Cannabis Use in Pregnancy: Person Centered Perspectives

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Disclosure Information (Required)

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- No Disclosures

Professional Society Recommendations

- Universal Screening:
  - Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)
  - Voluntary (ACOG, SAMHSA, CDC)
- Testing:
  - Not Recommended - Not an appropriate measurement of addiction (ACOG, ASAM, SAMHSA
  - Definitive testing required “when the results of inform decisions with major clinical or non-clinical implications for the patient” (ASAM)
  - Consent required (ACOG, ASAM, SMFM SAMHSA)

Screening	Testing
Selective	Universal

Professional Society Recommendations are grounded in Ethics and Opposition to Coercion

Revised
1/22

The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 664 • June 2016 *(Replaces Committee Opinion Number 321, November 2005)*
(Reaffirmed 2019)

Committee on Ethics

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Ethics in collaboration with committee members Mary Faith Marshall, PhD, and Brownsyne M. Tucker Edmonds, MD, MPH, MS. The Committee on Ethics wishes to acknowledge the assistance of Ashley R. Filo, MD, in the development of this document.

While this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Refusal of Medically Recommended Treatment During Pregnancy

ABSTRACT: One of the most challenging scenarios in obstetric care occurs when a pregnant patient refuses recommended medical treatment that aims to support her well-being, her fetus's well-being, or both. In such circumstances, the obstetrician–gynecologist's ethical obligation to safeguard the pregnant woman's autonomy may conflict with the ethical desire to optimize the health of the fetus. Forced compliance—the alternative to respecting a patient's refusal of treatment—raises profoundly important issues about patient rights, respect for autonomy, violations of bodily integrity, power differentials, and gender equality. The purpose of this document is to provide obstetrician–gynecologists with an ethical approach to addressing a pregnant woman's decision to refuse recommended medical treatment that recognizes the centrality of the pregnant woman's decisional authority and the interconnection between the pregnant woman and the fetus.

Legal Interventions During Pregnancy H-420.969

Topic: Pregnancy and Childbirth	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2018
Action: Reaffirmed	Type: Health Policies
Council & Committees: NA	undefined

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant **Women**:

(1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.

(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.

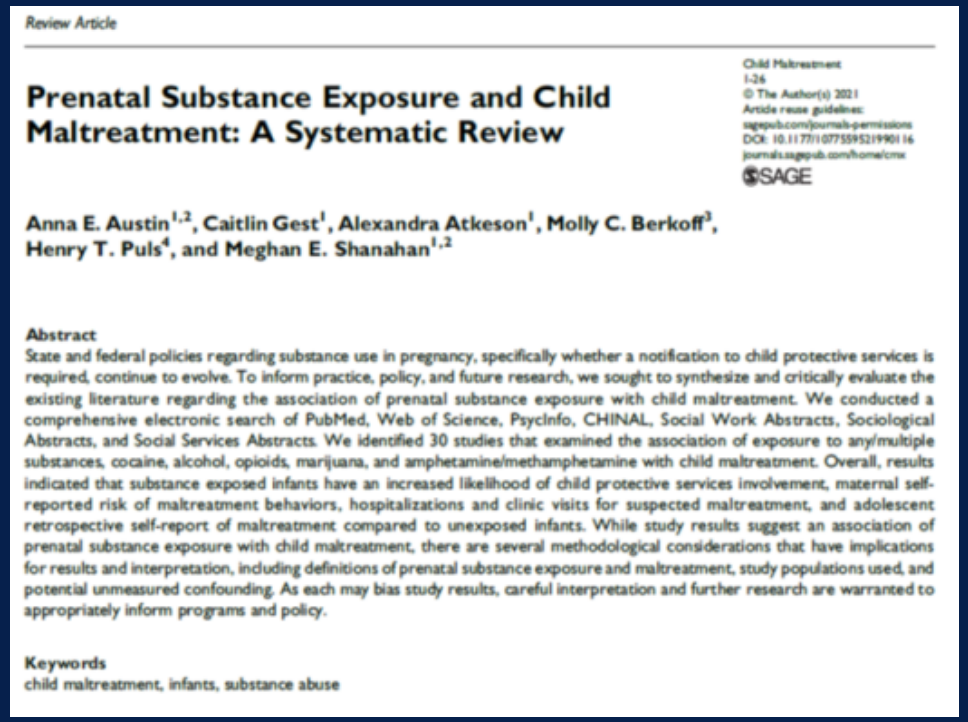
Child Abuse Prevention Treatment Act (CAPTA)

- 2003 (in response to “crack babies”) – CAPTA amended to require states to arrange for “plans of safe care” for infants affected by “illegal” substance use
- 2016 – CAPTA amended to require “plans of safe care” for infants affected by any substance (interpreted to include MOUD – buprenorphine or methadone)
- [No funding allocated for presumed care in either amendment]
- 2022 – CAPTA reauthorization ….

States must have: "policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) 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 a Fetal Alcohol Spectrum Disorder [FASD], including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants.”

Substance Use in Pregnancy and Child Maltreatment: Where is the Evidence?

- Substance-exposed infants have increased likelihood of child welfare involvement
- No strong evidence of substantiated maltreatment
- Overall literature is of poor methodological quality



Review Article

Prenatal Substance Exposure and Child Maltreatment: A Systematic Review

Child Maltreatment
1-26

DOI: 10.1177/10775595219901 16
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SAGE

Anna E. Austin[1,2], Caitlin Gest[1], Alexandra Atkeson[1], Molly C. Berkoff[3], Henry T. Puls[4], and Meghan E. Shanahan[1,2]

Abstract

State and federal policies regarding substance use in pregnancy, specifically whether a notification to child protective services is required, continue to evolve. To inform practice, policy, and future research, we sought to synthesize and critically evaluate the existing literature regarding the association of prenatal substance exposure with child maltreatment. We conducted a comprehensive electronic search of PubMed, Web of Science, PsycInfo, CHINAL, Social Work Abstracts, Sociological Abstracts, and Social Services Abstracts. We identified 30 studies that examined the association of exposure to any/multiple substances, cocaine, alcohol, opioids, marijuana, and amphetamine/methamphetamine with child maltreatment. Overall, results indicated that substance exposed infants have an increased likelihood of child protective services involvement, maternal self-reported risk of maltreatment behaviors, hospitalizations and clinic visits for suspected maltreatment, and adolescent retrospective self-report of maltreatment compared to unexposed infants. While study results suggest an association of prenatal substance exposure with child maltreatment, there are several methodological considerations that have implications for results and interpretation, including definitions of prenatal substance exposure and maltreatment, study populations used, and potential unmeasured confounding. As each may bias study results, careful interpretation and further research are warranted to appropriately inform programs and policy.

Keywords

child maltreatment, infants, substance abuse

The Brain and Development

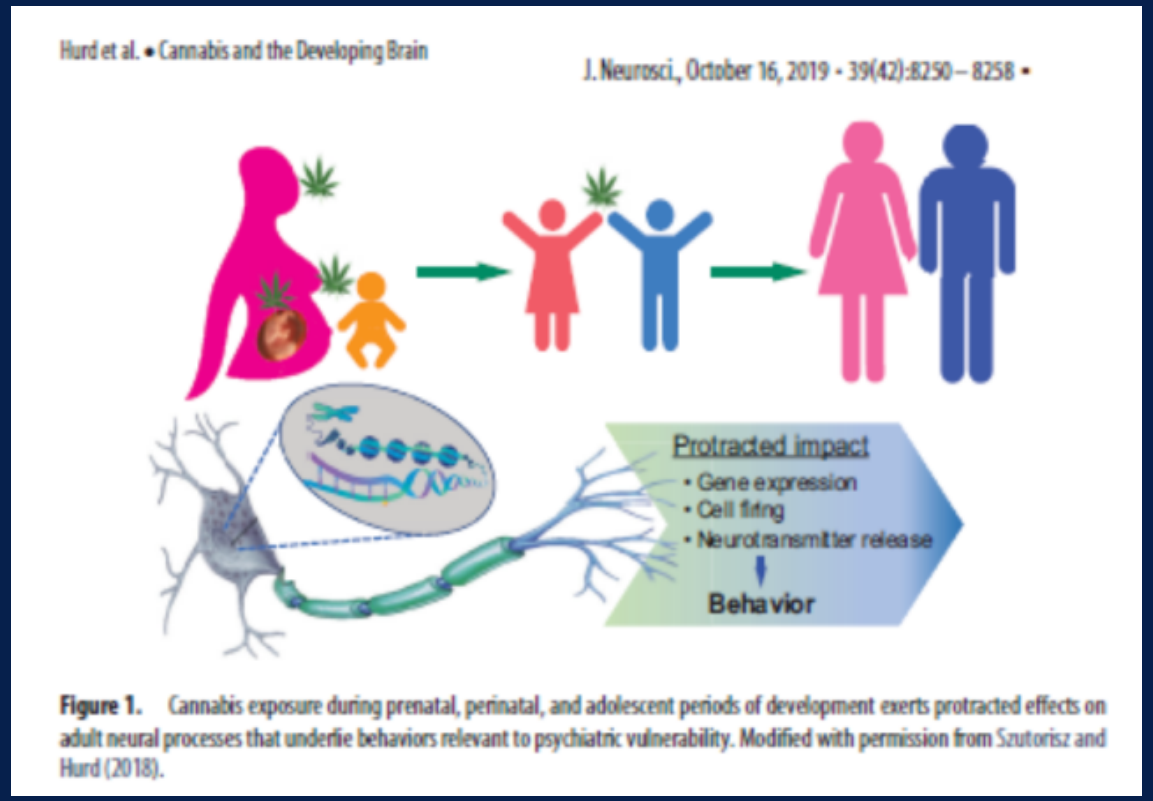


Figure 1. Cannabis exposure during prenatal, perinatal, and adolescent periods of development exerts protracted effects on adult neural processes that underlie behaviors relevant to psychiatric vulnerability. Modified with permission from Szutorisz and Hurd (2018).

- There is linear development of the brain from fetus through childhood and into young adulthood
- Hence time of exposure in utero <<< potential time of exposure as child
- Development is about more than exposure

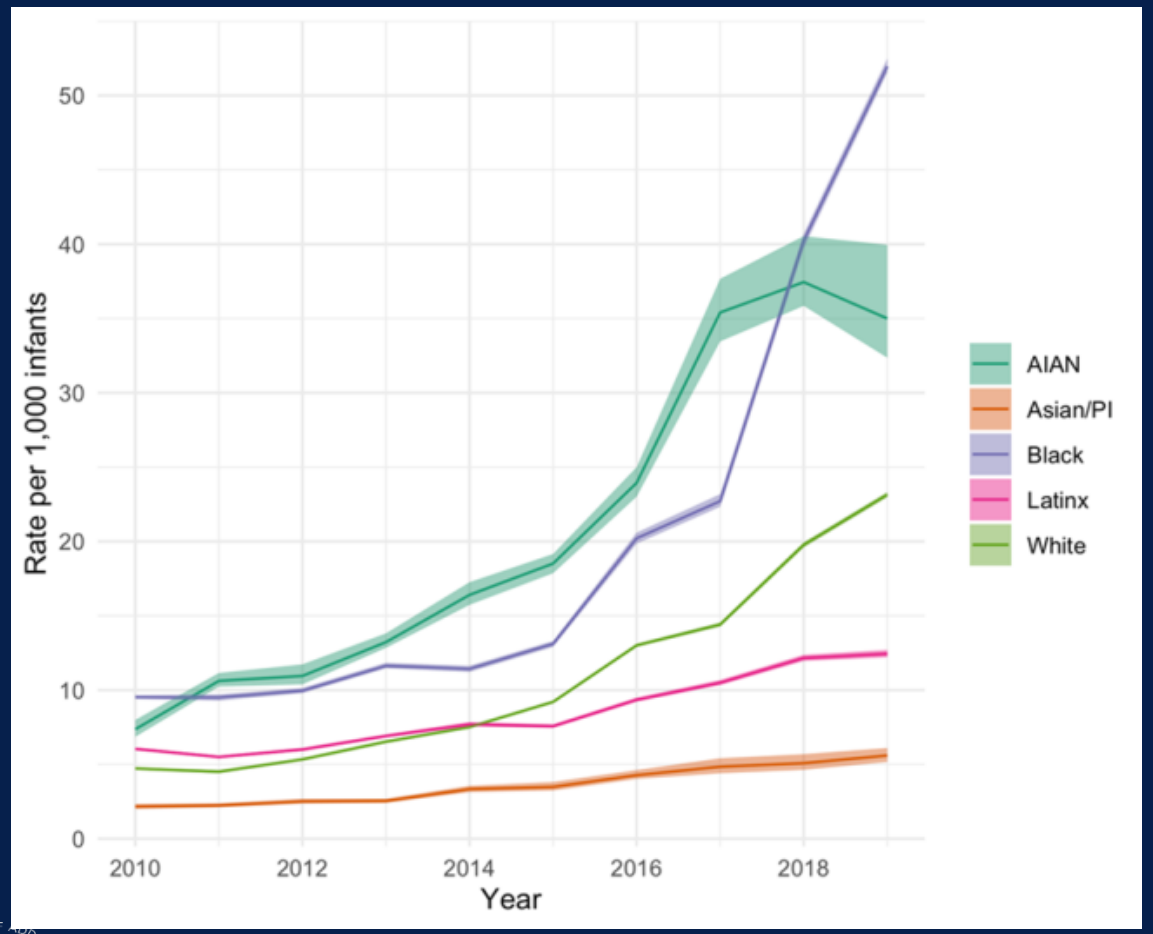
Provider Assumptions:
Social/Legal Distinctions = Biological/Public Health

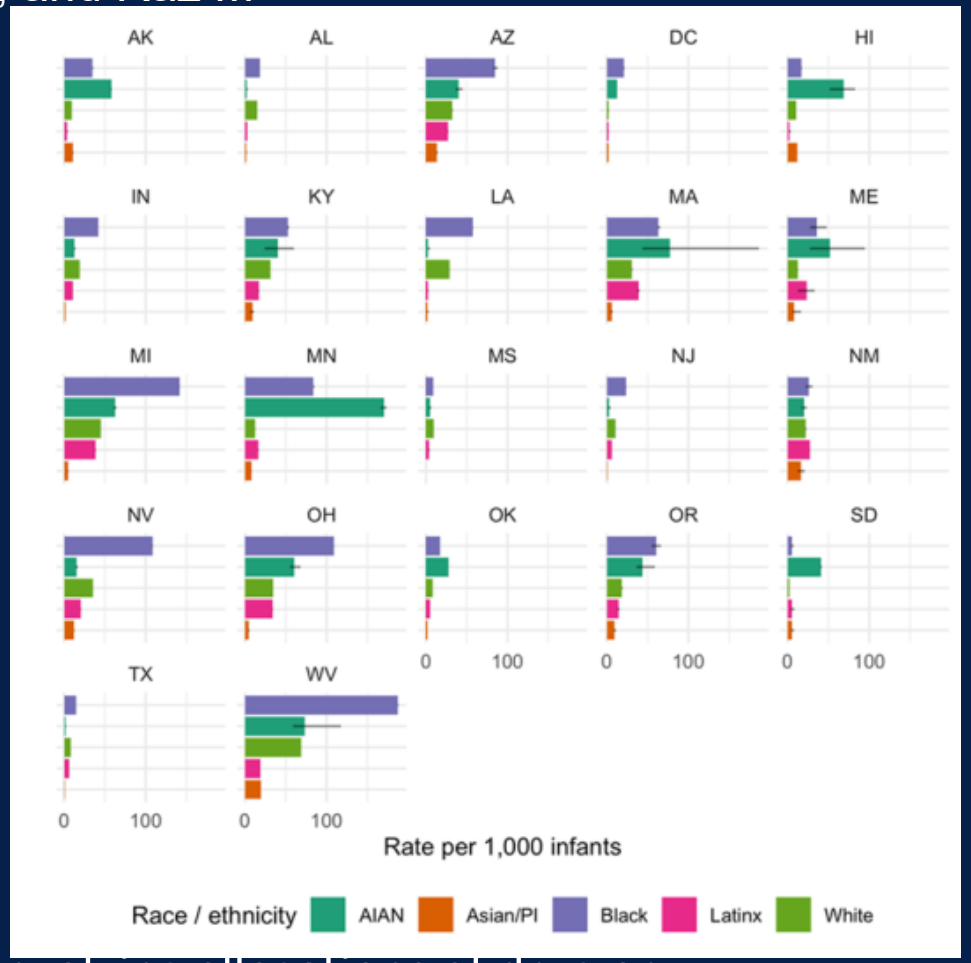
HARM

Known Teratogens: ACE-Inhibitors, Alcohol, Carbamazepine, Diethylstilbetrol (DES), Isotretinoin, Phenytoin, Tobacco, Valproic Acid (partial list)

Healthcare Provider reports of infants to Child Welfare has increased 400% in last decade

Manuscript in preparation by Edwards F, Terplan M, Roberts S, and Raz M

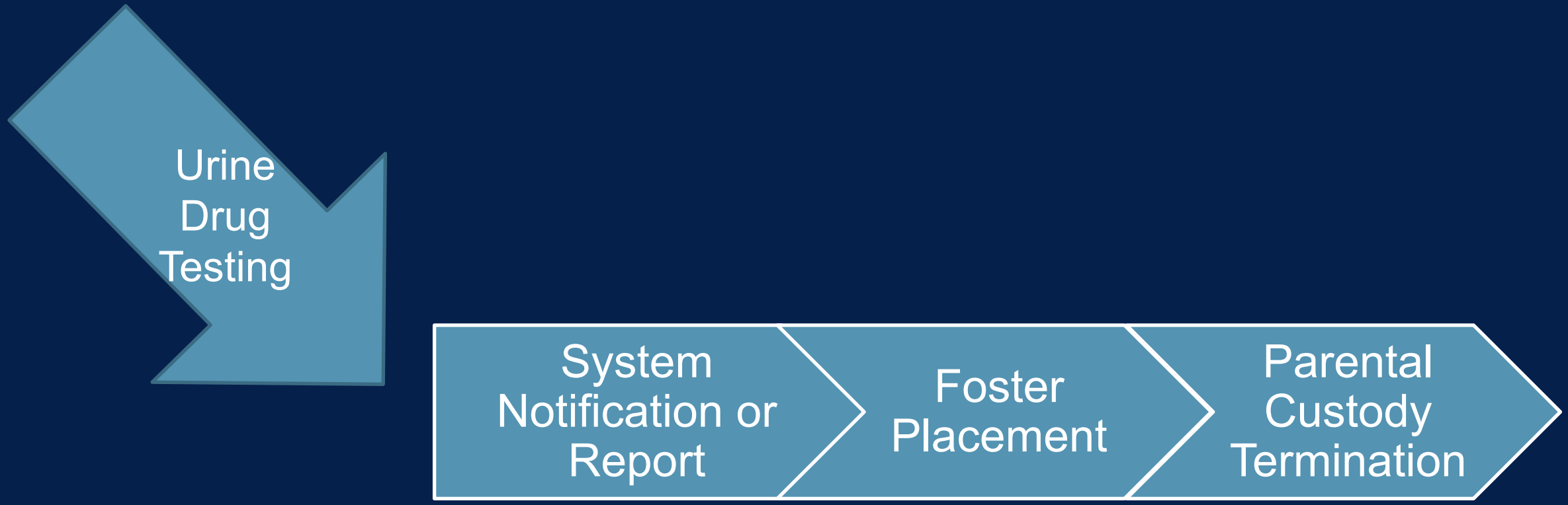




Screened-in reporting rate by medical professionals involving allegations of drug or alcohol use per 1,000 infants by race / ethnicity, 2010 - 2019D (National Child Abuse and Neglect Data System)

#ASAMAnnual2022

The Family Regulation System Pipeline (simplified)



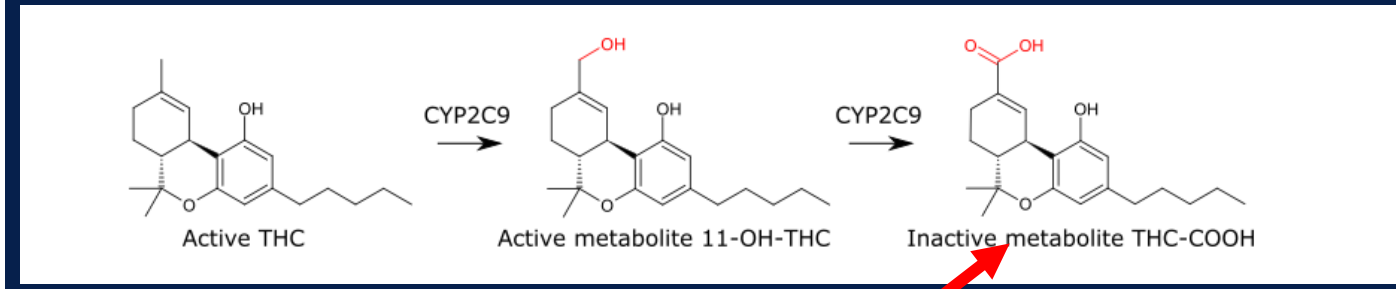
Cannabis and Urine Drug Testing: Misinterpretation

Point of Care Drug Test Result

"THC"

"THC" is NOT THC

It is THC-COOH – not psychoactive, highly lipophilic, remains in biologic matrix for up to 100 days following last cannabis use



"THC"

CAPTA and Drug Testing

- Is a Positive Drug Test The Same as Being “Affected” by substance exposure?
- Does CAPTA Require Maternal Testing at Delivery?
- Does CAPTA Require Testing Newborns for Drug Exposure?

- **NO**
- CAPTA is it clear that a demonstrable health impact beyond a positive test is needed

Problem 1: Professional Society Recommendations are not Observed

- Providers lack knowledge and often misinterpret urine drug tests or employ poor screening
- Do not know the difference between presumptive and definitive tests
- Are ill-informed about CAPTA/CARA
- Do not understand the consequences of a report or function of the family separation system
- Often work in systems with vague or absent policies

- Leads to both over-reporting and provider confusion and frustration

ORIGINAL ARTICLE

Urine drug test interpretation: What do physicians know?

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ABSTRACT

Objective: *To determine the level of urine drug test (UDT) interpretive knowledge of physicians who use these instruments to monitor adherence in their patients on chronic opioid therapy.*

Methods: *A seven-question instrument consisting of six five-option, single-best-answer multiple choice questions and one yes/no question was completed by 114 physicians (77 who employ UDT and 37 who do not) attending one of three regional opioid education conferences. We calculated frequencies and performed χ^2 analyses to examine bivariate associations between UDT utilization and interpretive knowledge.*

Results: *The instrument was completed by 80 percent of eligible respondents. None of the physicians who employ UDT answered all seven questions correctly, and only 30 percent answered more than half correctly. Physicians who employ UDT performed no better on any of the questions than physicians who do not employ UDT.*

Conclusions: *Physicians who employ UDT to monitor patients receiving chronic opioid therapy are not proficient in test interpretation. This study highlights the need for improved physician education; it is imperative for physicians to work closely with certified laboratory professionals when ordering and interpreting these tests.*

Key words: urine drug test, chronic opioid therapy, interpretation, physician knowledge

INTRODUCTION

The United States has one of the highest levels of prescription opioid use in the world, and the rate is increasing, accompanied by a parallel increase in abuse of such medications.[1,2] Abuse of opioids is often associated with concomitant abuse of other drugs, both illicit and unauthorized licit.[3-5] Physicians, apprehensive about clinical, medicolegal, and regulatory risks, are increasingly using urine drug tests (UDTs) as an objective means of behavioral monitoring in patients on chronic opioid therapy. Little information exists, however, concerning physicians' knowledge of accurate interpretation of these tests. Our objective in this preliminary study was to determine the level of physician proficiency in UDT interpretation, particularly with regard to frequently prescribed opioids and common drugs of abuse.

METHODS

Neither we nor others were able to identify any published, validated psychometric tools purporting to evaluate physicians' UDT interpretive knowledge in the context of the medical clinic.[6] A seven-question survey comprising six five-option, single-best-answer multiple choice questions and one yes/no question about UDT interpretation was developed by two of the authors, one (GMR) a board-certified pain management specialist and the other (RB) a board-certified clinical chemist and toxicologist. The survey was designed to be used in a preliminary and exploratory study of several aspects of physicians' knowledge about UDT. No formal psychometric validation was conducted on the instrument. The survey content was generated on the basis of the most common and/or critical interpretive errors seen in our tertiary care medical center and community-based primary care clinics. Four questions concerned administration of prescription opioids, one question concerned administration of heroin, one question concerned passive inhalation of marijuana, and one question concerned ingestion of poppy seeds. The questionnaire was vetted by seven experts in the field of clinical and forensic toxicology (including three directors of Substance Abuse and Mental Health Services Administration-certified drug testing laboratories and the chief toxicologist for the state of North Carolina), which led to refinement of the survey questions. The questionnaire can be found in the Appendix. The study was approved by the University of Florida College of Medicine's institutional review board.

Problem 2: Cognitive Dissonance in Practice, "Test and Report"

- Public Health vs. Criminalization – can't be both
- Conflict between providing health care and mandatory reporting
  - Drug screening, testing, and lack of (or poor) consent erodes provider/patient trust
  - Creates a climate of "mutual mistrust"
  - And contributes directly to provider moral injury

- "The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement." ACOG 2020, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy*

Do Less Harm: Return to Basics

- Testing for clinical indications only – (what we teach Medical Students!)
- Hospital Policies Needed
  - Clear indications for testing
  - Explicit verbal and written consent prior (both pregnant person and newborn)
- Staff training on urine drug test interpretation
- Acknowledge how we are all socialized in racialized and punitive drug policies
- Resist coercion and criminalization

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