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Perinatal Substance Use Screenings in Marin County: a brief overview of screening protocols and identifying gaps in care

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By

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Abstract

Introduction
Perinatal substance use continues to be a major public health issue in women's health. The purpose of this study was to determine the frequency of substance use screenings in care and assess how well the existing services in Marin County are serving the needs of pregnant and parenting women and identifying the gaps and/or weaknesses in current practice.

Methods
Data for this study was collected via semi-structured interviews with five professionals that worked at the local community clinic, hospital and a non-profit agency. Some questions were slightly modified to be configured toward the participant's specific profession.

Results
Results from the interviews reveal common screening practices though some were less formal and more conversational and there is no technical universal screening tool used. Participants also noted several common themes in gaps of care, in terms of patient's views toward health care, needed improvements, common substances seen, the difference between the hospital and clinic protocol, adolescents, and African Americans.

Discussion
Findings suggest more training and a cohesive approach to screening should be implemented for both hospital and clinic settings. More understanding is needed for other care physicians as well as a need to address the gaps in care for the younger adolescent population, African Americans, and changing the negative perception of healthcare maternal patients have toward them. Examining other social determinants of health are also future implications to consider in perinatal and postnatal care.

Executive Summary

Background & Problem Statement

Substance use during pregnancy presents multiple adverse health effects on both the mother and the fetus. Not only does it have detrimental effects on the mother's health, the fetus is much more susceptible to long-term or irreversible damage in their development. The Diagnostic & Statistical Manual of Mental Disorders (DSM-5) defines substance use disorder as "when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home (Burns, Coleman-Cowger, & Breen, 2016)." In Marin County, a very affluent area, the prevalence of substance use in pregnant women has escalated over the years, resulting in harmful effects to women and their fetus. Limited resources are available in Marin to help mothers receive assistance and treatment with their substance use disorder(s).

It is widely accepted that substance use is discouraged during pregnancy, and women are encouraged to seek abstinence while pregnant to provide the best childcare for their babies' first year (Prince & Ayers, 2019). Only a minor portion of the pregnant population with substance use issues are identified and treated (Burns, Coleman-Cowger, & Breen, 2016). The most commonly used substance in pregnancy is nicotine, followed by alcohol, marijuana, and cocaine (Forray, 2016). Vaping is a newer method of nicotine use that has been presumed to be less harmful than cigarette smoking, although most attitudes think the risk is not worth it for such a vulnerable population. The continued use of such substances can lead to poor pregnancy and neonatal outcomes, specifically increased risk of long-term physical, cognitive, behavioral, and academic problems for children (Muhuri & Gfroerer, 2009). Attitudes about substance use during pregnancy have varied across medical providers and mothers.

Cannabis

Cannabis is the most commonly used illicit drug in the US and is the only substance that has seen significant increases in consumption and prevalence of use in the past decade (Emery, Gregory, and Levin, 2016). It is the third most commonly used substance during pregnancy following tobacco and alcohol (Emery et al, 2016). For the mother, there has been an association between perinatal marijuana use and pregnancy complications such as shorter gestation, dysfunctional labor period, preterm birth, low birth weights, and stillbirth (Holland, Nkumsah, Morrison, Tarr, Rubio, Rodriguez, Kraemer, Day, Arnold, & Chang, 2017). For the fetus, there are neurobehavioral consequences that can follow such as cognitive, learning, and behavioral problems which can lead to hyperactivity, attention problems, memory, and difficulty with reading and spelling (Holland et al., 2017). Although there have been adverse consequences, research is still limited in some areas regarding marijuana use during the perinatal period. The recent legalization of marijuana in several states over the past few years has likely influenced many user's attitudes about its use and find it harmless.

Most pregnant women perceive use of the drug once or twice per week to be of little to no risk (Scheyer, Melis, Trezza, & Manzoni, 2019). In one observational study, women also reported that though they received regular obstetric care, they did not receive any helpful information about perinatal marijuana use from health care providers or social workers (Jarlenski, Tarr, Holland, Farrell, & Chang, 2017). Because of this, most women stated that they conducted their own Internet searches for information about perinatal marijuana use and watching videos (Jarlenski et al, 2017). The lack of information did not bother some women because some indicated that they had stopped smoking marijuana once they found out they were pregnant, while others assumed that the providers and social workers did not provide adequate counseling. This made mothers feel as if marijuana was not a significant concern for the outcome

of their pregnancy or that it implied its use was not a serious risk (Jarlenski et al, 2017). Mothers also felt resentment toward social workers because the workers were more focused on child welfare agencies potentially being involved after the delivery of the baby instead of providing resources to help women stop using marijuana during pregnancy. This indicates a representative population of women who take initiative in receiving appropriate care, but not feeling that their care was fulfilled to prevent use of something they perceive as potentially harmful. Providers and social workers may not emphasize or educate their clients enough about the importance of not indulging in the illicit substance.

Alcohol

Alcohol is the second most used substance during pregnancy and no amount is considered safe during pregnancy (Roozen, Peters, Kok, Townend, Koek, & Curfs, 2018). The US Substance Abuse and Mental Health Services Administration (SAMHSA) noted in a recent study that about 5% of entries for treatment services were utilized by pregnant women with low numbers of them with alcohol issues and higher numbers for other drug uses (Burns et al., 2016). Drinking alcohol during pregnancy places the fetus at risk for birth defects, growth impairment, developmental disabilities, and neurodevelopmental dysfunction (Burns et al., 2016). Fetal Alcohol Spectrum Disorder (FASD) is a common condition that can affect the fetus for mothers who use, and can lead to poorer mental health outcomes. The severity of FASD depends on the level, pattern, and timing of prenatal alcohol exposure before and during pregnancy as well as diet, environmental, maternal age, and genetic makeup factors (Roozen et al., 2018). A study in Western Australia found that the use of provided educational resources for health professionals to their patients about prevention of prenatal alcohol exposure, consequences, and FASD was

effective in their use (Payne, France, Henley, D'Antoine, Bartu, O'Leary, Elliott, & Bower, 2011). Of those interviewed, 69.8% had seen the materials, 77.1% used them, and 48.5% said the materials helped to change their practice or intention to change their practice (Payne et al., 2011). Altogether, 91.5% of the health professionals in the study agreed that drinking 5 or more alcoholic drinks on one occasion would harm the fetus. Ultimately, the study proved that health professional's knowledge increased with the use of the materials and change in attitudes surrounding FAS and advice they give to pregnant women about consuming alcohol. In Australia, most providers in a particular study (88.1%) believed that pregnant women should avoid alcohol and those planning to become pregnant in the future should abstain (78.2%) (Payne et al., 2011).

There are several screenings that providers are recommended to use to screen their patients, including the Cut Down, Annoyed, Guilty, and Eye Opener (CAGE) and Alcohol Use Disorders Identification Test (AUDIT) (Prince & Ayers, 2019). These were general screening tools that were not specified for pregnant patients, therefore an obstetrician developed the T-ACE/T-ACER-3 and it was validated by the American College of Obstetricians and Gynecologists (ACOG) as well as the National Institute on Alcohol Abuse and Alcoholism. The obstetrician based the T-ACE on three questions assessing a patient's annoyance with criticism of her drinking, her requirement of eye openers, and her alcohol tolerance (Prince & Ayers, 2019). The CDC also recommends using the Behavioral Risk Factor Surveillance System (BRFSS) to assess alcohol use among pregnant women (Burns et al., 2016).

Vaping

Electronic cigarettes ("e-cigs") also known as vaping, have become increasingly popular as smoking rates have decreased. Traditional cigarette smoking during pregnancy is linked to

increased risk of miscarriage, cleft lip/palate, premature birth, and SIDS following birth (Whittington, Simmons, Phillips, Gammill, Cen, Magann, & Cardenas, 2018). The development of newer electronic nicotine delivery systems (ENDSs) are newer tobacco products that were introduced to the US in 2007, including, hookah, vape pen, vaporizers, and electronic cigarettes (e-cigs) (Whittington et al., 2018), Overall perceptions of ENDSs for pregnant women and general smokers are that they are less harmful than traditional cigarettes, which has increased their motivation to quit traditional cigarettes or reducing cigarette smoking (Whittington et al., 2018). One survey reported that of 252 OB/GYNs, fewer than 53% consistently screen patients for exposure to tobacco products, which may contribute to the reasons that there are limited research on the effects of vaping (Whittington et al., 2018).

Participants that posted in an online forum discussing nicotine use thought symptoms of nicotine withdrawal by pregnant mothers cause too much stress and that abrupt cessation is unsafe and unhealthy for women and their babies (Wigginton, Gartner, & Rowlands, 2016). Harm reduction is necessary, and posters within the forum thought that providers should enforce and emphasize this more in care. They also viewed vaping as less harmful and safer and that it could be managed by the smoker (mother) to be able to eventually cease use. Ironically, medical practitioners were described as supportive of vaping per their own personal claims (Wigginton et al., 2016).

Attitudes Surrounding Substance Use

Provider and Maternal Perceptions

It is critical that medical professionals receive appropriate and competent training in screening patients. One study (Oser, Biebel, Harris, Klein, & Leukefeld, 2011) showed that gender difference had an influence on OB/GYN's screening practices, with female practitioners

more likely to believe in the effectiveness of screening and discussing sensitive topics with patients, and motivated to provide screening as a part of care because they believe screening could produce a behavioral change. Another study highlighted how obstetric providers were not familiar with risks of marijuana use in pregnancy, perceived marijuana to not be as dangerous as other illicit substances, prioritized other counseling topics, and mentioned a need for more information and training on addressing perinatal marijuana use overall (Holland, Nkumsah, Morrison, Tarr, Rubio, Rodriguez, Kraemer, Day, Arnold, & Chang 2016). When and if providers did counsel patients on use, their primary approach was the legal consequences or involvement of child protective services, which may explain many patients' fears to disclose their substance use status (Holland et al., 2016). Another reason that may explain the underrepresentation of mothers disclosing their use status is from mothers who reported they felt guilty and remorse of use and the fear of the loss of their children out of home care (Burns et al., 2016). Women also reportedly have many perceived concerns and/or risks in disclosing their substance use, specifically feeling embarrassed and guilty about use, fearing imprisonment, prosecution, or losing custody of their child/children (Chang et al., 2018). Prior research suggests that pregnant women with substance use disorder(s) consider testing and reporting of their use to be punitive rather than potentially helpful or resourceful (Jarlenski et al., 2017). These implications altogether portray mothers' legal concerns and of the repercussions, stigma, shame, and fear of being viewed as a "bad mother" as well as a need to address women's mental health regularly during pregnancy to ensure she is supported.

Recommendations/Treatments

Healthcare professionals are a significant contributor to the concept of harm reduction especially within the realm of alcohol consumption for pregnant women. They are considered to

be the best source of information and should have expert advice especially during the perinatal period, therefore should be prepared with effective education materials (Payne et al., 2011). The ACOG and the American Academy of Pediatrics recommend that clinicians caring for pregnant women ask their patients at their initial prenatal visit about their drug use and provide education (Chang et al., 2017). The questions they ask should be presented in a nonjudgmental manner, to increase trust that is needed to obtain an accurate history and to retain mothers for ongoing care (Burns et al., 2016). The World Health Organization (WHO) recommends engaging women in improving their mental health before becoming pregnant since women are at the highest risk of substance use disorders during their reproductive years and mental health problems are most prevalent at childbearing ages (Prince & Ayers, 2019). This ensures women will achieve psychiatric stability and reduces negative mother and fetus outcomes. A study found that an integrated care approach for mothers resulted in many finding the environment safe and welcoming which allowed them to be more forthcoming about their issues and establish trust with providers, more access to care, women felt supported, and program engagement and rapport increased (Marcellus, MacKinnon, Benoit, Phillips, & Stengel, 2015).

Additionally, OB/GYN's should be advocates for patients and education for not only patients but also providers is necessary to continue with the unknown, yet possible harmful effects of ENDSs and to help prevent fewer toxins being exposed to fetus and mom (Whittington et al., 2018). Though clinical evidence suggests that e-cigs are safer than smoking, there are still many concerns surrounding long-term effects for fetal development and online forums suggested that women refrain from them altogether (Wigginton et al., 2016). Pregnant women using cannabis should be offered support for cessation and relapse prevention at each prenatal visit throughout pregnancy (Burns et al., 2016). Asking a mother about her perceived level of severity can create

discussion about other problematic areas such as trauma and abuse, with special attention to high risks, as well as brief intervention, counseling, education, and psychologically based treatment for dependency. The 5 A's approach (Ask, Advise, Assess, Assist, and Arrange) is also a well-known tool to use for cases related to tobacco use and is recommended by the United States Preventive Services Task Force (USPSTF) and the ACOG though more intensive interventions may be required (Burns et al., 2016).

Supervised detoxification may be necessary for those with more severe alcoholism, likely as an inpatient (Burns et al., 2016). Many pharmacotherapies available for alcohol dependence are contraindicated for pregnant women, yet withdrawal can lead to fetal distress and/or death. There is a specific need to focus on psychological and social approaches with assertive follow-up throughout and post pregnancy (motivational interviewing). Patient-provider communication is essential to care, with other interventions including counseling by midwives, screening via nonmedical community workers, and multimedia and educational efforts aimed to improve knowledge (Forray & Foster, 2015). There is clear evidence of the negative effects of alcohol, tobacco, and illicit drug use being harmful during the perinatal period, though vaping and cannabis use still needs to be thoroughly researched.

Agency Profile

The County of Marin's Department of Health and Human Services (HHS) is a government entity that strives to promote and protect the health, wellbeing, safety, and self-sufficiency of all people in Marin. They are the largest department in Marin County and currently have four divisions: planning and administration, behavioral health and recovery services, public health, and social services.

The public health department features an executive staff that is led by the Director of Health and Human Services, a Behavioral Health and Recovery Services Director, a Social Services Director, and a Public Health Officer. The Department is situated at the Marin Health and Wellness Campus in San Rafael, which features a variety of services for the public including a community clinic, all in one location. It was funded from a master settlement agreement to address Marin's most critical health needs. The Connection Center is the heart of the campus and is host to many of the programs and services provided to the community. It is known as the center point for health promotion, prevention activities, meetings, and contact information needed for other county services. There is a vast bilingual and multicultural staff who assist the public for case management, billing services, health insurance enrollment, referrals, and assistance accessing services. To address risk factors that affect health and quality of life, the Connection Center has educational materials in English and Spanish and LCD screens that exhibit topics that feature health-related activities. The topics were chosen via community focus groups and meetings as well as input from HHS staff.

The Maternal, Child, and Adolescent Health (MCAH) Program is a subsidiary program under the County of Marin's Family Health Programs. The program develops prevention and early intervention strategies to promote the health of the women, infants, children, and adolescents of Marin County with a special focus on low-income and vulnerable populations. MCAH program staff is involved in outreach, advocacy, policy development, assessment, and program planning to increase access to family-centered, culturally-competent systems of health services. The agency is headed by a director and program coordinator. Within the department, there is the Women, Infants, and Children Program (WIC), Marin Family Connections, Child Health Disability Prevention (CHDP), CA Children's Services (CCS), and the Childhood Lead

Poisoning Prevention Program (CLPPP). Each service aims to serve families by achieving equity for families and children to have access to the best services for a healthy, safe, and productive life. The Behavioral Health and Recovery Services unit also works closely with MCAH and provides resources to refer clients to behavioral health services to specialists such as clinicians and/or other therapists as needed.

Project goals and objectives

Originally, the two main goals of this project were to identify gaps in the system of care for pregnant and parenting women with SUD's in Marin and to develop an updated, specific resource directory for mothers/expecting mothers who are experiencing SUD's and for service/clinical providers to use (Appendix A). The initial plan was to interview pregnant and parenting mothers, but proved to be tricky to conduct interviews. Ultimately, it was determined that professional providers within the wellness campus would be easier to outreach to and could have just as much thorough insight and experience with their patients. Conducting interviews were delayed due to the difficult impact of the coronavirus pandemic. Outreaching in conjunction with my preceptor to potential participants was delayed until the pandemic calmed down (around June), but five were able to be completed instead of the original 10-15 interviews.

Though a draft of a resource directory was made and to be edited after interviews (Appendix F), it was saved on the fieldwork site computer and unable to be accessed due to the coronavirus pandemic and shutdown of the facility. Around mid-March, restrictions were put in place that prevented anyone from going to their workplace. There were also plans to create new and updated educational materials to be available on the wellness campus and within the clinic as a secondary goal but was also unable to access. The draft lists specific providers and agencies

that are known in Marin to assist with pregnant and parenting mothers. Due to its inaccessibility, the final draft was unable to be completed.

Methods

Objective

The purpose of this project was to understand the prominence of screening for substance use in parenting and pregnant mothers in Marin County and the gaps in care mothers do not receive. For this project, a qualitative analysis was used to determine the frequency of substance use seen in screenings done by providers and staff perspectives on the issue. Another task was to see what services were not available and what providers and staff viewed as a necessity to the community.

Sample

Five healthcare professionals (perinatal case manager, substance abuse counselor, obstetrician, and two pediatricians) that worked at the local Marin Community Clinic and local organizations were purposefully chosen via purposive sampling from my preceptor's recommendations. These recommendations were based on the relevance of the provider and staff experience because of their interests in women's maternal health per the MCAH's close work with them.

Recruitment

An introduction email (Appendix B) was sent to potential participants via the MCAH for the project and outlined the goals and purpose of the interview. Out of twelve participants that were emailed, two emailed back with contact information the same day and were interviewed. One of the participants additionally forwarded the email to seven other providers that were

knowledgeable about perinatal substance use in the community. Of those participants that were forwarded the introduction email, three were interviewed. Two participants had great connections within their organization and forwarded the original email. Phone calls were made to each participant as they provided them via email along with their availability. Due to the coronavirus pandemic and shelter at home orders from the state, participants that were emailed but did not respond likely had restricted availability or were too busy dealing with other significant changes.

Procedure

Semi-structured interviews were conducted via phone calls with a 12-question item survey for providers and staff to answer. The length and scheduling of interviews varied for provider's availability and staff within a three week time frame. Interviews lasted an average of 30-45 minutes per session. Purposive sampling was used to recruit participants based on the MCAH director's close network and relationships with providers that often work together. All providers listed references on other prospective participants during the interviews and often cross referenced each other.

Measures

A 12-item questionnaire (Appendix C) was created and used based on the influence of one study's use of a questionnaire from a Washington Health Department that used a 10-item questionnaire (Oser, Biebel, Harris, Klein, & Leukefeld, 2011). Though the original article was inaccessible to use their specific items, questions were modified as described from Oser and colleagues' (2011) measures section. The dependent variable was how regularly providers screen for substance use and if they do at all. The independent variables were motivations for

screenings, if they felt there were enough resources for perinatal substance use, and if screenings would help effectively promote a positive behavioral change for their patients.

The interview tool used was modified with suggestions and authorized to use from the MCAH director. Ultimately, the questions were placed in order of focusing first on screening, then referral and motivational interviewing, and finally treatment resources. The questions were also edited to more open-ended questions to obtain significant data for each response. Responses were recorded via notes typed using Microsoft Word during the interview. After each interview, notes were highlighted to review themes and develop best practices in addressing substance use in pregnant and parenting mothers.

Challenges

Some of the challenges that arose were availability of the staff due to the coronavirus pandemic and shelter at home enforcement. There was also limited data received during some of the interviews due to different professions and their approaches in care based on their background. The quality of the answers from each question mostly were thorough and enough information was able to capture a satisfactory general depiction of the frequency of substance use in mothers who struggle. Resources were also provided and all participants stated what they felt was missing or lacking and had some feedback and insight from other program methods and on what is needed in Marin. A codebook was created and dissected using the qualitative analysis software N-Vivo to interpret and find themes.

Goals of the Interviews

Some of the main goals of data collection were:

1. To identify barriers in care for pregnant/parenting mothers with SUD's
2. To determine the frequency of screenings from provider perspectives/protocols

3. To identify motivating factors that make providers conduct screenings
4. To identify resources needed in Marin for more maternal support

Interview Results & Data Analysis

Qualitative data analysis using the N-Vivo software platform grouped together several common themes that were identified. The definition for each theme (Appendix E) was used to group similar ideas and attitudes in order to identify major themes.Findings were summarized in identifying common screening protocols and addressing the gaps in care as well as resources currently available and needed within Marin.

The top themes (Appendix D) that participants noted in identifying barriers and resources needed for mothers with SUD's were necessary areas of improvement, review of screening practices and protocols done and more outreach to adolescents. All of the participants mentioned areas of improvement that needed in care of pregnant and parenting mothers with SUD's and within their own working systems, as well as a need to better serve African American mothers and have better universal screening practices. Few positive interactive experiences were reported, primarily only on what participants viewed what a positive interaction would be perceived as in their opinion.

Emergent Themes

Areas for Improvement

Every participant had commentary on areas of improvement needed in their work environment as well as commentary on procedures and programs they wished to see in the community. One provider noted how they "would love to change how they help manage substance use in the neonatal, postnatal care period. Whatever they could do to help that would be very beneficial especially for the bonding time, also consider working closer with pediatrics

who helps check the baby, nursery, mother, etc." The next provider mentioned she wanted to adopt an approach that other hospitals were using, where they "moved toward keeping mom and baby together for bonding. In the postpartum period, she is interested in wanting to know how to help mothers who have substance use disorder(s) and how more support could be provided to reduce stigma and provide better and more competent care for their issues as well as partner with other outside organizations to help" as well. Another significant barrier mentioned was that "programs should be more accessible programs for mothers with postpartum depression, because they are expensive and can be hard to access. More Spanish speaking groups should be considered." The protocol in the clinic's screening was addressed, with one provider stating they would "love to see the clinic ending the use of urine toxicology testing because it does not serve nor benefit patients" which also may contribute to stigma and pregnant/parenting mother's resistance to treatment.

One provider also mentioned that there was a lack of diversity as far as gender-based services, stating that there were "very male dominated treatment centers" which could also affect services. The same provider also mentioned significance in the "lacking support for transwomen and women experiencing homelessness" which could also explain more barriers to having accessible treatment in terms of socioeconomic and gender identity status.

Screening Practices

The AUDIT-C was the only main professional screening tool (SAMHSA) that formally addressed a specific SUD. Another provider disclosed that they followed the SAMHSA guidelines and memorized the NIDA-Modified tool to identify risky substance use in their adult patients. Verbal and conversation screening practices were accounted for and notated in all

participant responses, most clarifying they did not use a specific tool per say, but conversationally were able to screen their patients. Both pediatricians noted they used the HEADS assessment, which is tailored toward adolescents and focused on the least threatening topics then later getting to more sensitive topics.

Adolescents

Three participants noted the lack of care and support in addressing adolescent audiences and prenatal care. Two participants were unsure of the full scope of OB/GYN practices since it was not their field of medicine. Both providers also believed "meeting adolescents where they were at" was essential to help in screening, specifically with the use of wellness centers that were available on campus at one local high school. The same participants also mentioned the local teen clinic "Huckleberry Youth Programs" that primarily serves adolescents was a huge indicator of support and positive response in decreasing SUD's and pregnancy in younger teens. Huckleberry's mission is to educate, inspire, and support underserved youth to develop healthy life choices, to maximize their potential, and to realize their dreams (Huckleberry, 2020).

Common Substances Used

All participants provided substances that they commonly seen or have come across during their professional years in dealing with patients. There appeared to be a consensus of marijuana, tobacco, and alcohol being the most common substances mothers disclose that are mentioned during care. As one participant stated, "the most common ones that patients disclose willingly are alcohol, tobacco and marijuana. Patients say during pregnancy occasionally they have had alcohol and tobacco. Some patients say before pregnancy they were using alcohol or smoking but quit once they found out they were pregnant." This suggests differences in opinion

that mothers perceive the potential harm and effects that substances have on the mother and their fetus.

A participant noted how younger audiences perceived substance use during pregnancy and stated how "pregnant teens perceive drinking during pregnancy is bad. Instead, they vape or orally take THC thinking that it is safer" which may contribute to differences in opinion across age groups. Participants hinted at the point that the legality of marijuana during recent years may have also decreased stigma towards its use even for mothers. Only one participant mentioned that "they do not screen for drugs unless the client shares that with them."

One participant noted that there was a change in recent years, where "meth and heroin were past issues that were prevalent previously." Another participant also commented similarly saying "meth and opioids are the most common ones for illegal ones bought on the street but it is not as much of an issue as other less harmful substances." Methamphetamine, cocaine, heroin, and fentanyl were uncommon and were often referred to outpatient services when it was previously a prevalent issue within the maternal population.

Negative Perception of Healthcare

Almost all providers were aware of and contributed to their reasoning why mothers do not seek assistance with their SUD's or help overall for treatment. One provider noted that the "healthcare does not promote harm reduction or well-being enough. They too heavily focus on punishing and penalizing people." Another professional discussed the child welfare systems and how they "make it challenging to conduct screening and have good conversations about substance use. Many people have distrust in the healthcare system because of it" especially for vulnerable populations. The main barrier addressed that three providers discussed was stigma

around substance use, which was very huge. One health professional mentioned that "lots of pregnant people that are using are aware of how stigmatized they will be and are fearful of being judged, being a bad mother/parent, being seen as the opposite of what a good mother is and that there is just lots of pressure for moms, which keeps them from wanting to disclose their SUD or substance use status altogether."

Hospital vs. Clinic Environment

Some positive impressions were expressed over the clinic's services than the hospitals. Two providers mentioned the clinic has "great communication and referrals often are made within the clinic" and how they have a "robust behavioral health department connecting patients to the behavioral health team."

Evidently, there were several inconsistencies made between the hospital and clinic environment regarding protocols and patient care. One provider mentioned the difference, that "at the hospital, OB/GYNs are all over the place with screening, because they "know" their patients, whereas MCC has one protocol." Similarly, the next professional mentioned that "she works at the hospital and during pregnancy there is heterogeneity within the OB/GYN providers because some are testing and following the recommended guidelines, but some are not. She has seen at-risk women go to OB/GYN practices and not be screened for drugs at all." Another professional mentioned how "MCC has a very diverse environment in terms of patients and who they serve but separate from the hospital because the hospital is an unjust environment and features a lot of benefits for wealthy white patients, while patients on Medi-Cal or Medicare do not receive the same benefits." Bias appears to be significant and evident in terms of the differences between the hospital and clinic from professional perspectives.

African Americans

Consensually, three participants mentioned that the African American community was not properly served in Marin, especially in healthcare. One person mentioned that "the system disproportionately targets people of color, especially black people and indigenous persons." Another informant noted the significance of having a leader or someone representative of your own group. The explanation was that "there is likely a lack of care especially for black patients because few providers are not a reflection of them, which leads to lack of trust. That is a long-term hurdle and negative issue that the clinic and hospital have in serving them in Marin and why they likely are not served as well." People of color in Marin have long experienced discrimantion and more needs to be done to provide patient-centered care and ensure competency training continues.

Discussion & Implications

Altogether, providers should be competent in care for mothers with SUD's just as much as any other patient. Cultural competency training should continue and be visible as the resource directory already has implemented. Mutually, all participants gave insight on a need for a universal screening protocol and an interest in more training and understanding more patient-care approaches to addressing the subject with patients. A genuine interest and curiosity in progression and improvement in care was apparent, and an interest in the effects of vaping was also common. The more common substances such as marijuana and alcohol appeared to be the most common substances that professionals encountered in the pregnant and parenting mother's population as well as a need for more services. It was noted in two providers that in previous

years, for other common illicit drugs such as methamphetamine and heroin were prominent substances abused but has lessened over the years, which was a positive outcome. Two providers also alluded to other factors such as trauma and domestic violence and how they may coincide in terms of substance abuse and women's health. It could also attest to how those factors address a need for necessary care needed for women with those struggles, especially in mental health. Those interested in women's health and maternal care would benefit from this study's purpose and reviewing the need for their populations and how to be proactive in discussing this with women.

Patients and their providers should be able to maintain a solid foundation and relationship which would help continuity of care and a better perspective overall with the healthcare system. Trust and rapport with a provider are also significant factors for mothers with SUD's to continue care to reduce those stigmas of being a bad mother, fear of losing custody of their children, embarrassment and guilt, or being fearful of punitive repercussions (Burns et al., 2016). Gender and identity should also be considered, though a couple of participants noted the fact that there was a lack of diversity as far as people of color and male versus female dominated treatment centers. Only two participants mentioned the use of a formal screening tool (AUDIT-C and NIDA) with one being used as an incentive for insurance purposes and the other being used through their training. More SAMHSA guidelines should also be considered for practice in healthcare and counseling sessions. Future studies could show the significant changes in care after professionals are educated on different screening tools then a follow up interview on how effective the tool(s) are or if they ended up adopting one.

Some of the strengths of the study were having providers that work concurrently within the hospital and clinic and having providers with a dual perspective in each environment. Not

only were they familiar with the procedures for each, they also were familiar with the systems that other healthcare professionals engaged in and did not hold to a higher standard. Having a concrete concept on the differences between care in the hospital and clinic is also vital for the possibility of integrated health models. Cultural competence training was also included in the directory in terms of the provider having completed training or not. Cultural competency training increases awareness and knowledge on topics on diversity and inclusion. Having this displayed on a resource may also increase a mother's faith that their care is being treated by a professional who appreciates them without judgment or bias.

Some of the limitations of this study were not interviewing male providers and health professionals, as well as not interviewing primary care physicians. Another limitation was not having designated questionnaires for each provider (OB/GYN, counselors, social workers, etc.). Another good population that would have been a good idea to interview and have a tool for would be primary care physicians (PCP) specifically for those who see parenting mothers that are already raising their children and/or expecting to have more children. This would gage attention towards the mother's use and view the protocol done by PCP's for screening and assistance. Purposive sampling was used to recruit participants based on the MCAH director's close network and relationships with providers that often work together and to focus the project on clinical and service providers. Purposive sampling is when a researcher relies on his or her own judgment when choosing members of a population to participate in the study.

For this study, no staff from rehabilitation and treatment centers were interviewed. A clinical perspective would have given more insight on treatment. More specifically, the Marin Treatment Center and Center Point were both mentioned by three providers as follow up services that they were aware of available for women. Center Point would have been a good resource of

information especially because one of their programs focuses on women and children. Per their website, “70% of the women remained employed and reunited with their families following completion of the program; over 90% remained abstinent and free of child welfare involvement; over half had regained custody of their minor children; and more than 85% were employed and had secured stable housing (CenterPoint, n.d).” Some of these other social determinants of health should be considered and used in future studies as well. Because of the impact of the 2020 coronavirus pandemic and stay at home orders, the study was presumed to be limited to essential workers but providers were unavailable due to busier schedules and likely adjusting to the new norm from the mandates. Having a perspective from mothers would also likely have created a better snapshot of support needed and a perspective on their end of healthcare and their experiences.

Another limitation was that providers were all female and it was a very small population of participants to interview. Due to the timing and because of COVID-19 as well as state and local restrictions, it was understandably a struggle to recruit participants and added to having some limited results. Having a more variety in other health professions that often deal with the pregnant and parenting mothers' population may have presented an array of other issues and barriers to address as well as more ideas for improvement and organizations to consider or implement in Marin.

Recommendations

In terms of screening, there are many recommendations the pediatricians expressed that their universal screening is incorporated and universal with younger teens, therefore could be merged into one question. Marin needs to promote further education that should continue to be displayed and placed at the forefront of prenatal care and screenings should be universal to

incorporate a holistic approach. An adult version of the HEADSS assessment should also be considered to implement in pre- and post-natal care. To decrease stigma, attention should not solely be focused on the mother's SUD(s) but her mental, emotional, and physical well-being. One participant noted that question 8 on the questionnaire about "programs that they wished were available" should be tailored to patients because they likely have a better perspective on the needs in their own community. This may likely positively correlate with a need for more support groups, whether in a physical or online forum format that should be considered for women to express their concerns and wishes for help.

It is essential that other healthcare professionals be engaged in the severity of SUD's within the pregnant and parenting mother's population and having a proper, universal method to assess and assist in their care. The ACOG and the AAP both recommend that clinicians ask their patients about their substance use at their initial visit, and should continue thereafter, especially if a mother shows more risks (Chang et al., 2017). Education on the potential risks and harms substances have on the fetus and the mother should be presented and reminded to patients at their prenatal appointments as well as assessing risks of the mother's SUD's and giving a warm hand off within the clinical setting as stated by current providers. SAMHSA currently offers a guide called the Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants that can be utilized during prenatal sessions and they also have suggestions on how to help treat mothers on various substances (SAMSA, 2020). More training workshops should be held focused on substance use during pregnancy and the negative harms it has on both the fetus and the mother. Wellness training should also be considered for health professionals to target pregnant and parenting mothers and create a harm reduction approach in care for women. Group sessions or a local conference with local providers may present a

cohesive plan to create a universal screening approach that providers and counselors may find useful to implement in their practice setting. As previously stated, patient-provider communication is essential to this population to improve knowledge and education to help reduce the chances of use during pregnancy (Forray & Foster, 2015).

Marin appears to be lacking in support and care for younger teens and mothers with SUD's, as well as for women of color, especially African American women. Programs should be implemented in focusing on youth and policy should be focused on a universal approach for screening in both the clinic and hospital setting. Providers should be on the same page to maintain consistency in screening for both the pre- and post-natal period to reduce bias in their patient populations and consider having a more diverse workforce since that was a primary concern. Other professional and evidence-based screening tools, such as the 5 A's or the BRFSS assessments should also be considered in Marin to determine the most effective and ways to determine a pregnant or parenting mother's risk and SUD status to receive the best care possible that can be provided.

Pregnant women experience many struggles mentally, physically, emotionally and socially with pregnancy. We cannot assume that all their issues are visible. With compassionate integrated care, proper screening protocols, resources, and support, we can help destigmatize mothers with SUDs and promote healthier outcomes for themselves and their children.

Resources

Burns, L., Coleman-Cowger, V. H., & Breen, C. (2016). Managing Maternal Substance Use in the Perinatal Period: Current Concerns and Treatment Approaches in the United States and Australia. *Substance abuse : research and treatment*, *10*(Suppl 1), 55–61. https://doi.org/10.4137/SART.S34558

Chang, J. C., Holland, C. L., Tarr, J. A., Rubio, D., Rodriguez, K. L., Kraemer, K. L., Day, N., & Arnold, R. M. (2017). Perinatal Illicit Drug and Marijuana Use. *American journal of health promotion: AJHP*, *31*(1), 35–42. https://doi.org/10.4278/ajhp.141215-QUAL-625

Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. (n.d.). Retrieved August 2, 2020, from https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

Emery, R. L., Gregory, M. P., Grace, J. L., & Levine, M. D. (2016). Prevalence and correlates of a lifetime cannabis use disorder among pregnant former tobacco smokers. *Addictive behaviors*, *54*, 52–58. https://doi.org/10.1016/j.addbeh.2015.12.008

Forray A. (2016). Substance use during pregnancy. *F1000Research*, *5*, F1000 Faculty Rev-887. https://doi.org/10.12688/f1000research.7645.1

Forray, A., & Foster, D. (2015). Substance Use in the Perinatal Period. *Current psychiatry reports*, *17*(11), 91. https://doi.org/10.1007/s11920-015-0626-5

Jarlenski, M.P., Tarr, J.A., Holland, C.L., Farrell, D., & Chang, J.C. (2016). Pregnant Women's Access to Information About Perinatal Marijuana Use: A Qualitative Study. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *26 4*, (452-9)

Marcellus, L., MacKinnon, K., Benoit, C., Phillips, R., & Stengel, C. (2015). Reenvisioning success for programs supporting pregnant women with problematic substance use. *Qualitative health research*, *25*(4), 500–512.

https://doi.org/10.1177/1049732314551058

Mission & History. (n.d.). Retrieved July 20, 2020, from https://www.huckleberryyouth.org/history/

Muhuri, P. K., & Gfroerer, J. C. (2008). Substance Use Among Women: Associations with Pregnancy, Parenting, and Race/Ethnicity. *Maternal and Child Health Journal*, *13*(3), 376–385. doi: 10.1007/s10995-008-0375-8

Oni, H. T., Buultjens, M., Abdel-Latif, M. E., & Islam, M. M. (2019). Barriers to screening pregnant women for alcohol or other drugs: A narrative synthesis. *Women and birth : journal of the Australian College of Midwives*, *32*(6), 479–486. https://doi.org/10.1016/j.wombi.2018.11.009

Oser, C., Biebel, E., Harris, M., Klein, E., & Leukefeld, C. (2011). Gender differences in provider's use of a standardized screening tool for prenatal substance use. *Journal of addiction medicine*, *5*(1), 36–42. https://doi.org/10.1097/ADM.0b013e3181ccec2ex

Payne, J., France, K., Henley, N., D'Antoine, H., Bartu, A., O'Leary, C., Elliott, E., & Bower, C. (2011). Changes in health professionals' knowledge, attitudes and practice following provision of educational resources about prevention of prenatal alcohol exposure and fetal alcohol spectrum disorder. *Paediatric and perinatal epidemiology*, *25*(4), 316–327. https://doi.org/10.1111/j.1365-3016.2011.01197.x

Prince MK, Ayers D. Substance Use in Pregnancy. (Updated 2019) In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK542330/

Rodriguez, J. J., & Smith, V. C. (2019). Epidemiology of perinatal substance use: Exploring trends in maternal substance use. *Seminars in fetal & neonatal medicine*, *24*(2), 86–89. https://doi.org/10.1016/j.siny.2019.01.006

Roozen, S., Peters, G. Y., Kok, G., Townend, D., Nijhuis, J., Koek, G., & Curfs, L. (2018). Systematic literature review on which maternal alcohol behaviours are related to fetal alcohol spectrum disorders (FASD). *BMJ open*, *8*(12), e022578. https://doi.org/10.1136/bmjopen-2018-022578

Scheyer, A. F., Melis, M., Trezza, V., & Manzoni, O. J. J. (2019). *Consequences of perinatal cannabis exposure* doi:https://doi.org/10.1016/j.tins.2019.08.010

Whittington, J. R., Simmons, P. M., Phillips, A. M., Gammill, S. K., Cen, R., Magann, E. F., & Cardenas, V. M. (2018). The Use of Electronic Cigarettes in Pregnancy: A Review of the Literature. *Obstetrical & gynecological survey*, *73*(9), 544–549. https://doi.org/10.1097/OGX.0000000000000595

Widnes, S. F., & Schjøtt, J. (2017). Risk perceptions regarding drug use in pregnancy. *American Journal of Obstetrics and Gynecology*, *216*(4), 375–378. doi: 10.1016/j.ajog.2016.12.007

Wigginton, B., Gartner, C., & Rowlands, I. J. (2017). Is It Safe to Vape? Analyzing Online Forums Discussing E-Cigarette Use during Pregnancy. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *27*(1), 93–99. https://doi.org/10.1016/j.whi.2016.09.008

Women & Children's Programs. Articles. (n.d.). Retrieved July 8, 2020, from http://www.cpinc.org/index.php?option=com_content

Appendices

Appendix A:

Goals & SMART Objectives

Goal:	**Parameter**
1. To identify gaps in the system of care for pregnant and parenting women with SUD's in Marin. ● By April, I will have contacted at least 10-15 providers that have direct perinatal specified services. ● *Create an interview guide* ○ Start & End Date: March 2020 ○ Tracking measure: create a list of questions that will be approved by preceptors ● *Email providers and schedule phone interview* ○ Start & End Date: March 1-April 30th, 2020 ○ Tracking measure: book interview on a calendar ● *Ask questions conducive to new ideas surrounding services specifically for pregnant and/or parenting mothers* ○ Start & End Date: March 1-April 30th, 2020 ○ Tracking measure: notes taken from interview	Specific Measurable Achievable Realistic Time-framed
2. To develop a specific resource directory for mothers/expecting mothers who are experiencing SUD's and for service/clinical providers to use. ● By the end of spring semester, I will have a completed resource/provider directory tailored to expecting or current mothers that are experiencing SUD's ● *Create a draft of current resources available for moms* ○ Who is responsible: BW ○ Start and End Date: January 31st-May 2020 ○ Tracking Measure: completed initial draft of current services ● *Integrate other local sources that may offer specified services/accommodations for moms* ○ Start and End Date: ○ Tracking Measure: completed initial draft of current services	Specific

● *Create at least 2 updated educational pamphlets that mothers can use* ○ Start and End Date: January 31st-May 2020 ○ Tracking Measure: approval from SR/JS to be able to leave in public areas around the health and wellness campus	
	Measurable
	Achievable
	Realistic
	Time-framed
3. To learn about the frequency of screening substance use during the perinatal period for mothers in Marin. ● By the end of spring semester, I will have learned about several screenings that providers use for mothers who abuse substances during and after pregnancy. ● *Attend at least three Maternal Child, Adolescent Health (MCAH) meetings for community perspective on maternal care* ○ Start & End Date: 2/1/2020-7/1/2020 ○ Tracking measure: maintain attendance record with SR ● *Conduct interviews with OB/GYN or other providers who screen mothers* ○ Start & End Date: 3/6/2020-3/27/2020 ○ Tracking measure: notes from interview, answers to questions asked	Specific
	Measurable
	Achievable
	Realistic
	Time-framed

Appendix B:

Hi friends- we are very interested in improving the system of care for pregnant and parenting women who use substances. Our fabulous intern, Breanna Williams, will be conducting key informant interviews (by phone) with perinatal service providers to learn more about your screening practices and about the gaps that exist in the system of care. We would be very grateful if you could participate in a 15-20 minute phone interview in the near future.

Breanna's introduction: Hello, my name is Breanna Williams and I am a graduate student at the University of San Francisco. I am studying to receive my Masters in Behavioral Health and Public Health. I have been conducting fieldwork for my capstone due this August. I am currently working with the County of Marin Maternal Child & Adolescent Health program focusing on perinatal substance use in Marin. This interview should last about 15-30 minutes. You are welcome to skip any question you do not wish to answer and if needed, you are welcome to end the interview at any time. No identifying information will be provided in my report and will remain confidential. All the information provided will be used to understand the frequency and importance of screening, and to identify gaps in the system of care.

1) Please contact Breanna cc'd above with your phone number and availability ASAP.

2) Please forward this request to community partners or others within your agency whose input would be valuable, or send suggestions for people to include who might be involved in doing substance abuse screening and/or referrals for this population.

3) We will make the findings available to all participants.

Appendix C:

Interview Guide

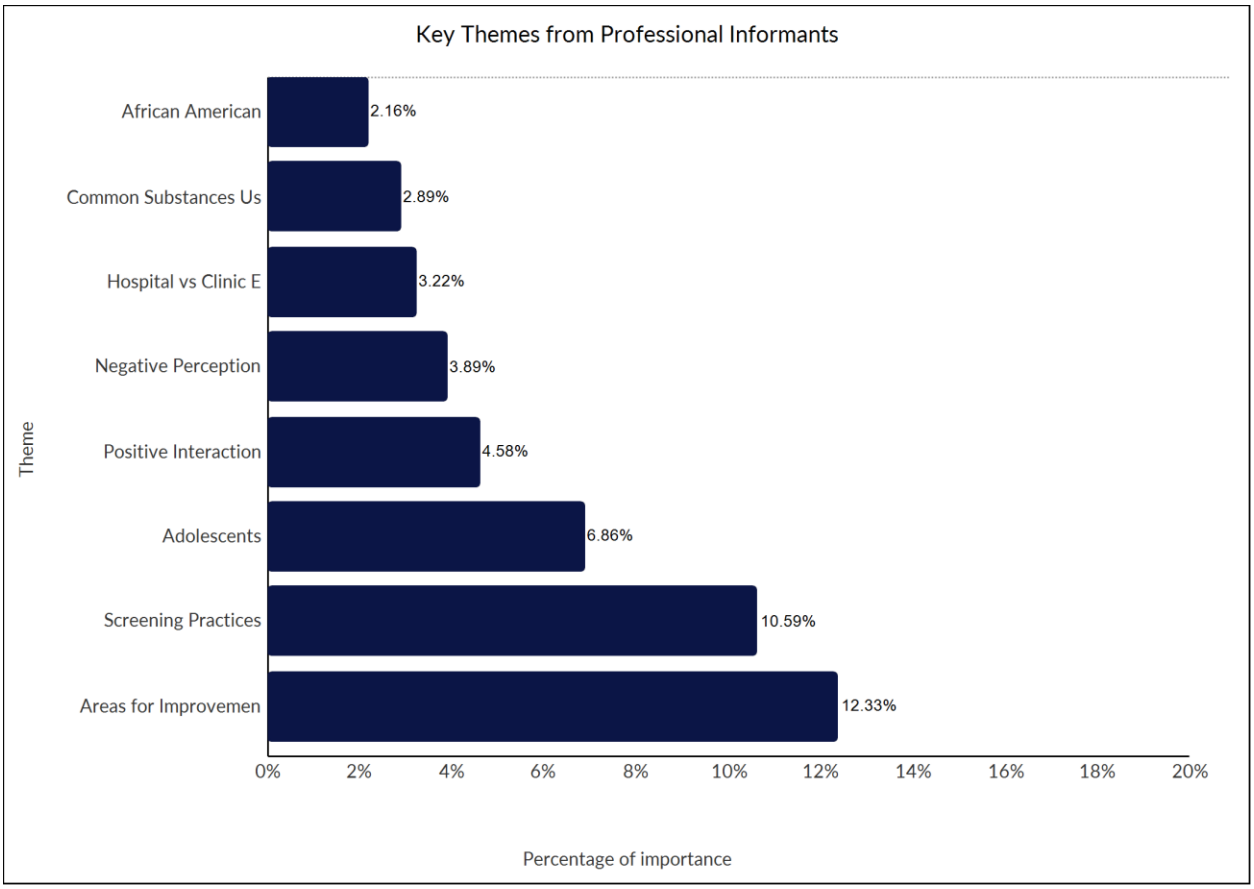
Research Question: How regularly do providers screen for substance use in pregnant or parenting mothers and what conditions motivate them to?

Key Informant Interview Questions:

1. Do you routinely screen your patients for substance use?
2. What prompts you to conduct a screening? What makes it challenging for you to conduct screening? (What specific concerns do you have about screening?)
3. Do you use a screening tool?
    a. Yes: Which one(s)?
    b. No: Have you heard of CAGE, T-ACE, TWEAK, 4 P's or considered using any of them?
4. What are the most common substances that women screen positive for? What are the most common illegal substances that women are using? What are the most common substances women are voluntarily seeking treatment for?
5. What are barriers to screening pregnant and parenting women for substance use in your setting?

6. Do you feel comfortable with motivational interviewing?
7. What are some referrals and/or programs available that you refer pregnant women to? (can be local or further)
8. Are there any other programs you wish were here in Marin to support mothers with SUD's? (can be one you know, have seen, or found via research, word of mouth)
9. Which populations are not well served by existing resources? (teens, non-English speakers, immigrants, low-income, POC, etc.)
10. How does your organization address co-occurring disorders among pregnant women, such as depression, anxiety, suicidal thoughts, etc.?
11. Is there anything else you'd like to contribute regarding perinatal substance abuse screening, referral, or treatment?
12. Who else would you consider a good contact to discuss this issue with? (providers, organizations, etc.)

Appendix D:



Appendix E:

Name	Description	Files	References

Adolescents	anything pertaining to the adolescent group of women at childbearing age	1	15
African American	any referral to Black Americans, ethnic group of Americans with total or some ancestry from any of the black groups in Africa	1	4
Areas for Improvement	anything that was included that participant is interested in implementing, improving services and making them more accessible, services or protocols that should be provided or could be worked on for pregnant and parenting mothers	1	22
Common Substances Used	anything relating to the most common illicit or legal substances used, seen, or disclosed in screenings with pregnant and parenting mothers	1	9
Hospital vs Clinic Environment	differences or similarities as far as protocol, beliefs, etc. in the hospital and clinic environment	1	7
Negative Perception of Healthcare	anything related to the negative perspectives, beliefs, or experiences in healthcare that causes pregnant or parenting mothers less chance of seeking healthcare	1	8
Positive Interactions	relating to the significance trust and rapport of building relationships with patients and what constitutes a good relationship with a provider	1	8
Screening Practices	current practices or screenings used when seeing patients	1	24

Appendix F:

AGENCY DIRECTORY

Provider	Service Type	Population(s) Served	Cultural Capacity/Specialty	Languages Spoken	Address	Contact Information	Hours of Operation	Basic/Limited Disability Access
Bay Area Community Resources	General Outpatient Intensive Outpatient	Adult Women (18+) Perinatal	Gender-Specific (Female) Pregnancy		103 Shoreline Pkwy San Rafael, CA 94901 www.bacr.org	415-328-6269	Mon-Thurs 8:30AM-4PM	Basic
Center Point Inc	Residential	Adult Women (18+) Perinatal	Gender-Specific (Female) Pregnancy		Protected San Rafael, CA www.cpinc.org	415-456-6655	24 hours/7 days	Basic
Marin Treatment Center	Opioid (Narcotic) Treatment Program	Adult Women (18+) Perinatal	Medication Assisted Treatment	Spanish	146 Lincoln Ave, San Rafael, CA 94901 www.mtcinc.org	415-457-3755	Dosing Hours: M-F 7AM-11:30AM Sat/Sun: 7:45AM-10:30AM Holidays: 9:30AM-10AM	Basic

AGENCY DIRECTORY

PROVIDER DIRECTORY

BAY AREA COMMUNITY RESOURCES

Last Name	First Name	License	National Provider ID #	License #	Completed Cultural Competence Training?

Coleman	Michael	Licensed Marriage & Family Therapist	1356616684	A3006108	Yes
Cosby-Frost	Amy	Licensed Marriage & Family Therapist	1841218492	LMFT 42309	Yes
Goldstein	Steven	Certified Substance Use Disorder Counselor	1194114652	LMFT 14645	Yes
Kantarowski	Laura	Psychologist	1992287122	PSY 7739	Yes
Meneweather	Leslie	Associate Marriage & Family Therapist	1740528645	AMFT 80280	Yes
Milton	Paul	Certified Substance Use Disorder Counselor	1407237126	C058100618	Yes
Rexford	Brittney	Registered Substance Use Disorder Counselor	1770003071	R1214130915	Yes
Williams	Patricia	Certified Substance Use Disorder Counselor	1700275104	Aii52480218	Yes
Williams	Dolores	Licensed Clinical Social Worker	1821454174	LCSW 26155	No

CENTER POINT

Last Name	First Name	License	National Provider ID #	License #	Completed Cultural Competence Training?
Barton	Justin	Registered Substance Use Disorder Counselor	1992269930	R1335740119	Yes
Breslin	Alexandra	Associate Marriage & Family Therapist	1801374624	AMFT 113948	Yes

Brown	Paulette	Certified Substance Use Disorder Counselor	1831621879	8306	Yes
Browning	Tom	Registered Substance Use Disorder Counselor	1063793727	C14751214	Yes
Fregoso	Anthony	Certified Substance Use Disorder Counselor	1871153536	R7454	Yes
Hallman	Jon	Certified Substance Use Disorder Counselor	1376070490	C039000816	Yes
Jupiter	Addie	Certified Substance Use Disorder Counselor	1053523803	8380	Yes
Katz	Stacey	Licensed Professional Clinical Counselor	1265930481	7221	Yes
Krueger	Faith	Certified Substance Use Disorder Counselor	1063926467	Ci07840617	Yes
Lord	Anthony	Registered Substance Use Disorder Counselor	1376070440	R1269111117	Yes
Marshall	Precious	Registered Substance Use Disorder Counselor	1285287854	R1347860519	Yes
Moore	Dion	Registered Substance Use Disorder Counselor	1336709054	R1358230810	Yes
Naeve	Ronald	Certified Substance Use Disorder Counselor	1427339365	Aii060440918	Yes
Owens	Rebecca	Certified Substance Use	1568749648	Aii059970618	Yes

		Disorder Counselor			
Ramos	Melvy	Registered Substance Use Disorder Counselor	1568900983	R1264730917	Yes
Smith	Karl	Certified Substance Use Disorder Counselor	1356621148	9919	Yes
Smith	Ada	Licensed Marriage & Family Therapist	1306067483	LMFT 15644	Yes
Taylor	Rodney	Licensed Marriage & Family Therapist	1588058697	LMFT 12402	Yes
Taylor	Sushma	Licensed Marriage & Family Therapist	1275927394	LMFT 24269	Yes

MARIN TREATMENT CENTER

Last Name	First Name	License	National Provider ID #	License #	Completed Cultural Competence Training?
Beggs	Dawn	Registered Substance Use Disorder Counselor	1821483454	R1302680418	Yes
Cantu	Jonathan	Registered Substance Use Disorder Counselor	1932688033	R1323300918	Yes
Catan	Hope	Associate Marriage & Family Therapist	1427426527	AMFT 100862	Yes
Diamond	Joan	Licensed Professional Clinical Counselor	1023365392	LPCC 3239	No
Dominguez	Rebecca	Registered Substance Use Disorder Counselor	1699215608	R1295680318	Yes

Kameron	Alessandra	Associate Substance Use Disorder Counselor	1295944809	Ci1870315	Yes
Laffey	Rajena	Registered Alcohol & Drug Technician	1821640913	R1351840619	No
Lee	Yuen	Licensed Vocational Nurse	1639626757	VN275623	No
Maillo Cabrera	Juan	Licensed Marriage & Family Therapist	1306161617	LMFT 103938	Yes
Moriguchi	Ryoko	Licensed Marriage & Family Therapist	1811029713	LMFT 47591	Yes
Norman	Royal	Certified Substance Use Disorder Counselor	1609106608	N0312291432	Yes
Obranovich	Cherie	Registered Psychologist	1518389501	29613	Yes
Ogg	Aubrey	Physician's Assistant	1245757194	54769	No
Panaligan	Edelyn	Registered Substance Use Disorder Counselor	1679000442	R1311800618	Yes
Quinones	Jenine	Registered Substance Use Disorder Counselor	1487710026	R1322440918	Yes
Tocher	Danielle	Licensed Marriage & Family Therapist	1962729772	LMFT 114138	Yes