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Accuracy of Three Screening Tools for Prenatal Substance Use

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Abstract

Objective—To compare and evaluate the accuracy of three screening tools in identifying illicit drug use and prescription drug misuse among a diverse sample of pregnant women.

Methods—This prospective cross-sectional study enrolled a consecutive sample of 500 pregnant women, stratified by trimester, receiving care in two prenatal clinical settings in Baltimore, Maryland, from January 2017 to January 2018. All participants were administered three index tests: 4P's Plus, NIDA Quick Screen- Modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), and the Substance Use Risk Profile-Pregnancy scale, and administered reference tests (urine and hair drug testing) at the in-person baseline visit. To assess test–retest reliability of the index tests, screening tool administrations were repeated one week later by telephone. For each screening tool, sensitivity, specificity, positive predictive value, negative

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predictive value and test-retest reliability were computed. Results were stratified by age, race, and trimester of pregnancy.

Results—Of the 500 enrolled pregnant women, 494 completed the index screening tools, 497 completed reference testing, and 453 underwent test-retest analysis. For the 4P's Plus, sensitivity = 90.2% (84.5, 93.8), and specificity = 29.6% (24.4, 35.2). For the NIDA Quick Screen-ASSIST, sensitivity = 79.7% (71.2, 84.2), and specificity = 82.8% (78.1, 87.1). For the SURP-P, sensitivity = 92.4% (87.6, 95.8), and specificity = 21.8% (17.4, 27.2). Test-retest reliability (phi correlation coefficients) was 0.84, 0.77, and 0.79 for the 4P's Plus, NIDA Quick Screen-ASSIST and the SURP-P, respectively. For all screening tools, there were differences in validity indices by age and race, but no differences by trimester.

Conclusion—The SURP-P and 4P's Plus had high sensitivity and negative predictive values, making them more ideal screening tests than the NIDA Quick Screen-ASSIST. A clear recommendation for a clinically useful screening tool for prenatal substance use is crucial to allow for prompt and appropriate follow-up and intervention.

Precis

By comparing results of three prenatal substance use screening tools with biochemical verification, two were found to have satisfactorily high sensitivity, while the third had greater specificity.

Introduction

Substance use during pregnancy is a significant public health issue in the United States, with increasing illicit drug use observed among pregnant women from 2015 to 2017.¹ According to the 2016 National Survey on Drug Use and Health (NSDUH), self-reported past-month illicit drug use (inclusive of non-medical use of prescription drugs) is 14.3% among pregnant adolescents ages 15 to 17 years, 10.1% among pregnant young adults (18 to 25 years), and 5.6% among pregnant adults (26 to 44 years).² These rates vary by trimester, with substance use typically decreasing over the course of pregnancy.³ Substance use during pregnancy may lead to multiple health and social problems for both mother and child, including miscarriage, stillbirth, low birth weight, prematurity, physical malformations, and neurological damage.⁴

The American College of Obstetricians and Gynecologists (ACOG) strongly recommends substance use screening for pregnant women,⁵ and a 2012 expert panel convened by the Centers for Disease Control and Prevention (CDC) concluded that prenatal substance use screening should be universal.⁶ Although many providers use biologic testing to determine use, a positive urine toxicology does not provide any context regarding temporality of use or indications of problematic use. While validated alcohol and tobacco screening tools have been recommended by the United States Preventive Services Task Force (USPSTF), no specific substance use screening tool has been recommended for use with pregnant women to identify prescription drug misuse or other illicit drug use.

In finding a substance use screening tool that is efficacious for pregnant women, it is particularly important to ensure that it works in all subgroups, as studies show varying substance use by age,² race,⁷ and trimester.³ The primary aim of this study is to compare and

validate screening tools within prenatal clinics to determine validity in identifying illicit drug use and prescription drug misuse among a diverse sample of pregnant women. The three screening tools utilized in this study – 4P’s Plus,⁸ NIDA Quick Screen- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST),⁹ and Substance Use Risk Profile-Pregnancy scale (SURP-P)¹⁰ - were chosen because they are brief and are the only ones listed by the World Health Organization (WHO) to have been validated (though not all with a pregnant population) and to allow for screening of multiple substances.⁴

Our end goal is to provide evidence-based guidance to clinicians and encourage adoption of the recommended screening tool(s) into clinical practice. This is a first step in offering the USPSTF “good quality research”¹¹ that screens pregnant women for prescription and illicit drug use and, thus, provides evidence for a recommendation for a standardized substance use screening tool.

Methods

In this cross-sectional prospective study, we enrolled pregnant women presenting to two prenatal clinics in Baltimore, Maryland, USA, from January 2017 to January 2018. Participants were approached during a routine prenatal visit and enrolled according to predefined inclusion criteria: pregnant at the time of encounter (pre-determined by clinic staff); age 18 years or older; able to speak and understand English sufficiently to provide informed consent; and natural hair length at least 3 cm to allow for hair drug testing. All participants provided informed consent and signed a Health Insurance Portability and Accountability Act (HIPAA) authorization, to allow access to electronic health records.

All patients entering the clinical sites for prenatal appointments were approached by research staff at check-in and asked to read a brief description of the study to determine interest in participating. If a patient expressed interest, research staff escorted her from the waiting area to a private room, further described the study, and determined whether she met all eligibility criteria. If eligibility criteria were met, informed consent and HIPAA authorization were obtained. The research visit took 20–30 minutes on average. Enrolled participants were compensated a total of \$75 for their time (\$50 for first visit and \$25 for 1-week telephone follow-up) using a reloadable gift card.

We conducted this study in accordance with Standards for Reporting of Diagnostic Accuracy (STARD) criteria.¹² As such, all participants were administered the three index tests (4P’s Plus, NIDA Quick Screen-ASSIST and SURP-P, in a randomized order) and reference standard (urine and hair drug testing) at the first research visit. The index tests were administered verbally by the research assistants with participants providing verbal answers. Urine samples were collected before the index tests were administered, but results were not available to either the research assistant or the participant until completion of index tests. Hair samples were collected during the same session in which index tests were administered and shipped immediately for reference testing, with results available only after 48 hours. Urine results were shared with participants at the end of the baseline visit, and hair results were shared by telephone within 48 hours of receipt by research staff. Participants who

screened positive from screening tools or biologic testing were encouraged to speak with their physician about substance use and were offered educational materials and referrals. To assess test-retest reliability of the index tests, we examined the results of repeated screening tool administrations (in randomized order) one week apart, with the second administration occurring via telephone, and conducted correlation analysis. To our knowledge, none of the screening tools have been validated for administration over the telephone. Study protocol and methodology are detailed further in a separate report.¹³

The WHO guidelines for identifying and managing substance use during pregnancy⁴ reference 13 validated screening instruments for substance use, but of those listed, 8 assess alcohol only. Of the remaining 5, one is an inpatient-only measure and one is a 200-item measure. Three possible brief measures emerged that screen for more than one substance among pregnant women.

The 4 P's Plus has been previously validated in a sample of pregnant women.⁸ The 4 P's Plus adaptation used in this study consists of 7 questions. If there was an affirmative response to any of the latter 4 questions, the screen was considered "positive" and follow up questions were asked about past-month quantity of use.

The NIDA Quick Screen-ASSIST is a two-part screening tool. The NIDA Quick Screen⁹ consists of one stem question and then assesses use of: (1) *alcohol*, (2) *tobacco products*, (3) *prescription drugs for non-medical reasons*, and (4) *illegal drugs*. Only if a participant endorsed use of prescription drugs for non-medical reasons or illegal drugs in the past year did the interviewer proceed to the ASSIST (items 2–7). For purposes of validation, both the Quick Screen and ASSIST were given to all participants to complete (Table 1). Responses to the ASSIST were summed to create a Substance Involvement (SI) score for each substance. Each SI score was classified utilizing NIDA's classifications as: lower risk (scores 0–3), moderate risk (scores 4–26), or high risk (scores 27+). For validation purposes, moderate and high risk were considered "positive" screens.

The SURP-P¹⁰ consists of 3 items (Table 1). Scoring involved classifying the number of alcoholic drinks consumed in the month before pregnancy as none compared with any, and then counting the total number of other affirmative items. Negative responses for all items yielded an individual to be considered low-risk, one affirmative response yielded an individual to be considered moderate risk, and two or three affirmative responses yielded an individual to be considered high-risk for substance use (not just alcohol and marijuana). Both moderate- and high-risk classifications were considered a priori to be a screen "positive."

In order to determine the validity of each screening tool, we utilized urine and hair testing. Urine testing was used to validate whether a positive screen was indicative of current substance use, which is the primary purpose of the screening tools. It is possible that a participant may not have used substances in the past week but used in the past 3 months. This is a strong possibility in a population of pregnant women who often discontinue use upon learning of their pregnancy or as pregnancy progresses. In this case, urine would not validate a positive screen, but hair testing would. While not an indicator of current substance

use, we utilized hair testing to validate the screening tools on less recent substance use. Thus, we utilized both urine and hair drug testing (combined results) as the reference (gold) standard to capture recent substance use (up to past 90 days).^{16,17} We utilized the Alere iCup® 14-Panel urine multi-drug test to determine the presence of 14 different substances. Hair samples taken at enrollment were sent to a commercial laboratory where screening and confirmatory testing were conducted, thus providing up to a 90-day window of substance use history that allowed us to validate the time frames queried by the three screening tools.^{15,16} Data were collected on all currently prescribed drugs and associated dosage through participants' electronic health records to help distinguish legitimate use from misuse of prescription medications such as buprenorphine, methadone, benzodiazepines and barbiturates. Reference standard test results were not available to assessors at the time of administering index tests.

The primary outcome measures were: the sensitivity, specificity, positive predictive value and negative predictive value of each of the three index tests; and the test-retest reliability of each. Secondary outcome measures were differences in sensitivity, specificity and test-retest reliability for each of the screening tools by age, trimester, and race.

The sample size of 500 was established at the study design phase and determined from a power analysis. The power calculations were based on the primary aim, which was to conduct validity analyses to determine sensitivity, specificity, and how each screening tool compares to the others and to the reference standard in identifying prescription and illicit drug use. The sample size of 500 participants was based on a one-sample binomial approach, the full methodology, including the sample size derivation, has been published.³ Based on a one-sample binomial approach, with a sample size of 500 participants, as long as no more than 35 individuals test positive in the biologic drug tests without a positive screening tool result, we can be 95% confident that the false negative rate in the population is under 10%. Also, as long as no more than 15 individuals test positive in the urine drug test without a positive survey screen result in the study, we can be 95% confident that the false negative rate in the population is under 5%. By McNemar's Test, if results between any pair of surveys disagreed for at least 15% of study participants, 500 is a sufficient sample size to determine this is significant disagreement. After a preliminary sample size of 500 was chosen, a power analysis was conducted to determine the detectable differences in validity by age, race, and trimester of the enrolled participants. The power of this additional aim with a sample size of 500 was examined. The power of the test of proportions is calculated based on the difference in the proportion of false negatives in each age group, race, and trimester of pregnancy.

Descriptive analyses were conducted to show sociodemographic characteristics of the sample. For continuous variables, a one-way analysis of variance (ANOVA) model was used to test for a relationship between such variables and trimester; if the necessary assumptions were not met for ANOVA, a Kruskal-Wallis test was conducted. Chi-square tests for relationships between categorical variables and trimester were conducted. We established sensitivity and specificity for each of the 3 index tests – 4P's Plus, NIDA Quick Screen-ASSIST and the SURP-P. Sensitivity was calculated as the proportion of persons with a positive reference test who also had positive index tests. Specificity was the proportion of

persons with a negative reference test who also had negative index tests. Positive predictive value (PPV) was the proportion of persons with positive index tests who also had positive reference tests; and negative predictive value (NPV) was the proportion of persons with negative index tests who also had negative reference tests. We then calculated test-retest reliability by comparing responses on the index tests with repeat responses obtained 1 week later and provide correlations and phi coefficients for each pair. A phi coefficient of >0.50 was considered acceptable. Invalid or indeterminate reference test (urine or hair) results were excluded from the analysis, as were observations with missing results. Analyses were conducted with Stata version 13.

This study was reviewed and approved by the Institutional Review Boards of the University of Maryland School of Medicine and Battelle Memorial Institute. No adverse events were reported by participants or identified by research staff in connection to this study.

Results

We approached 1170 pregnant women to participate in our study; 719 (61.5%) were interested and met eligibility criteria; of these, 500 (69.5%) were enrolled into the study (Figure 1). Of the enrolled participants, 497 provided biologic samples for drug testing (497 urine, 495 hair). A total of 494 participants received at least 1 of the 3 index screening tools: 485 were administered the NIDA Quick Screen-ASSIST, 491 were administered the 4P's Plus, and 492 were administered the SURP-P. For test-retest reliability, 453 participants were retested with the 3 index screening tools, with 47 participants (9.4%) lost to follow up.

There were 152, 176, and 172 participants in their first, second, and third trimesters, respectively. The distribution of race, education, age, number of previous pregnancies, job status and marital status did not differ across trimesters (Table 2).

Prevalence rates of illicit drug use and prescription drug use as determined by reference standard tests are presented in Figure 2. The most frequently used substance was cannabis, with almost 1/3 of the sample ($n=152$) testing positive.

Table 3 provides results on validity indices of the screening instruments. Using a combination of hair and urine sample drug testing as the reference standard, sensitivity for detecting substance use was higher for the SURP-P and 4P's Plus than the NIDA Quick Screen-ASSIST. Specificity and false negative rates were highest for the NIDA Quick Screen-ASSIST, followed by the 4P's Plus, then the SURP-P.

Correlation (phi) coefficient for test-retest concordance for the 4P's Plus was 0.84, for NIDA Quick Screen-ASSIST was 0.77, and for SURP-P was 0.79. The mean (SD) number of days from test to retest was 7.7 (1.5). Each test-retest analysis excluded 20 of the total respondents due to missing data.

Table 4 contains sensitivity, specificity and test-retest reliability by demographic characteristics. Women age 18–25 years (vs. 26+ years) had significantly lower specificity on the NIDA Quick Screen-ASSIST [70.1% (59.7, 80.0) v. 88.0% (82.8, 92.1)]. There were significant differences in specificity by race between Non-Hispanic Blacks and Non-

Hispanic Whites; specificity for the 4P's Plus was 36.8% (29.6, 44.4) and 13.3% (6.6, 21.7), respectively, and specificity for the SURP-P was 29.3% (22.7, 36.7) and 7.8% (3.3, 16.1), respectively. There were no differences in sensitivity or specificity by trimester for any of the 3 screening tools.

Discussion

In order to be effective, a screening test must have a high sensitivity to ensure that true positives are not missed.¹⁸ Failure to detect and appropriately treat substance use during pregnancy can have long term detrimental effects for both mother and child. In this study validating three self-reported screening tools for substance use during pregnancy, we found that the SURP-P and 4P's Plus performed similarly with high sensitivity and negative predictive values, making them more ideal screening tests than the NIDA Quick Screen-ASSIST, which had a lower sensitivity with a similar negative predictive value.

High sensitivity often comes at the expense of specificity, which was seen in the performance of these screening tools. The NIDA Quick Screen-ASSIST had the highest specificity, but its low sensitivity makes it less desirable as a screening test. Future studies may consider modifying the language of the NIDA Quick Screen to focus on the past 3 months instead of the past year, given changes in substance use that occur during pregnancy. The SURP-P and 4P's Plus had relatively low specificity. There were differences in performance of the screening tools based on age group, with the NIDA Quick Screen-ASSIST having improved specificity in women over 25 years. Both SURP-P and 4P's Plus had lower specificity for Caucasian women than for other racial groups. These differences may be related in part to differences in substance preference by subgroups. The three screening tools differ in the extent of substance use they assess. The NIDA Quick Screen-ASSIST assesses behavioral substance use patterns, such as frequency of alcohol, tobacco, and illicit drug use, and it uniquely assesses craving and functional consequences related to substance use. The SURP-P and 4P's Plus do not assess behavioral substance use patterns in such granular detail and do not assess craving or functional consequences of substance use. Furthermore, the SURP-P only inquires about past marijuana and alcohol use and does not assess other substances; the 4P's Plus is less specific in its assessment of substance use patterns. Each screening tool takes a different approach in assessing substance use but all are intended to screen for multiple substances.

The high false positive rate needs to be taken into account when recommending these screening tools. The repercussions of a false positive drug screen cannot be ignored, particularly with stigmatization and the current legal climate regarding pregnant women who use substances, which is punitive in many states.¹⁹ The high negative predictive value of these screening tools means that providers can be reasonably assured that a woman who screens negative is not using substances. A positive screen, however, should never be considered diagnostic but instead the nidus for further investigation and initiation of a conversation between the provider and patient. The primary purpose of screening tests should be to identify women who may have problematic substance use in order to provide education, assistance and referral to treatment services to improve their health and pregnancy outcomes.

Of the three screening tests analyzed, two have been previously evaluated in a pregnant population, but only one previous study used biologic (urine) confirmatory testing. While the NIDA Quick Screen-ASSIST has been validated across several populations, it had not previously been validated with pregnant women. Chasnoff et al found an 87% sensitivity and 76% specificity in the 4P's Plus screening tool in pregnancy.⁸ Yonkers and colleagues found a 91% sensitivity and 67% specificity in the SURP-P screening tool for low-risk populations, and a lower sensitivity (57%) and higher specificity (88%) with a high-risk population.¹⁰ Ours is an advancement from these prior studies in that it uses urine and hair screening as the gold-standard confirmatory testing. Using biologic confirmation, the sensitivities were slightly higher in our population than seen in Chasnoff's and Yonkers' validation studies but our specificities were much lower. This may be because the biologic testing identified more positives than would have been self-reported in previous studies, and the 4P's Plus and SURP-P do not directly ask about current substance use in as explicit a way as does the NIDA Quick Screen-ASSIST.

Biologic screening tests, although considered the gold standard, are not without flaws. Both urine and hair testing have been shown to produce false positives and are unable to give information regarding timing or dosage of drug use.²⁰ Urine tests, although relatively easy to obtain, are subject to variable excretion rates meaning that a negative toxicology test does not necessarily exclude the possibility of recent use, particularly for those drugs with a short half-life. Although hair sampling tests for a longer duration of exposure, its collection is more arduous and not likely to be employed in most obstetric practices.

Although our study has the strength of using two biologic tests to confirm use, these tests evaluate for a different group of substances, with hair testing not including benzodiazepines, barbiturates or tricyclic antidepressants, which makes comparison of the two difficult. Neither biologic test measured alcohol use, which was not a focus of this study. This may explain why the sensitivity of the screening tools decreased slightly when a combination of hair and urine was taken into account. Drugs are typically eliminated much sooner from the urine than from hair, resulting in different timeframes of use being tested. In our study, 13 participants had inconclusive hair sampling. Although the number of inconclusive hair samples was relatively low in this sample, exclusion of inconclusive tests from analysis may have resulted in an underestimation of the actual sensitivity of these screening tools.

There were some additional limitations to the study. The study population represents a sample of women willing to enroll in a study regarding substance use screening tools in pregnancy and may inherently be more likely to admit use. The study population was willing to provide biological specimens, and results from biological specimens were reasonably correlated with results from self-report. The confidential nature of the screening tests may have increased the likelihood that women would self-report substance use, although previous studies have shown a relatively high willingness among pregnant women to admit use of substances.²¹ Two of the three survey instruments have been studied in pregnancy. The high prevalence of substance use within our population may make it less applicable for lower risk populations. The test-retest reliability (test vs. retest administered a week apart) may have been subject to the "practice effect," a phenomenon in which responses on a questionnaire may be "improved" by prior exposure to the question. However, Marx *et al* (2003)²²

compared two retest samples on self-reported quality of life, one 2 days post-test and the other 2 weeks post-test and found no significant differences in test-retest reliability between the two time intervals.

Despite these limitations, this study has several strengths. The use of confirmatory biologic markers is an objective comparison to assess the efficacy of a screening tool for prenatal substance use. Comprehensive testing evaluated a large number of substances from both hair and urine. The use of both urine and hair specimens decreases the chance of false negatives with infrequent use that can be an issue with urine testing alone. The sample size was large, and the population was diverse socioeconomically and well distributed over all trimesters. The test-retest reproducibility of the results was high.

Treatments for prenatal substance use markedly improve outcomes,²³ lending support to the development and implementation of a screening test according to the WHO Wilson criteria.²⁴ Substance use screening in pregnancy needs to have a lower threshold than in the non-pregnant population because occasional, recreational use likely represents problematic use in a pregnant woman when the same pattern of use may not have qualified as such prior to conception. Although screening with biologic tests such as urine toxicology have utility for confirmatory testing, screening questionnaires are low cost, non-invasive and allow self-report of use, which may provide context and assist in the building of a trusting doctor-patient relationship which is essential in the treatment of substance use disorders. Both are useful, with some evidence that neither is clearly superior to the other.²⁵

Our study found that the SURP-P and 4P's Plus were highly sensitive screening tools across all trimesters, races and age groups. The dissemination of a strong and clear recommendation for a clinically useful prescription and illicit drug screening tool for pregnant women is highly significant, relevant for public health, and will likely increase screening, thus providing greater opportunity to intervene with women who may use substances during pregnancy.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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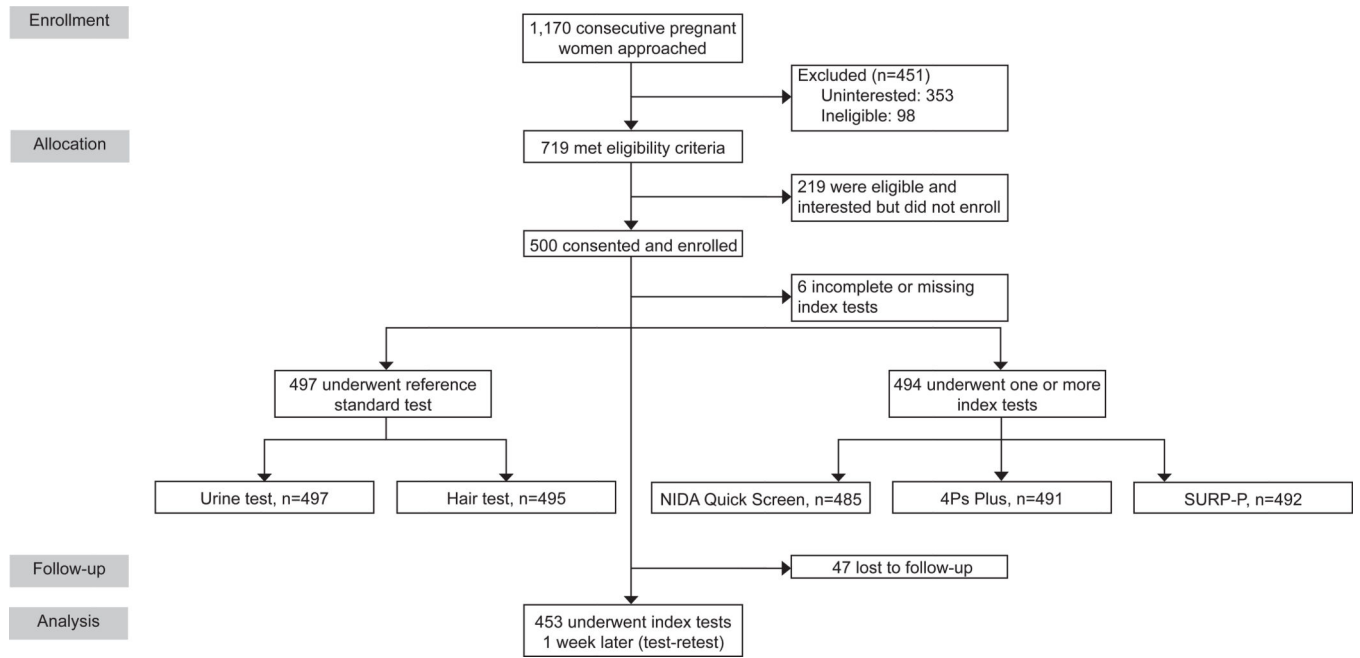


Figure 1:
Flow diagram. SURP-P, Substance Use Risk Profile-Pregnancy scale.

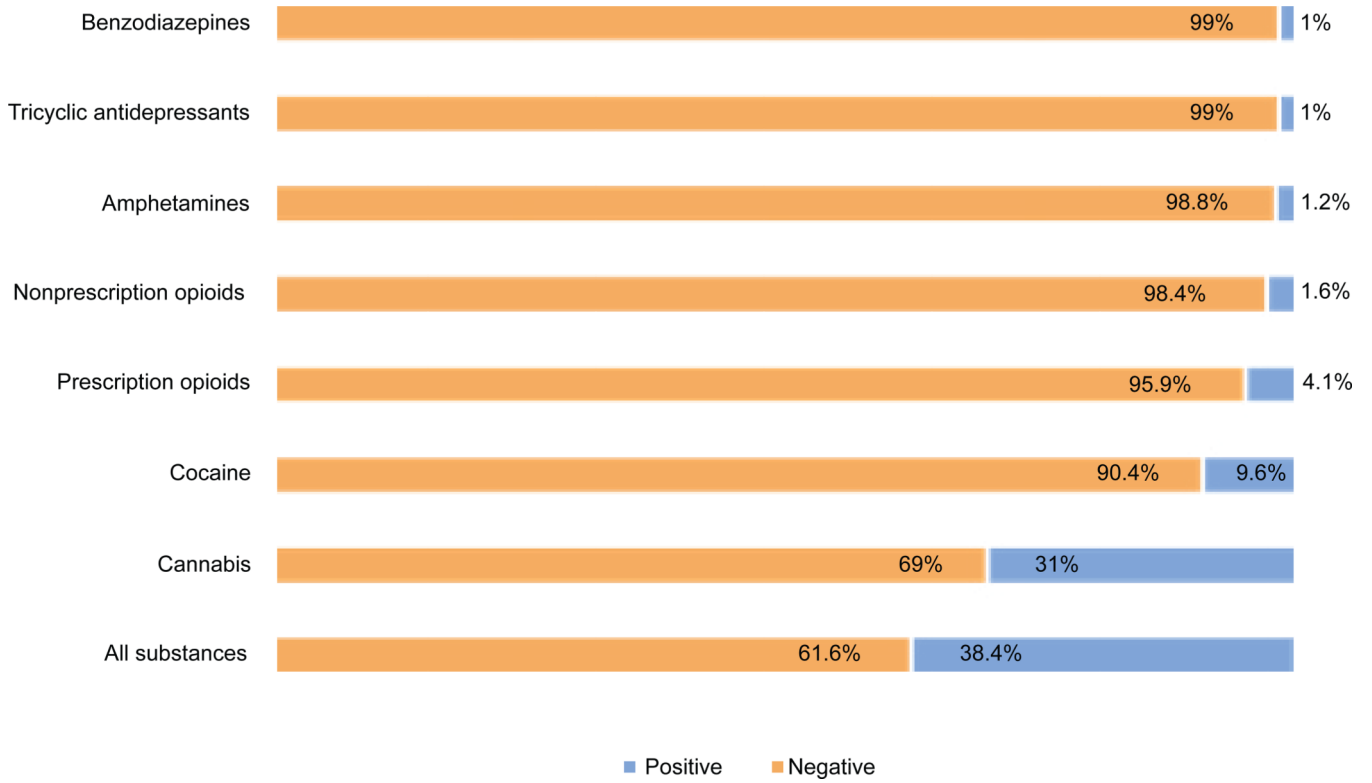


Figure 2.
Prevalence rates by substance.

Table 1:Pregnancy Drug Screening Tools[#]

SCREENING TOOL	QUESTIONS
NIDA Quick Screen-ASSIST	
Quick Screen^a	<ol style="list-style-type: none"> 1. In the past year, how often have you used the following? <ol style="list-style-type: none"> a. Five or more alcohol drinks in a day for men or 4 or more alcohol drinks in a day for women, b. tobacco products, c. prescription drugs for non-medical reasons, and d. illegal drugs.
ASSIST^b	<ol style="list-style-type: none"> 1. In your lifetime, which of the following substances have you used? (response options of yes or no); 2. In the past three months, how often have you used the substances you mentioned? (response options of never, once or twice, monthly, weekly, and daily or almost daily for items 2–5) 3. In the past three months, how often have you had a strong desire or urge to use (each substance)? 4. (During the past three months, how often has your use of (each substance) led to health, social, legal or financial problems?) 5. During the past three months, how often have you failed to do what was normally expected of you because of your use of (each substance)? 6. Has a friend or relative or anyone else ever expressed concern about your use of (each substance)? 7. Have you ever tried to control, cut down or stop using (each substance)? 8. Have you ever used any drug by injection?
SURP-P^c	<ol style="list-style-type: none"> 1. Have you ever used marijuana? 2. How many alcoholic drinks have you consumed in the month before knowing you were pregnant? 3. Do you feel the need to cut down on your alcohol or drug use?

^aResponse options for each substance are: never, once or twice, monthly, weekly, and daily or almost daily. For purposes of validation, both the Quick Screen and ASSIST were given to all participants to complete.

^bSubstances assessed are: tobacco products; alcohol; cannabis; cocaine; amphetamine-type stimulants (ATS); sedatives and sleeping pills (benzodiazepines); hallucinogens; inhalants; opioids; and “other” drugs.

^cScoring involves classifying the number of alcoholic drinks consumed in the month before pregnancy as none versus any, and then counting the number of affirmative items. Negative responses for all items yields a low-risk individual, one affirmative response yields a moderate risk individual, and two or three affirmative responses yield a high-risk individual.

[#]4P’s Plus questionnaire not included because it is covered by copyright, the researchers purchased a license to administer to participants.

Table 2.

Summary Statistics

Variables	Categories	1st Trimester (n=152)	2nd Trimester (n=176)	3rd Trimester (n=172)	P-Value ⁵
Maternal Age mean (SD)		27.6 (4.92)	28.4 (5.42)	27.5 (5.24)	0.19
# of Previous Pregnancies ¹ median (range)		2 (0–9)	2 (0–10 or more)	2 (0–10 or more)	0.41
Race Freq. (n, %)	African American/ Black	110 (72.37%)	126 (71.59%)	116 (67.44%)	0.68
	Caucasian/White	28 (18.42%)	37 (21.02%)	38 (22.09%)	0.68
	Other/Multiracial ²	13 (8.55%)	12 (6.82%)	14 (8.14%)	0.68
	Missing	1 (0.66%)	1 (0.57%)	4 (2.33%)	0.68
Education (Last grade completed) Freq. (n, %)	Less than High School	35 (23.03%)	28 (15.91%)	21 (12.21%)	0.25
	High School Graduate	59 (38.82%)	72 (40.91%)	71 (41.28%)	0.25
	Some College	22 (14.47%)	36 (20.45%)	28 (16.28%)	0.25
	College Graduate	34 (22.37%)	38 (21.59%)	48 (27.91%)	0.25
	Unavailable	2 (1.32%)	2 (1.14%)	4 (2.33%)	0.25
Marital Status Freq. (n, %)	Married ³	51 (33.55%)	66 (37.50%)	75 (43.60%)	0.29
	Widowed/Divorced/ Separated	4 (2.63%)	3 (1.70%)	6 (3.49%)	0.29
	Never Married	96 (63.16%)	105 (59.66%)	87 (50.58%)	0.29
	Unavailable	1 (0.66%)	2 (1.14%)	4 (2.33%)	0.29
Job Status Freq. (n, %)	Working Full-Time or in the Military	72 (47.37%)	80 (45.45%)	66 (38.37%)	0.26
	Working Part-Time	19 (12.50%)	23 (13.07%)	24 (13.95%)	0.26
	Unemployed ⁴	59 (38.82%)	71 (40.34%)	74 (43.02%)	0.26
	Unavailable	2 (1.32%)	2 (1.14%)	8 (4.65%)	0.26

¹Number of pregnancies was unavailable for 1 first trimester respondents, 2 second trimester respondents, and 5 third trimester respondents.

²The “Other/Multiracial” group includes respondents who chose “Some other group” or more than one category.

³The “Married” group includes respondents who were married, living with someone as married, or married but living apart.

⁴The “Unemployed” group includes respondents who had a job but were unemployed or laid off, those who were not at work for various reasons, full-time homemakers, those in school or training, retired or disabled individuals, and those doing volunteer work.

⁵P-values are the results of a one-way analysis of variance (ANOVA) model to test for a relationship between age and trimester, a Kruskal-Wallis test for a relationship between number of previous pregnancies and trimester, and chi-square tests for relationships between all remaining variables and trimester.

Table 3.

Validity Indices for the 4 P's Plus, NIDA Quick Screen and SURP-P

	4 P's Plus	NIDA Quick Screen ASSIST	SURP-P
Sensitivity (95% CI) ^a	91.2 (85.7, 95.1)	83.5 (76.8, 89.0)	93.1 (88.0, 96.5)
Specificity (95% CI) ^a	28.6 (23.7, 33.9)	80.8 (76.0, 85.0)	21.0 (16.7, 25.9)
Positive Predictive Value (95% CI) ^a	39.0 (34.0, 44.1)	68.4 (61.3, 74.9)	37.0 (32.3, 41.9)
Negative Predictive Value (95% CI) ^a	86.7 (78.6, 92.5)	90.8 (86.8, 93.9)	85.9 (76.2, 92.7)
Sensitivity (95% CI) ^b	94.7 (88.5, 97.4)	85.4 (76.4, 89.5)	95.4 (90.7, 98.4)
Specificity (95% CI) ^b	28.7 (23.8, 33.6)	76.1 (71.4, 80.6)	21.1 (17.3, 26.1)
Positive Predictive Value (95% CI) ^b	32.6 (28.9, 38.8)	56.4 (50.1, 64.4)	30.6 (27.3, 36.5)
Negative Predictive Value (95% CI) ^b	93.6 (85.7, 96.7)	93.5 (88.8, 95.2)	92.7 (84.8, 97.3)
Sensitivity (95% CI) ^c	90.2 (84.5, 93.8)	79.7 (71.2, 84.2)	92.4 (87.6, 95.8)
Specificity (95% CI) ^c	29.6 (24.4, 35.2)	82.8 (78.1, 87.1)	21.8 (17.4, 27.2)
Positive Predictive Value (95% CI) ^c	44.1 (39.7, 50.0)	74.0 (67.8, 80.4)	42.0 (38.0, 47.9)
Negative Predictive Value (95% CI) ^c	83.0 (73.4, 88.9)	86.9 (81.3, 89.7)	82.3 (72.1, 90.0)

^aReference Standard: Hair Test Results^bReference Standard: Urine Test Results^cReference Standard: Hair and Urine Test Results Combined; positive on either urine or hair sample testing

Table 4.

Sensitivity, Specificity, and Test-Retest Analysis by Demographics

	4 P's Plus			NIDA Quick Screen ASSIST			SURP-P		
	Sensitivity	Specificity	Test-Retest	Sensitivity	Specificity	Test-Retest	Sensitivity	Specificity	Test-Retest
Age									
18-25	89.9 (81.5, 95.6)	40.2 (30.6, 52.4)	0.86 [‡]	81.0 (69.9, 88.3)	70.1 (59.7, 80.0)	0.72 [‡]	91.1 (83.0, 96.5)	29.9 (21.0, 41.5)	0.76 [‡]
26+	90.4 (82.2, 94.7)	25.2 (19.2, 31.3)	0.82 [‡]	78.6 (67.9, 84.8)	88.0 (82.8, 92.1)	0.78 [‡]	93.3 (86.9, 97.3)	18.5 (13.6, 24.5)	0.81 [‡]
Race									
African American/ Black	89.8 (84.1, 93.9)	36.8 (29.6, 44.4)	0.83 [‡]	80.0 (73.1, 85.8)	80.9 (74.3, 86.5)	0.74 [‡]	91.6 (86.3, 95.3)	29.3 (22.7, 36.7)	0.78 [‡]
Caucasian/ White	94.1 (71.3, 99.9)	13.3 (6.6, 21.7)	0.90 [‡]	64.7 (38.3, 85.8)	87.8 (79.7, 94.3)	0.83 [‡]	100.0 (80.5, 100.0)	7.8 (3.3, 16.1)	0.85 [‡]
Other/ Multiracial	75.0 (19.4, 99.4)	36.4 (19.8, 53.5)	0.76 [‡]	75.0 (19.4, 99.4)	78.8 (62.1, 91.3)	0.79 [‡]	100.0 (39.8, 100.0)	20.6 (8.4, 36.9)	0.82 [‡]
Trimester									
1st	90.0 (80.7, 95.9)	33.3 (23.4, 45.4)	0.77 [‡]	79.7 (68.7, 88.6)	84.6 (75.9, 92.7)	0.81 [‡]	91.4 (82.5, 96.8)	25.6 (16.6, 37.2)	0.86 [‡]
2nd	92.5 (82.3, 96.8)	24.3 (16.0, 33.6)	0.85 [‡]	81.4 (70.3, 89.7)	80.4 (70.5, 87.2)	0.75 [‡]	95.5 (88.0, 99.1)	18.3 (11.7, 27.8)	0.72 [‡]
3rd	87.0 (73.7, 95.1)	31.9 (23.3, 40.9)	0.88 [‡]	71.7 (56.5, 84.0)	83.6 (75.8, 89.9)	0.76 [‡]	89.1 (76.4, 96.4)	22.4 (15.1, 30.8)	0.79 [‡]

[‡] A phi coefficient 0.50 indicates an acceptable level of correlation.