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

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Ethical Principles
The authors affirm having followed professional ethical guidelines in preparing this work. These guidelines include obtaining informed consent from human participants, maintaining ethical treatment and respect for the rights of human or animal participants, and ensuring the privacy of participants and their data, such as ensuring that individual participants cannot be identified in reported results or from publicly available original or archival data.

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SYNOPSIS

Objective. Clinicians caring for families impacted by substance use disorder often feel uncomfortable assessing for child protective concerns in the setting of non-prescribed parental substance use. This leads to a lack of standardization of care, where some clinicians choose to not ask any questions about the care of children for fear of receiving information that will leave them in an uncomfortable position as a mandated reporter, while others may reflexively report any identification of substance use to child protective services. The primary aim of this descriptive manuscript is to present a framework developed by a multidisciplinary team in a medical setting to address concerns about a recurrence of parental substance use.

Design. We will highlight the development, implementation, and evolution of a clinical decision-making framework designed to help standardize clinicians' discussions around whether substance use could be affecting a parent's ability to safely care for their children.

Discussion. Five main assessment areas will be discussed, including: 1). Safety of the child while substance use is occurring; 2). Safety of parental use patterns; 3). Parental treatment engagement; 4). Willingness to escalate treatment services; and 5). Stability of the home environment. We will present a clinical scenario to highlight how the framework is used as an aid to determine action planning with respect to immediate safety concerns, treatment escalation, and opportunities to maximize recovery supports. We discuss the challenges we've experienced and opportunities that arise in attempting to incorporate the principles of harm reduction within the context of assessments of child safety and well-being.

Keywords

parental substance use; child safety; clinical decision making; harm reduction; family well-being

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INTRODUCTION

Untreated parental substance use disorders (SUD) can affect caregiving and parent-child attachment (Mirick & Steenrod, 2016; Smith & Wilson, 2016). Approximately 12% of children under 17 years old in the United States live in a household where at least one parent has a SUD (Lipari, 2017). Between 2010–2014, 41% of people with an opioid use disorder were living with at least one child, and fewer than 30% of these individuals received treatment (Feder et al., 2018). Yet, outside of mandated child welfare reporting, medical providers often receive little guidance on how to think about family well-being during periods of active substance use. Treatment tailored to families is limited; in 2019 only 3% of residential treatment facilities in the U.S. offered beds for residents' children even though the majority of women (55–70%) in SUD treatment in the U.S. have children (Harris et al., 2022).

Pregnancy can be a motivating time for people to enter substance use treatment, increase engagement with the health care system, and receive medications to treat addiction (Xu et al., 2023). However, the postpartum year, when women with SUD are parenting young

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children or are separated from them, is a time of increased risk of overdose (Forray et al., 2015; Schiff et al., 2018). Stigma, high levels of parental stress (in part due to mandated reporting at delivery and child welfare investigation), postpartum mood disorders, metabolic changes that affect addiction treatment medication doses, and exhaustion can all impact mother-infant dyad bonding, parenting, and substance use recovery (Chapman & Wu, 2013; Kroelinger et al., 2019; Meinhofer et al., 2020). The federal government aimed to address this period of increased vulnerability by requiring “Plans of Safe Care” for infants affected by substance use at delivery (Lloyd Sieger et al., 2021; Lloyd Sieger & Rebbe, 2020). While the intent of this legislation is to increase resources for safety planning, there is still a major gap in utilization of these plans and support for provider decision-making about child safety in the context of ongoing use (Lloyd Sieger & Rebbe, 2020).

One frequent response to parental substance use is the separation of children from birth parents by Child Protective Services (CPS) due to a common assumption that parental substance use is equivalent to child abuse and neglect. However, the relationship between substance use and child abuse or neglect varies by many factors including frequency and type of use (Kepple, 2018). The increase in prenatal substance exposure has been associated with an increase in mandated reporting to CPS after delivery across the United States (Hirai et al., 2021; Prindle et al., 2018; Radel et al., 2018). Although CPS filings and removals are intended to prevent harm to the infant or child, separation and even a filing itself can also impact attachment and development and have negative health outcomes for the child and parent (Carroll et al., 2021; Howard et al., 2011; Waddoups et al., 2019; Work et al., 2023). Among children, foster care placements are associated with involvement in the juvenile carceral system and increased mental health issues and SUDs (Doyle, 2007; Goodkind et al., 2020). Cross-sectional data from the National Survey of Children’s Health found that children in foster care have significantly worse mental health outcomes than all other groups, except for those who were adopted after foster care (Turney & Wildeman, 2016). Longitudinal and qualitative research in Canada have demonstrated an association between custody loss and risk of overdose, trauma and poor mental health outcomes among parents, with potentially exacerbated outcomes among indigenous women (Kenny et al., 2015, 2021; Thumath et al., 2021; Wall-Wieler et al., 2017). Further, CPS reporting disproportionately impacts Black families with increased rates of reporting and substantiated cases among Black families (Berkman et al., 2022; Kim et al., 2017; Massachusetts Department of Children and Families, 2021; Roberts, 2002; Roberts & Nuru-Jeter, 2012). Additionally, children of color who were removed from their families on the basis of parental substance use are less likely to be reunified with their families compared to white children (Lloyd Sieger, 2020; Roberts, 2022)

The Substance Abuse and Mental Health Services Administration recommends using a multidisciplinary collaborative care model to inform decisions around parental substance use (National Center on Substance Abuse and Child Welfare, 2021). Utilizing team-based approaches that consider the unique context, strengths, and risks of parents and families may reduce clinician burnout and trauma that can accompany these challenging decisions. We aim to discuss the development and use of a clinical decision-making framework at a multidisciplinary clinic caring for pregnant, parenting, and postpartum people with SUD and their families. This framework aims to standardize care and utilize the strength of

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collective decision-making to improve family outcomes and minimize the harms from unnecessary family separation. First, we describe how the principles of harm reduction informed framework development. Next, we present the framework, and apply it to a clinical case. Finally, we reflect on implementation challenges and discuss our ongoing efforts to strengthen and evaluate this approach.

Applying the Principles of Harm Reduction to Parents with SUD

Broadly speaking, harm reduction is a philosophy and approach that aims to prevent associated harms and reduce risk without holding complete behavior cessation as the ultimate goal (Harm Reduction International, n.d.). The principles of harm reduction include: humanism, pragmatism, individualism, autonomy, incrementalism and accountability without termination (Table 1) (Hawk et al., 2017). In the setting of substance use, naloxone and syringe distribution programs are evidence-based services that have been shown to save lives (Khan et al., 2022; Levengood et al., 2021; Marshall et al., 2011; Taylor et al., 2021; Wodak & Maher, 2010). However, evidence-based harm reduction services are rarely tailored to the specific needs of families. For example, Mazel et al. suggest strategies such as providing naloxone in the post-delivery period to people with a history of overdose or providing childcare services to support exhausted parents postpartum (Mazel et al., 2023). This is especially important given the role that stigma and abstinence-focused requirements from child welfare or courts play in preventing parents and postpartum people from accessing harm reduction services (Wolfson et al., 2021).

In context of the known negative maternal and child health outcomes associated with family separation, and potential benefits of parental caregiving, there is a need for research into family-oriented harm reduction principles applied to clinical decision-making with a parent's return to or ongoing substance use. For example, Reed and colleagues argue that benefits of providing breastmilk to newborns may sometimes outweigh risks of substance exposure through breastmilk, even in the setting of recent substance use (Reed et al., 2023).

The principles outlined by Hawk et al. can be used as a framework to improve respectful and realistic clinical approaches to substance use in the context of highly stigmatized and surveilled behaviors such as parental substance use.

CLINICAL CONTEXT AND FRAMEWORK DEVELOPMENT

This framework was created by clinicians working in an urban academic medical center in the northeastern United States in an outpatient clinic providing multidisciplinary, co-located care to pregnant and parenting people with SUD and their infants during pregnancy and in the first several years post-delivery. This framework was first developed in 2019, informed by our first eighteen months of clinical experience caring for families impacted by SUD and the principles of harm reduction (Table 1). To develop the framework, we outreached to other clinicians caring for pregnant, parenting, and postpartum people with SUD and their children in similar multidisciplinary teams across the country to learn from their approaches (Schiff et al., 2022). Our hospital's Child Protection Team and perinatal social workers with expertise in psychosocial assessments of families and child welfare provided feedback, and a draft was shared with the Massachusetts state CPS agency. Bringing together a diverse group

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of perspectives and expertise was critical to developing buy-in and trust across disciplines with at times disparate views on parental substance use. We continue to update and modify the framework as needed based on our clinical experiences. We recently added a new question modeled after Dr. Seidman and colleagues in California, aimed at addressing the inequities in perinatal SUD care (Seidman, 2023).

Assessment Domains

The purpose of this framework is to create a time to pause and carefully consider how clinical decisions can reduce harm to families and to utilize the strength of collective decision-making and multidisciplinary perspectives. Clinicians are prompted to ask questions that use a strengths-based approach that considers the immediate safety of the child during ongoing use, the broader familial context, and strategies in place to ensure child well-being. By prioritizing a family-based approach, this framework acknowledges that we must often balance competing risks to promote the health of both parent and child.

The framework consists of five domains: safety of child, safety of parent, engagement in treatment, need for and openness to escalating treatment services and stability of the home environment. There are specific questions within each domain (explored in detail below and shown in Table 2) that clinicians can ask their patients directly and use to consider the parent's context, history and resources. These responses inform subsequent multidisciplinary discussions as described in the following section. The questions may also prompt discussion about possible harm reductive strategies moving forward.

Child Safety and Well-Being

This domain acknowledges that substance use does not equal neglect, and child safety and well-being should be assessed by nuanced questions exploring the context of use, particularly when the child cannot express their own needs and safety (Kepple, 2018). The initial set of questions focuses on identifying when parental substance use occurs, where the child is and who the child's caretaker is during these times. This includes asking about the location of use, route of administration and type of substance used. Clinicians will assess whether children could have a substance exposure by asking where the substance is and whether there is concern for substances being stored, manufactured, or sold in the home. One question that has been identified to be particularly helpful in understanding a parent's ability to plan for keeping a child safe is: if a child were to get sick and need medical attention while the substance use is occurring, who would be available to safely drive or take the child to the emergency room?

Safety of Parent

This domain aims to assess the impact of the specific substance and how the substance is used by the parent. In situations where there is evidence of use only via toxicology test and not via self-report, further questioning with the parent may be helpful to understand the type of use, including frequency, location, and time of day. Parents sometimes choose not to disclose their use, often out of shame or fear of punitive consequences (Paris et al., 2020). In those cases, utilizing toxicology testing as a starting point to tease out factors that may have contributed to an exposure or return to substance use, including presence of a

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coercive partner, response to trauma, or untreated mental health concerns, is valuable (Jarvis et al., 2017). Additionally, identifying and addressing any changes in parental behaviors that are concerning to the clinical team rather than focusing on a toxicology test can be helpful for patients who may need to adjust their course but are not ready to disclose specific use to the team. Similarly, identifying ways that the parent may be trying to keep themselves safer to reduce harms from substance use, including whether they use alone, their pattern of use and whether they have naloxone available, can inform understanding around risk of overdose or other complications that would impact parents from being able to resume caregiver responsibilities following periods of use.

Engagement in Treatment

The next domain is informed by the harm reduction principles of individualism and incrementalism by asking about strengths and challenges in treatment engagement (Hawk et al., 2017). Questions focus on how the parent is engaging in the recommended addiction treatment, both in our clinical program and in the community, and considers whether there have been positive changes based on the parent's individual context. For example, are they receiving medication for their SUD, attending community-based groups, or visiting recovery community centers? Are there active releases of information with those collaterals to confirm treatment engagement? Have they had trouble keeping up with recommended appointments for their medical and behavioral health? What are barriers to treatment engagement that can be identified, and are there other types of treatment that the parent identifies that would be supportive?

Need for and Openness to Escalating Treatment Services

When recommended, an assessment of a parent's interest and willingness in increasing treatment engagement includes escalating frequency of clinical visits, arranging for collaborative conversations with clinical-community teams, or entering a higher level of community-based treatment (ASAM, 2023). Identifying a parent's self-care behaviors, available family supports they utilize or could call upon for additional help, including to care for their children if needed, ensuring children are attending daycare/school outside the home, and other protective factors can help determine if they have the supports necessary to meet increased treatment recommendations (Kumar et al., 2021). It is important to appreciate that not all additional treatment adds value and that sometimes adding services can lead to further strain on the individual and family. This decision should be individualized based on each parent's needs and circumstances (Epstein & Street, 2011).

Stability of the Home Environment

Finally, external factors including other home safety concerns, such as risk of violence or housing instability, is assessed (Elardo et al., 1975). This domain is drawn from the harm reduction principle of pragmatism, recognizing that behaviors occur within a broader context (Hawk et al., 2017). By understanding potential harms in the surrounding environment (the trigger) instead of focusing attention exclusively on parental use (the behavioral response), the team has the opportunity to contextualize behaviors and stressors which may lead to a clearer sense of treatment needs. Identifying all members who live in the home, whether

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they are aware of the parent's substance use, and any associated risks if they themselves are using substances should be assessed.

Assessment and Management

When parental substance use is identified, a clinician caring for the family with the support of a social worker is responsible for meeting with the parent and reviewing the relevant assessment questions with them. If at any point in the safety assessment the assessing clinician determines that the family is in imminent danger, an urgent filing or safety response is completed (Figure 1). If no immediate concerns are identified, a multidisciplinary huddle is called, ideally within 48 hours, to review the framework together and discuss concerns for abuse/neglect or concern for safety with parenting. The multidisciplinary team usually meets as a group for 30 minutes and can include a pediatrician, social worker, family/addiction medicine physician, psychiatrist, nurse and peer recovery coach. The team walks through the framework to prompt a discussion about protective factors and risk factors in the context of parental substance use and the child's needs. The meeting is facilitated by the team member who called the huddle. After reviewing all domains, the team considers how the parents' identity(ies), power, privilege, bias, and/or structural determinants of health impact this case. The team uses the framework to intentionally acknowledge and address structural inequities. For example, how did racism, language, differential access to care, poverty, and stigma play a role in the response to the reviewed questions (Seidman, 2023)?

At times, further information or consultation is needed after these huddles, including reaching back out to the patient and collaterals at home and in the community or obtaining consultation from the hospital Child Protection Team. Following the team discussion, the clinical team communicates any concerns directly to the parent. If the family has an existing case with CPS, a shared call between CPS and clinical and community providers identified on a parent's Plan of Safe Care document (a document required at delivery for all substance-affected dyads) may be recommended. If a shared call is not agreed to, the clinical team will revisit whether a new filing is appropriate. If there is no open case with CPS, the team will determine if the threshold for mandated reporting has been met. When no child protective concerns or harm has been identified, the team begins with substance use recurrence prevention planning and enhancing treatment planning and supports. If revised treatment goals are not met or any safety concerns arise, a CPS report is filed.

CASE STUDY

Case Presentation

To examine how this framework has been used we present a recent case (with key details changed to protect privacy). Sarah is a 33-year-old single mother with opioid use disorder (OUD) receiving injectable extended release (XR) buprenorphine, parenting a nine-month old, living at an extended family member's home. Following a period of sustained remission in treatment during pregnancy and postpartum for over a year, Sarah shared the ongoing use of non-prescribed benzodiazepines, and a urine toxicology test was positive for fentanyl

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(immunoassay plus confirmatory testing), likely related to contamination of the drug supply with fentanyl. Concern was raised when the patient missed several weekly appointments.

Management and Outcome

After reaching the patient and discussing concerns with her, the team reviewed details about her care using the framework together.

Child Safety and Well Being: With respect to child safety, non-prescribed substance use occurs once infant is asleep at night while the infant's grandmother is also at home and supporting caregiving. The infant has a history of multiple medical complexities who has made it to all primary and specialty care visits, and the infant appears well-bonded to parent at medical visits. A CPS case is open for this family and a recent home visit completed without concerns.

Parental Safety: With respect to parental safety, Sarah endorses non-medical use of counterfeit prescription medications via oral route while alone, which she identifies as a safer alternative to prior injection opioid use. She confirms she has naloxone available.

Stressors at home with maternal grandmother impacted parent's mood and anxiety. Her extended family is verbally abusive and blaming of parent for infant's congenital medical complications. Recent escalation of child protective services (CPS) involvement triggered additional self-medication for anxiety over potential loss of custody, and Sarah's shame over her use prevented her from having an initial honest conversation with care team.

Treatment Engagement: With respect to treatment engagement, Sarah has been receiving injectable XR buprenorphine monthly which reduces overdose risk; however, she missed several visits between injections with her psychiatrist, counselor and SUD team members for added support, and she is now endorsing cravings despite XR medication. She had previously been referred to an intensive outpatient program but has not started, and she is intermittently working with a recovery coach.

Treatment Escalation: With respect to treatment escalation, Sarah previously had been willing to come weekly to clinic for increased supports. She is currently contemplating residential treatment.

Stability of Home Environment: Finally, with respect to her home environment, she has stable housing but has an unhealthy relationship with family members who support Sarah in providing full time caregiving for the infant.

To review the impact of identity, power, privilege, and bias, we discussed that Sarah identifies as a Hispanic woman who is English speaking, who comes from a cultural context that heavily places individual blame for substance use disorder. She has the appropriate resources to care for her infant's multiple medical needs. After review, the team felt that there were no imminent safety concerns to the child. A care escalation plan was identified and the patient was started on supplemental sublingual buprenorphine, with weekly prescriptions. A residential program was recommended to remove stressors of family

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dynamics. Additionally, a shared call, that brought together team members from the parent's "Plan of Safe Care" including clinicians, CPS, and community supports, was scheduled. After the shared call, the infant remains in the parent's care with monthly interdisciplinary meetings for more frequent communication across clinical and community teams.

DISCUSSION

Developing and utilizing this framework in our multidisciplinary team has not been without challenges over the past five years. It remains a work in progress that continues to evolve, informed by patient experiences, new staff perspectives, and changing social and political contexts. To support other teams interested in developing a similar approach, we aim to share several lessons learned including: the power of team decision making, the challenge of coordinating time-sensitive outpatient team huddles, and a need to both counter traditionally held beliefs around who is responsible for assessing child safety while also acknowledging the limits of a single outpatient clinical care team.

Bringing the Team Together Reduces Provider Bias and Pressures on a Single Individual to Make Difficult Decisions

Caring for families impacted by SUD can be difficult and challenging work, with high rates of vicarious trauma and burnout leading to staff turnover. Additionally, when we rush into decisions or make decisions in isolation, we risk having biases sneak into our decision making more than when we take the time to pause, review, and reflect as a multidisciplinary group. Grappling with difficult decisions together as a group also builds trust; over time, the team believes that it is possible to come to consensus over less straightforward cases and support family well-being. Team members often experienced distress over the feeling of being part of system that historically has been biased against individuals with a history of prior CPS involvement related to parental substance use. Coming together as a team to make decisions, identify and address areas of systemic bias and racism, and when possible advocate on behalf of keeping a family together through a structured process also assisted in mitigating a sense of helplessness clinicians can experience when the right services are often not available for families.

Finding the Time with an Outpatient team with Multiple Roles and Competing Priorities is Challenging

When our clinic started, we had no full-time staff and only one day a week of social work support with clinicians carrying other responsibilities throughout the week. We developed this framework as a response to needing to learn on-the-fly skills that were often felt to be in the domain of social work and child protection. It was challenging to find the time needed outside of clinical hours to spend on these reviews and required a team that donated many hours to these conversations. As our clinical team grew, and staffing changed to include a full-time nurse care manager and social worker, we had more availability of clinicians trained in making child protection decisions, which enhanced group decision-making. Staffing turnover, changing clinic structure, and a new physical space during the COVID-19 pandemic impacted our shared communication abilities. Ongoing self-reflection is necessary to identify the strengths of each team member, reassess if the team has the

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right voices/team members present, and discuss how to potentially bring patients into these conversations.

Sharing in the Risk of Caring for Families Impacted by SUD

When our team began these assessments, there were four commonly held beliefs around substance use and parenting that we had to challenge. First, some were concerned that because we are not able to physically go into the home to do a safety assessment like a CPS investigator can, a filing would be necessary. In response, we developed partnerships with our voluntary home visit programs including our hospital's perinatal visiting nursing agency, Early Intervention, and a community program providing in-home child parent psychotherapy and recovery coaching (Lowell et al., 2023; Peacock-Chambers et al., 2023). Through these partnerships, we often were able to have additional trained clinicians support families and see the home environment firsthand. Second, we heard that our state CPS agency has access to information about our patients that we did not know, thus a filing was necessary. In our experience, this information often relied on historical case files. While these files described past risk, they did not accurately capture a family's current status. Third, there was a sense that any disclosure of substance use should be shared with CPS, and that they are the experts in determining if that use is leading to child abuse/neglect. Yet, child welfare experts have called for toxicology testing to not be used as a parenting test; reflexively reporting all use overburdens underfunded CPS agencies and too often leads to families not coming to seek care when they need it most (National Center on Substance Abuse and Child Welfare, 2021). Finally, we heard that CPS cases are necessary to prevent harm from something happening in the future. Yet, supporting our patients through mandatory filings at delivery highlighted the harms of unnecessary filing and open cases without clearly reducing future risks (Work et al., 2023). Too often, mandatory filing for prenatal substance use misaligned the focus on substances and minimized important risks from structural determinants of health, intimate partner violence, psychiatric decompensation, and housing insecurity.

Our framework was designed as an attempt to share in the risks involved with caring for a marginalized population at risk for substance use recurrence that can impact child safety and well-being. Rather than reflexively reporting, our clinical team has worked to develop skills and expertise to go beyond a typical evaluation in a busy outpatient practice, and grapple as a team with domains impacting child safety and family well-being. Yet we've also had to understand the limits to the involvement and assessments that we can make and support each other and our patients when filings are felt to be necessary. Pre-established trusting relationships with CPS offices who are aware of our clinical approach to supporting families in the setting of a recurrence of use and going beyond the usual structures to assess for child safety has been critical to address the often felt doubt and disbelief felt between CPS and SUD treatment systems (Green et al., 2008; Kerwin, 2005).

IMPLICATIONS FOR PRACTICE AND THEORY

As our framework evolves, ongoing research is needed to understand the effectiveness of our decision-making processes. First, the framework was designed by a clinical team including a peer with lived experience, but we had limited patient involvement in establishing our

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approach. Currently, decision making is limited to the clinical team, and the patient is informed afterwards about the results of the discussion. Focus groups are planned to learn from the perspectives of both parents on how their care team can better address ongoing substance use. Second, clinician burnout across the healthcare system is increasing, which has significant impacts on patients, clinicians and the healthcare system (Shanafelt et al., 2022; West et al., 2018). Future research with clinicians should explore whether this framework can be used as a strategy to reduce distress, vicarious trauma, and improve morale. Third, given our team's clinical focus on pregnancy and early childhood, this framework was designed with the unique needs of infants and pre-school aged children. We also acknowledge that not all practices have the staff and structure to create a multidisciplinary approach with a lengthy decision-making framework in a busy outpatient practice caring for either a parent or a child. A wide range of clinicians respond to parental substance use, and future research should explore whether this framework could be adapted for us in a general pediatric or adult setting instead of a specialized substance use clinic for families.

Additionally, the intention of the framework is to ensure child safety, promote harm reduction in clinical care, and increase support for parents who are using drugs amid a complex and punitive environment and growing knowledge that family separation also causes harms. Research exploring the impact of strategies, such as this framework, aimed at grappling with challenging questions of how to maintain parent and child safety and well-being during ongoing parental substance use is needed to continue to improve clinical care. We acknowledge that given the many serious consequences to disclosing substance use including the potential loss of custody, at times, relying on patient self-report can result in a delay in identifying a return to use. Similarly, asking these questions may feel intrusive to patients who may understandably mistrust the medical system due to the punitive response to parental substance use. Future research should explore whether the framework has an impact on quantitative outcomes, including CPS filings, family health outcomes and addiction treatment engagement and retention.

Finally, this is a work in progress, particularly our thinking around acute protective and safety concerns and our overall goal of child and family well-being. We have focused on intermediate process measures informing our implementation but hope to move towards measuring the impact on parents and families moving forward. We continue to learn daily from our patients and families and are committed to iterating this approach to improve both their experiences and family outcomes.

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Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article and/or its supplementary materials.

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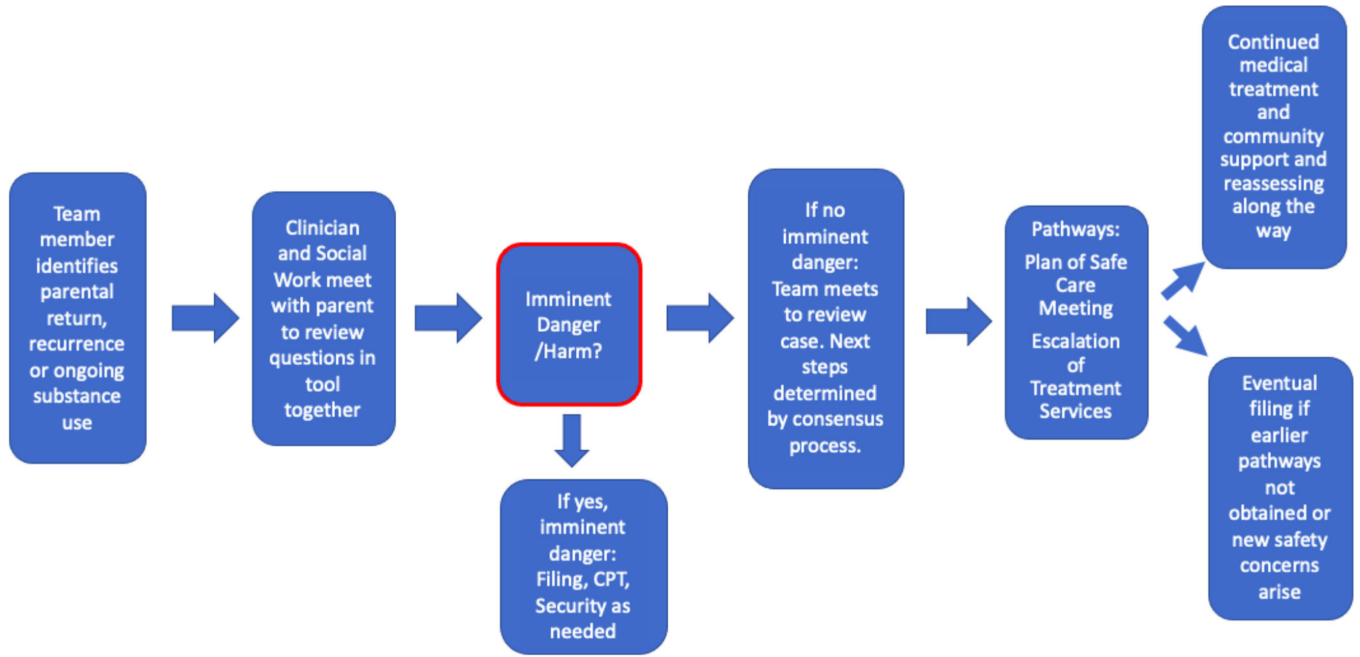

Figure 1.
Clinical Workflow Integrating the Family Safety Assessment Tool.

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Table 1.

Principles of Harm Reduction and Applications to Family Well-being Assessment Framework.

Principle	Definition (from Hawk et al., 2017)	Interpretation in the context of substance use and parenting	Domains covered	How does interpretation help support assessment of child well-being?
Humanism	Providers value, care for, respect, and dignify patients as individuals. People do things for a reason; harmful health behaviors provide some benefit to the individual, and those benefits must be assessed and acknowledged to understand the balance between harms and benefits.	Valuing parents as experts in their children's needs Providing support in other areas of the parent's life may address underlying reason for substance use Acknowledge that structural racism and sexism have resulted in discriminatory permission of who is and is not "allowed" to parent	Safety of use patterns	Recognition of the need for alternate, safe caregivers when substance use occurs is a strength of parent Identification of opportunities for discussions around safe storage of substances in a home with children Addressing underlying drivers of substance use may decrease risks to child safety unrelated to substance use (e.g., intimate partner violence)
Pragmatism	None of us will ever achieve perfect health behaviors. Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum.	Parents fear child removal, so they may minimize and hide substance use to keep their family together Parental substance use is common and substance use recurrence is a predictable part of a SUD Risks to the child vary depending on how a substance is used and where they are stored	Safety of child; Engagement in treatment; Safety of use patterns; Willingness to escalate treatment services	Planning with families for safe caretaking when/if use occurs ensures children have unimpaired caregivers Focusing on parental functioning (including: ability to be present with child, attunement to emotional and physical needs, showing affection, attachment and bonding) is more indicative of parenting safety than toxicology test results
Individualism	Every person presents with his/her own needs and strengths. People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options.	Context (location, setting) of parental substance use can mediate the impact on child Parents use their strengths to promote child well-being and healthy growth and development while using substances When the child cannot speak for their own needs, their well-being is assessed through a triangulation of updates between family, medical team and community supports Parenting skills and behaviors may not have been well modeled in a parent's own upbringing but can be learned to keep children physically and emotionally safe	Safety of Child; Engagement in treatment; Safety of use patterns; Willingness to escalate treatment services; Stability of the home environment	Parents want what is best for their child and use their strengths to promote child well-being When a parent's focus has shifted away from the needs of the child to prioritize the needs or desires of the parent, an alternate and safe caregiving space should be offered An assessment of individualized parenting needs can identify opportunities for education and supports
Autonomy	Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices to the best of their abilities, beliefs, and priorities.	Consideration of patient -driven treatment planning including understanding of individual context behind specific treatment interest or avoidance Punitive or coercive approaches can deter parents from seeking SUD treatment	Engagement in treatment; Willing to escalate treatment/ participation in self care	Parent-child bonding and attachment can promote best outcomes for children and support parental substance use recovery In the setting of active SUD clinicians must balance benefits of providing breastmilk, familial connection, and bonding, with the harms of child separation
Incrementalism	Any positive change is a step toward improved health, and positive change can take years.	Asking comprehensive questions about child and parent safety opens conversations about further harm reductive practices	Engagement in treatment; Safety of use patterns	Parents may not always openly disclose information at all times Parents will share what they feel is in their best interest to disclose,

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	It is important to understand and plan for backward movements.	Identify and name protective factors and steps forward parent has taken for child well being in order to amplify readiness for change and celebrate forward progress		given often punitive responses in the setting of disclosure Discussing steps parents are taking to keep their children safe and use safely themselves opens up space for ongoing conversations
Accountability without termination	Patients are responsible for their choices and health behaviors. Patients are not “fired” for not achieving goals. Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own.	Acknowledging small positive changes and continually reassessing child safety and well-being “Perfect parenting” is unrealistic; positive parenting and attachment should be promoted.	Willingness to escalate treatment services	When use occurs, treatment and recovery supports should be enhanced rather than terminated, including more frequent visits with clinicians for the whole family to assess for signs of abuse or neglect When parents see themselves as partner in process vs a defendant, they are more likely to work towards positive change

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Table 2.

Framework for Addressing Ongoing Substance Use While Parenting.

Domain	Questions to address in assessment with parent	Additional questions for multidisciplinary huddle to assess protective/risk factors
Child Safety and Well-Being	Where does/did substance use happen? (e.g.: in the home or outside the home?)	Can clinic team talk to other caregivers to confirm safety?
	Where was/is child when parental substance use occurs? Who was watching the child?	Has child ever been exposed/had a known ingestion of substance/medication?
	Where is drug paraphernalia kept (e.g.: in the home, within reach of children?)	Any concerns about growth and development? Does the family attend scheduled appointments? Vaccinations up to date? Medical issues being addressed by caregiver?
	Do parents have a safe space where substance and/or medications are stored?	Does the child attend day care?
	If the child was to become sick when parents are using substances, who would be available to safely drive/take child to the emergency room?	
Safety of parental use	What is the patient actively doing to keep themselves safer with drug use? Does use occur alone? If use occurs with others, do they take turns? If use occurs alone, do they let someone know they are using?	What substance is being used? What are risks associated with this substance?
	Does the parent have naloxone, sterile injection equipment or safer smoking equipment?	Does the parent endorse/disclose active use?
	Does the parent have a recent history of medical complications from drug use? (e.g. overdose, skin and soft tissue infections, osteo, endocarditis, epidural abscesses)	What is known about reasons behind active substance use? • Untreated mental health concerns? • Coercive partnership? • Responding to trauma?
Engagement in treatment	Is the parent asking for treatment? What types of medical/behavioral/community supports do they say would be helpful? Is the parent taking medication for their SUD? If not engaging, were there familial or work barriers to showing up?	For patients on methadone, do collaterals at methadone clinic exist? Do Releases of Information (ROIs) exist between outside treatment/community providers?
Willingness to escalate treatment services/ Participation in self-care	Is the parent willing to increase frequency of engagement at clinic or other recovery supports?	What supports do they have/maintain?
	If appropriate, would they consider a higher level of community based treatment (IOP, residential, etc)?	Is there a willingness by the parent to accept recommended treatment escalation plan?
	What does parent do for self-care?	
Stability of the home environment	Who else lives in the home (grandparents, other family, partner, older children, etc.)? Are any of these people actively using drugs?	Are there any other safety concerns in the home (e.g.: violence, housing instability)?