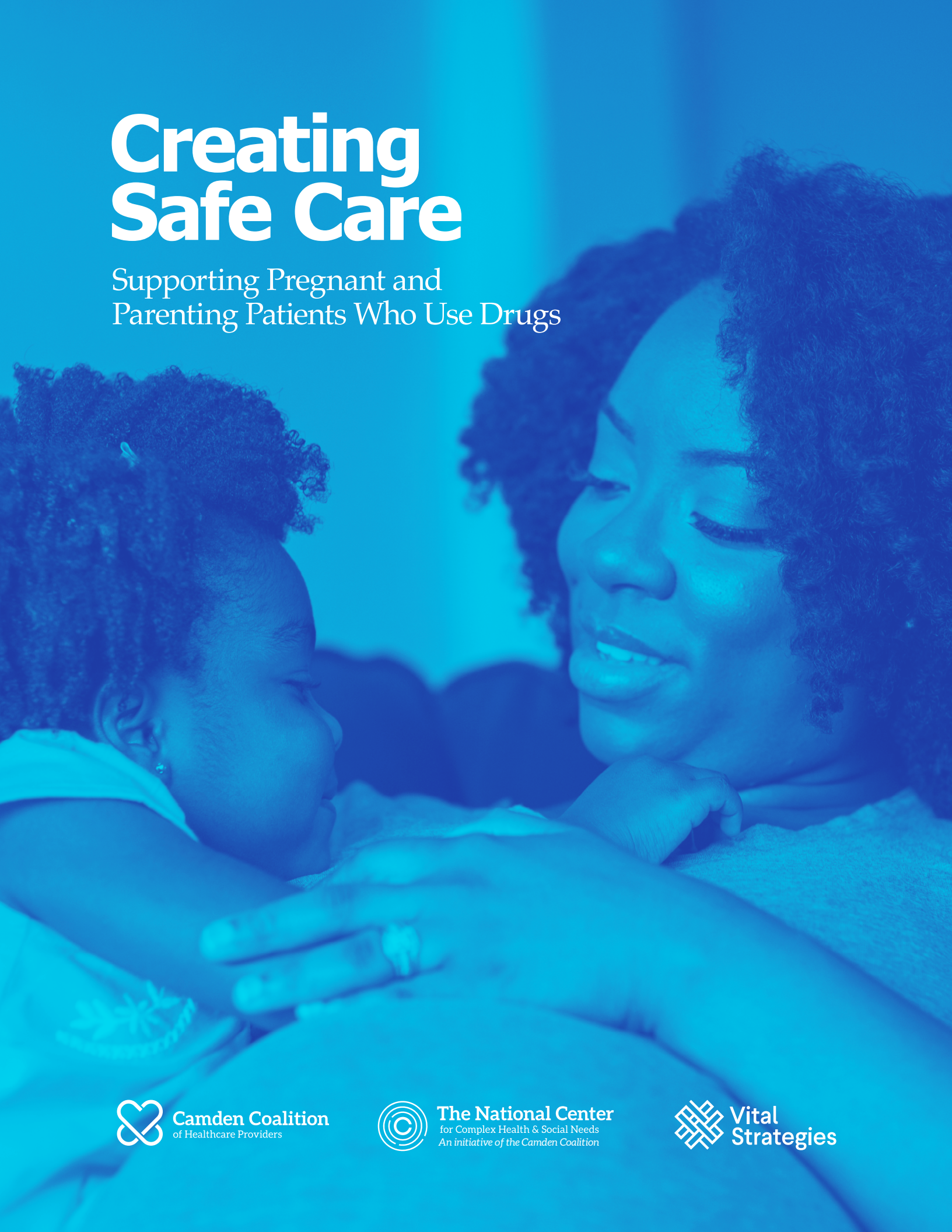
Creating Safe Care

Supporting Pregnant and Parenting Patients Who Use Drugs



Camden Coalition of Healthcare Providers

The National Center for Complex Health & Social Needs
An initiative of the Camden Coalition

Vital Strategies

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I think one of the best practices is having a clear understanding of what is happening in your county and state, related to Plans of Safe Care and child protective services. The less you understand, the less you can collaboratively develop a plan with patient, family.

COMMONLY USED ACRONYMS AND ABBREVIATIONS	
4Ps	Parents, Partner, Past and Present
AAFP	American Academy of Family Physicians
AHR	Authentic Healing Relationships
AUDIT-C	Alcohol Use Disorders Identification Test-Concise
CAPS	Clinical Administered PTSD Scale
CAPTA	Child Abuse Prevention and Treatment Act of 1974
CARA	Comprehensive Addiction and Recovery Act
CDC	U.S. Centers for Disease Control and Prevention
COACH	Create a care plan, Observe the normal routine, Assume a coaching style, Connect tasks with vision and priorities, Highlight progress with data
CPS	Child Protective Services
DEQ	Distressing Event Questionnaire
DMV	Department of Motor Vehicles
ELS	Evaluation of Lifetime Stressors
FASD	Fetal Alcohol Spectrum Disorder
FTM	Family Team Meeting
GAD-2	Generalized Anxiety Disorder Scale—2
GAD-7	Generalized Anxiety Disorder Scale—7
HITS	Hurt, Insult, Threaten, Scream

COMMONLY USED ACRONYMS AND ABBREVIATIONS	
IPV	Intimate Partner Violence
MAT	Medications for addiction treatment
MI	Motivational Interviewing
MINT	Motivational Interviewing Network of Trainers
MLP	Medical-legal partnership
MOUD	Medications for opioid use disorder
NAS	Neonatal abstinence syndrome
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
OARS	Open-ended questions, Affirmations, Reflective listening and Summarization
OB-GYN	Obstetrician-gynecologist
OUD	Opioid use disorder
PACE	Partnership, acceptance, compassion, empathy
PCOR	Patient-Centered Outcomes Research
PCP	Primary care provider
PHQ-2	Patient Health Questionnaire—2
PHQ-4	Patient Health Questionnaire—4
POSC	Plans of Safe Care
SAMHSA	Substance Abuse and Mental Health Services Administration

COMMONLY USED ACRONYMS AND ABBREVIATIONS	
SBIRT	Screening, Brief Intervention and Referral to Treatment
SDM	Shared Decision-Making
SdoH	Social determinants of health
STAT	Slapped, Threatened and Thrown
SUD	Substance use disorder
SURP-P	Substance Use Risk Profile—Pregnancy
T-ACE	Tolerance, Annoyed, Cut-down, Eye-opener
TAA	Trauma Assessment for Adults
TWEAK	Tolerance, Worried, Eye-opener, Amnesia, K[C]ut-down
UDS	Urine drug screen
WAST	Women Abuse Screening Tool
WHO	World Health Organization
WIC	Women, Infants and Children
WIDUS	Wayne Indirect Drug Use Screener

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Key Experts

We conducted interviews with on-the-ground providers, legal and health experts, and state policy and administration officials. Interviewees were identified by the Overdose Prevention Program at Vital Strategies, a leading global public health organization, as well as providers and policymakers known to the Camden Coalition team.

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Child Welfare Policy, Parental Substance Use, and Maternal Health

For decades, hospital systems have played a critical role in our country's "war on drugs," which includes policing pregnant and parenting patients – largely Black, Latinx and poor patients. Families of color are disproportionately reported for abuse and neglect, and their cases are more likely to be selected for investigation and substantiated upon investigation than those of white, non-Hispanic families.[1] And once they are substantiated for abuse or neglect, parents of color are more likely to have their children removed and placed into foster care. Efforts to reform drug policy have focused more on criminal and sentencing issues, and less on child welfare and the significant role that race, class and type of substance use have on prenatal and postnatal care.

1 Cort, N. A., Cerulli, C., & He, H. (2010). Investigating health disparities and disproportionality in child maltreatment reporting: 2002-2006. Journal of public health management and practice: JPHMP, 16(4), 329–336. https://doi.org/10.1097/PHH.0b013e3181c4d933

Pregnant and parenting people who use drugs[2,3] frequently encounter stigmatization, not to mention face significant negative legal consequences for their drug use. Given their risk of being reported to a child welfare agency and the resulting punitive repercussions, including possible separation from their infant, this population will often refrain from seeking prenatal care. Not only do parents encounter long-term legal implications such as terminations of parental rights,[4,5] but a study found that mothers who are separated from their children also have increased odds of overdose.[6]

One reason for this cycle is the Child Abuse Prevention and Treatment Act of 1988 and subsequent amendments, known as CAPTA/CARA (which stands for the Comprehensive Addiction and Recovery Act). These acts incentivized states to create a system of care for pregnant people with substance use disorders (SUDs) and contributed to the health system's response to parental substance use. To receive funding, states were required to create a system for health care workers to notify child welfare agencies in response to an infant's substance exposure.[7] Importantly, *notification* under CAPTA/CARA is distinct from a child protection *report*; a CAPTA/CARA notification does not necessarily require a child welfare investigation, although there are differing views on this. CARA, which was passed by Congress in 2016, expanded the requirements for Plans of Safe Care to infants affected by exposure to any substances, including those that aren't criminalized (i.e., alcohol and tobacco), as well as the affected family or caregiver.[8]

These unstandardized, punitive drug and child welfare policies have contributed to removing a significant proportion of children of color from their homes.[9] Native American youth, Black children, and multiracial and Hawaiian/Pacific Islander children are overrepresented in foster care.[10] One study in a New York hospital system found that although Black children only made up a small percentage of pediatric patients (19%), they accounted for almost half of the health system's reports to Child Protective Services (CPS) and had four times greater odds of being reported than white pediatric parents.[11] Additional research demonstrates how hospitals that care for larger proportions of Medicaid patients have higher CPS

2 This language is intended to capture the full continuum of use, up to and including substance use disorder. It bears noting that many of the harmful and punitive policies and practices described in this toolkit affect pregnant and parenting people with any level of drug use, not just a diagnosable substance use disorder.

3 Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. Health & Justice, 3 (1). https://doi.org/10.1186/s40352-015-0015-5

4 Termination of parental rights means that: "The parent-child relationship no longer exists, the parent no longer gets to raise the child, the parent usually has no right to visit or talk with the child, the parent no longer has to pay child support. The parent is removed from the child's birth certificate, the child can be adopted without the parent's permission."

5 Legal Aid Center of Southern Nevada. (n.d.). *Overview of terminating parental rights.* Family Law Self-Help Center. Retrieved Nov. 23, 2021, from https://www.familylawselfhelpcenter.org/self-help/adoption-termination-of-parental-rights/overview-of-termination-of-parental-rights

6 Meaghan Thumath, et al., International Journal of Drug Policy, https://doi.org/10.1016/j.drugpo.2020.102977

7 A plan of safe care is defined by the Children's Bureau as "a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following his or her release from the care of a health care provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver." U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau. Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families. 2019. https://www.childwelfare.gov/pubPDFs/safecare.pdf

8 National Advocates for Pregnant Women. Understanding CAPTA and State Obligations. 2020. https://mk0nationaladvoq87fj.kinstacdn.com/wp-content/uploads/2020/11/2020-revision-CAPTA-requirements-for-states-10-29-20-1-1.pdf

9 Child Welfare Information Gateway. (2016). *Racial disproportionality and disparity in child welfare.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf

10 Meinhofer, A., Onuoha, E., Angleró-Díaz, Y., & Keyes, K. M. (2020). Parental drug use and racial and ethnic disproportionality in the U.S. foster care system. *Children and Youth Services Review*, 118, 1–4. https://doi.org/10.1016/j.childyouth.2020.105336

11 Cort, N. A., Cerulli, C., & He, H. (2010). Investigating Health Disparities and Disproportionality in Child Maltreatment Reporting. *Journal of Public Health Management and Practice*, 16(4), 329–336. https://doi.org/10.1097/phh.0b013e3181c4d933

reports for these patients, signifying biased reporting for lower-income populations.[12] Nationally, health care workers contribute to a significant percentage of child welfare reports involving parents with children aged 0-1 years, in addition to those with older children.[13,14] This is due in large part to a myriad of policy, administrative and cultural practices that encourage health care workers to report substance use as an incident in and of itself or as a contributor to child abuse or neglect. Family separation exacerbates a health care crisis for families and is often a difficult decision for health care workers. This toolkit is designed to interrupt this harmful cycle and equip health care workers with the knowledge and tools they need to make reporting the last resort.

Research has shown that health care workers express a range of attitudes and confidence related to providing care for pregnant and parenting people who use drugs.[15] A survey published in the American Journal of Obstetrics and Gynecology (2020)[16] found that health care workers believe that people with SUD need treatment. However, the same workers simultaneously make negative moral judgments toward people with SUD, and often disagree with participation in methadone treatment as well as treatment with other Medications for Opioid Use Disorder (MOUD) because, in their view, it substitutes one drug for another.[17]

Yet new best practices and approaches to these issues are emerging. The Camden Coalition has worked with pregnant and parenting people with SUDs in South Jersey as well as with countless programs and professionals in health care, social service and other treatment environments. In addition, the Camden Coalition's National

Center for Complex Health and Social Needs has provided technical assistance to states, health systems and social service providers to help them meet the needs of this population. There is an urgent and important opportunity to:

- Challenge health care workers' stigmatizing beliefs that may lead to the unnecessary separation of families
- Provide care that prioritizes support and family preservation
- Educate health care workers on the history of the criminalization of drug use and its incorporation into health care and child welfare settings, with the purpose of mitigating disproportionate rates of child welfare involvement and family separation
- Encourage and empower health care workers to become more effective advocates for their patients
- Challenge policies that erode the relationship between health care workers and patients and break up families

12 Rebbe, R., Mienko, J. A., Brown, E., & Rowhani-Rahbar, A. (2019). Hospital Variation in Child Protection Reports of Substance Exposed Infants. *The Journal of pediatrics*, 208, 141–147.e2. https://doi.org/10.1016/j.jpeds.2018.12.065

13 U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021). Child Maltreatment 2019. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment

14 National Center on Substance Abuse and Child Welfare. (2016). *Child welfare and alcohol & drug use statistics*. https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.asp

15 Ko JY, Tong VT, Haight SC, Terplan M, Snead C, Schulkin J. Obstetrician-gynecologists' practice patterns related to opioid use during pregnancy and postpartum-United States, 2017. *J Perinatol*. 2020;40(3):412-421. doi:10.1038/s41372-019-0535-2

16 The American College of Obstetricians and Gynecologists. (2020, December). *Opposition to criminalization of individuals during pregnancy and the postpartum period*. https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period

17 Williams, Margaret A., et al. "671: Healthcare Care Providers' Roles and Attitudes towards Substance Use Disorder during Pregnancy." American Journal of Obstetrics and Gynecology, vol. 222, no. 1, Jan. 2020, p. S427, https://www.ajog.org/article/S0002-9378(19)32056-3/fulltext

"I have a sense nationally… of how inconsistent and random almost or not coherent different practices [of CAPTA and CARA] are different places—more specifically, in NYC, it seems very clear on an anecdotal level...that there are many hospitals in New York City…that seem to routinely test almost everyone during labor and delivery…even when testing is counter to the policies that are supposed to govern this."

This toolkit presents best practices and new and emerging models from the field that align with the above goals, with tools designed to be family-focused and nonpunitive and to recognize the spectrum and variability of substance use. Specifically, we intend the tools and resources in this document to be a helpful guide for providers serving pregnant and parenting patients by providing a framework for productive collaboration with social workers, child welfare officials and the legal system, so as to prevent family separation and unnecessary substance use reporting. To develop these materials, we conducted interviews with 30 on-the-ground providers, legal and health experts, state policy and administration officials, and parents whose children have been taken into the child welfare system. These new practices are grounded in their real-life expertise and offer care options focused on harm reduction principles and evidence-based treatment and support.[18] Our hope is that this toolkit offers a helpful go-to resource for anyone in the health field who is interested in promoting standards of care and government policies oriented toward family preservation and overdose prevention.

Toolkit materials are organized into five categories:

A. Relationship Building
B. Screening
C. Treatment and Care Planning
D. Reporting
E. Providers as Partners

The toolkit provides health care workers with harm reduction strategies for substance use screening and working with child welfare. The implementation of some of these tools will be dependent on the nature of the working environment. Interacting with child welfare can be a stressful care experience, and providers working in home visitation settings may not have the same access to safety protocols and colleague support as those practicing in hospital settings. Thus, before implementing tools, it is important to be mindful of safety and to establish safety protocols for all parties involved. It is also important to note that state and local laws and hospital policies differ across the country, and consequently may affect the degree to which some of these tools can be implemented.

The tools are intended to be easy for health workers to use, replicate and adapt in their work with pregnant and parenting clients. We hope that the distribution and use of these materials will result in new best practices and resources for the field. ●

18 Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. *Principles of Harm Reduction*. https://harmreduction.org/about-us/principles-of-harm-reduction/

Tools and Resources for Care Delivery

The following section reflects what we believe are emerging and best-in-class approaches in care delivery, based on our research and interviews with stakeholders across the country.

"People who are pregnant and use substances are deathly afraid of the health care system, and rightly so, because they walk into the office or clinic and they are stigmatized over and over again. I have witnessed it with my clients and you know, the minute that [the provider] hears they use drugs, then it's like 'you are going to kill your baby, you're hurting your baby.' Even if we bring up MATs, it's just all about the baby… so that turns away the parent from seeking further help from any type of health officials."

2A Relationship Building

IN THIS SECTION

Pregnant and parenting people who use substances are inclined to underreport their substance use until they have built a relationship with their service provider and feel safe to disclose the full extent of their use.[19] Pregnant people involved with prenatal substance use are far more likely to delay their prenatal care or not initiate care at all, compared to pregnant people who are not involved with substance use.[20] Literature cites stigma from health care providers and fears of encountering criminal, legal and child welfare system (CW) consequences from prenatal drug use as some of the chief barriers that prevent women from seeking care.[21,22] Emerging best practices show that developing a trusting relationship with patients can reduce the chances of adversarial interactions, interactions that patients fear will result in social or legal repercussions.[23] It is also important that the health care providers in the patient's ecosystem of care have a relationship with one another to improve patient outcomes. Taking a compassionate, family-centered approach with the patient and connecting with others involved in their care can reveal health and social needs that may contribute to their substance use.[24]

1. Provider Patient Relationship

Health care workers are in a position to provide person-centered and nonstigmatizing care to promote positive outcomes associated with consistent prenatal care, including healthier outcomes for mothers and babies. Yet pregnant and parenting people who use substances may end up avoiding or disengaging from prenatal care[25] because of discrimination, stigmatization, social ostracization and punitive public policies. This can lead to adverse outcomes including low birth weight, prematurity in infants and maternal mortality.[26] For these reasons, it is crucial for health care providers to create a judgment-free zone in the delivery of care. Using evidence-based practices such as motivational interviewing (see 1c, below) and trauma-informed care[27] are some of the ways that providers can establish trusting relationships with patients early in the pregnancy.

19 Hubberstey, C., Rutman, D., Schmidt, R. A., Van Bibber, M., & Poole, N. (2019). Multi-Service Programs for Pregnant and Parenting Women with Substance Use Concerns: Women's Perspectives on Why They Seek Help and Their Significant Changes. *International journal of environmental research and public health, 16*(18), 3299. https://doi.org/10.3390/ijerph16183299

20 Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice, 3*(1), 2. https://doi.org/10.1186/s40352-015-0015-5

21 Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice, 3*(1), 2. https://doi.org/10.1186/s40352-015-0015-5

22 Angelotta, C., Weiss, C. J., Angelotta, J. W., & Friedman, R. A. (2016). A moral or medical problem? The relationship between legal penalties and treatment practices for opioid use disorders in pregnant women. *Women's health issues: official publication of the Jacobs Institute of Women's Health, 26*(6), 595–601. https://doi.org/10.1016/j.whi.2016.09.002.

23 Committee Opinion No. 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist, Obstetrics & Gynecology: January 2011 - Volume 117 - Issue 1 - p 200-201 https://doi.org/10.1097/AOG.0b013e31820a6216

24 Family-centered practice is "based on the belief that the best way to meet a person's needs is within their families and that the most effective way to ensure safety, permanency, and well-being is to provide services that engage, involve, strengthen, and support families." https://clas.uiowa.edu/nrcfcp/what-family-centered-practice

25 NIDA. 2017, July 1. Treating Opioid Use Disorder During Pregnancy. Retrieved from https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy on 2021, July 16

26 Polak, K., Kelpin S., & Terplan, M. (2019). Screening for substance use in pregnancy and the newborn. *Seminars in Fetal and Neonatal Medicine*, 24(2), 90-94. https://doi.org/10.1016/j.siny.2019.01.007

27 Trauma-informed care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma; that emphasizes physical, psychological, and emotional safety for both providers and survivors; that creates opportunities for survivors to rebuild a sense of control and empowerment." (Hopper et al., 2010)

1. Provider Patient Relationship

TOOLS

A. Guide for creating authentic healing relationships →

Authentic Healing Relationships emerge when care professionals establish trusting relationships with their patients, demonstrate honesty and transparency in care interactions, and prioritize continuity of care. This tool can be used as a template to build Authentic Healing Relationships with patients.

B. COACH reference guide →

The COACH tool identifies practices and techniques that care teams can use to establish an authentic healing relationship with patients. It can be used to track progress in supporting participants as they move toward their goals.

C. Motivational interviewing script →

Motivational interviewing is an evidence-based, person-centered communication method that taps into an individual's intrinsic motivation to engage in changing their health behavior, say, by exploring and resolving ambivalence. This tool includes tips and prompting questions that providers can use in their patient interactions.

D. Clinical guidance for treating pregnant and parenting women with Opioid Use Disorder and their infants →

The clinical guidance for treating pregnant women with OUD provides intervention guidelines and recommended approaches to caring for pregnant and parenting people with OUD. This tool can be adapted by practitioners to improve outcomes for this specific population.

E. Plans of safe care learning modules →

This set of modules from the National Center on Substance Abuse and Child Welfare guides health practitioners through the process of developing sound plans of safe care.

"Some of the more promising practices are the collaborations that have been established, so some of the perinatal collaboratives, community based collaboratives that are really looking at how to get upstream…and are working with women who are pregnant to be provided services and developing plans of safe care with them prior to them ever coming to the hospital, so that when they arrive at the hospital the have a plan. That prevents a lot of CPS involvement."

2. The Importance of Provider Partnerships

Cross-collaboration between community organizations and care providers is an effective method for delivering comprehensive and culturally competent care. The patients involved with The Mothering Project, located at Mount Carmel Clinic in Manitoba, Canada, have had successful health outcomes because of the facility's comprehensive care that is achieved through relationships with community organizations.
The Center for the Study of Social Policy's Developmental Understanding and Legal Collaboration for Everyone (DULCE) initiative also utilizes cross-sector partnerships to address social determinants of health and provide robust multidisciplinary support to families. These relationships are necessary to connect patients with optimal resources, stigma-free treatment and harm reduction–centered care.[28]

Leaders in the field also emphasized the value of a lifetime approach to substance-exposed children, one that stretches beyond infancy. This includes building strong relationships with WIC staff, Early Intervention and preschool/Head Start. Studies have also demonstrated the benefits of harm reduction–focused care for pregnant and parenting people.[29]

28 Nathoo, T. and Poole, N. (2017). Indigenous Approaches to FASD Prevention: Indigenous Mothering. Vancouver, BC: Centre of Excellence for Women's Health. https://bccewh.bc.ca/wp-content/uploads/2018/01/IndigFASD-MOTHERING_Jan2018.pdf

29 Nathoo, T. and Poole, N. (2017). Indigenous Approaches to FASD Prevention: Indigenous Mothering. Vancouver, BC: Centre of Excellence for Women's Health. https://bccewh.bc.ca/wp-content/uploads/2018/01/IndigFASD-MOTHERING_Jan2018.pdf

2. The Importance of Provider Partnerships

TOOLS

A. Guidance for forming partnerships with legal advocates, social work experts and other potential supports for parents →

Collaborating across a patient's provider circle is essential for improving the well-being of those living with SUD, who are likely to have additional complex health and social needs. This tool offers recommendations on how to identify other providers and actors within a patient's circle and leverage those relationships to improve patient outcomes.

B. Maternal opioid misuse model →

Fragmented care for pregnant people can be a barrier to providing comprehensive care. This model from the Center for Medicare and Medicaid Services highlights the importance of coordinated care for pregnant and parenting people with opioid use disorder, and the positive outcomes that result from such coordination.

C. Resource databases

Community resources can provide patients with additional support by assisting them with locating housing, financial and legal aid, as well as many other necessary support services. Findhelp.org and Neighborhood Navigator are two databases that can help you find community resources for your patients.

Findhelp.org by Aunt Bertha

Neighborhood Navigator by AAFP

"[One successful clinic] really focused on creating a relationship with the child welfare agency, and creating credibility. Being able to articulate what services they offered, that they were as invested in the health of mom and infant, but invested from a preservation perspective."

2. The Importance of Provider Partnerships

TOOLS

D. Medical-legal collaboration

Because this subpopulation is likely to encounter legal issues, medical-legal partnerships can be crucial to addressing other social needs outside of health care. The following tools provide guidance on how to work alongside legal representatives to support parents and families in child welfare cases.

1. Toolkit: bringing lawyers onto the health center care team to promote patient and community health → The ideal method of infusing legal interventions into a clinical setting is through the development of formal Medical-Legal Partnerships (MLPs). If your organization is interested in developing an MLP, please see the toolkit, above, from the National Center for Medical-Legal Partnerships.

2. Parent court planning calendar → The family court planning worksheet includes a monthly and daily calendar to assist parents with keeping track of appointments, court dates and action items.

3. Contact information worksheet → The contact information worksheet provides spaces to record phone numbers, email addresses and physical addresses for the parent's child welfare and legal representatives.

4. Family court preparation and documentation review worksheet → The preparation and documentation review worksheet includes spaces for the parent to keep track of court orders, letters of support and future goals/safety plans.

5. Family court letter of support template → Provider support through the legal process can have an impact on the court's decision. A well-documented history of engagement can strengthen a patient's case. This template provides a structure for writing letters of support that can be used by providers to help aid parents during their legal cases.

6. Legal advocacy letter of support guide → The Letter of Support Advocacy Template is meant to serve as an example to help providers brainstorm the best course of action for their patients and practice. This guide and its corresponding template do not constitute legal advice and are for informational purposes only. Please contact an attorney for specific legal advice.

7. I-HELP Chart → The National Center for Medical-Legal Partnerships developed the I-HELP chart (Income, Housing and Utilities, Education and Employment, Legal status, and Personal and family stability) to help providers understand how legal aid can be incorporated into the care process.

2. The Importance of Provider Partnerships

TOOLS

E. Guide for navigating family team meetings →

Family Team Meetings can offer an opportunity for providers to support a family in a child welfare case by participating in a meeting with the family and child welfare staff. This resource includes information and recommendations on how providers can assist with family team meetings.

F. Guide for team huddles →

Team huddles can be an important strategy for providers. At the Camden Coalition, team huddles are a way to ensure that team members are providing trauma-informed care to patients and to each other. This guide offers suggestions for structuring and facilitating team huddles.

G. Debriefing tool →

Engaging with this population inevitably exposes providers to tragedy and trauma. Having a debriefing session for affected team members creates a space for support and mustering team resilience. This conversation guide includes a script of prompting questions and suggestions for structuring and facilitating debriefing sessions.

"You want to get families connected with community based resources, only so much of real parenting support comes from medical communities, some of it is WIC, or family resource centers, parenting classes, food, diapers, play groups, helpful for kids and parents, you want to build those connections. A few moms in recovery told me that addiction is a disease in isolation and parenting is impossible to do by yourself, so trying to build that support."

3. Person-centered Language

Person-centered language is a way to avoid making punitive and negative associations about substance use, or placing blame on individuals. The use of stigmatizing language can have many adverse effects, including decreasing a patient's sense of hope, imparting shame and contributing to care avoidance.[30] By focusing on communication and changing the terms we use (i.e., using "person living with substance use disorder" instead of "addict"), providers can positively impact their relationships with patients and help increase patients' understanding that their condition is a disease, not a character flaw. Additionally, providers should also recognize that not all patients who use substances have a substance use disorder, and adapt their language accordingly (i.e., "individual who uses substances").

30 National Institute on Drug Abuse. (2021, July). *Words matter: Terms to use and avoid when talking about addiction.* https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

3. Person-centered Language

TOOLS

A. Guideline for best language for providers to use with patients →

This tool is adapted from Health Quality Ontario's document, A Plain Language Checklist for Health Care Professionals, and the Camden Coalition's work on nonpejorative language and nonviolent communication.

B. Guidelines for person-centered language →

It is important for providers to be aware of their language when working with a highly stigmatized subpopulation. Using nonstigmatizing language can encourage patients to be more open and create opportunities for patients to advocate for themselves in a positive way. This guide includes a list of stigmatizing words and phrases and explains the negative effect they can have on the provider-patient relationship. It also offers alternative language for providers.

C. Nonviolent and compassionate communication →

The Nonviolent Communication Model, also known as Compassionate Communication, is a conversation method providers can employ to create a safe and welcoming environment during care interactions. There are four essential communication components of the model: observations, feelings, needs/values and requests.

"'I wish they would be compassionate and empathetic and put themselves in their clients' shoes or think about if it was their family. They are human beings and…they have the right to be treated with compassion and care and nurtured…it is very hard to bond with the child when you have been stigmatized throughout the entire pregnancy."

"We really see women as vessels for having children, we never really see them as whole people, but if you did [see them as whole people], you would screen them when they reach childbearing age… a lot of the adolescents' practices do that, so then if the adolescent becomes pregnant, you don't have to reintroduce that information in the OB chart"

2B Screening

IN THIS SECTION

Providers need to understand their personal biases and prejudices, which are key drivers in disproportionate substance use screening and reporting. These behaviors are a reflection of systemic racism and discrimination.[31] The importance of screenings and an empathetic approach is easily understood in the health care community, whether it's a mammogram to find breast cancer or a colonoscopy to detect colon cancer. The same empathy and tact must translate to substance use screenings. Understanding a patient's social and health experiences can allow providers to give whole-person, trauma-informed care. Similarly, screening for substance use "should be conducted in a clinically appropriate and therapeutic manner. To ensure that information is gathered and addressed effectively, screening may be part of a formal process, a brief intervention, and referral treatment (SBIRT) protocol."[32]

1. Addressing Co-occurring Issues (Within Health Care)

Prenatal substance use often does not exist in isolation. Many individuals who are using drugs and alcohol while pregnant may also be experiencing intimate partner violence (IPV), mental health issues, complicated housing situations, etc. Studies show links between IPV and substance use for pregnant women[33] and engagement with lifetime community violence.[34] Thus, health care providers must be informed on best practices and resources for addressing co-occurring issues.

31 Agrawal, S., & Enekwechi, A. (2020). It's time to address the role of implicit bias within health care delivery. Health Affairs. Published. https://doi.org/10.1377/hblog20200108.34515

32 Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

33 Velez, M. L., Montoya, I. D., Jansson, L. M., Walters, V., Svikis, D., Jones, H. E., Chilcoat, H., & Campbell, J. (2006). Exposure to violence among substance-dependent pregnant women and their children. Journal of substance abuse treatment, 30(1), 31–38. https://doi.org/10.1016/j.jsat.2005.09.001

34 Velez, M. L., Montoya, I. D., Jansson, L. M., Walters, V., Svikis, D., Jones, H. E., Chilcoat, H., & Campbell, J. (2006). Exposure to violence among substance-dependent pregnant women and their children. Journal of substance abuse treatment, 30(1), 31–38. https://doi.org/10.1016/j.jsat.2005.09.001

1. Addressing Co-occurring Issues (Within Health Care)

TOOLS

A. Social determinants of health screening tool →

The Social Needs Screening Tool from the American Academy of Family Physicians screens for five core health-related social needs, including housing, food, transportation, utilities and personal safety, using validated screening questions, as well as for the additional needs of employment, education, child care and financial strain.

B. Screening for co-occurring drug use and additional life and health issues →

Addressing co-occurring social and health issues is a key part of providing whole-person care. This screening tool is adapted from SAMHSA's document Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants.

"[As a provider] you want to make sure there are wraparound services for [the patient], so not just having the baby, but making sure they have therapy or a psychiatrist or just someone to talk to… you want to make sure you ask all of these questions, and always preface them with, 'I am asking you this because I want to make sure you have the best outcome you could possibly have.'"

2. Racial Disparities in Drug Testing and Reporting

Research demonstrates that racial disparities and inequities exist when it comes to medical providers' referrals to the Child Welfare System. Although universal screening is touted as a mechanism to increase patient connections to care and reduce CPS reports for children of color, research demonstrates that in some cases it has actually increased child welfare involvement for this population.[35] Given the existing racial disparities, [36] national experts interviewed for this toolkit concluded that in settings where universal drug testing is not the policy, testing should only be administered in clinical situations where a positive drug test will inform the course of care. Relatedly, providers should always indicate their reason for testing.

National experts described the practice of testing newborns for substances as a common method of getting around testing the pregnant parent. Excessive drug testing of infants without the informed consent of parents happens disproportionately in populations of color. This practice often results in false-positive results, because the medications administered to treat opioid use disorder during pregnancy (i.e., methadone, buprenorphine[37]) make it difficult to interpret test results. The tools below are practices that aim to mitigate racial disparities in drug testing.

35 Roberts, S. C. M., & Nuru-Jeter, A. (2011). Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *The Journal of Behavioral Health Services & Research, 39*(1), 3–16. https://doi.org/10.1007/s11414-011-9247-x

36 Cort, N. A., Cerulli, C., & He, H. (2010). Investigating Health Disparities and Disproportionality in Child Maltreatment Reporting. *Journal of Public Health Management and Practice, 16*(4), 329–336. https://doi.org/10.1097/phh.0b013e3181c4d933

37 U.S. Centers for Disease Control and Prevention. (2021, July 21). *Opioid use disorder and pregnancy.* https://www.cdc.gov/pregnancy/opioids/treatment.html#:%7E:text=Methadone%20and%20buprenorphine%20are%20first,behavioral%20therapy%20and%20medical%20services

2. Racial Disparities in Drug Testing and Reporting

TOOLS

A. Information to consider when screening patients for substances →

Implementing hospital wide guidelines for testing can be a way to address individual biases in clinical settings. These recommendations are intended to support providers in developing and advocating for standard, bias-free indicators to include in their clinical practice.

B. Guidelines for informed consent →

Informed consent and shared decision-making are important aspects of building an ongoing trusting relationship with a patient. This resource from the American College of Obstetricians and Gynecologists outlines principles that providers can use to support patient-centered informed consent.

C. Sample informed consent forms →

This patient consent form developed by Penn Family Care allows the provider to gather information that will inform whole-person, family-centered care. We encourage providers to tailor this form to their needs and consult their legal team to determine what policies and procedures are already in place.

D. Drug screening conversation guide →

Implementing family-centered, strengths-based[38] and trauma-informed principles is vital to providing treatment and support to patients. This conversation guide includes best practices and conversation prompts for providers as they screen patients for substance use.

E. Screening, Brief Intervention, and Referral to Treatment (SBIRT) →

SBIRT is a comprehensive care model that should be used for individuals living with substance use disorder (SUD) and those who may develop SUD. This tool provides information on SBIRT, recommended validated screening tools, and zones of risk for continued substance use based on their screening results.

F. Information to consider before biological drug testing (as a last resort) →

Biological drug testing is not the preferred method for detection of substances during pregnancy because it can yield false positives[39] and does not reflect a person's ability to parent or detect the frequency or severity of the drug use.[40] However, some physicians may feel they need to test the parent for substances. This guide informs physicians about protocol for consent and the limitations of biological testing.

38 A strengths-based approach "involves a shift from a deficit approach, which emphasizes problems and pathology, to a positive partnership with the family. The approach acknowledges each child and family's unique set of strengths and challenges, and engages the family as a partner in developing and implementing the service plan." https://www.childwelfare.gov/pubPDFs/strengthsbased.pdf

39 Polak, K., Kelpin, S., & Terplan, M. (2019). Screening for substance use in pregnancy and the newborn. *Seminars in Fetal and Neonatal Medicine*, 24 (2), 90–94. https://doi.org/10.1016/j.siny.2019.01.007

40 Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., Blake-Lamb, T., Guille, C., Landau, R., Minkoff, H., Prabhu, M., Rosenthal, E., Terplan, M., Wright, T. E., & Yonkers, K. A. (2019). Substance use disorders in pregnancy: Clinical, ethical, and research imperatives of the opioid epidemic: A report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics and Gynecology*, 221(1), B5–B28. https://doi.org/10.1016/j.ajog.2019.03.022

"For pediatric practice, treat addiction and recovery as the chronic medical condition it is—we take care of kids with asthma, diabetes, attention-deficit/hyperactivity disorder, using those same tools and approaches to supporting parents in recovery and strong early childhood development: develop a team, build a registry (list of kids with asthma, make sure they all have asthma action plans, get flu shots, check in on their med management,) certain things we can do proactively to make sure we are staying on top of managing chronic conditions."

2C Treatment and Care Planning

Connecting to resources before reporting

IN THIS SECTION

As part of our landscape analysis, many practitioners stressed the importance of care planning prenatally or even before pregnancy when possible. Uncovering substance use during pregnancy is critical for connecting the patient to behavioral and pharmacological treatments.[41] Early care planning initiation can improve retention in prenatal care, reduced incidence and severity of neonatal abstinence syndrome (NAS), and markedly better maternal and child health outcomes.[42] [43] SAMHSA recommends creating interdisciplinary teams of practitioners, such as pediatricians, neonatologists and lactation consultants, to help assemble care plans and assist the parent and infant during their transition home after discharge.[44] Additionally, including the patient in creating their own care plan can empower them and strengthen engagement.

1. Refusal of Treatment and Coercive Medical Tactics

In protecting patient autonomy, providers are encouraged to respect a patient's right to refuse medical care. The use of coercive treatment and medical recommendations often prohibits patients from declining care and further perpetuates unequal power dynamics.[45] Oversight entities such as the American College of Obstetricians and Gynecologists and the American Medical Association recognize a patient's right to refuse medical care, and the college condemns "coercive medical or surgical interventions for pregnant people, including the use of the courts to mandate medical intervention for unwilling patients."[46] Tools are available for an alternative approach.

41 The American College of Obstetricians and Gynecologists. (2017). Committee opinion No. 711: Opioid use and Opioid use disorder in pregnancy. *The American College of Obstetricians and Gynecologists, 130*(2), 1–14. https://doi.org/10.1097/aog.0000000000002235

42 The American College of Obstetricians and Gynecologists. (2017). Committee opinion No. 711: Opioid use and Opioid use disorder in pregnancy. *The American College of Obstetricians and Gynecologists, 130*(2), 1–14. https://doi.org/10.1097/aog.0000000000002235

43 NIDA. 2017, July 1. Treating Opioid Use Disorder During Pregnancy. Retrieved from https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy on 2021, July 16

44 Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

45 American College of Obstetricians and Gynecologists. (2016). Refusal of Medically Recommended Treatment During Pregnancy. Committee Opinion 664. *The American College of Obstetricians and Gynecologists, 127,* e175-e182. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy

46 American College of Obstetricians and Gynecologists. (2016). Refusal of Medically Recommended Treatment During Pregnancy. Committee Opinion 664. *Obstet Gynecol, 127,* e175-e182. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy

1. Refusal of Treatment and Coercive Medical Tactics

TOOLS

A. The SHARE Approach →

The SHARE Approach presents a five-step process for shared decision-making that includes exploring and comparing the benefits, harms and risks of each option through meaningful dialogue about what matters most to the patient. The Agency for Healthcare and Research Quality has developed a series of modules to support providers in making decisions with their patients.

B. Shared decision-making guide →

Shared Decision-Making (SDM) is defined as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences".[47] This model rests on supporting a process of deliberation and on understanding that decisions should be influenced by exploring and respecting 'what matters most' to patients as individuals, and that this exploration in turn depends on them developing informed preferences.[48]

C. Informed consent and shared decision-making learning resources →

Understanding informed consent and shared decision-making processes is critical in caring for pregnant patients who are using substances. The following tool lists learning resources that can help physicians hone their clinical skills for guiding patients through informed consent and SDM.

47 Elwyn, G., Laitner, S., Coulter, A., Walker, E., Watson, P., & Thomson, R. (2010a). Implementing shared decision-making in the NHS. *BMJ, 341*, 5146. https://doi.org/10.1136/bmj.c5146

48 Elwyn, G., Frosch, D., Thomas, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared decision-making: A model for clinical practice. *Journal of General Internal Medicine, 27*(10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6

2. Harm Reduction

Harm reduction is "…a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."[49] As presented in the Camden Coalition's Medications for Addiction Treatment toolkit, harm reduction is an effective way to reduce risk and anticipate that a patient may continue to use substances or relapse while under medical care. This approach can also be a critical link for engaging with patients.[50] Harm reduction models can result in increased prenatal visits and reduced rates of postpartum depression.[51] Understanding the principles of harm reduction within the framework of drug use is vital for providers. A number of practice guides are available.

49 National Harm Reduction Coalition. (2021). *Principles of harm reduction.* https://harmreduction.org/about-us/principles-of-harm-reduction/

50 Camden Coalition of Health Care Providers. (2019, September 26). *Medications for addiction treatment: Providing best practice care in a primary care clinic.* https://camdenhealth.org/resources/20081/

51 Wright, T.E., Schuetter, R., Fombonne, E. *et al.* Implementation and evaluation of a harm-reduction model for clinical care of substance using pregnant women. *Harm Reduct J* 9, 5 (2012). https://doi.org/10.1186/1477-7517-9-5

2. Harm Reduction

TOOLS

A. Pregnancy and substance use: a harm reduction toolkit →

Pregnant people and their families can use this information to understand their rights, access services and find high-quality, evidence-based care.

B. Harm Reduction module →

This resource provides tips and resources for how Harm Reduction can be used in practice.

C. MAT in pregnancy fact sheet for healthcare workers →

The CDC and SAMHSA recommend that pregnant women with a substance use disorder (SUD) do not immediately stop using substances because of health complications associated with withdrawal. Instead, they should enter into Medication-Assisted Treatment and continue to use it after they deliver to help safely manage their substance use. The CDC and SAMHSA also advise providers to educate patients on notable benefits of pharmacotherapy during pregnancy. This fact sheet includes high-level information on how providers can work with patients receiving MAT prenatally.

D. Eat, Sleep, Console model for treating NAS →

Studies show that newborns are less likely to need drug treatment while being treated with the Eat, Sleep, Console model. This tool from Yale New Haven Children's Hospital provides guidelines on how to monitor the behavior of newborns exposed to substances to determine how to treat them while keeping parent and baby together.

"My key first strategy when working with this population is turning it into a judgment free zone, recognizing that women aren't immediately able to stop using drugs and those cravings don't go away suddenly just because they become pregnant…so this means I'm taking care of the whole person, and I'm working on outcomes that are good for both mom and baby…whatever her goals are, I'm focusing on working toward goals that are helpful for both mom and baby, are recognizing the barriers the mom is going to face coming into clinical care."

"[CAPTA and CARA] very explicitly states that it does not define what is child abuse or neglect—that is really up to individual states…This assumption, that if there is a substance-exposed newborn, that necessitates a report to CPS for that county and state to get CAPTA funding is inaccurate. This is not true, but is misunderstood I think on purpose because these are not regulations that are set up in a way to be well understood and they are just easily misleading."

2D Reporting

IN THIS SECTION

Although child maltreatment rates have markedly decreased since 1990, current trends demonstrate increasing maltreatment claims involving CPS related to parental drug use.[52,53] Indeed, 2017 marked the sixth consecutive year of increases in cases reported to CPS for parental drug and alcohol use. In 2016, this reason for referral was involved in 39% of all youth removals by CPS.[54,55] Such referrals have risen by 53% since 2007, leading to present rates, where 131 in 100,000 children in the United States enter foster care each year due to a drug or alcohol referral.[56] This outcome disproportionately affects Black families.[57]

The District of Columbia and 42 states require health care professionals to report parents to CPS in response to infants "who show evidence at birth of having been prenatally exposed to drugs, alcohol, and other controlled substances."[58] A notification is legally required by CAPTA but "is not considered a report of child abuse or neglect unless there is evidence of maltreatment or risk of harm to the infant."[59]

Although federal CAPTA legislation makes the distinction between a notification and a report, only 14 states[60] specifically distinguish the two in their laws.[61] For example, in Nebraska, if a health care provider believes that a child is unsafe in their home, the provider must report the situation to child welfare authorities; however, if they do not feel the child is at risk for harm, they can submit a de-identified notification to CPS.[62]

In states where there is a distinction between notifications and reports, CPS agencies may also choose whether to meaningfully distinguish between the two. Thus, agencies may continue with an investigation of notifications.

Establishing a distinction between a report and a notification to CPS has yielded enhanced family partnership between patients and their health care providers and has improved implementation of Plans of Safe Care.[63] Thus it is imperative for providers to contemplate and remain educated on the many implications associated with reporting, such as trauma and family separation.[64] Moreover, research shows "the system of detecting and reporting drug use during pregnancy, which [may] lead to removal of newborns from custody of the mother, is rife with race and class bias"; thus "most reports to child protection services based on positive newborn drug tests come from hospitals that serve poor minority communities."[65]

Experts encourage providers to standardize the reporting process, to consider the perceived risks to the child/children when substance use is identified, and if there is perceived risk, to consider how CPS could mitigate that risk.

52 Sepulveda, K., & Williams, S. (2019, February 29). *One in three children entered foster care in 2017 because of parental drug abuse.* Child Trends. https://www.childtrends.org/blog/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse

53 National Center on Substance Abuse and Child Welfare. (2016). *Child welfare and alcohol & drug use statistics.* https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.asp

54 National Center on Substance Abuse and Child Welfare. (2016). *Child welfare and alcohol & drug use statistics.* https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.aspx

55 Sepulveda, K., & Williams, S. (2019, February 29). *One in three children entered foster care in 2017 because of parental drug abuse.* Child Trends. https://www.childtrends.org/blog/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse

56 Sepulveda, K., & Williams, S. (2019, February 29). *One in three children entered foster care in 2017 because of parental drug abuse.* Child Trends. https://www.childtrends.org/blog/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse

57 Skrypek, M., Woodmass, K., Rockymore, M., Johnson, G., & Wells, S. J. (2017). Examining the potential for racial disparity in out-of-home placement decisions: A qualitative matched-pair study. *Children and Youth Services Review*, 75, 127-137.

58 Child Welfare Information Gateway. (2020). Plans of safe care for infants with prenatal substance exposure and their families. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

59 Child Welfare Information Gateway. (2020). Plans of safe care for infants with prenatal substance exposure and their families. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

1. Considerations When Reporting to Child Welfare

This toolkit provides health care workers with harm reduction strategies for screening for substance use and working with CPS. The implementation of some of these tools will depend on the nature of the working environment, including workplace policies, and state and local laws. Interacting with CPS can be a stressful experience, and providers working in home visitation settings may not have the same access to safety protocols and colleague support as those practicing in hospital settings. Thus, before implementing tools, it is important to be mindful of the safety of everyone involved, and to establish shared safety protocols.

The tools outlined below are intended to prevent unnecessary reporting by helping practitioners better understand the process of a child welfare case and, importantly, what information to include when reporting is necessary.

60 California, Connecticut, Delaware, Georgia, Iowa, Louisiana, Maine, Michigan, New Mexico, New York, North Carolina, Pennsylvania, Vermont, and Virginia.

61 Child Welfare Information Gateway. (2020). Plans of safe care for infants with prenatal substance exposure and their families. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

62 National Center on Substance Abuse and Child Welfare (NCSACW), Administration on Children, Youth, and Families (ACYF), & Children's Bureau (CB). (n.d.). *How states serve infants and their families affected by prenatal substance exposure: Identification and Notification.* National Center on Substance Abuse and Child Welfare. https://ncsacw.samhsa.gov/files/prenatal-substance-exposure-brief1.pdf

63 National Center on Substance Abuse and Child Welfare (NCSACW), Administration on Children, Youth, and Families (ACYF), & Children's Bureau (CB). (n.d.). *How states serve infants and their families affected by prenatal substance exposure: Identification and Notification.* National Center on Substance Abuse and Child Welfare. https://ncsacw.samhsa.gov/files/prenatal-substance-exposure-brief1.pdf

64 Sangoi, L. (2020, June 23). "*Whatever they do, I'm her comfort, I'm her protector": A report on the child welfare and foster system by Movement for Family Power.* Drug Policy Alliance. https://drugpolicy.org/resource/MFPreport

65 Roberts, D. (1999). The Challenge of Substance Abuse for Family Preservation Policy. J. Health Care L. & Poly, 3, 72. https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1590&context=faculty_scholarship

1. Considerations When Reporting to Child Welfare

TOOLS

A. Increasing hospital and provider education about CAPTA requirements →

CAPTA and state requirements can be misunderstood and misapplied. This tool is intended to educate hospitals and providers about CAPTA requirements.

B. The Child Welfare System[66] — overview of the purposes and functions of the child welfare system →

Child welfare systems are not only complex but also vary by state. This fact sheet from the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau gives a brief overview of the purposes and functions of child welfare from a national perspective.

C. What information to include (or not to include) when making a CPS call →

The conversation following the reporting can create tension in the provider-patient relationship, especially if the patient feels upset and betrayed. This conversation guide includes prompts providers can implement to have a patient-centered and trauma-informed conversation.

D. Post CPS call conversation guide →

The conversation following the reporting can create tension in the provider-patient relationship, especially if the patient feels upset and betrayed. This conversation guide includes prompts that providers can use to have a patient-centered and trauma-informed conversation.

66 Child Welfare Information Gateway. (2020). How the child welfare system works. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/factsheets/cpswork/

2. Health and Social Impacts of Family Separation

Family separation can result in adverse outcomes for the parent and child, including association with unintentional fatal overdose of the parent.[67] Adverse long-term outcomes for children who exit the foster care system include placement instability,[68] lack of stability in schooling, and exiting care without permanency.[69]

Not only are Black youth overrepresented within the foster system, but there are also disparities in how their cases are processed. In comparison with white children, Black children are more often placed outside of their home, experience a greater number of placement changes once in the system, and have a lower reunification rate with their families. [70] The persistence of these racial inequities within the system suggests that structural racism has led to excessive reporting of children of color to CPS.

67 Thumath M., Humphreys D., Barlow J., et al. Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. Int J Drug Policy. 2021;91:102977. doi:10.1016/j.drugpo.2020.102977

68 Dworsky, A., Napolitano, L., & Courtney, M. (2013). Homelessness during the transition from foster care to adulthood. *American journal of public health, 103 Suppl 2*(Suppl 2), S318–S323. https://doi.org/10.2105/AJPH.2013.301455

69 Clemens, E. V., Lalonde, T. L., & Sheesley, A. P. (2016a). The relationship between school mobility and students in foster care earning a high school credential. *Children and Youth Services Review, 68*, 193–201. https://doi.org/10.1016/j.childyouth.2016.07.016

70 Cénat, J. M., McIntee, S.-E., Mukunzi, J. N., & Noorishad, P.-G. (2021). Overrepresentation of Black children in the child welfare system: A systematic review to understand and better act. *Children and Youth Services Review, 120*(105714), 1–16. https://doi.org/10.1016/j.childyouth.2020.105714

3. Impact On The Providers: "It's a two-way street"

The provider's responsibility as a mandated reporter for perceived child maltreatment contributes to fears related to their liability in this role. As mandated reporters, health care providers are entrusted with the responsibility of reporting suspicion of child abuse or neglect. Providers often cite such reporting requirements as disruptive to the development of a trusting provider-patient relationship.[71] Providers report experiencing vicarious trauma as a result of reporting substance use to child welfare agencies. [72] The tools in this section can support providers as they navigate sensitive conversations about CPS reporting with the patient and their team.

71 ACOG Committee Opinion No. 473: substance abuse reporting and pregnancy: the role of the obstetrician-gynecologist. (2011). *Obstetrics and gynecology, 117*(1), 200–201. https://doi.org/10.1097/AOG.0b013e31820a6216

72 Perry, B. D. (2014). *The cost of caring: Secondary traumatic stress and the impacts of working with high-risk children and families.* Child Trauma Academy. https://ncwwi.org/index.php/resourcemenu/resource-library/work-conditions-and-benefits/1462-the-cost-of-caring-secondary-traumatic-stress-and-the-impact-of-working-with-high-risk-children-and-families/file

3. Impact On The Providers: "It's a two-way street"

TOOLS

A. Debriefing tool →

Notification and/or reporting is a difficult decision to make, one that often has an impact on the provider and the team. This tool is designed to help the patient's care team debrief and discuss the potential fallout resulting in the decision to notify or report to CPS.

B. Accountability meeting guide →

National experts agree that the decision to report should not rest on one person but should instead be a collective decision made by the patient's care team. This guide is intended to aid the facilitation of these conversations.

"When I make a decision to involve Child Welfare Services, what I do is a little different…I do it with the parents or with the caregiver…I think a lot of people use [Child Welfare Services] behind the scenes, but don't tell [the parent] [they] told [Child Welfare Services]. I do it with parents all the time, with mothers, with caregivers, with anybody…I tell moms why, I tell moms the reasons, I tell them what they can expect… and I try and sit down with mother or parent and try to have them be part of that call because I think the response is much better."

"If when you deliver and the social worker comes and you can't take the baby home, I want you to call me. I want the name of the social worker who did this…Like this idea that our responsibility [as a health care provider] didn't begin and end in the specific confines of the clinic, and that our job was to be their advocate, their partner, and sometimes their voice in places where I carry more authority than the person does."

2E
Providers as Partners

IN THIS SECTION

Providers who have gained the trust of patients are in a unique position to advocate for and partner with parents to mitigate the adverse outcomes of CPS reporting. Providers can work with family defense attorneys and child welfare systems to develop family-centered approaches to treatment and care that promote family preservation and reunification.

1. Provider Advocacy: Supporting Parents Through The Process

Identifying perinatal substance use early in the pregnancy and building a trusting relationship enables providers to serve as ongoing support for the parent.[73] Patients who are supported by providers as they work to meet child protective services requirements during the pregnancy are likely to have fewer traumatizing interactions with the child welfare system.[74] Providers can amplify support for their patients by connecting them to parent advocates. These are individuals who have personal experience with the child welfare system and can act as mentors and advocates to parents who are engaging with CPS for the first time.[75] Community organizations, such as Rise in New York City, elevate parent advocates through specialized training so they can better support families in the child welfare system. The tools in this section can support providers as they navigate these partnerships.

73 ACOG Committee Opinion No. 473: substance abuse reporting and pregnancy: the role of the obstetrician-gynecologist. (2011). *Obstetrics and gynecology, 117*(1), 200–201. https://doi.org/10.1097/AOG.0b013e31820a6216

74 Substance Abuse and Mental Health Services Administration. (2016). *A collaborative approach to the treatment of pregnant women with opioid use disorders* ((SMA) 16–4978). Rockville, MD: Substance Abuse and Mental Health Services Administration. https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

75 https://www.risemagazine.org/wp-content/uploads/2019/06/ACS-PA-Initiative-Evaluation-Report-1.31.2019.pdf

1. Provider Advocacy: Supporting Parents Through The Process

TOOLS

"One of the biggest things is being an advocate and a change agent in this area, recognizing that nobody has advocated for this population, nobody has wanted to touch this population… knowing what is available in your community makes you a good provider… knowing what the services are, where to connect people, not just giving somebody a number, but making sure there is a warm handoff… so actually making sure [the patients] have the services they need, knowing what's available, becoming an activist and an advocate for the things that Mom needs, is super important."

A. Plan of safe care →

Plans of safe care are intended to address the needs of the child and family. Developing a safe plan of care can be a transformational practice when leveraged to include collaboration with other community providers and family supports early in the pregnancy. This tool offers guidance on how to create a plan of safe care with the parent. Refer to the Child Welfare Gateway's Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families to align with your state's requirements.

B. Closed-loop referral best practices →

Referrals to other community or health providers may require follow-up from the referring provider. This tool is intended to highlight best practices that providers can adopt to close the loop on referrals.

C. Quick tips: Legal advocacy for nonlawyers →

Patients receiving medication-assisted treatment (MAT) frequently face concurrent legal issues. If your organization does not provide legal services on-site or other legal advocacy resources, this page contains basic information about legal encounters your patients may face to help inform your practice and empower you to advocate for your patients. This guide and corresponding template does not constitute legal advice and is for informational purposes only. Please contact an attorney for specific legal advice.

D. Talking points for supporting the development of self-advocacy skills →

Patients receiving MAT often face concurrent legal issues, and they may encounter resistance from legal professionals and other related services regarding the use of MAT. This tool can help the provider navigate these obstacles. You may want to consider adapting these questions to create a simple worksheet for patients to complete on their own or in a clinical or group setting for use in advocacy situations.

Appendix

This toolkit is intended to serve as a helpful resource for health care providers, and also an open invitation to the field to develop new and even better approaches, protocols and best practices for working with pregnant and parenting people who use drugs. Much policy work remains to confront and rectify the laws and regulations that have led to the racially disproportionate and punitive practices that exist today. Providers are uniquely positioned to support parents, children and families experiencing these issues, and to promote a supportive systems response. There is tremendous consensus among a diverse set of stakeholders around the need for reform and improvement in current laws and practices. We hope this toolkit can contribute to that work.

1. Child Welfare System Acronyms

CHILD WELFARE SYSTEM ACRONYMS[76]		
CP	Concurrent Planning	"A process of working toward one legal permanency goal (typically reunification) while at the same time establishing and working on an alternative permanency goal in case the primary goal cannot be accomplished in a timely manner. It is a backup plan to move children/youth more quickly to a safe and stable permanent family."
CPP	Child Permanency Plan	"A plan developed for children, youth and families by county child welfare agencies. The CPP lists the goals of the child and child's family (usually either going home to the biological parent(s), being placed for adoption or being placed with a relative), as well as the services that must be provided to achieve the goals."
CPS	Child Protective Services	"The social services agency designated (in most states) to receive reports, conduct investigations and assessments, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public social service agencies, such as departments of social services."
FGDM	Family Group Decision-Making	"A planning process that brings together the child's parents' extended family members and others with an interest in ensuring a child's safety."
IFSP	Individualized Family Service Plan	A written document that outlines the early intervention services that a child and family will receive.
GAL	Guardian Ad Litem	"A lawyer or layperson who represents a child in juvenile or family court. Typically, this person considers the best interests of the child and may perform a variety of roles, including those of independent investigator, advocate, adviser and guardian for the child. A layperson who serves in this role is sometimes known as a court-appointed special advocate (CASA)."
IEP	Individual Education Plan	"A federally mandated statement of goals written for each child with a disability that is developed, reviewed and implemented in a school-based setting."

76 These definitions were replicated from PA Families incorporated, which can be found at: http://pafamiliesinc.org/understanding-systems/office-of-children-youth-and-families/acronyms-and-definitions-of-terms-used-in-the-child-welfare-system

1. Child Welfare System Acronyms Continued

CHILD WELFARE SYSTEM ACRONYMS		
ILP	Independent Living Program	"A program that assists youth who are transitioning from an out-of-home care placement in receiving services necessary to become independent. Programs provide youth with services such as stable, safe living accommodations, basic life-skill and interpersonal skill-building techniques, educational opportunities, assistance in job preparation and attainment, trauma-informed mental health care, and physical health care."
TPR	Termination of Parental rights	Termination of Parental Rights is a special type of trial to permanently sever parental relationships with children in Division of Child Protection and Permanency matters.
Founded report		If there has been any judicial adjudication based on a finding that a child who is subject of the report has been abused, including the entry of a plea of guilty or nolo contenderee or a finding of guilt to a criminal charge involving the same factual circumstances involved in the allegation of abuse.
Indicated report		If an investigation by the county agency or the department determines that substantial evidence of the alleged abuse exists based on any of the following: • Available medical evidence • The child protective service investigation • An admission of the acts of abuse by the perpetrator
Expunge		To strike out or obliterate entirely so that the stricken information may not be stored, identified or later recovered by any means, whether mechanical or electronic.

2. Substance Use Acronyms

SUBSTANCE USE ACRONYMS	
AMP	Amphetamine
AOD	Alcohol and Other Drug Program
ASI	Addiction Severity Index
ATSH	Addiction Treatment Starts Here
AUDIT-C	Alcohol Use Disorders Identification Test
BAM	Brief Addiction Monitor
BAR	Barbiturates
BH	Behavioral Health
BHC	Behavioral Health Consultant
BHCC	Behavioral Health Care Coordinator
BLS	Basic life support
BUP	Buprenorphine
BuTrans	Buprenorphine Transdermal System
BZO	Benzodiazepine
CAADC	Certified Advanced Alcohol and Drug Counselor
CATC II	Certified Addiction Treatment Counselor (Level II)
CBC	Complete blood count
CHS	Cannabinoid hyperemesis syndrome
CMP	Comprehensive metabolic panel
CNS	Central nervous system
COC	Cocaine
COWS	Clinical opiate withdrawal scale
CURES	The Controlled Substance Utilization Review and Evaluation System
DAST	Drug Abuse Screening Test
DATA 2000	Drug Addiction Treatment Act of 2000
DEA	Drug Enforcement Agency
DOJ	U.S. Department of Justice

2. Substance Use Acronyms Continued

SUBSTANCE USE ACRONYMS	
DSM-5	Diagnostic and Statistical Manual of Mental Disorders - 5
DUI	Driving under the influence
DWI	Driving while intoxicated
EtOH	Ethyl alcohol
HRC	Harm reduction coalition
ICD- 10	Tenth version of the international statistical classification of Disease and Related Health Problems
IM	Intramuscular injection
IOP	Intensive outpatient program
LCSW	Licensed Clinical Social Worker
LFTS	Liver function tests
LMSW	Licensed Master Social Worker
MAT	Medications for addiction treatment
MDMA- 3,4	Methylenedioxymethamphetamine
MED	Morphine equivalent dose
MET	Methamphetamine
MME	Morphine milligram equivalent
MRN	Medical record number
MTD	Methadone
NA	Narcotics Anonymous
NAS	Neonatal abstinence syndrome
NCM	Nurse Care Manager
NEG	Negative
NICU	Neonatal intensive care unit
NMDA	N-methyl-D-aspartate
NTP	Narcotics Treatment Program
Nx	Naloxone
OBAT	Office-based addiction treatment

2. Substance Use Acronyms Continued

SUBSTANCE USE ACRONYMS	
OBOT	Office-based opioid treatment
OIH	Opioid-induced hyperalgesia
OP	Outpatient program
OPI	Opiates
OTC	Over-the-counter
OUD	Opioid use disorder
PDMP	Prescription drug monitoring program
PHQ9	Patient health questionnaire - 9
PIHP	Prepaid Inpatient Health Plan
POS	Positive
PTSD	Post-Traumatic Stress Disorder
QI	Quality Improvement
QID	Four times a day
RPR	Rapid plasma reagin
S/Sx	Signs and symptoms
SA	Suicide attempt
SAMHSA	Substance Abuse and Mental Health Services Agency
SBIRT	Screening, Brief intervention and Referral to Treatment
SODH	Social determinants of health
SI	Suicide ideation
SL	Sublingual
SQ	Subcutaneous
SSRI	Selective serotonin reuptake inhibitor
SUD	Substance Use Disorder
TAPS1 or TAPS2	TAPS1 or TAPS2 - Tobacco, Alcohol, Prescription medications and other substances 1 or 2 Tool
THC	Tetrahydrocannabinol

2. Substance Use Acronyms Continued

SUBSTANCE USE ACRONYMS	
TNQ	Treatment needs questionnaire
UDS	Urine drug screen
URICA	University of Rhode Island Change Assessment
UTOX	Urine toxicology screen
VTAs	Ventral tegmental areas

3. Obstetric Care Acronyms

OBSTETRIC CARE ACRONYMNS	
EDC	Estimated day of confinement (delivery due date)
EGA	Estimated gestational age
EFW	Estimated fetal weight
ELF	Elective low forceps
LMP	Last menstrual period
LNMP	Last normal menstrual period
PMP	Previous menstrual period
ROM	Rupture of membranes
RBOW	Rupture of bag of water
AROM	Artificial rupture of membranes
SROM	Spontaneous rupture of membranes
PROM	Premature rupture of membranes
FHT	Fetal heart tones
GFM	Good fetal movement
IUP	Intrauterine pregnancy
IUGR	Intrauterine growth retardation
PIH	Pregnancy induced hypertension
CST	Contraction stress test
NST	Nonstress test
OCT	Oxytocin challenge test
C/S	Cesarean section
U/S	Ultrasound
Q	Quickening
PP	Postpartum

3. Obstetric Care Acronyms Continued

OBSTETRIC CARE ACRONYMNS	
AMA	Advanced maternal age
AUB	Abnormal uterine bleeding
BCP	Birth control pills
BRF	Breastfeeding
BUFA	Baby up for adoption
CE	Cervical exam
CTX	Contractions
D & C	Dilation and curettage
D & E	Dilation and evacuation
DUB	Dysfunctional uterine bleeding
FLM	Fetal lung maturity
FTP	Failure to progress
FWB	Fetal well being
GDM	Gestational diabetes mellitus
GMF	Good fetal movement
GTPAL	Gravida, term, preterm, abortions, living
L&D	Labor and delivery
LBW	Low birth weight
LGA	Large for gestational age
NSVD	Normal spontaneous vaginal delivery
OCP	Oral contraceptive pill
OCT	Oxytocin challenge
PAPP-A	Pregnancy associated plasma protein
PNV	Prenatal vitamins

3. Obstetric Care Acronyms Continued

OBSTETRIC CARE ACRONYMNS	
PPD	Postpartum day
PTL	Preterm labor
SAB	Spontaneous abortion
SB	Stillborn
SDE	Suction, dilation and evacuation
SGA	Small for gestational age
TOP	Termination of pregnancy
VBAC	Vaginal birth after cesarean section
VFI	Viable female infant
VMI	Viable male infant

4. Legal Acronyms

LEGAL ACRONYMNS	
CS or CSE	Child Support (Enforcement)
DAG	Deputy Attorney General, the state's attorney especially in DCPP matters
DCF	Department of Children and Families
DCPP	Division of Child Protection and Permanency
FRO	Final Restraining Order
LG	Law Guardian, the child's attorney in a DCPP matter
MC	Municipal Court
OPD	Office of the Public Defender
OPR	Office of Parental Representation, part of OPD; they provide PDs for parents accused of abuse or neglect in a DCPP matter
PD	Public defender
PO	Probation officer
ROR	Released on own recognizance (without bail)
SLAP	Sheriff's Labor Assistance Program, supervised work in the community in lieu of jail
TRO	Temporary Restraining Order

B

Policy Timeline →

C

CPS Flow Chart →

Creating Safe Care

Supporting Pregnant and Parenting Patients Who Use Drugs

Camden Coalition
of Healthcare Providers

The National Center
for Complex Health & Social Needs
An initiative of the Camden Coalition

Vital Strategies