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FROM THE FIELD

Pregnant and Postpartum People with Substance Use Disorders: Understanding the Obstetrical Care Provider's Roles and Responsibilities

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Abstract
Peripartum individuals with substance misuse are a high-risk population that challenge clinicians and child welfare specialists alike. Federal legislation was updated in 2016 with the Comprehensive Addiction Recovery Act (CARA) to improve care via expanded screening and treatment referrals for peripartum women with substance misuse. The implementation of CARA requires providers to update their policies and procedures in order to meet the requirements outlined by this legislation. As this is a new process, this paper reviews the new administrative reporting and safety planning requirements relevant to obstetrical care providers and provides examples of best practice for different clinical scenarios. Given the variable state laws, confidentiality concerns, influence of stigma and health inequities on substance use treatment, and the fragmented healthcare system, implementation of CARA will challenge obstetric, pediatric, and mental health care providers along with child welfare services. All entities involved must work together to create effective and efficient protocols to address the CARA requirements. Health systems must also evaluate and update methods and interventions to assure that policies improve family stability and well-being.

Keywords Maternal substance use · Obstetrics · Child welfare · Comprehensive Addiction Recovery Act · Plan of Safe Care

Introduction

Pregnant and parenting persons with substance use disorders (SUDs) are a high-risk population who pose clinical and child welfare dilemmas for obstetric, pediatric, and addiction providers alike. Substance use is prevalent among pregnant patients, with one in five endorsing alcohol or illicit drug use (predominantly cannabis), and one in twenty testing positive for illicit substances (Substance Abuse and Mental Health Services Administration, n.d.). SUDs have severe implications on maternal and fetal health and are associated with a two-fold risk of inadequate prenatal care (Gopman, 2014). The American College of Obstetricians and Gynecologists (ACOG) recommends screening all patients for SUDs, and offering brief intervention and referral for treatment (SBIRT) for at risk individuals ("Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice," 2015).

Substance use during pregnancy is associated with increased involvement of Child Protective Services (CPS), foster care utilization, and drug use among offspring (McLafferty et al., 2016). Pregnancy is a pivotal time to encourage SUD treatment as concerns about the negative

Significance This article describes the obstetrical care provider's role in reporting and managing substance use in line with recent policy changes to promote family stability and wellbeing.

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impact of illicit drugs on the health of fetus and the desire for future child custody are strong motivating factors to curb substance misuse (Frazer et al., 2019; Lester et al., 2004). Parenting and substance use treatment go hand-in hand, as individuals who maintain child custody are more likely to complete drug treatment, leading to improved family outcomes (Gifford et al., 2014). Through identifying and referring pregnant and parenting persons for treatment, maternal and child welfare outcomes can be promoted.

The Child Abuse Prevention and Treatment Act (CAPTA), federal legislation addressing child abuse and neglect originally enacted in 1974, was amended in 2016 with the Comprehensive Addiction Recovery Act (CARA) (Child Abuse Prevention and Treatment Act (CAPTA); Public Law 114–198, the Comprehensive Addiction and Recovery Act of 2016 (CARA), 2016; U.S. Department of Health and Human Services; Adminisration on Children, n.d.). CARA is intended to promote family functioning by expanding the role of state governmental agencies and updating reporting requirements to include exposure to illicit and prescribed substances. Providers are now mandated to evaluate, and may be required to offer services and develop safety plans when concerned about perinatal substance exposure (Lloyd et al., 2019). States must now identify the number of infants exposed to substances in utero using a "CAPTA notification", an administrative form without identifying information, to count the number of infants affected by prescribed opioids, medical cannabis, benzodiazepines, or for any infant born with an abstinence or withdrawal syndrome due to identified substance exposure.

Clinicians also now are required to develop a Plan of Safe Care (PoSC), a patient-centered plan to address the needs of the pregnant or parenting person and infant with the goal of improving engagement in services to reduce the progression of parental substance use and child maltreatment. The PoSC is a state-specific document with different standards depending on which regulatory bodies are involved. Interested providers should reference the *On The Ground* resource from the National Center for Substance Abuse and Child Welfare, which compiles each state's current guidelines and forms (National Center on Substance Abuse and Child Welfare, n.d.). For instance, the PoSC may focus on identifying family strengths and goals, safety concerns and precautions, supports and protective factors, current involvement in family services, and referrals for new services (National Center on Substance Abuse and Child Welfare, n.d.).

CAPTA notification and PoSC are different than CPS reporting requirements, which did not change with the 2016 legislation. Clinicians must continue to report child maltreatment to child welfare authorities in accordance with state policy, which varies in terms of which substances require reporting, whether to report cases of unborn children, and the level of evidence needed to report a case ("Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice," 2015; *Substance Use During Pregnancy | Guttmacher Institute*, n.d.; Jarlenski et al., 2017). With a CPS report, authorities receive protected health information, investigate the allegation, and may take over clinical and administrative tasks for the family if allegations are confirmed.

The decision-tree depicted in Fig. 1 shows our recommended clinical roles and responsibilities which are subject to variability depending on state law, clinical circumstances, and the medical system's administrative rules and regulations. We recommend that the PoSC be completed during pregnancy with the provider who has the strongest alliance with the pregnant or parenting person. If not already completed, Fig. 1 shows the best provider to complete the PoSC in various clinical situations and when a obstetrical provider would be responsible.

Given the fragmented healthcare system, and confusing clinical and administrative requirements mandated by CARA, this article aims to educate women's health clinicians on new policies, to provide examples of best practices, to discuss implementation challenges and to propose solutions for caring for these families.

Clinical Vignettes

Vignette 1

A 25-year-old woman using intravenous heroin presented to the hospital with leg pain. She was found to be 15 weeks pregnant and admitted for treatment of cellulitis and heroin

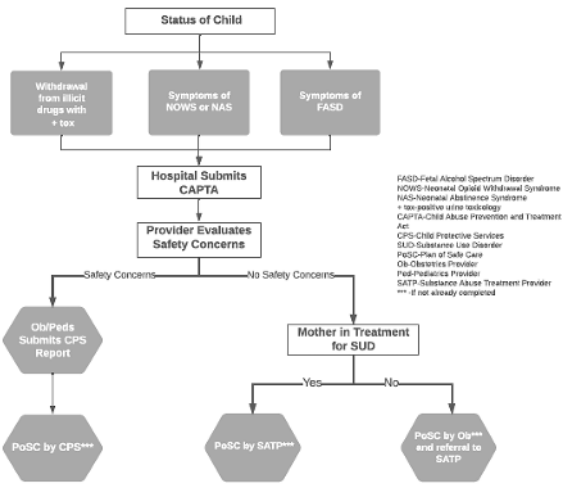

Fig. 1 Decision-tree depicting a clinical algorithm for CAPTA notifications, CPS reporting and PoSC completion when an infant is exposed to substances in utero

withdrawal. The patient's skin infection improved, and she was initiated on methadone for opioid withdrawal. She was discharged five days later after SUD counseling and was referred to a methadone maintenance treatment (MMT) program. She missed MMT and other prenatal appointments despite significant outreach and went into preterm labor at 34 weeks gestation. The infant was admitted to the NICU for Neonatal Opioid Withdrawal Syndrome (NOWS), leading the hospital to submit a CAPTA notification.

On postpartum day two, the mother left the hospital against medical advice while she had opioid withdrawal symptoms and refused to engage in SUD treatment. On postpartum day six, the infant's pediatrician submitted a CPS report for neglect after the mother was unreachable for multiple days. CPS completed the PoSC after locating the mother, motivated her to engage in treatment, and referred her for MMT and parenting classes. During the CPS investigation, it became clear that the mother had a toddler who was left unsupervised overnight; for this reason, the toddler and infant, once medically stabilized, were placed into foster care with the grandmother. The mother engaged in SUD treatment and parenting skills training, and regained custody after clinical stabilization six months later.

Vignette 2

A 35-year-old woman presented to her obstetrician during her second trimester with severe nausea. A week prior, her friend suggested she try smoking cannabis, which she told her obstetrician that she used twice to good effect. SUD screening was completed with a validated verbal measure and the doctor determined that although the patient had used cannabis, she was low risk for a SUD diagnosis. The obstetrician educated the patient about the harms of cannabis use during pregnancy (i.e. neonatal motor deficits, low birth weight, preterm birth, and potential long-term neurologic effects (Metz & Borgelt, n.d.)and prescribed the appropriate medications to treat hyperemesis gravidarum. The doctor did not order a UDS as it would not change management and may have harmed the treatment alliance. At her next appointment, the patient's symptoms were much improved, and she denied further cannabis use. The remainder of her pregnancy was uncomplicated. At delivery, there was no need for a CPS report, CAPTA notification, nor PoSC.

Vignette 3

A 40-year-old woman with a remote history of mild opioid use disorder after a motor vehicle accident complicated by back pain presented to a covering obstetrician in her second trimester. The patient reported severe back pain which was unresponsive to over-the-counter analgesics. The covering obstetrician assessed her risk factors for SUD relapse, counseled the patient on risks and benefits of opioids during pregnancy, ordered appropriate imaging, and prescribed a two-week supply of low dose oxycodone for back pain as needed. At her 28 week prenatal visit, the patient appeared sedated to her primary obstetrician. The provider used validated verbal screening measures along with the SBIRT protocol to assess her use due to concern for SUD relapse. The patient reported continued use of opioids from a friend for back pain with mild withdrawal symptoms and cravings when she tried to cut down. The provider assessed and diagnosed the patient with an opioid use disorder using the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). The doctor counselled the patient, acquired written consents, referred the patient to pain management and physical therapy, ordered a UDS, and completed a PoSC to be uploaded into the medical record. The patient was referred to SUD treatment, but given the wait-time for evaluation, the obstetrician initiated the patient on buprenorphine with consultation from addiction medicine. Delivery and post-operative management were uncomplicated: the patient's pain was managed with non-opioid analgesics and urine toxicology from mother and infant were positive for buprenorphine. The infant was closely monitored for withdrawal and had mild symptoms of NOWS. The obstetrician reviewed and updated the PoSC with the patient before discharge, facilitated quick follow up with a SATP, and the hospital submitted a CAPTA notification. There was no CPS report as there were no safety concerns once the infant was delivered because the woman was currently engaged in SUD treatment and her opioid use disorder was well-managed.

Discussion of Vignettes

Providers have variable opinions of illicit substances depending on their own sociopolitical views, training, reading of medical literature documenting its effects, as well as the specific drug's legality, and social acceptability. Within each category of drug and mechanism of use there are different risks, and many women use multiple substances. The most ethical way to approach this complexity is to view all substances through a common lens to eliminate clinician bias (Lester et al., 2004).

The CARA legislation highlights the ethical issues related to the tension between the rights of the pregnant and parenting person, and the newborn. The first vignette illustrates that when a child's safety is threatened, there is minimal variability among clinicians and longstanding CPS reporting standards remain. A more flexible clinical interpretation can be used only when a child's welfare is not in

acute jeopardy, such as in Vignette 2 and 3. Specifically, Vignette 2 demonstrates how providers must consider the risks of in utero substance exposure against the risks of violating a patient's confidentiality and exposure to potential legal ramifications.

Vignette 3 highlights that many providers, including obstetricians, can lack the training, time, and resources to appropriately manage patients with SUDs (Gassman, 2003). The scenario stresses that pregnancy and parenting can also be associated with relapse, especially when prescribing opioids for pain(Rodriguez & Smith, 2019). As there are multiple providers involved, guidelines with clear delineation of responsibilities are needed to minimize diffusion of responsibility and maximize the likelihood that the PoSC's tasks are appropriately completed and clinically useful. In Vignette 3, the obstetrician (or the social workers affiliated, if available) was the most appropriate clinician to complete the PoSC because the patient had not yet enrolled with a SATP at delivery and there were no child welfare concerns.

Challenges to Implementation of CARA

Screening, Disclosure and Ethics

In implementing CARA, providers must weigh the mother's autonomy against the child's safety. ACOG recommends that all women of child-rearing age be periodically verbally screened for substance use, and that those who are identified should be consented for a UDS ("Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice," 2015). Despite this, provider bias and the clinical environment greatly influence substance use screening and disclosure practices. Black women are more likely to be tested for substance use with urine toxicology and have it documented in the medical record (Kunins et al., 2007). Single women with poor psychological, financial and social functioning, or with delivery complications, such as placental abruption or preterm labor are also more likely to be screened (Kerker et al., 2004). Provider settings also influence practice, as white women are less likely to be tested in private practices as compared to public healthcare settings (Kerker et al., 2006). Additionally, child welfare reporting is greatly dependent on the provider's sociopolitical view on substance use, the legality of substance, the patient's race, and other concurrent risk factors (Prindle et al., 2018). Black and low-income women are more likely to be reported to child welfare for suspected substance use (Paltrow & Flavin, 2013). Therefore, standardized practice guidelines are critical in order to mitigate bias in history taking, substance use testing, child welfare reporting, and the inadvertent criminalization of minority women.

Confidentiality

Confidentiality poses an ethical dilemma between beneficence and autonomy when considering how to document and communicate substance use. Improving collaboration among providers must be balanced with a patient's individual wishes and rights regarding the sharing of protected health information (PHI).

Title 42 of the Code of Federal Regulations (CFR) Part 2 is a federal confidentiality law initiated in 1975 to protect the disclosure of substance use to encourage persons who use drugs to seek treatment (*Electronic Code of Federal Regulations*, 2020). Federally assisted SATP cannot disclose information related to a patient's substance use unless the patient provides consent and specifies the entities to receive the information. This law was revised in 2020 to facilitate better coordination of care but nonetheless addiction providers may hesitate disclosing information due to fear of worsening stigma and potentially discouraging engagement in care. CARA requires that SATP providers complete the PoSC for qualifying patients after obtaining proper consent, which can be completed outside of the medical record if there are privacy concerns so that families can still benefit from the service. If a pregnant or parenting person refuses, that should be clearly documented and readdressed, and the provider should consider whether the concern about child endangerment may trump confidentiality.

Providers who practice in a "non-Part 2 site", such as obstetric providers, are not covered by this law but instead operate under the Health Insurance Portability and Accountability Act (HIPAA) to keep PHI confidential (U.S. Department of Health and Human Services, 2019). PHI can be communicated for purposes of coordination among providers, health care operations, and reimbursement. Many health systems are concerned about inappropriate dissemination through the EMR as it deals with sensitive substance use information; as a result, many institutions use a paper PoSC. Since the PoSC focuses on the overall health of the pregnant or parenting person and infant and is often triggered by a "non-Part 2" provider, we suggest that the EMR include the PoSC or documentation of PoSC completion. Although there is no standard of care in this regard, our clinical opinion is that if there is consent, the PoSC should be located in both the pregnant or parenting person's and infant's EMR for efficient and effective collaboration.

Conclusions

Treating pregnant and parenting persons with SUDs offers a unique challenge to a varied network of clinicians and child welfare providers. The new CARA legislation expanded reporting requirements and added specific safety planning procedures. Training in confidentiality, coordination with child welfare systems, and substance use screening and education must be implemented to improve collaboration among a dispersed network. All entities involved must mutually identify goals, roles and responsibilities to successfully implement this new legislation. Systems must also collaborate to track, evaluate, and update methods and interventions to improve family stability and well-being.

Clear guidelines and training must be developed so that providers know when they are responsible for creating a PoSC. Identifying the best provider for each type of patient problem would help limit diffusion of responsibility and initiate alliance building with the appropriate clinician. Additionally, information technology can be useful in decreasing the administrative burden via facilitating screening for SUDs with validated questionnaires, consent acquisition, making referrals, communication among various entities, and CAPTA notification.

As state guidelines differ, clinicians should become familiar with the requirements within their practice setting which can be reviewed in SAMHSA's useful reference guide(National Center on Substance Abuse and Child Welfare, n.d.)[1]

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Consent to Publish All authors have approved and agreed to submission to the journal.

[1] This project was approved by the Albert Einstein College of Medicine Institutional Review Board. The manuscript is not based upon patient data. The authors confirm that this research was conducted in accord with prevailing ethical principles.

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