TOOLS

Relationship Building

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Guide to Building Authentic Healing Relationships

Authentic healing relationships between patients and providers emerge when care professionals establish security, demonstrate genuineness, and provide continuity in their practice. These relationships are critical for building trust, motivating patients, and optimizing health outcomes for both the pregnant individual and their baby.

Template for Creating Authentic Healing Relationships (AHR)

The Authentic Healing Relationships tool is adapted from the Camden Coalition Authentic Healing Relationships care model, the American Academy of Family Physicians' document Tips on Building Doctor/Patient Relationships. It is also informed by Grinberg, Hawthorne, LaNoue, Brenner, and Mautner's study on the AHR care model and by expert interviews.

"Include the patient when making a call to CPS if possible. Mitigate effects of removal to the best of your ability. Do not place a call and then terminate the relationship. The call is part of the treatment plan."

Guide to Building Authentic Healing Relationships

Establishing Security

During patient-provider interactions, providers should aim to achieve the following to **establish secure relationships** with their patients:

Demonstrate Acceptance

Use **person-centered language** when speaking with your patient. Meet the patient where they are in their care process.

Be Reliable

Be a source of support for your patient by responding to messages and calls within 24 hours, as well as following through on promised tasks.

Be Present and Attentive

Reduce outside interferences during meetings with the patient,[78] by turning off cell phones and alarms.

Engage in active listening. Concentrate on what the patient is communicating verbally and nonverbally.[79]

Be mindful of your nonverbal body language. Engage in active eye contact and refrain from closed-off postures, like crossing your arms.

Set Boundaries

Setting personal boundaries with your patient is **a healthy part of the care process**. You are an important ally for your patient during their treatment process, but it is critical to **be transparent about your capabilities as a provider**.

Guide to Building Authentic Healing Relationships

Demonstrating Genuineness

During patient-provider interactions, providers should aim to achieve the following to **establish genuine relationships** with their patients:

Be Honest and Transparent

Involve patients in each step of the care process and educate them about potential outcomes.

Consult with patients before sharing information with other actors, such as CPS and social workers.

Be open about potential medical and legal outcomes of the patient's situation.

Show Respect

Employ care that reflects cultural humility and is respectful of the patient's unique customs.[81]

Evaluate your own personal biases and their effect on your care delivery.[82]

Allow the patient to be an active participant in care discussions.[83]

Demonstrate Interest

Take the time to **learn about your patient as a unique individual**, such as personal interests, worries and living situations.

Ask about alternative treatments that your patient may be using.[84]

Discuss the patient's lifestyle.[85] Use a Social Determinants of Health screening tool to understand additional challenges your patient may be facing, such as with housing, unemployment, food insecurity, etc.

Guide to Building Authentic Healing Relationships

Providing Continuity

During patient-provider interactions, providers should aim to achieve the following to **provide continuous and reliable care** to their patients:

Important Links

COACH reference guide

Prioritize Follow-up Care

Emphasize the necessity of follow-up care to patients and understand barriers that may prevent them from accessing this care.

Check in with patients not only to remind them about medications and appointments but also to discuss emotions or difficult life situations that are arising.

Connect to Community Services

Connecting patients with additional resources outside of primary care will ensure that they are able to **continue care through various stages of the care process.**

Community resources will also be able to **provide necessary services that are not readily available** in primary care settings, like transportation, which are essential for optimizing treatment outcomes.

Motivational Interviewing Script

Motivational interviewing is a form of collaborative conversation for strengthening a person's own motivation and commitment to change. Further information and learning tutorials about motivational interviewing can be found through the Motivational Interviewing Network of Trainers (MINT) organization website. They are an international organization dedicated to helping care professionals improve their motivational interviewing skills.

The Motivational Interviewing Script guidelines are adapted from the Camden Coalition tool **Protocol-AD1.1 Motivational Interviewing for Change Regarding Addiction**.[86]

Note the following before beginning:

- This protocol will describe the process of speaking with a patient about drug usage in a way that allows patients to motivate themselves to pursue healthy behaviors.
- Before attempting this protocol, make sure you have been trained on how to use motivational interviewing effectively.
- Speaking about changing patients' regular behaviors can take a long time and entail many long conversations. Keep this in mind when engaging a patient about creating healthy habits.

Employ motivational interviewing techniques to speak with patients about substance use

Use the acronyms PACE (partnership, acceptance, compassion, empathy) and OARS (open-ended questions, affirmations, reflective listening and summarization) to help guide you with motivational interviewing.

Communicate respect for the patients and **ask them for permission** to talk about their substance use instead of lecturing them about it.

Important Links

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

Plans of safe care learning modules

Learning Resources

PACE

OARS

Motivational Interviewing Script

Descriptions	Examples
Questions for **eliciting change talk**:	• "What would you like to see differently about your current situation?" • "If you were to decide to adapt behaviors, what would you have to do to make this happen?" • "What support resources do you need in order to change?" • "What's the best thing you could imagine that could result from changing?"
Measure patient's change scale in making the change happen so they can visualize what they would need to do to change:	• "On a scale of 1 to 10, how important is this change? How confident are you in making this change?"
Using **open-ended questions** allows for deeper conversation:	• Start off your questions with "What, How, Tell me about…" etc.
Using **reflective listening** means paraphrasing the patients' comments back to them after listening closely to their feelings and concerns:	• "It sounds like you are…"
Help patients feel like they are not alone by making **normalizing statements** indicating that many people experience difficulty changing:	• "That is not unusual; a lot of people make several attempts in […] before they succeed."
Elicit statement **supporting self-efficacy** by allowing patients to mention past successes and build self-confidence:	• "You mentioned you managed to do […] in the past, how did you do it back then?"
Make **affirmative statements** to help patients recognize their efforts to achieve change and success:	• "With all the obstacles you have now, it's [impressive/amazing/wonderful] that you've been able to do […]"

Guidance for How Providers Can Make Partnerships with Other Actors

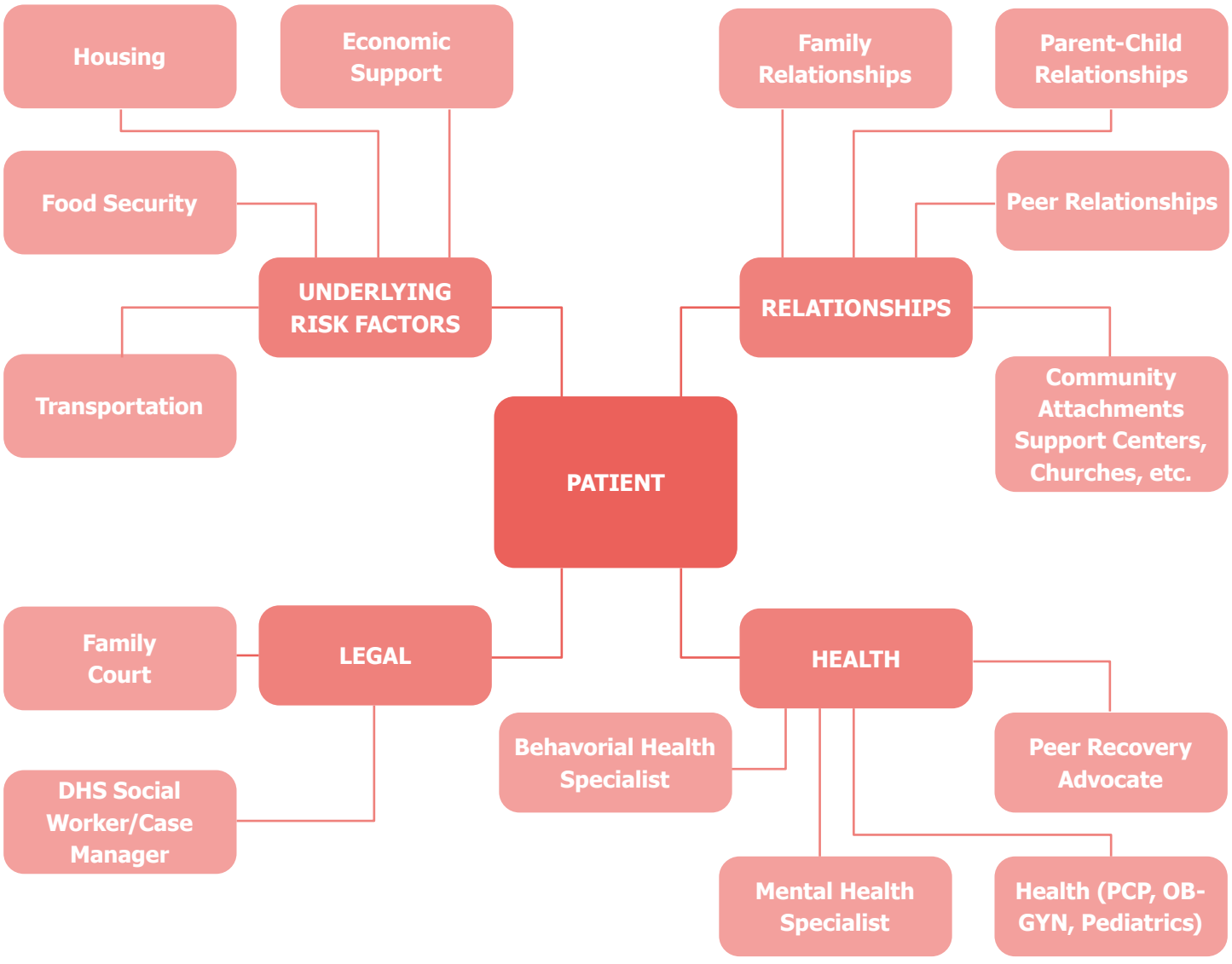
Guidance for forming partnerships with legal advocates, social work experts and other potential supports for parents.

Cross-Continuum Team

The Cross-Continuum Teaming tool is adapted from the Camden Coalition teaming tool for patients with complex health and social needs. Patients living with complex needs often interact with many providers in the health care system and across the community. Identifying agencies and people currently engaged with the patient can be a helpful practice. The Cross-Continuum Team worksheet helps identify people who may be a partner or advocate for the patient, thus moving the person toward a stable plan of care. The diagram below gives an example of many of the Cross-Continuum Team members who may be involved with a patient.

"Some things are in control of the provider (offer ways to avoid reporting, share potential consequences of CPS involvement, ask parent to call doctor if the baby is taken away at birth, advise parent to note the name of the hospital social worker involved in their care). Support doesn't begin and end in the confines of the clinic."

Guidance for How Providers Can Make Partnerships With Other Actors



Guidance for How Providers Can Make Partnerships With Other Actors

Chart of [CLIENT INITIALS] existing relationships/ Cross-Continuum Team

Relationship (family, friend, provider, community organization, etc.)	Type of Relationship (strong, weak, stressed)	Potential Long-term Support (yes or no)	Notes/Action Items

Important Links

Maternal Opioid Misuse Model

Resource Databases

1. Findhelp.org by Aunt Bertha
2. Neighborhood Navigator by AAFP

Toolkit: Bringing lawyers onto the health center care team to promote patient and community health

Parent Court Planning Calendar

Contact Information Worksheet

Family Court Preparation and Documentation Review Worksheet

1. **Have I talked to my child welfare caseworker, and do I know what will be discussed at this court hearing?**

2. **Have I talked to my parental rights lawyer and provided progress updates?**

Notes from Family Team Meeting on _____
Month | Day | Year

Court-Ordered Activities

1. **Parenting classes**—start date?

2. **Substance use evaluation**—completed?

Family Needs

1. **Parent recovery**

- Started on Medication Assisted Treatment on _____
  Month | Date | Year
  - Letter of support?

2. **Housing**

- Applied for emergency assistance on _____
  Month | Date | Year
  - Documentation?

3. **Income**

- Applied for food stamps and government assistance on _____
  Month | Date | Year
  - Documentation?

Other Documentation/Letters of Support:

Programs:

- MAT provider progress letter
- Substance use counselor/program progress letter
- Other programs parent is involved with

Documentation of tasks completed:

- DMV receipt of getting ID
- Paperwork proving application for income or housing benefits

Parent Preparation Worksheet

1. My Goals for Court

- What are my goals for the upcoming family court hearing?

- What could get in the way of these goals?

2. Safety Planning

- If I get upset or overwhelmed I will use the following coping strategies:

- If I feel like using before or after court I will put the following safety plan into action:

Family Court Letter of Support Template

Organization's Letterhead

[PARENT DOB]
[XXXXX COUNTY FAMILY DIVISION]
[ADDRESS]

Re: **[PARENT NAME]**
DOB: **[PARENT DOB]**

To the Honorable Judge:

[EXAMPLE: I am **[PARENT NAME'S]** caseworker on the **[ORGANIZATION'S NAME]** program, and I am writing the court to provide updates on her progress. **[ORGANIZATION'S NAME]** provides high-touch community-based care coordination to mothers. Our program seeks to assist women in meeting their personal and family goals and improve overall wellness through resource connection and strengthening supports.]

1-2 sentences describing your relationship to parent and/or your program.

[EXAMPLE: **[PARENT NAME]** has set the following goals for her work with us: maintain sobriety, reunite with her children, and acquire housing for her and her family.]

1 sentence about what you are working on with the parent.

[EXAMPLE: **[PARENT NAME]** has shown strong engagement and commitment to her goals. She meets with our team every week and consistently follows through on follow-up tasks.]

1-2 sentences about parent's strengths

[EXAMPLE: We are currently working with **[PARENT]** on locating appropriate housing for her family. **[PARENT]** has contacted the following community resources for assistance: Volunteers of America, Board of Social Services and Project HOME.]

1-2 sentences about what areas of support the family needs

[EXAMPLE 1: The court can support this family by encouraging DCPP to use all available resources to assist with housing.]

1 sentence about how the court can support the family

If there are any questions or concerns please don't hesitate to contact me at **[PHONE NUMBER]**.

Sincerely,

[NAME, TITLE, ORGANIZATION]

Legal Advocacy Letter of Support Guide

The Letter of Support Advocacy Template is an example to help providers brainstorm what makes sense for their patients and practice. Medication-assisted treatment (MAT) providers should always consider federal and local laws regarding patient privacy and release of information. As a best practice, providers should review letters with patients prior to sending them to ensure that patients are comfortable with the amount and type of information disclosed, including how the involvement with the MAT provider is characterized. If a patient has an attorney, their attorney may be the best person to help providers develop the most effective letter for the individual situation. If your patient is open to this type of coordination and provides authorization, consider speaking with them and asking how you might help the legal situation, such as through writing a letter of support or examination. Ask if they would consider reviewing and providing feedback on the letter prior to sending.

Child protection matters

- **Patient is a parent:** Judges, caseworkers, mandated substance abuse or psychological assessments, Court Appointed Special Advocates (CASAs)—a whole host of individuals may make remarks or specific orders about your patient ending MAT. A letter of support or further advocacy may mean the difference between your patient's being able to retain custody of their child or reunite if their child is in the care of someone else.
- **Patient is a child:** Some states allow youth to remain in foster care until they are 21 years old. This means that theoretically, you can encounter an MAT patient who may be a child in foster care. In addition to all of the individuals above, the young person's birth family, partner, partner's extended family and foster parents may play a critical role in supporting the young adult. Your advocacy for foster children may be crucial in helping them develop appropriate future plans and goals, as well as helping their support network understand the role of MAT in reaching those goals.

During court hearings

- Judges may order a client to remain "100 percent sober" or discontinue MAT, not viewing it as a sustainable treatment for substance use and not considering it "true sobriety." If the patient has a paid or court-appointed attorney, you may want to consider how you can coordinate with your patient so that they can effectively respond to this type of rhetoric.
- A letter to the judge also may be helpful in this circumstance.

Probation/pretrial supervision

- Pretrial occurs, as the word indicates, prior to trial, while probation is a type of sentence that sometimes occurs after a matter is adjudicated. Both involve a form of regular check-in or monitoring, sometimes involving substance screenings. Patients may be encouraged to wean or discontinue MAT during this process, so a letter of support may be especially beneficial.

Legal Advocacy Letter of Support Guide

Some Avenues for Advocacy

If/when detained by police

Some types of MAT may alter a patient's presentation. This may mean that they appear intoxicated when they are not. Consider making patients aware of side effects and helping them articulate that they are on medication if they are stopped by police. It is also helpful for them to differentiate the side effects of those while on illicit drugs.

Context of intended use

What type of case is this, and how could a letter from our practice be useful?

Patient's desire to share

How much information is the patient personally comfortable disclosing?

Not wanting to over-disclose and lead to increased liability for patient

Do all parties know the patient has SUD?

Do all parties know what substance the patient was using?

Specificity level

How much detail does the situation require?

Pregnant patients

If the patient is pregnant, be sure to include a brief statement supporting the use of MAT in pregnancy based on research and individual assessment of the patient.

Authorship

Who is doing the writing? MDs tend to have more credibility with the court, but individual therapists or other staff may know the client and their progress better.

Consider drafting the letter collaboratively, ensuring that the treating physician is at least one of the signers.

Learning Resources

I-HELP Chart

Disclaimer

This guide and corresponding template do not constitute legal advice and are for informational purposes only. Please contact an attorney for specific legal advice.

Guide for Navigating Family 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 participate in family team meetings.

Family Team Meeting Participation Fact Sheet

You may want to consider participating in a Family Team Meeting to support a patient/family in their Child Welfare Case. Here is some information to help you navigate your first Family Team Meeting experience with a parent.

What is a Family Team Meeting (FTM)?

- Most child welfare systems use "Family Team Meetings" (FTM), which bring together parents/families, child welfare workers and their supervisors, a nurse (if children in the family have been placed in a resource home), and any people that the parents choose to provide them with support; some meetings even include the kinship or foster home resource if a child is placed out of the home.
- The meetings follow a standardized structure and are held at regular intervals, approximately every three months, and could be called at any point by parent or worker.
- FTMs usually follow a standardized agenda, designed with a strengths-based approach to guide a conversation about the family's strengths, needs, and desired outcomes.
- The meeting culminates in creating a plan to address their needs and goals.

Who can participate?

- Any support people the parent chooses can participate in an FTM.

How can I participate?

- Prioritize collaboration with the patient, and always ask permission before discussing their case with other providers:
    - I.e.: Ask the parent/patient if they would like your support at their upcoming FTM.
- Connect with the participant's CPS worker—this is best done by having the parent call the worker and put you on speaker to "meet" the worker.
- Ask for a copy of the meeting agenda in advance if possible.
- Be sure to get the caseworker's contact information for follow-up.

Discuss with the parent what kind of support you can and cannot offer

- If you cannot participate in person, consider calling in or providing a letter of support.
- Always be transparent about what information you can and will share at the meeting.

Take a couple of minutes to prepare with the parent before the meeting:

- Prepare and write down any questions you have for the CPS case manager.
- What support/resources do you or the parent need from CPS to be successful in meeting treatment goals?
- Ask about upcoming meetings or family court dates, and how you can support the parent.

Team Huddles: Building a Culture of Resilience

This tool is one easy way to start building a culture of support and resilience in the workplace. Incorporating 15-minute team huddles into the day or week offers opportunities for team members to build a sense of community, bond, and encourage regular self-care practices.

- Choose the day, time and cadence for team huddles.
- Make a rotating schedule so that all team members have the opportunity to lead the huddle activities.
- Start and end the huddles promptly.[87]
- Emphasize that it's not about work—it's about connecting as a team.
- Allow room for training and reminders.

Activity Suggestions

Feel free to come up with your own activity. These are just some ideas.

Mindfulness Mondays	Treat Yourself Tuesdays	Wisdom Wednesday	Thumbs-up Thursdays	Freestyle Fridays
Lead or download a guided meditation. Share sights, smells or sounds noticed on the way into work today.	Teammates share one self-care goal for the day and choose an accountability partner. Share self-care practices.	Teammates share a new fact or "life hack" that they recently learned or have practiced for many years.	Shout out a teammate for something they did well this week.	Choose an activity like line dancing, trivia, sharing weekend plans, etc.

Debriefing Tool

Health care workers are commonly exposed to tragedy, trauma, and death. However common these events may be, they should never be normalized. Opportunities for colleagues and peers to process and support each other after particularly difficult events at work can reduce the impacts of vicarious trauma, like compassion fatigue. Managers can play a key role in supporting staff through one-on-one supervision and encouraging a supportive organizational culture that builds resilience.

Preparation

- **Whenever possible, supervisors should have a concrete plan for how a team member receives sensitive information about a patient outcome.**
  - Avoid situations where someone learns upsetting news in a casual way.
    - Examples: in the hallway, break room or other non private work spaces
  - Group versus individual settings
    - Ideally, the supervisor schedules one-on-one time with the team member to allow space for processing before returning to work tasks. However, some may feel more comfortable debriefing about the situation in group settings.
    - Be mindful that each person processes difficult care interactions differently.
- **Debriefings should be time bound, and the team member should be made aware of how much time has been allocated.**
- **Employees should also research what mental health benefits they are entitled to receive at their place of work.**

Debriefing Tool

Conversation Guide

- ○ **Supervisor should ask open-ended questions and leave room for silences to allow the team member to process after receiving news of a patient outcome.**
  - *"I know you had a close relationship with this patient. How are you feeling hearing this news?"*
- ○ **Supervisor should seek opportunities to normalize feelings and offer affirmations.**
  - *"These feelings are a normal part of the process…"*
- ○ **Opportunities for growth/did we learn something new?**
  - *"Were existing protocols used appropriately, and do any of them need to be updated?"*
  - *"Did you and other staff have proper training and tools for decision-making?"*
  - *"Were there any red flags we missed that could help inform our future practice?"*
    - Reviewing/revising protocols/practices
    - Self-care plan for the day, week, month
    - Follow-up check-in if appropriate
- ○ **Opportunities to discuss care planning**
  - *"What are your concerns now that this situation has occurred?"*
  - *"What should the next steps be in the care process?"*
  - *"What are the next steps for working with CPS?"*
- ○ **Discuss safety of the employee. This discussion may depend on where the provider usually practices their care (in an office setting versus a home visitation setting).**
  - *"Does your safety feel jeopardized by the situation that occurred?"*
  - *"What can be done in the future to increase safety protocols?"*

Wrap-up

- ○ **Next steps:**
  - Supervisor summarizes conversation
  - Next steps may include:
    - Reviewing/revising protocols/practices
    - Self-care plan for the day, week, month
    - Follow-up check-in if appropriate

Guidelines for Best Language for Providers to Use With Their Patients

Guidelines for Language That Providers Should Use With Their Patients

This tool is informed 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.

Address patients with respect

When addressing a patient with Substance Use Disorder (SUD), use person-centered language, such as referring to the client by their preferred name and pronouns, using respectful language[88]

Use strengths-based language

"Use words like 'hope' and 'recovery'"[89]

Provide description of functional strengths and limitations[90]

Treat patients as you would like your family members to be treated—with dignity and respect[91]

Learn about your patient's background (community, culture, education level, etc.) prior to communicating health information

Ask about your patient's learning style

Understanding how your patient learns is essential for how you can communicate information to them

Provide simple learning resources

Use bullet points on medical handouts

This will allow you to concisely and simply show key messages

Use images to help patients visually understand the information you are communicating to them

This method of communication is also more inclusive of those patients who are not able to read

Use simple and focused language

Begin discussions with the most critical information that your patient needs to understand[92]

Keep your sentences short and simple[93]

Avoid jargon that individuals without medical experience may not understand[94]

Take time to explain specific phrases and define terms pertaining to SUD and Child Protective Services (CPS)

Avoid acronyms that individuals without medical experience may not understand[95]

Give your patient a list of acronyms associated with pregnancy, SUD and Child Welfare (CW) so the parent will have a reference guide

Guidelines for Person-Centered Language

More information and learning resources about person-centered language can be found through the University of Minnesota's Person-Centered Language Clinical Tips resource tool and Resources for Integrated Care's Person-Centered Language Tip Sheet.

This tool is adapted from the National Institute on Drug Abuse's Document Words Matter: Terms to Use and Avoid When Talking About Addiction.

Substance Use

INSTEAD OF...	USE...	BECAUSE...
• Addict • User • Substance or drug abuser • Junkie	• Person with substance use disorder • Person with opioid use disorder (OUD) or person with opioid addiction [when substance in use is opioids] • Patients • Person living with addiction • Person living with the disease of addiction	• Person-first language • The change shows that a person "has" a problem, rather than "is" the problem • The terms avoid eliciting negative associations, punitive attitudes and individual blame
• Alcoholic • Drunk	• Person with alcohol use disorder • Person who misuses alcohol/engages in unhealthy/hazardous alcohol use • Person in recovery or long-term recovery • Person who previously used drugs	• Person-first language • The change shows that a person "has" a problem, rather than "is" the problem • The terms avoid eliciting negative associations, punitive attitudes and individual blame

Guidelines for Person-Centered Language[98]

Substance Use

INSTEAD OF...	USE...	BECAUSE...
• Habit	• Substance use disorder • Drug addiction	• Inaccurately implies that a person is choosing to use substances or can choose to stop • "Habit" may undermine the seriousness of the disease
• Abuse	For illicit drugs: • Use For prescription medications: • Misuse • Used other than prescribed	• The term "abuse" was found to have a high association with negative judgments and punishments • Legitimate use of prescription medications is limited to their use as prescribed, by the person to whom they are prescribed. Consumption outside these parameters is misuse
• Opioid substitution replacement therapy	• Opioid agonist therapy • Medication treatment • Pharmacotherapy	• It is a misconception that medications merely "substitute" one drug or "one addiction for another"
• Dirty	For toxicology screen results: • Testing positive • The urine drug screen (UDS) was positive For nontoxicology purposes: • Person who uses drugs	• Use clinically accurate, nonstigmatizing terminology the same way it would be used for other medical conditions • May decrease patients' sense of hope and self-efficacy for change

Guidelines for Person-Centered Language[98]

Substance Use

INSTEAD OF...	USE...	BECAUSE...
• Clean	• Person with alcohol use disorder • Person who misuses alcohol/engages in unhealthy/hazardous alcohol use • Person is positive for toxicology screen results • Testing negative • The urine drug screen (UDS) was negative • For nontoxicology purposes • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs	• Use clinically accurate, nonstigmatizing terminology the same way it would be used for other medical conditions • Set an example with your own language when treating patients who might use stigmatizing slang • Use of such terms may evoke negative punitive implicit cognitions
• Addicted baby	• Baby born to mother who used drugs while pregnant • Baby with signs of withdrawal from prenatal drug exposure • Baby with neonatal opioid withdrawal/ neonatal abstinence syndrome • Newborn exposed to substances	• Babies cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome • Use clinically accurate, nonstigmatizing terminology the same way it would be used for other medical conditions • Using person-first language can reduce stigma

Guidelines for Person-Centered Language[98]

Mental Health

INSTEAD OF...	USE...	BECAUSE...
• Mental illness	• A mental illness • Mental illnesses	• "Mental illness is a broad term" and "does not reflect what a person is actually dealing with"[99] • "To be respectful of people's individual experiences, use language that also acknowledges that mental illnesses are not all the same"[100]
• Afflicted by mental illness • Suffers from mental illness • Victim of mental illness • Mentally ill person • Person who is mentally ill	• Living with a mental illness • Person living with a mental health issue • Person experiencing a mental illness (or challenge)	• "Having a mental health diagnosis isn't necessarily a negative thing," and "some people with mental health issues find that their experiences have actually changed their life for the better"[101] • "People with mental health issues are able to live fulfilling, healthy lives. And there are a wide range of treatments"[102] • "To accept someone as a person first is not only more respectful, but honors many other parts of them outside their diagnosis"[103]
• Crazy • Psycho • Tweaker • Junkie	• They were diagnosed with….. • Person living with a mental health issue • Living with a mental illness	• "Avoid derogatory language"[104] and employ person-first language when speaking about someone living with a mental health issue

Guidelines for Person-Centered Language[98]

Mental Health

INSTEAD OF...	USE...	BECAUSE...
• Normal behavior	• Usual behavior • Typical behavior	• "There is no clear definition of what 'normal' is"[105]
• Committed suicide	• Died by suicide • Lost by suicide	• "To say someone 'committed suicide' suggests blame"[106]

Parenting

INSTEAD OF...	USE...	BECAUSE...
• Bad parent • Selfish parent • Parent who doesn't care • Parent who cares more about drugs than their baby	• Describe the parent's strengths and areas where they can grow their parenting skills • A parent living with addiction	• Every parent will have strengths and weaknesses when it comes to caring for their child • It is important to use strengths-based language when describing the parent's skills

Nonviolent and Compassionate Communication

The model of Nonviolent Communication,[107] also known as Compassionate Communication, can be useful in thinking about this aspect of the communication process. This model includes four steps that providers can implement when communicating.

Nonviolent and Compassionate Communication Model

Needs/Values

What I need or value (rather than a preference or specific action) that causes my feelings. I communicate what is important to me (values, desires, needs, ideas and hopes).

"...because for me _____ is very important."

"because I need/value..."

Request

I'll ask for concrete acts that could contribute to the well-being of my life and/or will allow me to achieve what is important to me without demanding it.

"Would you be willing to...."

"So, I would like for you (or the group or organization) to..."

Observations

I describe an event that I perceive (observe, hear, remember, imagine) to contribute to or harm my well-being.

"When I see, hear..."

Feelings

I express how I feel in relationship to that event.

I describe how I feel (emotions or sensations rather than thoughts) in relation to what I observe.

"I feel..."

Tools

Screening

Addressing Co-occurring Issues Within Health Care

A. Screening for Co-Occurring Drug Use and Additional Life and Health Issues 29

Racial Disparities in Drug Testing and Reporting

A. Information To Consider When Screening Patients for Substances 32

B. Sample Informed Consent Forms 36

C. Drug Screening Conversation Guide 38

D. Screening, Brief Intervention, and Referral To Treatment (SBIRT) 39

E. Information To Consider Before Biological Drug Testing (As a Last Resort) 43

"The reason to avoid the urine screen—it is very fraught with difficulty with false positives and negatives, plus, it's only a point in time screening, it doesn't pick up past use, or it can pick up occasional use which may not be indicative of a substance use disorder, but once it's in the chart, it's a red flag for CPS. When you do a verbal screening, it's a conversation followed by services."

Screening for Co-occurring Drug Use and Additional Life and Health Issues

Steps for Establishing Care

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

Learning Resources

Social determinants of health screening tool

Learn the patient's history with mental health, domestic violence and past trauma

Co-occurring health and social issues are prevalent for patients who are living with substance use disorder (SUD).[108]

Action Items

- ○ Be mindful of the social bias and stigma of drug use, mental health, and domestic violence that your patient may have experienced in the past and how it is affecting their current ability to access care.
- ○ Work with a multidisciplinary team to understand patient's other behavioral, physical, and mental health conditions, and develop a targeted plan for addressing each issue.[109]
- ○ Screen patients for mental health conditions, intimate partner violence and past trauma.
- ○ Be aware of the strong relationship between a substance use disorder and past trauma.

Screening for Co-occurring Drug Use and Additional Life and Health Issues

Screening for mental health, domestic violence and past trauma

Prenatal appointments present an opportunity to screen patients for other behavioral and mental health issues they may be experiencing.

Action Items

- ○ American Academy of Family Physicians (AAFP) recommended intimate partner violence screening tools:[111]
  - **HITS** (Hurt, Insult, Threaten, Scream)—self-report of physician administered
  - **STAT** (slapped, threatened and thrown)—physician administered)
  - **WAST** (Women Abuse Screening Tool)—self-reported
- ○ AAFP-recommended depression screening tools:[112]
  - **PHQ-2**
  - **PHQ-4**
- ○ AAFP-recommended anxiety screening tools:[113]
  - **Mini-SPIN**
- ○ Social phobia screening tool:
  - **GAD-2** (Generalized Anxiety Disorder scale)
  - **GAD-7** (Generalized Anxiety Disorder scale)
    - Incorporates GAD-2
    - Can reveal panic, social anxiety and post-traumatic stress disorders[114]
- ○ SAMSHA-recommended trauma screening tools:[115]
  - **CAPS** (Clinically Administered PTSD Scale)
    - Detects post-traumatic stress disorder and acute stress disorder for lifetime and current events
    - Structured administration
  - **DEQ** (Distressing Event Questionnaire)
    - Detects post-traumatic stress disorder for multiple events during lifetime
    - Self-administered
  - **ELS** (Evaluation of Lifetime Stressors)
    - Detects trauma history during lifetime
    - Structured administration
  - **TAA** (Trauma Assessment for Adults)
    - Detects trauma history during lifetime
    - Structured administration
    - Self-report version also available

Screening for Co-occurring Drug Use and Additional Life and Health Issues

Learn about the patient's Social Determinants of Health (SDoH) risk factors

Social Determinants of Health Screening Tools

In addition to screening and understanding your patient's co-occurring behavioral and mental health conditions, you should also learn about the social determinants of health risk factors that may influence their treatment and care. Screening for your patient's social determinants of health indicators is an essential aspect of the treatment and care process. Using scientifically approved tools to complete an SDoH evaluation will allow you to elevate the type of care that you provide and gain an enhanced understanding of barriers to care that your patient may experience. This screening process will also allow you to treat the whole patient, rather than their substance use alone.

Action Items

Types of screening tests:

- ○ PREPARE[116]
  - This tool screens for: personal characteristics, family and home, money and resources, social and emotional health, and other measures.
- ○ The EveryONE Project Toolkit[117]
- ○ The Accountable Health Communities Health-related Social Needs Screening Tool[118]
  - This tool screens for: financial strain, employment, family and community support, education, physical activity, substance use, mental health, disabilities.

Monitor drug interactions

Be aware of prescription drugs' influence on NAS outcomes

There is the possibility that pregnant women who are using substances and are also on anti-depressants, anticonvulsants and anxiolytics have a higher risk of giving birth to a child with NAS.[119]

Action Items

- ○ Women who are on buprenorphine and being treated for anxiety with benzodiazepines should be connected with a psychiatrist to try to reduce their benzodiazepine prescription during their pregnancy.[120]
- ○ "The dose of individual psychiatric medications should be evaluated for possible adjustment in the third trimester."[121]

Information to Consider When Screening Patients for Substances

Provide judgment-free care

- There is an immense amount of stigma toward individuals who use substances, particularly those who are pregnant.
- It is essential when caring for this population to create a judgment-free environment where the patient feels comfortable and safe.

Screen for Social Determinants of Health (SDoH) risk factors: caring for the whole person, not just their substance use.

- Although you are about to screen for substance use, remember to care for the whole person and recognize other factors contributing to their health.
- Screening for substance use alone allows room for provider bias, so it is critical to screen for social determinants of health risk factors. The following are some social determinants of health screening tools:
  - PREPARE[122]
  - The EveryONE Project Toolkit[123]
  - The Accountable Health Communities Health-related Social Needs Screening Tool[124]

Information to Consider When Screening Patients for Substances

Have a definition of what you are screening for and what method you will use

- ○ Educate patient on the test and processes of the results.
- ○ The following are screening tests that have been validated for detecting substance use in pregnant people:
  - ◦ Tolerance, Worried, Eye-opener, Amnesia, K[C]ut-down (TWEAK)[125]
  - ◦ Tolerance, Annoyed, Cut-down, Eye-opener, (T-ACE)[126]
  - ◦ Alcohol Use Disorders Identification Test-Concise (AUDIT-C)[127]
  - ◦ Parents, Partner, Past, and Present (4Ps)[128]
  - ◦ The Substance Use Risk Profile-Pregnancy (SURP-P)[129]
  - ◦ NIDA Quick Screen[130]
  - ◦ Wayne Indirect Drug Use (WIDUS)[131]

Universal screening: Evaluate the indicators you are using to assess patients

WHO recommends implementing universal substance use screening assessments for all pregnant patients.[132] However, keep in mind that universal screenings may not reduce racial disparities concerning toxicology testing, treatment and child welfare reporting.[133]

Providers should evaluate standardized screening indicators for toxicology testing and child welfare reporting for their effectiveness at reducing racial disparities.

Some evidence suggests that certain testing/reporting indicators, like poor birth outcomes and late prenatal care, may actually increase identification of Black women who already have higher rates of these health outcomes.[134]

Information to Consider When Screening Patients for Substances

Understand the limitations of screenings

Oral and verbal screenings are the preferred methods to detect substance use; yet many pregnant individuals will underreport their substance use in clinical settings, particularly during screens that are administered by a physician.[135]

Be prepared to administer brief intervention and treatment after screening

According to SAMSHA, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a validated care model that has demonstrated critical health benefits for patients.

- "Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment."[136]
- "Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change."[137]
- "Referral to treatment provides those identified needing more extensive treatment with access to specialty care."[138]

Build relationships with community resources

- It is critical to build relationships with community organizations and resources that address substance use and other social determinants of health risk factors.
- As a provider, knowing what is available in the community is helpful for understanding where to connect people, whom to connect them to, and when to make those connections to ensure there are warm handoffs.
- If this is done prior to screening for substance use and social determinants of health, parents can have smooth transitions of care.
- Additionally, services after the screening must be voluntary. If you make an array of services and benefits voluntary, you will learn what is most helpful to your patients.

Information to Consider When Screening Patients for Substances

Recognize structural racism in health care and its relation to screening and child welfare reporting

- It is essential to understand the history of the United States' Health care and child welfare systems and the deep-rooted systemic racism within both.
- People of color and Medicaid patients are often screened for substance use during pregnancy at much higher rates than their white counterparts.
- The overrepresentation of children of color in the United States' child welfare system is a persistent social and public health concern.
  - U.S. studies highlight that although Black children make up only 14% of the total population, they represent 23% of all the children in Child Protective Services (CPS) claims.[139]
- Not only are Black youth overrepresented within the welfare system, but additionally, there are disparities in how their cases are processed.
  - Black children are more often placed outside of their home, have a greater number of placement changes once in the system, and have a lower reunification rate with their families.[8]
- Resources for further reading about structural racism in the health care and child welfare systems:
  - Dorothy E. Roberts: Prison, Foster Care, and the Systematic Punishment of Black Mothers
  - Child Welfare Information Gateway: Child Welfare Practice to Address Racial Disproportionality and Disparity

Consent Form #1

Questions you may have about drug testing at _____
Insert name of organization

Because drug testing has often been used to punish people (kick them out of a program, evict them from housing, send them back to jail) people may feel they need to give a "good" urine.

Why do we do drug testing?

- To provide better health care for people with substance use disorders
- As one piece of information about how the medication is working
- To warn people if the substance they are using appears to be contaminated
- For insurance or other regulatory (state or federal) auditing purposes

We DO NOT do drug testing:

- Without your consent
- To kick you out of the program
- Because we do not trust you
- Because we want to catch you
- Because we want to get you in trouble

At _____ there are no good or bad urines, there are no clean or dirty urines. There is just
Insert name of organization

1. urine that is only from your body today, and
2. urine that is different from what is in your body today

What do we mean by "urine that is different from what is in your body today"?

Some examples:

- Urine from your body with a piece of Suboxone in it
- Urine from your body diluted with water, spit, bleach, soap, etc.
- Urine from someone else

We want to reassure you; we only need urine from your body. If you had a bad week and you know there will not be buprenorphine in your urine and/or a lot of other drugs will be in your urine, let us know so we can talk about it. Or let us know that you don't want to talk about it right now. We are here to work with you, not punish you!

Some signs that urine is different from what is in your body today:

- Urine that is cold and/or watered down
- Urine that has A LOT of pure Suboxone (buprenorphine) in it but very low levels of Suboxone metabolite (norbuprenorphine) that has passed through your body
- Urine that has chemicals in it that are not normally found in urine (sometimes called adulterants or oxidants)

This document uses content modified from the Project HOME document, which was created by Lara Carson Weinstein, MD, and Robin Debates, LCSW.

Consent Form #2

Medication for Opioid Use Disorder Medication Agreement

As a participant in the Penn Family Care MOUD Program for opioid use disorder:

1. I will do my best to keep all scheduled appointments and to let you know if I cannot keep my scheduled appointments.
2. I agree to use only the pharmacy my provider and I have discussed to fill my prescriptions.
3. I understand that if I miss a visit, there may be a gap in being able to get my medication.
4. I understand this program collects urine samples at every visit to help determine how effective my treatment is. See the "Questions You May Have About Drug Testing at Penn Family Care" handout for more information.
5. I will do my best to take my medication as I have discussed with my health care provider and to let my provider know about any changes or problems.
6. I understand that mixing other medications, especially benzodiazepines (for example, Valium®, Klonopin® or Xanax®) or alcohol can be dangerous, especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended doses. Because this can be dangerous, I agree to tell my provider if I get other opiates or benzodiazepines from any other health care providers, pharmacies or other sources.
7. I understand that if I use other opioids when I have been taking my medicine, I may not get high because buprenorphine and naltrexone block the effect of other opiates. I understand that if I keep using higher and higher amounts of opiates to try to get high, I could stop breathing and die.
8. I will do my best not to sell, share or give my medication to another person.
9. I understand that medication by itself may not be enough treatment for my problem(s). I will talk with my team about and seriously consider any recommendations for additional services such as medication management, counseling, group therapy, pain management, etc. I agree to the above terms and to begin/continue Medication for Opioid Use Disorder at Penn Family Care.

Patient name: _____
[Insert patient name]

Patient MRN: _____
[Insert patient number]

_____
Signature

_____
Date

Drug Screening Conversation Guide

Conversation Guide Outline

Obtain informed oral and written consent	• Informed oral and written consent should be obtained from the mother before testing her or her infant for substances. • The parent should also be informed about the right of refusal.
What should occur when drug use is identified	• If drug screening is indicated it should be done as early as possible to allow time to offer appropriate support resources to the pregnant person and family.
Why the screening is being performed should be explicitly explained by the provider in clear language	• "We are screening you for substance use today because…"
Providers should explain how the results will be used	• It is critical that providers take the time to explain to their patients about next care steps in light of a positive screening result. This is an important opportunity for the provider to be transparent and partner with the patient in their care journey.
Explain the procedure for collecting the test and offer options whenever possible	• Use plain language and avoid acronyms, as well as medical jargon. • Continually check in with the patient to ensure they understand the procedure.
Conversations after test results are received	• Discuss next steps with patients. • Actively include them in any conversations that need to occur with other professionals (i.e., CPS, social work, legal).
Address questions/concerns	• Answer your patient's questions with transparency and honesty. • Connect them to resources who will be able to assist them further with any questions, concerns or barriers to care.

Screening, Brief Intervention, Referral to Treatment[141]

When implementing substance use screenings, they should take place as early as possible during the prenatal care period, continue throughout the pregnancy, and be incorporated into the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model of care.

According to SAMHSA, the SBIRT model of care is a public health focused tool that boasts many benefits for patients and providers.

- "Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment."[142]
- "Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change."[143]
- "Referral to treatment provides those identified needing more extensive treatment with access to specialty care."[144]

Components of screening, brief intervention and referral to treatment table[145]

Component	Goal	Approach
Screening	Assess substance use and its severity	Patient-/computer-administered instrument or direct provider questions
Brief intervention	Increase intrinsic motivation to affect behavioral change (i.e. reduce or abstain from use)	1-5 Patient-centered counseling sessions lasting < 15 minutes using principles of motivational interviewing
Referral to treatment	Provide those identified as needing more treatment access to specialty care	Warm handoff to specialized treatment (e.g., provider-to-provider telephone call), which requires practitioner familiarity with community resources and systems of care.

Learning Resources

Components of screening, brief intervention and referral to treatment table is reprinted from Wright and Colleagues paper: The Role of Screening, Brief Intervention and Referral to Treatment in the Perinatal Period

Screening, Brief Intervention, Referral to Treatment[141]

Screening Instruments[146,147]

Verbal and written screenings should be conducted in an open and nonjudgmental manner.[148] This method of substance use detection is preferred over biological drug testing, as toxicology reports only "show evidence of use, but do not provide any information about the nature or extent of that use" nor "does a negative test…rule out substance use."[149] These tests also place greater emphasis on illegal drugs rather than on tobacco or alcohol.[150] Additionally, it is critical to keep in mind that although oral and verbal screenings are preferred methods of detecting substance use, many pregnant individuals will underreport their substance use in clinical settings, particularly during tests that are administered by the physician.[151] Polak and colleagues recommend employing screening tests that the patient can take without the presence of the physician, and using the Wayne Indirect Drug Use Screener (WIDUS) tool, which indirectly screens for substance use.[152]

Screening Instruments

Instruments	Substance	Validated in Pregnancy	Subjects Identified	Resource
(TWEAK) Tolerance, Worried, Eye-opener Amnesia, K[C]ut-down	Alcohol	Yes	At risk for drinking	TWEAK resource
(T-ACE) Tolerance, Annoyed, Cut-down, Eye-opener	Alcohol	Yes	At risk for drinking	T-ACE resource
(AUDIT-C) Alcohol Use Disorders Identification Test-Concise	Alcohol	Yes	At risk for drinking	AUDIT-C Resource
(4Ps) Parents, Partner, Past and Present	Any substance	Yes	Any affirmative answer is considered a positive screen	4Ps Resource
(SURP-P) The Substance Use Risk Profile-Pregnancy	Alcohol, illicit drugs	Yes	Any drinking or illicit drugs	SURP-P resource

Screening, Brief Intervention, Referral to Treatment[141]

Screening Instruments (Continued)

Instruments	Substance	Validated in Pregnancy	Subjects Identified	Resource
NIDA Quick Screen	Alcohol, tobacco, nonmedical prescription drug use, other drugs	Yes	At risk for drinking and drug use	NIDA Resource Guide: Screening for Drug Use in General Medical Settings
(WIDUS) Wayne Indirect Drug Use Screener	Correlates of drug use	Yes	Any drug use	WIDUS Resource

Learning Resources

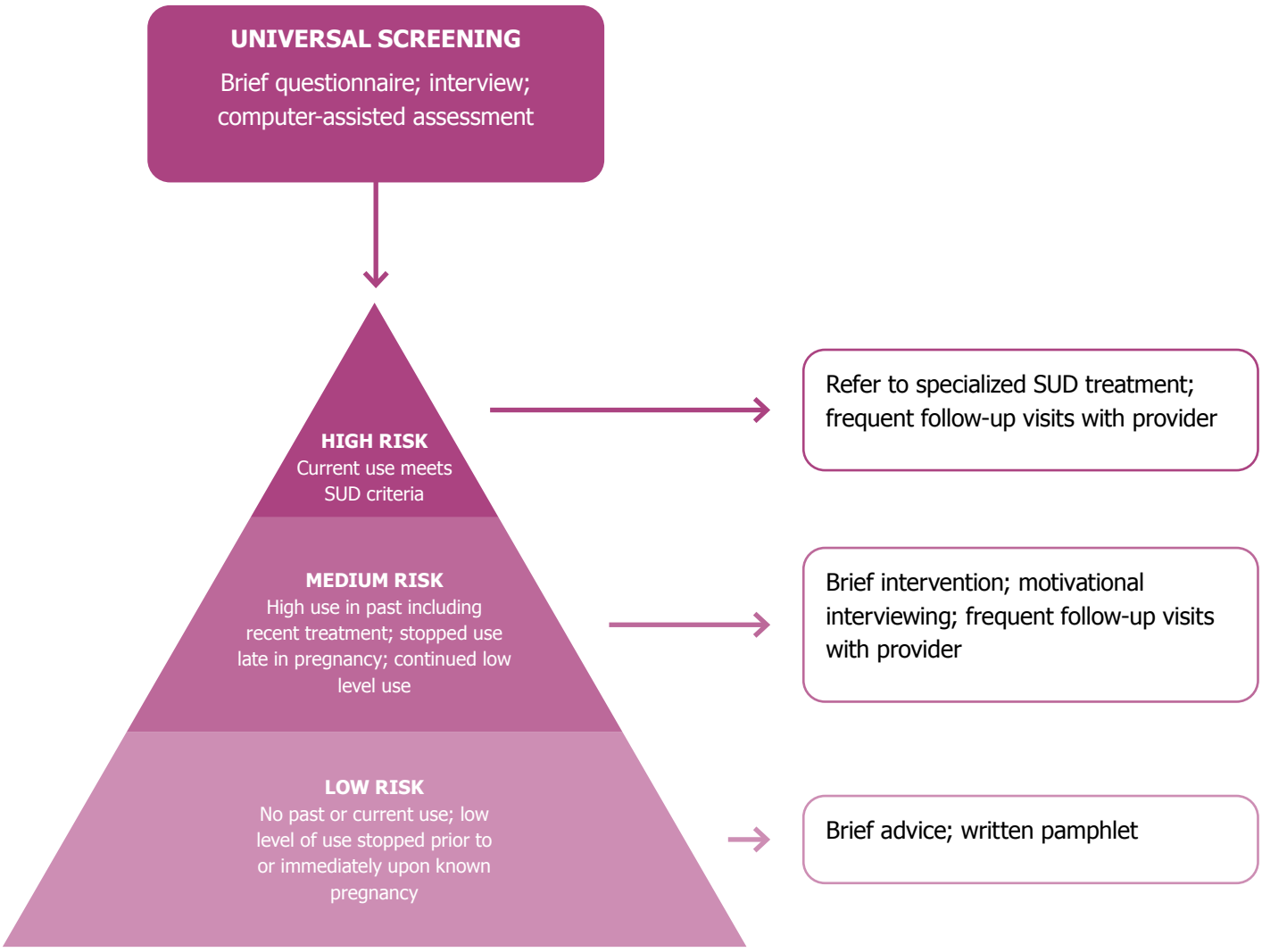
Screening instruments table was adapted from the Wright and Colleagues paper, The Role of Screening, Brief Intervention and Referral to Treatment in the Perinatal Period

"Talking about the racism entrenched in the child welfare system may not be initially persuasive to pediatric providers, but teaching them about the long-term generational damage that is done to children involved in the system has been more effective."

Screening, Brief Intervention, Referral to Treatment[141]

Zone of Risk

The following diagram demonstrates how women can be categorized for risk of substances based on their screening results.



Learning Resources

The Zones of Risk diagram is reprinted from Wright and Colleagues' paper: The role of screening, brief intervention and referral to treatment in the perinatal period

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.[153] However, some physicians may feel they need to test the parent for substances. These are some critical steps to keep in mind prior to administering a biological drug test:

Screening Instruments

Screening tools should ALWAYS be employed as a first step for substance use detection[154]	• If biological drug testing is carried out, it should be "conducted with patient informed consent and in compliance with state laws."[155]
Assess the benefits versus harms of biological testing	• Biological drug testing should only be carried out "when its benefits outweigh any potential harms, which include those related to mandatory state reporting laws."[156] • Drug tests should only be carried out if there is some concrete medical action that would be taken upon a positive screen. • I.e., there's no medical reason to test for marijuana.
Obtain informed oral and written consent before drug testing mother and/or baby	• Educate the pregnant individual about the testing process and the significance of a positive result. • Use Shared Decision-making tactics to discuss the biological drug test and any medical, social and legal steps as a result of a positive test. • "Participation in such procedures should be voluntary, and refusal to participate should not be clinically interpreted as evidence of substance use."[157]

Information To Consider Before Biological Drug Testing (As A Last Resort)

Screening Instruments

Be aware of the disadvantages of biological drug testing

Limitations include:

- Positive results are confined to the half-life of the substance, which may be relatively short for substances such as cocaine and alcohol
- Biological tests cannot detect the frequency or severity of the substance use[158]
- Biological tests can yield false positives and false negatives[159] and "there is no general agreement as to which…cutoffs should be used," for detection[160]
- Finally, biological drug tests are not indicative of a person's ability to effectively care for and parent their child

Be prepared to offer follow-up care services

- If a patient yields a positive drug test, providers are ethically responsible for connecting the patient to "education, motivational interviewing around behavior change, brief intervention, and referral to treatment as needed"[161]

"It seems clear on an anecdotal level...That there are many hospitals in NYC that routinely test almost everyone in labor and delivery. Even when testing is counter to the policies that are supposed to govern this. Primarily the public hospitals seem to be in this category of overtesting."

Tools

Treatment and Care Planning

Refusal of Treatment and Coercive Medical Tactics

A. Shared Decision-Making Guide 46

B. Informed Consent and Shared Decision-making Learning Resources 52

"When we know how to treat people better, it's what we do for people who use cigarettes during pregnancy. And alcohol. They are known to have potential long-term effects in some instances (unlike cocaine, opiates, meth). We don't criminalize cigarettes, we provide health care and talk about how to mitigate the harm that comes from smoking while pregnant—we care for the mother, and that could be a model for how we treat people differently."

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."[162] Physicians should implement SDM when caring for pregnant persons who are using substances, as the method provides the patient with the autonomy and information to choose their path for treatment.[163]

Learning Resources
The SHARE Approach

Conversation Guide and Model

The model has three steps: a) introducing choice, b) describing options, often by integrating the use of patient decision support, and c) helping patients explore preferences and make decisions. 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.[164]

"Discuss the process with the parent, get informed consent, and make her autonomous. Inform her about the call to CPS, invite her to participate, and discuss how she can work toward a goal with CPS. Inform her of how an interdisciplinary team can support her."

Shared Decision-Making Guide: Choice Talk

1 Step Back

Summarize and say: "Now that we have identified the substance use, it's time to think about what to do next."

2 Offer Choice

Beware that patients often misconstrue the presentation of choice and think that the clinician is either incompetent or uninformed, or both.

Reduce this risk by saying: "There is good information about how these treatments or care paths differ, and I'd like to discuss it with you."

- Offering a choice to patients also allows them to take an active role in their care process.

3 Justify Choice

Emphasize: 1. The importance of respecting individual preferences and, 2. the role of uncertainty

Personalizing preferences: explaining that each person has unique life factors and preferences that will influence their care process.

- Say: "Treatments have different consequences… some will matter more to you than to other people…"

Shared Decision-Making Guide: Choice Talk

Check Reaction

Choice of options may be disconcerting: some patients may express. Additionally, some patients may have concerns, but feel nervous to express them. Directly ask your patients what issues or concerns they may have, and leave time to process through them.

- Suggested phrases: "Shall we go on?" or, "Shall I tell you about the options?"

Defer Closure

Some patients react by asking clinicians to "tell me what to do…." We suggest deferring closure if this occurs, reassuring them that you are willing to support the process.

- Suggested phrases: "I'm happy to share my views and help you come to the right decision for you. But before I do so, may I describe the options in more detail so that you understand the possible outcomes?"

"It's okay to tell the patient how this feels to you as well e.g., 'This is not an easy decision for me, I don't want to do it, it's the process.' Honesty and transparency are important their own form of self-care."

Shared Decision-Making Guide: Option Talk

Check Knowledge

Even well-informed patients may be only partially aware of options and the associated harms and benefits, or of misinformation.

- Check by asking: "What have you heard or read about MOUD during pregnancy?"
- Also ask what the patient may have heard about child welfare involvement, and legal involvement after substance use is detected during pregnancy.

List Options

Make a clear list of the options, as it provides good structure.

- Jot them down and say: "Let me list the options before we get into more detail."

Describe Options

Generate dialogue and explore preferences. Describe the options (medical, legal and social) in practical terms.

- If there is more than one treatment option, say: "I would like to inform you about the possible treatment options."
- Point out when there are clear differences or where decisions are reversible. Say "these options will have different implications for you compared to other people, so I want to describe…"

Shared Decision-Making Guide: Option Talk

Harms and Benefits

Being clear about the pros and cons of different options is the heart of shared decision-making. Learn about effective risk communication, about framing effects, and about the importance of providing risk data in absolute as well as relative terms. Try giving information in "chunks."

Provide Patient Decision Support

Provide the patient with information or worksheets that allow them to visualize the options.

SDM may need more than one encounter. More extensive patient decision support tools may play a crucial role.

- Say: "These tools have been designed to help you understand options in more detail. Use them and come back so that I can answer your questions."

Summarize

List the options again and assess understanding by asking for reformulations. This is called a teach-back method and is a good check for misconceptions.

Shared Decision-Making Guide: Decision Talk

Focus on Preferences

Guide the patient to form preferences.

- Suggested phrases: "What, from your point of view, matters most to you?"

Elicit a Preference

Be ready with a backup plan by offering more time or being willing to guide the patient, if they indicate that is their wish.

Moving to a Decision

Try checking for the need to either defer a decision or make a decision.

- Suggested phrases: "Are you ready to decide?" or "Do you want more time? Do you have more questions?" or "Are there more things we should discuss?"

Motivational interview is an important aspect of Shared Decision-making. Please make use of the Motivational Interviewing Script that is also included in this toolkit.

Offer Review

Reminding the patient, where feasible, that a decision may be reviewed is a good way to arrive at closure.

Learning Resources

Shared Decision-Making Template: Choice Talk, Option Talk, and Decision Talk is adapted from the Elwyn et al., 2012 paper: Shared Decision-making: A Model for Clinical Practice

Informed Consent and Shared Decision-Making Learning Resources

Informed Consent and Decision-Making: The Informed Consent Process

This is an interactive course developed by the American Medical Association. The learning module aims to improve physicians' understanding of the following topics surrounding informed consent:

- Explain informed consent as a patient right.
- Define each step of the informed consent process.
- Describe the elements of informed consent.
- Explain when physicians may ethically withhold information from a patient.[165]

Informed Consent as Process and Applying the LEARN Model

This is an interactive course developed by the American Medical Association. The learning module aims to improve physicians' understanding of the following topics surrounding informed consent:

- Define key terminology around the topic of cultural competence
- Recognize the influence of patient's background on the consent process
- Describe the framework for communicating effectively with patients
- Apply the LEARN model to elicit patient understanding in their clinical situation
- Apply best practices to overcome barriers for truly informed consent.[166]

Informed Consent and Shared Decision-Making Learning Resources

The Limits of Informed Consent in the Overwhelmed Patient: Clinician's Role in Protecting Patients and Preventing Overwhelm

This is an interactive course developed by the American Medical Association. The learning module aims to improve physicians' understanding of informed consent in situations of emotional and informational overwhelm.[167] The course objectives are:

- Explain a new or unfamiliar viewpoint on a topic of ethical or professional conduct.
- Evaluate the usefulness of this information for his or her practice, teaching or conduct.
- Decide whether and when to apply the new information to his or her practice teaching or conduct.[168]

SHARE Approach Workshop

The SHARE learning resources are interactive modules developed by the Agency for Health care Research and Quality. The objective of the modules is "to support the training of health care professionals on how to engage patients in their health care decision-making."[169]

- Module 1: Shared Decision-Making and the SHARE Approach
- Module 2: Using Patient-Centered Outcomes Research (PCOR) in shared decision-making
- Module 3: Communication
- Module 4: Putting Shared Decision-Making Into Practice
- Module 5: Trainers' Module

Learning Resources

Pregnancy and Substance Use: A Harm Reduction Toolkit

Harm Reduction module

MAT in pregnancy fact sheet for health care workers

Eat, Sleep, Console model for treating NAS

National Advocates for Pregnant Women Understanding CAPTA and State Obligations

The Child Welfare System - Overview of the purposes and functions of the child welfare system

tools

Reporting

Considerations When Reporting to Child Welfare

A. Strengths Based Approach to Child-Welfare Calls 55

B. Post-CPS Call Conversation Guide 58

C. Debriefing Tool 61

D. Accountability Meeting Guide 63

"People at Bronx Defenders have taught me tactics—HOW YOU REPORT can make a big difference...you can say, I observe the following strengths in this family and in this mom and make sure this becomes part of the record from the beginning. In MA, many are desperate to get women into methadone treatment, but they are told once the women give birth have to turn them into child welfare. That's not true. But depends on who is saying it and who fails to resist."

Strengths-Based Approach to Child Welfare Calls

Safety Disclaimer

This toolkit provides health care workers with harm reduction strategies about screening for substance use and working with child welfare; however, the implementation of some of the 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, please be mindful of safety, and establish safety protocols.

Child welfare notifications versus child welfare abuse reports

Under section 106(b)(2)(B)(ii) of the federal Child Abuse Prevention and Treatment Act (CAPTA), the document mandates that states have:

- "Policies and procedures… to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder, including a requirement that **health care providers involved in the delivery of care of such infants notify the child protective services** system of the occurrence of such condition of such infants, **except that such notification shall not be construed to…**
  - **Establish a definition under federal law of what constitutes child abuse or neglect; or**
  - **Require prosecution for any legal action**[170]
- **THUS, 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."[171]
- **A report to CPS is required in instances when the neonate demonstrates symptoms of substance use exposure and is at possible risk for maltreatment.**
- Although federal CAPTA legislation makes the distinction between a notification and a report, only 14 states[172] specifically call out the difference between the two in their legislation.[173]
- Health care providers should take measures to learn about the specific notification and reporting requirements in their states.

Strengths-Based Approach to Child Welfare Calls

When possible, make the call to CPS with the parent

- We recommend trying to make the CPS call with the parent, but understand there may be situations where this is not possible.
- It is important to consider the safety of your environment and your access to colleague support (i.e., home visitation environment versus office setting).
- In applicable cases:
  - Inform the parent about the call to CPS, invite them to participate.
  - Tell the parent what you will be communicating to CPS ahead of the call, and address any concerns.
  - Finally, discuss how they can work toward a goal with CPS.
- Making the CPS call with the parent allows you to be transparent about the information that you are sharing with child welfare and builds trust with the patient.
- The parent's participation in the call also demonstrates they are actively taking part in asking for help and working collaboratively with the child welfare system.

Use person-first language when discussing the case

- It is critical to use person-first language when describing the parent in your clinical notes and to child welfare.
  - "To accept someone as a person first is not only more respectful, but also honors many other parts of them outside of their diagnosis."[174]
- Instead of saying: "I have a parent with a heroin addiction…"
  - Say: "I have a parent with an SUD history and is planning to deliver and wants to access community services to aid them with SUD treatment ahead of delivery."

Strengths-Based Approach to Child Welfare Calls

Use strengths-based language when describing the parent

- Every parent will have strengths and weaknesses when providing care for their child.
- When speaking with child welfare, do not highlight the parent's deficits; instead, stress what the parent has accomplished and what needs improvement using strengths-based language.
  - Example: "The parent is very committed to beginning treatment and caring for their child, but needs some assistance in..."
- Create an outline or script of what information you will be communicating to CPS prior to making the call.

Accurately represent the major facts of the case

- When speaking with child welfare about the parent, only discuss the facts of the case and do not include unnecessary details or personal opinions about the parent or situation.
  - Avoid saying information like: "Parent has holes in her shoes, dad not present, etc."
- Creating an outline or script of what information you will be communicating to child protective services prior to making the call will help prevent the retelling of unnecessary details.

Post–CPS Call Conversation Guide

Safety Disclaimer

This toolkit provides health care workers with harm reduction strategies about screening for substance use and working with child welfare; however, the implementation of some of the 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, please be mindful of safety, and establish safety protocols.

Prior to engaging in calls with CPS, keep in mind the following information:

- ○ Be open with your patient prior to providing care about your obligations as a mandated reporter and about what information would require a notification or report to child welfare.
- ○ Be aware of emotions: Reports and notifications to child welfare can elicit strong emotional reactions from patients who may feel angered and betrayed by the situation. Keep your supervisor and team members informed of instances where you will need to make calls to child welfare, so they are available to offer any assistance professionally or emotionally.

Post–CPS Call Conversation Guide

As you prepare to call CPS, invite the parent to participate in the call

- Making a call to CPS with the parent allows for honesty and transparency about the information that is being shared with child welfare.
  - Working closely with the parent on a report or notification to child welfare may help build your relationship and prevent the destruction of trust.
  - The parent's participation in the call also demonstrates they are actively taking part in asking for help and working collaboratively with the child welfare system.
- This also allows for you to have a post-call conversation with the parent to discuss next steps, current emotions and concerns.
- Say:
  - "I have to make a notification and/or report to CPS, but I would like you to be part of the call to child welfare so you know how the information is communicated and how the facts are represented."

After the call, discuss how CPS will proceed and what the parent should expect

- Educate the parent about what to expect after a report or notification.
- Do not place a call and then terminate the relationship with the patient—think of the call as part of the treatment plan.
- Say:
  - "Now that we have made the call together, these are the next steps…"
  - "Let's find a time to schedule your next visit."
  - "Do you need support with [transportation, housing, finances, etc.]? Can I connect you with some community organizations who can help offer support in…?"

Post–CPS Call Conversation Guide

Be honest about potential outcomes

- You may not be able to promise that the child won't be removed from the parent, but you can support and advocate for the parent through the process.
- Be an ally for the parent.
- Say:
  - "I cannot promise that child welfare will not remove your child from you, but I will be here to advocate for you in any way I can."

Ask the patient how you can best support them

- Making a report or notification to child welfare is an intense experience that can draw up many emotions.
- Ask the parent how you can best support them during this time, and offer to connect them to mental health resources.
- Say:
  - "This is an extremely difficult emotional situation. How can I support your mental health during this time?"

Tell the parent how this feels to you

- Deciding to make a call to CPS may also be emotionally exhausting for you as a provider, and it is okay to communicate these emotions to your patient.
- Say:
  - "This is not an easy decision for me. I don't want to do it, but it's the process. I know you're a good parent. Even still, I have to make this call."
- Remember that honesty and transparency are important and are their own form of self-care.

Debriefing Tool

Health care workers are commonly exposed to tragedy, trauma and death. However common these events may be, they should never be normalized. Opportunities for colleagues and peers to process and support each other after particularly difficult events at work can reduce the impacts of vicarious trauma, like compassion fatigue. Managers can play a key role in supporting staff through one-on-one supervision and by encouraging a supportive organizational culture that builds resilience.

Preparation

- **Whenever possible, supervisors should have a concrete plan for how a team member receives sensitive information about a patient outcome.**
  - Avoid situations where someone learns upsetting news in a casual way.
    - Examples: in the hallway, break room or other nonprivate work spaces
  - Group versus individual settings
    - Ideally, the supervisor schedules one-on-one time with the team member to allow space for processing before returning to work tasks. However, some may feel more comfortable debriefing about the situation in group settings.
    - Be mindful that each person processes difficult care interactions differently.
- **Debriefings should be time bound, and the team member should be made aware of how much time has been allocated.**
- **Employees should also research what mental health benefits they are entitled to receive at their place of work.**

Debriefing Tool

Conversation Guide

- ○ **Supervisor should ask open-ended questions and leave room for silences to allow the team member to process after receiving news of a patient outcome.**
  - *"I know you had a close relationship with this patient. How are you feeling hearing this news?"*
- ○ **Supervisor should seek opportunities to normalize feelings and offer affirmations.**
  - *"These feelings are a normal part of the process…"*
- ○ **Opportunities for growth/did we learn something new?**
  - *"Were existing protocols used appropriately, and do any of them need to be updated?"*
  - *"Did you and other staff have proper training and tools for decision-making?"*
  - *"Were there any red flags we missed that could help inform our future practice?"*
    - Reviewing/revising protocols/practices
    - Self-care plan for the day, week, month
    - Follow-up check-in if appropriate
- ○ **Opportunities to discuss care planning**
  - *"What are your concerns now that this situation has occurred?"*
  - *"What should the next steps be in the care process?"*
  - *"What are the next steps for working with CPS?"*
- ○ **Discuss safety of the employee. This discussion may depend on where the provider usually practices their care (in an office setting versus a home visitation setting).**
  - *"Does your safety feel jeopardized by the situation that occurred?"*
  - *"What can be done in the future to increase safety protocols?"*

Wrap-up

- ○ **Next steps:**
  - Supervisor summarizes conversation
  - Next steps may include:
    - Reviewing/revising protocols/practices
    - Self-care plan for the day, week, month
    - Follow-up check-in if appropriate

Accountability Meeting Guide

Systems of accountability are usually influenced by three factors:

- A clear definition of desirable goals or objectives
- The ability to measure and monitor goal achievement
- A set of consequences for providers or organizations if achievements regarding goals or objectives are not satisfactory.[175]

Agreement upon these factors often makes creating systems of accountability within health care difficult to achieve. However, team collaboration on an accountability system for providers who care for pregnant patients using substances is an essential step for providing harm reduction care and improved interactions with child welfare.

When implementing accountability meetings, work with your team members to set some ground rules for the meetings:

- ○ Immediate care team members should participate
- ○ Meetings to occur once a week
- ○ Start and end the meeting promptly
- ○ Establish department goals and methods to achieve the goals
- ○ Allow each person a chance to speak
- ○ One person should not dominate the conversation
- ○ Criticize plans of care, not individuals
- ○ Come with an open mind and a commitment to learning
- ○ Use person-centered language
- ○ Ask permission from the patient before discussing their case with other providers
- ○ Create list of items to follow up on for the next meeting

Accountability Meeting Guide

Provide ongoing education about the Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction and Recovery Act (CARA)

- A way for providers to hold themselves and their colleagues accountable is keeping up to date on CAPTA/CARA obligations about substance use and pregnancy
- National Advocates for Pregnant Women's Understanding CAPTA and State Obligations fact sheet is an informative resource for policy education
- Hospitals can work with peer recovery advocates to offer further training to mandated reporters

Use the meetings as a time to discuss ways to improve treatment planning

- Accountability meetings represent a time to discuss new ways to address patient needs and how to collaborate with child welfare.
- They can also serve as a moment to keep providers accountable for continuing to support their patients after a positive test.

Check in with providers to support them emotionally and professionally

- Reporting a parent to child welfare is an intense experience that can weigh heavily emotionally on providers.
- Accountability meetings can act as a way for providers to emotionally check in with one another and recommend tactics for providing self-care.

Accountability Meeting Guide

Plan ways to advocate for better hospital policies

- Accountability meetings can serve as a way to hold providers responsible for offering harm reduction and strengths-based care and hold the hospital system accountable for changing punitive substance use policies.
- Further guidance on how to be an advocate:
  - Families USA's Health Policy and Advocacy Toolkit

Call out racism in reporting and stigmatizing language

- A critical aspect of accountability meetings is educating providers about structural racism within the child welfare system and drawing attention to how this influences which patients they report to child welfare.
- The meetings are a crucial teaching moment for providers to adapt how they speak and write about people who use substances during pregnancy.
  - If a provider is not using person-centered language, the accountability meeting should educate the provider on the appropriate terms to use.

Tools

Providers as Partners

Provider Advocacy: Supporting Parents Through the Process

A. Quick Tips: Legal Advocacy for Nonlawyers 67

B. Talking Points for Supporting the Development of Self-Advocacy Skills 71

"Until recently, I have encountered very few providers and hospitals really sitting down and being thoughtful and intentional about this [reporting] requirement… The language of CAPTA uses 'notification' not 'report'- have never seen a hospital really make note of that"

Quick Tips: Legal Advocacy for Nonlawyers

Purpose

Patients receiving medication-assisted treatment (MAT) frequently face concurrent legal issues. The legal system often presents both a barrier to effective MAT and a tool for facilitating recovery. 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 engage in advocacy for your patients.

Considerations When Serving Clients Involved in the Legal System

- Be aware that many patients may not reference legal issues during patient encounters. Because of this, it is important to educate all patients about basic advocacy talking points should they encounter common legal issues regarding MAT.
- Remain open to providing legal advocacy in the form of letters.
  - You may find it helpful to designate a specific person as your "legal support navigator" or similar role. This person would be the primary contact for individuals experiencing legal issues who require letters of support, letters confirming adherence to MAT, and more.
  - While form letters may help you get started, the most effective letter is a personal one. Use only enough information to convey the desired message, while ensuring the letter clarifies that the individual is personally known to the practice.
- Build relationships with key partners.
  - If there are legal providers in the area who you frequently interact with, consider meeting with them to develop a mutual understanding of MAT by sharing core principles and general information about the role and implementation of MAT. Invite them to tour your facility. Speak with them in general terms about treatment protocols. Encourage them to ask questions about MAT. Ask them if there is any way you can set up a direct contact between organizations to facilitate coordination of care. Ascertain if there are ways you can help each other (e.g., via a direct referral process).

Learning Resources

Plan of safe care

Closed-loop referral best practices

Quick Tips: Legal Advocacy for Nonlawyers

Resources for the Team

- When writing a letter of support, you can use these instructions and template to get started. Once you have written a few, you may want to create a customized template for your clinic and/or add it as a document within your EHR.
- Talking points for helping MAT patients develop self-advocacy skills

DCPP cases (New Jersey specific)

Type of case

Child protection abuse/neglect case

Key players

- Parent's attorney (through OPR)
- Division's attorney (DAG)
- Child's attorney (LG)
- Caseworker: may be investigation worker, permanency worker, adoption worker or others, depending on stage and type of case
- Transportation worker: responsible for transporting children and supervising visits

Municipal cases

Type of case

Traffic court arraignment for lesser offenses such as fines and fees issues

Key players

- Municipal prosecutor
- Public defender
- Court clerk/administrator

Criminal cases in Superior Court

Type of case

What many people think of as "court"

Key players

- Prosecutor
- Public defender or private defense attorney

Quick Tips: Legal Advocacy for Nonlawyers

Managed care organizations operate case management teams that provide additional services or help answer questions about how to get patients into behavioral health settings. Reach out to your network representative, or have the patient or OBAT Navigator call the MCO member services to learn more about the in-network resources and the MCO case management support for behavioral health needs.

Drug Court

Type of case

Cases diverted from other courts due to the nature of the offense and the client's substance use

Key players

- Prosecutor
- Public defender or private defense attorney
- Ancillary personnel

Civil Commitment

Type of case

Typically, proceeding for individuals to be placed or remain in inpatient mental health treatment

Key players

- DAG or the State's attorney
- Public defender from Division of Mental Health Advocacy
- Hospital staff

Quick Tips: Legal Advocacy for Nonlawyers

Glossary of Terms

There are a lot of abbreviations you may encounter when advocating for MAT patients in the legal context:

CASA	Court-appointed special advocate, a layperson sometimes appointed to follow and support a child for the duration of a DCPP matter
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 (formerly DYFS)
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
TPR	Termination of Parental Rights, a special type of trial to permanently sever parental relationship with child in DCPP matters
TRO	Temporary restraining order

Learning Resources

- **MyResourcePal**—social service directory that also includes information on legal resources

Talking Points for… Supporting the Development of Self-Advocacy Skills

Purpose

Patients receiving medications for addiction treatment (MAT) often face concurrent legal issues, and they may encounter resistance from legal professionals and other related services regarding the use of MAT. MAT providers should consider helping patients develop the ability to explain their course of treatment, self-advocate, and to troubleshoot ways to explain MAT when they receive conflicting recommendations. The questions and talking points below can help the provider navigate this. You may want to consider adapting these questions to a simple worksheet for patients to complete on their own or in a clinical or group setting.

What medication(s) are you taking?

Patient should be able to list the medications they are using.

"My doctor prescribed me [Medication]."

Patient may also want to offer that MAT is part of a full treatment plan that includes monitoring or other services.

"It's not just a medicine. My doctor developed a full treatment plan for me that includes groups, individual counseling [or whatever other supports patient receives]."

What is the dosage?

Patient should be able to mention the indication, dose, frequency, route and time of administration.

"I take [dosage] of [Medication] by [route] every morning for [indication]."

Patient may want to include how often they visit the provider for evaluations and refills.

"Every [duration], I go back to the doctor to get reassessed and get a refill."

Why do you take it?

Help the patient learn to emphasize the medical nature of substance use disorder.

"I am diagnosed with [substance use disorder]. Like any diabetes or high blood pressure meds, MAT helps me treat this disease and keeps me healthy."

It may help the patient to emphasize that the provider made an individual assessment and recommended this course of treatment.

"My doctor took the time to evaluate my case, and this was their clinical recommendation."

Help the patient understand the expectations of MAT and what otherwise would occur if the patient were not taking MAT.

Talking Points for…Supporting the Development of Self-Advocacy Skills

Are there any side effects you've noticed that might concern others? How do you explain them?

Side effects that mimic intoxication may make law enforcement, legal professionals or other service providers assume they are using substances again.

Help the patient identify the types of side effects they may personally experience that may appear like intoxication.

"Sometimes [Medication] makes me [groggy or other applicable side effect]. This is a side effect of the medication. My doctor told me that it is common and works with me to adjust my dose so that I experience fewer side effects."

Help the patient understand the effects that they would otherwise experience if they were using illicit prescription drugs versus those effects while being on MAT.

"Although I experience the side effect, I am still able to function appropriately and with purpose, compared to the side effects I would have experienced while using illicit opioids."

Are you just replacing one addiction with another?

This is a commonly held misperception about MAT and one your patient may encounter in various contexts.

Help the patient understand what addiction actually means.

Help them identify a short personal phrase that counters this wrongly held belief.

"No, MAT is a medical treatment for a medical condition, like any other. [Medication] helps my body work properly when it wasn't before—like insulin for someone living with diabetes. It also helps me focus on what is important in my life, such as achieving my own life goals. Most important, it lets me take control of my life and overcome addiction."

How can you care for a child [or do other relevant activity] while taking [Medication]?

Because of actual or assumed side effects, legal professionals and related providers may assume that patients cannot do a particular activity or adequately care for their home or child.

This is why learning about possible side effects and distinguishing ones they would otherwise experience from not using MAT is crucial for patients.

"Some people worry MAT might make me too [drowsy or other side effect] to care for my child. I don't experience that side effect."

"Unlike when I was using [heroin, fentanyl, or other other opioid(s)], I feel 'normal' and not high when I take MAT and don't have cravings or withdrawal symptoms."

"I do experience [side effect], but I have a plan in place (e.g., my family member is there for the hour of the day when my side effects occur until they subside)."

Resources

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