CCR § 51341.1(h)(1)(A)(iv)	X*	
Treatment and Planning			
Individual care planning	22 CCR § 51341.1(h)(2)(A)	X*	
Mother/child habilitative and rehabilitative services	22 CCR § 51341.1(c)(4)(A)	X	
Access to services	22 CCR § 51341.1(c)(4)(B)	X	
Education to reduce harmful effects of SUD on mother and fetus	22 CCR § 51341.1(c)(4)(C)	X	
Coordination of ancillary services	22 CCR § 51341.1(c)(4)(D)	X	

*Not exclusive to pregnant and parenting women

Appendix A: Regulation Requirements Chart Continued

Section Requirements	Regulation	DMC / DMC-ODS	SUBG
Referrals			
Refer to the appropriate SUD treatment services	45 C.F.R. § 96.131(c) 45 C.F.R. § 96.131(d)(1)		X
Interim Services			
Provide interim services	45 C.F.R. § 96.131(d)(2)		X
Capacity Management			
Monitor capacity	45 C.F.R. § 96.131(d)(2)		X
Notify DHCS upon reaching 90% capacity	45 C.F.R. § 96.126(a)		X
Waiting List			
Maintain waiting list	45 C.F.R. § 96.126(d)		X
Maintain contact with woman awaiting admission into treatment	45 C.F.R. § 96.126(c)		X
Transportation			
Provide and/or arrange for transportation to and from medically necessary services	22 CCR § 51341.1(c)(4)(B) 45 C.F.R. § 96.124(e)(5)	X	X

*Not exclusive to pregnant and parenting women

Appendix A: Regulation Requirements Chart Continued

Section Requirements	Regulation	DMC / DMC-ODS	SUBG
Case Management			
Provide case management services	45 C.F.R. § 96.124(e)(5)		X
Provide primary medical care	45 C.F.R. § 96.124(e)(1)		X
Provide primary pediatric care	45 C.F.R. § 96.124(e)(2)		X
Provide gender-specific treatment	45 C.F.R. § 96.124(e)(3)		X
Recovery Support			
Develop and provide beneficiary with discharge plan	22 CCR § 51341.1(h)(6)(A)	X*	
Treatment Modalities			
Residential treatment services	22 CCR § 51341.1(b)(20)		X
Outpatient treatment services	22 CCR § 51341.1(d)(2)	X*	
Narcotic treatment programs	22 CCR § 51341.1(d)(1)	X*	
Group counseling	22 CCR § 51341.1(b)(11)(B)	X*	
Intensive outpatient services	22 CCR § 51341.1(d)(3)	X	X
Transitional housing	MHSUDS Information Notice NO.: 16-059- Room and Board for Transitional Housing		X

*Not exclusive to pregnant and parenting women

ENDNOTES

[1] California Health and Safety Code (HSC) §11757.50 through 11757.61

[2] 45 Code of Federal Regulations (CFR) 96; HSC §11757.50 through 11757.61

[3] 22 California Code of Regulations (CCR) § 51341.1

[4] California Welfare and Institutions Code (WIC) § 14184.100 through 14184.800

[5] Title 42, United States Code Section 300x-22(b)

[6] DHCS, Mental Health and SUD Services (MHSUDS) Information Notice (IN) 21-014, Exhibit C – Exchange Program Summary – Part I

[7] NASADAD. Guidance to States: Treatment Standards for Women with SUD (2008).

[8] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[9] HSC §11757.50 through 11757.61; 22 CCR § 51341.1

[10] Lester, B. M., Andreozzi, L., & Appiah, L. (2004). Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*, *1*, 5. Retrieved from: http://doi.org/10.1186/1477-7517- 1-5

[11] 45 CFR § 96.124(e)

[12] HSC § 11757.59(a)

[13] 22 CCR § 51341.1(c) (3)

[14] 22 CCR § 50260

[15] 22-23 (ca.gov)

[16] I 23-34 (ca.gov)

[17] Forray, A. (2016). Substance use during pregnancy. F1000Research, 5, F1000 Faculty Rev–887. Retrieved from: http://doi.org/10.12688/f1000research.7645.1

[18] 45 C.F.R. § 96.131(a)

[19] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[20] Forray, A. (2016). Substance use during pregnancy. *F1000Research*, *5*, F1000 Faculty Rev–887. Retrieved from: http://doi.org/10.12688/f1000research.7645.1

[21] 45 CFR § 96.126(e)

[22] 45 CFR § 96.131(b)

[23] 45 CFR § 96.131(b)

[24] 45 CFR § 96.125

[25] 45 CFR § 96.124(e)(5)

[26] 22 CCR § 51341.1(c)(4)(B)

[27] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[28] 42 CFR § 440.130

[29] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[30] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[31] 45 C.F.R. § 96.124(e)(3)

[32] 45 C.F.R. § 96.124(e)(3)

[33] 45 C.F.R. § 96.124(e)(4)

[34] Substance Abuse Treatment: Addressing the Specific Needs of Women [Internet]. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. (Treatment Improvement Protocol (TIP) Series, No. 51.) 2 Patterns of Use: From Initiation to Treatment. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK83243/

[35] SAMHSA TIP 35 Enhancing Motivation for Change in Substance Use Disorder Treatment

[36] CA 20-0006-A Approval Package

[37] 22 CCR § 51341.1(h)(1)(A)(i-iii); 22 CCR § 51341.1(h)(1)(A)(vi)

[38] 22 CCR § 51341.1(h)(1)(A)(iv)

[39] 22 CCR § 51341.1(g)(1)(A)(iii)

[40] 22 CCR § 51341.1(h)(1)(A)(v)(a-b)

[41] BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services

[42] WIC § 14184.402(e)(1)

[43] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

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[45] CA 20-0006-A Approval Package

[46] 22 CCR § 51341.1(h)(2)(A)

[47] 22 CCR § 51341.1(h)(2)(A)

[48] 22 CCR § 51341.1(h)(2)(A)

[49] 22 CCR 51341.1(c)(3)

[50] 22 CCR 51341.1(c)(4)

[51] 22 CCR § 51341.1(g)(1)(B)

[52] 42 CFR § 8.12

[53] 9 CCR § 10270

[54] 9 CCR § 10270(d)(5)

[55] 9 CCR § 10270(e)

[56] 45 CFR § 96.131(d)(1)

[57] 22 CCR § 51341.1(g)(1)(B)

[58] 45 CFR § 96.131(d)(2)

[59] SAMHSA TIP 35 Enhancing Motivation for Change in Substance Use Disorder Treatment

[60] SAMHSA TIP 35 Enhancing Motivation for Change in Substance Use Disorder Treatment

[61] 45 CFR § 96.121

[62] 45 CFR § 96.126(b)(1)

[63] 45 CFR § 96.126(b)(2)

[64] 45 CFR § 96.121 (Interim Services or Interim Substance Abuse Services)

[65] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[66] 45 CFR § 96.126(a)

[67] 45 CFR § 96.131(d)(2)

[68] 45 CFR § 96.131(c)

[69] 45 CFR § 96.131(c)

[70] Redko, C., Rapp, R. C., & Carlson, R. G. (2006). Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users. *Journal of Drug Issues*, *36*(4), 831– 852. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2396562/

[71] 45 CFR § 96.126(c)

[72] 45 CFR § 96.126(c)

[73] 45 CFR § 96.126(c)

[74] 45 CFR § 96.126(d)

[75] 45 CFR § 96.126(b)(2)

[76] 45 CFR § 96.126(d)

[77] CalOMS_Tx_Data_Collection_Guide_JAN 2014

[78] 45 CFR § 96.124(e)(5)

[79] 45 CFR § 96.124(e)(5)

[80] 22 CCR § 51341.1(c)(4)(B)

[81] All Plan Letter 22-008, Non-Emergency Medical and Non-Medical Transportation Services. May 18, 2022

[82] 22 CCR § 51341.1(c)(3)

[83] 22 CCR § 51341.1(h)(6)(A)

[84] 22 CCR § 51341.1(h)(6)(A)

[85] 22 CCR § 51341.1(h)(6)(B)

[86] Recovery and Support | SAMHSA

[87] 22 CCR § 51341.1(c)(4)

[88] 22 CCR § 51341.1(d)(2)

[89] 22 CCR § 51341.1(d)(1)

[90] 9 CCR § 10360

[91] 22 CCR § 51341.1(d)(5)

[92] 22 CCR § 50260

[93] 22 CCR § 51341.1(b)(20)

[94] 22 CCR § 51341.1(c)(4)(A)

[95] 22 CCR § 51341.1(b)(11)(B)

[96] 22 CCR § 51341.1(d)(3)

[97] HSC § 11757.59(b)(2)(E); 22 CCR § 51341.1(c)(3); 22 CCR 51341.1(c)(4)(A)

[98] HSC § 11757.59(b)(2)(E); 22 CCR § 51341.1(c)(3); 22 CCR 51341.1(c)(4)(A)

[99] NASADAD. Guidance to States: Treatment Standards for Women with Substance Use Disorders (2008). Retrieved from: http://nasadad.org/wp-content/uploads/2010/12/Guidance-to-States-Treatment- Standards-for-Women1.pdf

[100] 22 CCR 51341.1(d)(4)

[101] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[102] 22 CCR § 101151 through 101163

[103] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[104] 22 CCR § 51341.1(c)(4)(A); 22 CCR § 102358; HSC § 1596.792(e)

[105] 22 CCR § 102358; HSC § 1596.792(e)

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[108] SAMHSA. TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, (2009)

[109] NASADAD. Guidance to States: Treatment Standards for Women with Substance Use Disorders (2008). Retrieved from: http://nasadad.org/wp-content/uploads/2010/12/Guidance-to-States-Treatment- Standards-for-Women1.pdf

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