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"Risk versus Risk" addressing family safety, 42-CFR, equity, and child welfare reporting mandates in pregnant and parenting people who use substances:

Lessons from a multidisciplinary collaboration

AMERSA workshop - November 16, 2024

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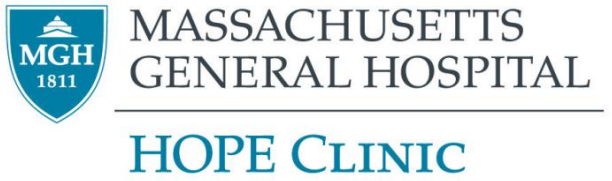
Acknowledgments

- Non-Presenting authors
  - Patricia Rosell, MSW
  - Latisha Goullaud
  - Miriam Renz ,LCSW
  - Melissa Maitland, LCSW
  - Nicole Gerniglia, NP

- Research Coordinators
  - Alexindra Wheeler
  - Gayla Walt
  - Adrian Caiazzo

- Our teams and patients



Disclosures:

None of the authors have relevant disclosures

This is not legal advice and none of us are lawyers

Learning objectives

By the end of this workshop the audience should be able to…

1. Explore how 42CFR protections in an integrated medical and behavioral program for pregnant and parenting people can be used to promote patient autonomy and family safety
2. Utilize a clinical decision-making framework for thinking about risk with patients who are in caregiver role
3. Describe a framework for engaging in difficult conversations around pregnancy, parenting, substance use and trauma

Core Values

Parents who use drugs should be treated with dignity and respect when they seek care for themselves and their children

Parenting is hard, and non-punitive approaches that allow the parent, infant, dyad, and family to thrive should be promoted

Child safety is everyone's responsibility

Slide adapted from Mishka Terplan, 2022

RISK versus RISK

Caregiver substance use

Children whose parents or caregivers use drugs or alcohol are at increased risk of short- and long-term sequelae ranging from medical problems to psychosocial and behavioral challenges.

AAP Clinical Report: Families Affected by Parental Substance Use

Published 2016, reaffirmed 2022

Family separation

Highly stressful experiences, like family separation, can cause irreparable harm, disrupting a child's brain architecture and affecting his or her short- and long-term health. This type of prolonged exposure to serious stress - known as toxic stress - can carry lifelong consequences for children.

AAP Statement Opposing Separation of Children and Parents at the Border

Colleen Kraft , May 2018

Pediatrics (2016) 138 (2): e20161575.

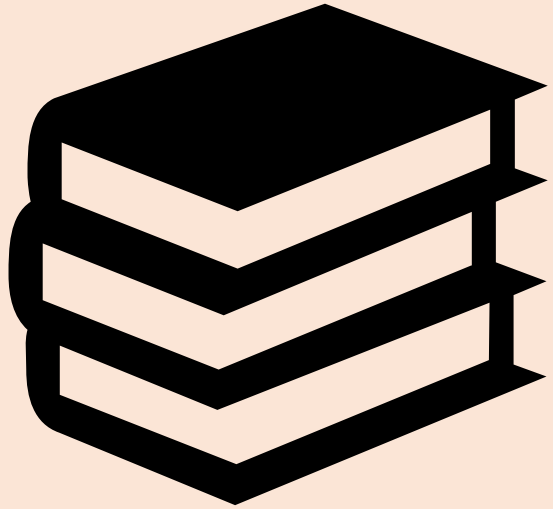
IDEAL	Improve child and caregiver health outcomes by keeping families together while they get the support they need
REALITY	Pregnant and parenting people fear engaging with the medical system due to fear of child removal and prosecution Our medical teams struggle with the complexity of dual risk when it comes to SUD and children
FUTURE	Work together to improve our systems of care to promote trust, engagement and family safety

Part I: 42CFR Protections, privacy, and engagement in care

“42CFR Part 2”

Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records

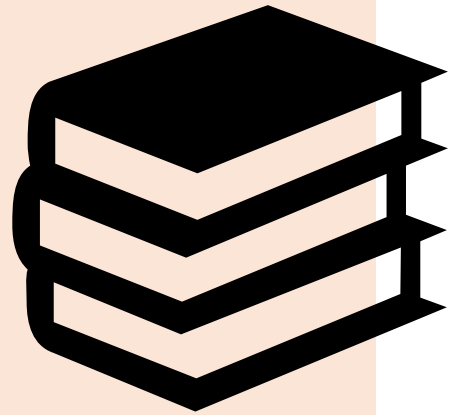
- A federal regulation that protects the privacy and confidentiality of patients receiving SUD treatment
- Programs are prohibited by federal law from sharing SUD treatment records with law enforcement officials seeking to investigate or prosecute a patient without appropriate court orders or specific patient consent



https://www.federalregister.gov/public-inspection/2024-02544/confidentiality-of-substance-use-disorder-patient-records.

What practices fall under 42CFR Part 2

- In general, applies specifically to any program that “holds itself out” as providing diagnosis, treatment or referral for treatment for SUD
  - All specialty SUD programs
  - Integrated addiction care in general medical settings **is subject to individual health system legal distinctions** and you should speak with your legal team to explore



https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html

Initial privacy at HOPE Clinic: Patients sign to “open” their 42cfr records

	Visible in OPEN Department
Psychiatric notes	✓
Substance use visit notes	✓
Toxicology tests	✓
HOPE Clinic appointment dates and times	✓
Obstetrical notes and labs	✓
Pediatric notes and labs	✓
Prescribed medications	✓
Allergies	✓

CASE 1

28 G2P1 3-year remission on BUP/NAL

Prenatal care at MGH HOPE Clinic

To demonstrate recovery, urine tox collected week prior to delivery

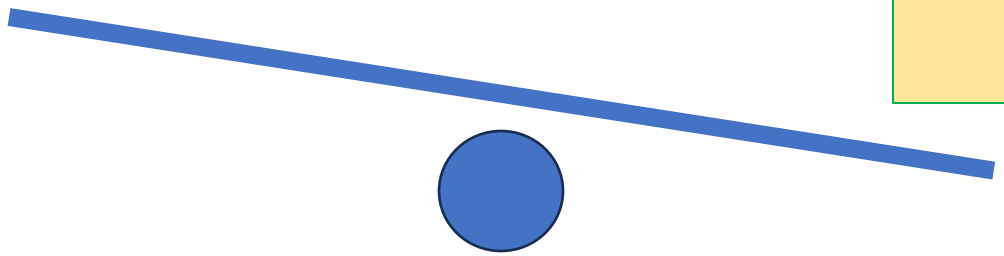
Preliminary positive for fentanyl, sent out for confirmation

Hospital SW shared preliminary result with CPS at delivery filing for being on MOUD

Evolution of privacy at MGH HOPE Clinic

What is the right BALANCE?

Safety of obstetrical patients in hospital through open records



Safeguard privacy to reduce fear of repercussions from honest sharing of SUD and avoidance of care

Evolution of privacy at MGH HOPE Clinic

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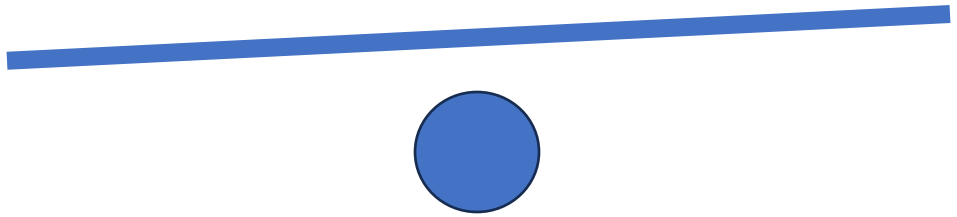


CASE 2

34y G2P1
Disclosed non-Rx BUP for self-treating back pain

Shared with OB she’s having trouble stopping in pregnancy

Not interested in perinatal clinic because of open records

2023 new privacy option at HOPE Clinic: Patients can chose between keeping SUD/psych information 42CFR-protected versus open

	Visible in OPEN Department	Visible in 42 CFR Protected Department
Psychiatric notes	✓	✗
Substance use visit notes	✓	✗
Toxicology tests	✓	✗
HOPE Clinic appointment dates and times	✓	✗
Obstetrical notes and labs	✓	✓
Pediatric notes and labs	✓	✓
Prescribed medications	✓	✓
Allergies	✓	✓

After updated 42CFR privacy options, patient amenable to get care at HOPE Clinic for medication management and supports

Case led to re-evaluation of communication streams with inpatient obstetrical team in preparation for delivery

There are some benefits to information sharing within our hospital

Reduce trauma of delivery hospitalization

Patient control of own narrative

Understanding of patient's engagement in care during pregnancy

Strengths-based sharing

Addressing potential concerns

Support inpatient team

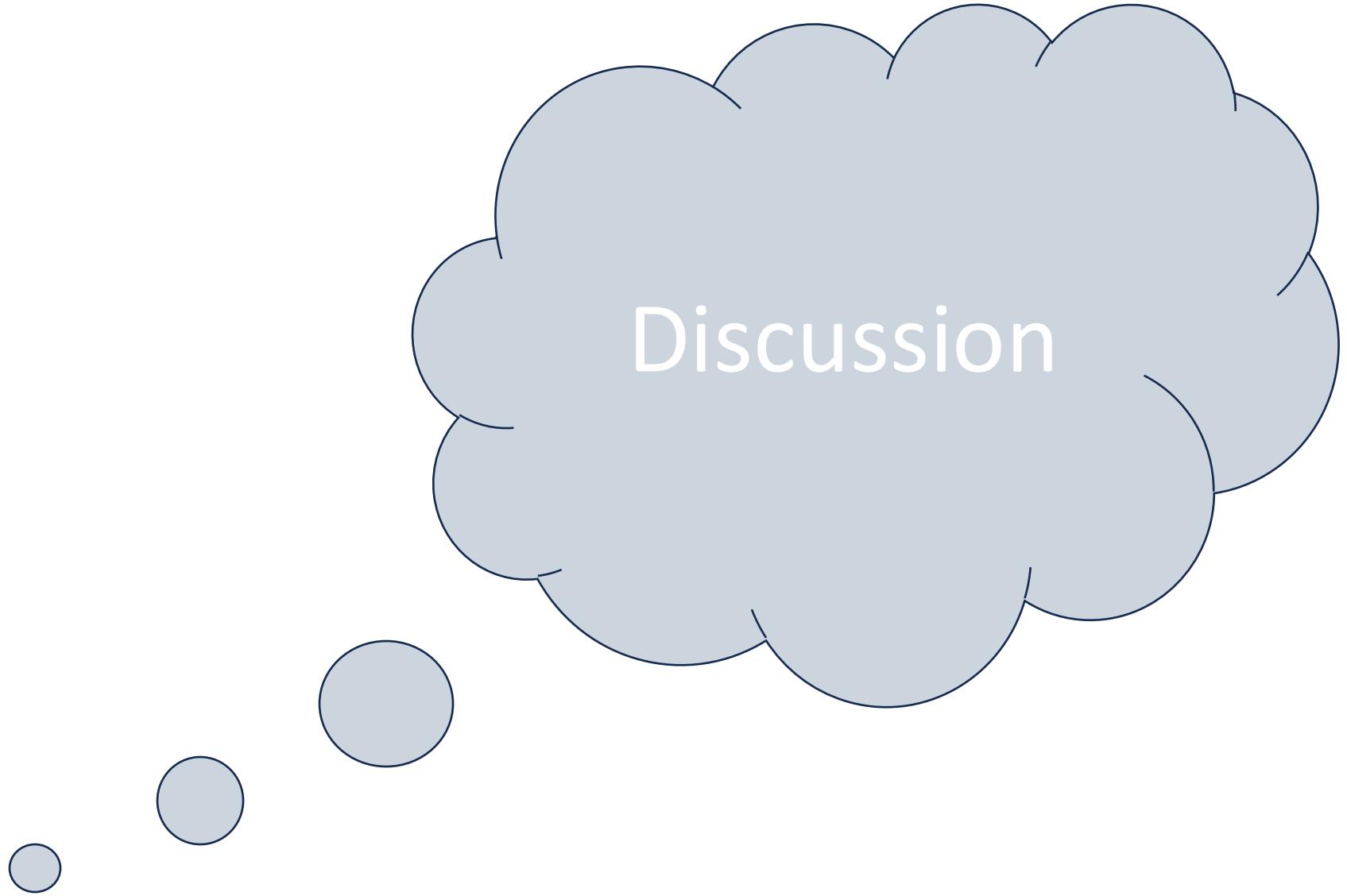
With support, patient was able to tell her partner about her medications and the monitoring baby would need post-delivery

Once communication options explained, she signed consent and welcomed communication with inpatient team

HOPE Clinic Data: January-October 2024

78% chose open department

22% chose closed


Discussion

Take-home points

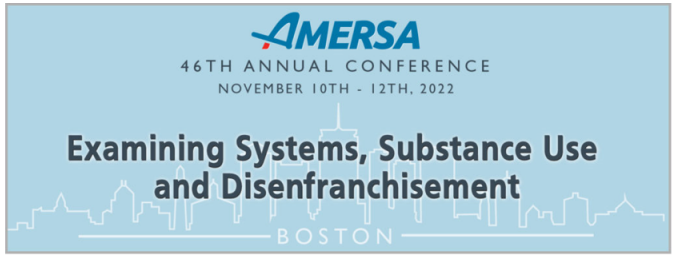
42CFR protections can promote patient comfort with and trust in care team

Privacy rules are complicated, require clear explanation of impact on patient care

Important for patients to understand risks of absent communication for those who chose “closed department” and identify ways to support relevant information sharing

Part II: Development of a Clinical-Decision Making Framework to Address Parental Substance Use and Child Safety

AMERSA 2022 Plenary Fall Out → 2024 Workshop



Beyond the Evidence Base: Preserving Dignity and Countering Discrimination in Pregnancy and Parenting

Lisa Sangoi, JD - Movement for Family Power
Mishka Terplan, MD, MPH - Friends Research Institute
Nikki Bell Peña - Living In Freedom Together-LIFT Inc

- Concern raised about talking about harms of separation without talking about potential harms from children experience active parental addiction
- Providing care for families impacted by addiction requires a frequent assessments of well being and child safety

Lack of Standardization in Response to Parental Substance Use

Clinician A

- Addiction trained clinician chooses not to ask any questions about the care of children for fear that receiving this information leaves them in uncomfortable position as a mandated reporter

Clinician B

- Psychiatrist in a busy private practice reflexively reports all parental disclosure of substance use to child protective services

Case 1 – SUD in Remission at Delivery

38 G4P1→2, 1 year remission OUD (on BUP) and CUD
Late transfer of care after transitioning to residential treatment for couples

- **Plan of Safe Care / Recovery Portfolio** completed at delivery
- **No acute protective concerns** identified, no CPS filing
- Plan for outpatient care at multidisciplinary SUD clinic
- Mom, dad and baby discharged to residential program
- No issues identified at 2 week follow up for weight check and postpartum visit

Case 1 (cont) - Escalation of concern at 1 month

- Missed 1 month WCC, 2wk Pedi follow up
- Phone outreach after missed visit
  - Reported discharged from family residential due to interpersonal conflict between partner and staff - now staying in hotel with partner, car getting repaired
- Presented for in-person visit 10d later
  - Disclosed intranasal cocaine use

~~PREGNANCY~~ parenting? AND SUBSTANCE USE

A HARM REDUCTION TOOLKIT

NATIONAL HARM REDUCTION COALITION

Academy of Perinatal Harm Reduction

Applying Harm Reduction Principles to Child-Well Being and Safety Assessment

Principle	Application to Child-Safety Assessments
Humanism	Valuing parents as experts in their children's needs
Pragmatism	Parental substance use is common and substance use recurrence is a predictable part of a SUD
Individualism	Context (location, setting) of parental substance use can mediate the impact on child
Autonomy	Punitive or coercive approaches can deter parents from seeking SUD Tx
Incrementalism	Identify and name protective factors parent has taken for child well being in order to celebrate forward progress

Hawk, 2017; Table developed by Galya Walt, In Press – *Schiff et al. Parenting and Practice, 2024*

Applying Harm Reduction Principles to Child-Well Being and Safety Assessment

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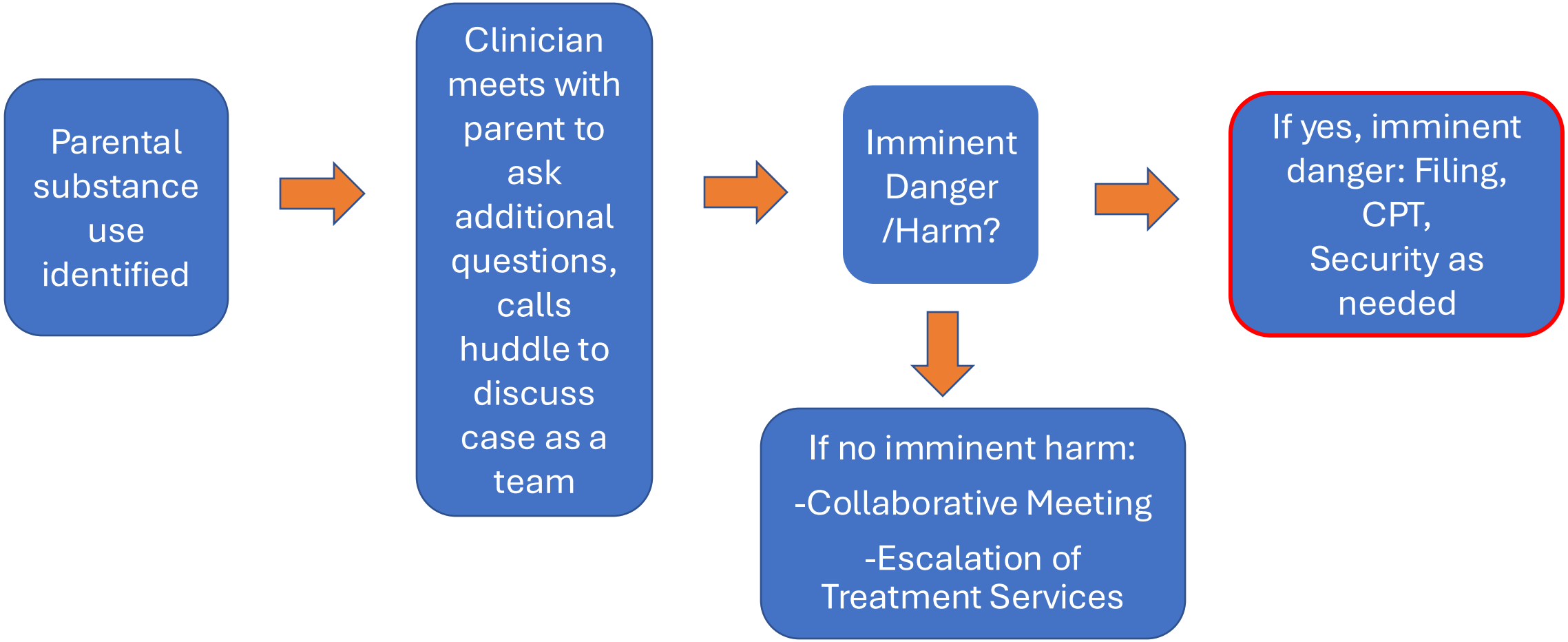
Incrementalism	Identify and name protective factors parent has taken for child well being in order to celebrate forward progress
Accountability w/o termination	"Perfect parenting" is unrealistic; positive parenting and attachment should be promoted.

Clinical Approach to Addressing Ongoing Substance Use While Parenting

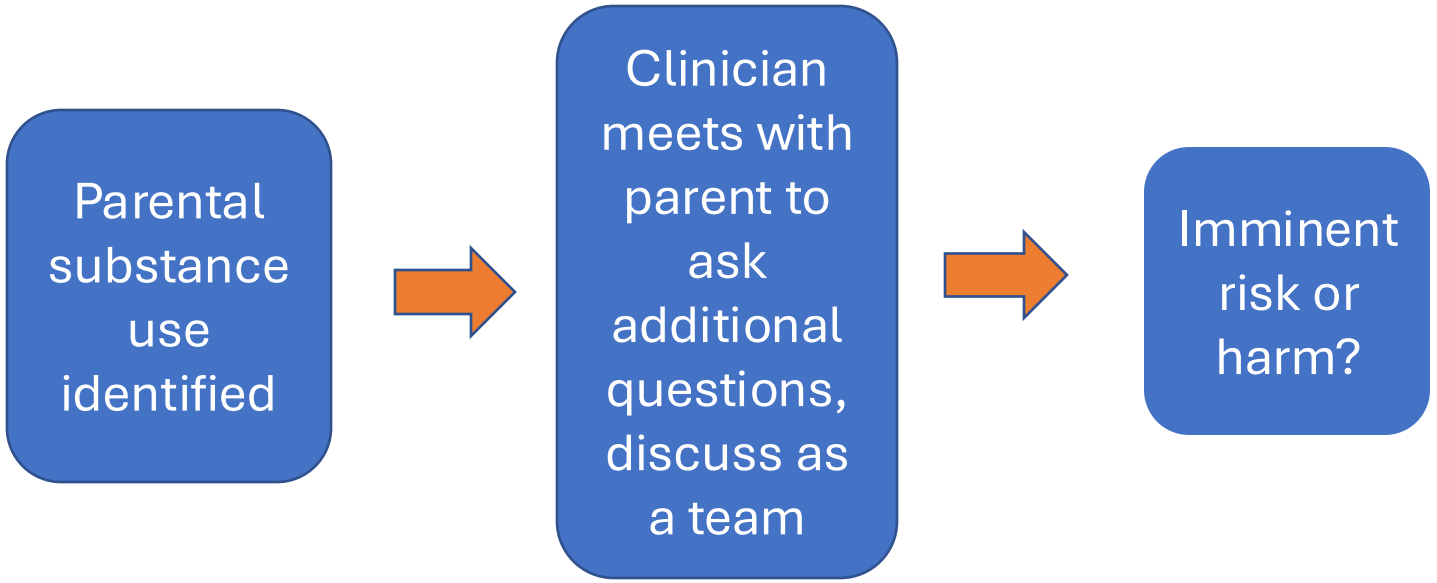


Safety Assessment Framework

Domain	Application to Child-Safety Assessments
Safety of child	Where does/did substance use happen? (i.e: inside/outside home?) If the child was to become sick when parents are using substances, who would be available to take child to the emergency room?
Safety of use patterns	What is the patient actively doing to keep themselves safer with drug use? Does use occur alone?
Engagement in treatment	Is the parent asking for treatment? Does the parent endorse active use? What is known about reasons for active substance use?
Willingness to escalate treatment services	Is the parent willing to increased frequency of engagement at clinic or other recovery supports?
Stability of the home environment	Who else lives at home? Are there any other safety concerns in the home (i.e: violence, housing instability)?
Social determinants of health (SDOH) and structural racism	How did identities, power, privilege, bias or SDOH affect this case?

Case: Disclosure of IN cocaine while caregiving

- Safety assessment with mom in clinic utilizing framework



- Caregiver responsible for child during periods of use
- Reported substances used outside of hotel room where newborn is cared for
- Missed pediatric visits, weight trending down at current visit
- Help-seeking caregiver, self disclosed use
- Minimal outside supports

Case: Disclosure of IN cocaine while caregiving

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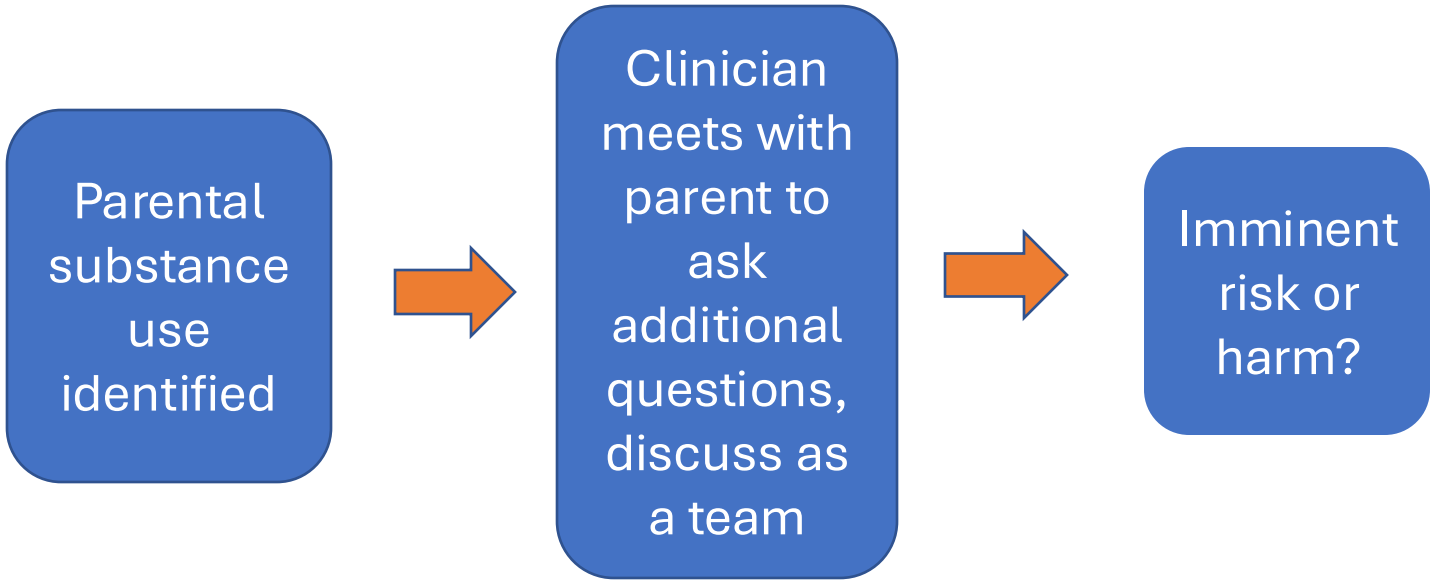


- Caregiver responsible for child during periods of use
- Missed pediatric visits, weight trending down at current visit
- Minimal outside supports
- **If child were to become acutely ill, no clear unimpaired caregiver**

Take-home points

Harm reduction principles can be applied to substance use and parenting

A structured framework for assessing parental substance use can provide a guidepost for collective decision making surrounding child safety conversations

Bringing team together reduces provider bias and pressures on a single individual to make difficult decisions

By sharing the risk of caring for families impacted by SUD, unnecessary filing can be avoided

Part III: Engaging in trauma-informed child safety discussions

Patient Reflections

“you created a space where honesty can happen”

“consistently checking in on my mental health”

“They wanted what was ultimately safe for me and him”

“told me I wasn’t a bad mom”

Trauma Informed Child Safety Discussion

- Honor the body and the physiologic trauma response
  - Fight, flight, freeze
  - “Downstairs brain” with impaired self regulation
  - Be prepared to help with grounding

Trauma Informed Child Safety Discussion

- Honor patient rights and dignity:
  - Know and abide by patient privacy laws
  - Affirm your commitment aloud to your patient

Trauma Informed Child Safety Discussion

- Prioritize transparency and candor
  - Be honest about your concerns
  - Give the parent the choice to be with you while you call child welfare

Trauma Informed Child Safety Discussion

- Prioritize autonomy, agency, and participation
  - Share safety planning with the parent: “We came up with a plan.”
  - Help them get back into “upstairs brain”
  - This can protect against traumatization

Trauma Informed Child Safety Discussion

- Emphasize family strengths
  - Elicit strengths from the parent and praise strengths you've observed
  - Share these with your patient and with child welfare

Trauma Informed Child Safety Discussion

- Interpret Urine Toxicology tests (if that's part of your role)
  - Don't outsource interpretation to child welfare staff

Trauma Informed Child Safety Discussion

- Use your multidisciplinary team
    - Another team member may tag in to support the patient
    - Circle back with the team, debrief

Trauma Informed Child Safety Discussion

- Honor the body and the physiologic trauma response
- Honor patient rights and dignity
- Prioritize transparency and candor
- Prioritize autonomy, agency, and participation
- Highlight strengths (don’t leave that question empty!)
- Interpret urine toxicology tests
- Teamwork
- **3 Ps**

Trauma Informed Child Safety Discussion

- **Secondary trauma**
  - **Pay attention! “If you work at a paint store, you’ll get covered in paint.”**

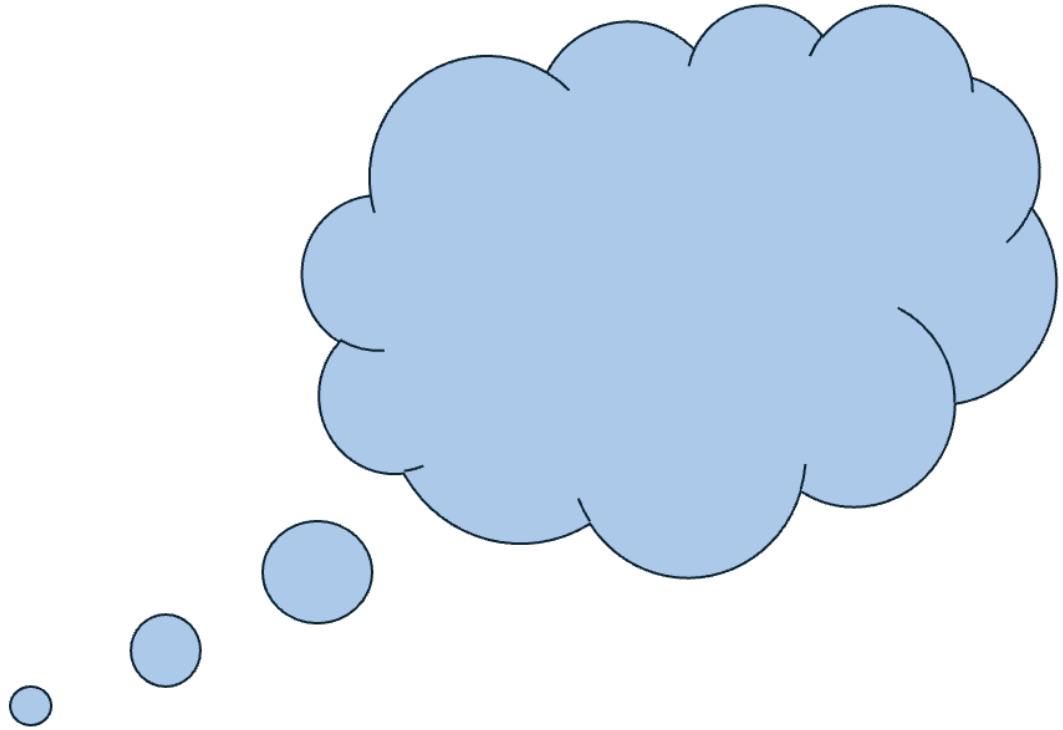
How to have hard conversations – The 3P's

Pace

Presence

Perspective

*credit to Patricia Rosell, LICSW



Discussion: 3P’s framework & family centered CPS reporting

Learning objectives

By the end of this workshop the audience should be able to…

1. Explore how 42CFR protections in an integrated medical and behavioral program for pregnant and parenting people can be used to promote patient autonomy and family safety
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3. Describe a framework for engaging in difficult conversations around pregnancy, parenting, substance use and trauma

THANK YOU!

Lynn Community Health Center

PRISM
PeRInatal Substance use research & advocacy at MGH

MGH 1811
MASSACHUSETTS GENERAL HOSPITAL
HOPE CLINIC