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Illicit Substance Use, Pregnancy, and Perinatal Screening Practices

by
Norlissa Cooper

DISSERTATION
Submitted in partial satisfaction of the requirements for degree of
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GRADUATE DIVISION
of the
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Illicit Substance Use, Pregnancy, and Perinatal Screening Practices

Norlissa M. Cooper

Abstract

Introduction: Perinatal illicit substance use is a critical public health issue because of the potential health implications for the birthing individual and fetus. While the specific substances used over time has changed (e.g., crack cocaine, heroin, methamphetamines, opioids, and marijuana), concern for the health of the birthing individual and fetus, as well as, creating mechanisms to monitor perinatal substance use has remained constant. In an attempt to address perinatal illicit substance use, several policies at the federal, state, and institutional levels have been developed and implemented. These policies typically include universal screening or targeted/risk-based screening and can be completed via questionnaire, verbal interview, or biological specimen toxicology. In addition, these policies and practices are often disproportionately used against birthing individuals of color and those living in low-resourced communities. The purpose of this dissertation is to investigate perinatal illicit substance screening practices at the institutional level (i.e., hospitals).

Research Question and Aims: What are the implicit purposes of perinatal illicit substance screening in the postpartum period. The specific aims of this dissertation are to: (1) describe the implicit purpose(s) of perinatal illicit substance screening in the postpartum setting from the perspective of healthcare workers, (2) to explore the perceived influences of illicit substance screening in the postpartum setting on the birthing individual, and (3) identify possible alternatives to perinatal illicit substance screening in the postpartum period.

Methods & Procedures: This qualitative study was designed as a critical ethnography within the contexts of the social construction of a target population theory. Participants were recruited

from birthing hospitals located in the United States. A purposive sample of 36 healthcare workers providing care to birthing individuals in the acute care intrapartum and postpartum periods were recruited. Data were collected using semi-structured interviews, participant observations, interdisciplinary team meeting observations both in person and virtually, and field notes.

Summary of the Findings: A theoretical analysis of the social construction of target populations theory in the context of perinatal illicit substance use screening was conducted to better understand state level policy approaches taken to address perinatal illicit substance screening. The social construction of target populations provided the framework needed to understand why specific punitive and/or supportive policy tools were selected when designing public policy. In describing the implicit purposes of illicit substance screening in the acute care postpartum period from the perspective of healthcare workers, eight themes emerged from the data: *connecting patients with resources; assessing risk/safety; managing care; engaging with social service agencies; surveillance; reinforcing institutional racism; preventing government intervention; and fulfilling a legal, moral, or ethical duty*. These themes were categorized as either the perceived, interpreted, or implied purpose and helped to uncover instances of institutional racism and institutional bias in screening. In describing the perceived influences of perinatal illicit substance screening, most healthcare stakeholders reported that perinatal illicit substance screening was subject to both provider bias and institutional racism. The subsequent outcome(s) of such screening as reported by participants included institutional surveillance, child separation, and the criminalization of birthing individuals. The implicit purposes and perceived influences focused on institutional (i.e., hospital) illicit substance screening policies. While participants expressed the utility of some screening, the harmful effects of screening and the lack of resources available

to address substance use cannot be ignored. Unlike previous studies exploring perinatal illicit substance screening, the majority (n=31, 86%) of participants were registered nurses, nurse midwives, and advanced practice nurses. Lastly, this study addresses gaps in existing research by focusing on the postpartum period and examining the purpose of screening. In conclusion, the discovery of such a broad range of implicit purposes ranging from supportive to punitive coupled with punitive perceived influences suggest that the risk for harm associated with perinatal illicit substance screening in the postpartum period does not outweigh the potential benefits. That said, the routine use of perinatal illicit substance screening should be eliminated and stakeholders identify concrete situations in which screening should occur.

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List of Abbreviations and Definitions

For the purposes of this paper, the following abbreviations and list of words refer to or are defined as the following:

1. **Birthing individuals** refers to individuals, i.e., women and birthing individuals, who give birth to neonates
2. **Black, Indigenous and People of Color (BIPOC)** refers to Black, Indigenous and People of Color
3. **Health care workers** refers to one that provides health care related services in the acute care setting
4. **Intrapartum period** refers to the onset of labor through the birth of the neonate
5. **Illicit substance** refers to marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain pills, tranquilizers, stimulants, and sedatives
6. **Licit substance** refers to alcohol, tobacco, and medications taken as prescribed
7. **Opioid epidemic** refers to the rise in opioid use in the 2000's
8. **Perinatal illicit substance screening** refers to the process of evaluating the absence, presence, or use of illicit substance via, verbal or written questionnaires, or toxicology screening in the postpartum period.
9. **Postpartum period** refers to the in-patient intrapartum period through the in-patient postpartum period.
10. **Screening** refers to the process of evaluating the absence, presence, or use of licit or illicit substance via self-report, verbal or written questionnaires, or toxicology screening.

11. **The Social Construction of Target Populations** refers to the policy theory proposed by Schneider and Ingram that focuses on agenda setting in politics.
12. **Targeted/Risk-based screening** refers to the screening of patients based on the absence or presence of established criteria.
13. **Universal screening** refers to the screening of all patients for illicit substance use irrespective of perceived risk factors.

Chapter 1
Introduction

Introduction

Perinatal illicit substance use has been and continues to be a public health issue because of the potential health complications associated with its use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016; Forray, 2015). Illicit substance use is defined as the use of marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamines and the misuse of prescription pain pills, tranquilizers, stimulants, and sedatives (Center for Behavioral Health Statistics and Quality, 2017). In 2019, Marijuana was the most commonly used substance among pregnant individuals in the past month followed by the misuse of psychotherapeutics (i.e., stimulants, tranquilizers, and sedatives) and opioids (Center for Behavioral Health Statistics and Quality, 2020). In terms of any substance (licit or illicit), tobacco and alcohol are the most commonly used substances by pregnant individuals (Center for Behavioral Health Statistics and Quality, 2020).

Opioid use disorders, which involve the use of illegal substances such as heroin and/or the misuse of prescription opioids such as oxycodone or morphine, are on the rise among individuals giving birth in hospital settings (Haight et al., 2018). Between 1999 and 2014, the prevalence of opioid use disorders among those giving birth in hospitals more than quadrupled, increasing from 1.5 per 1,000 deliveries to 6.5 per 1,000 deliveries (Haight et al., 2018). Given this increase, one could reasonably question how illicit substances are being screened for and detected at birth.

Images put forth by the media and rhetoric used by elected officials and policy makers spurred the development of several policies and protocols at the institutional (i.e., hospital), local, and state levels aimed at detecting and deterring illicit substance use (Lester et al., 2004; Price et al., 2018; Thomas et al., 2018). These policies reflect various screening approaches (e.g.,

targeted, risk based, and universal), reporting requirements, signage requirements, treatment access, definitions of child abuse and neglect, allowances for involuntary commitment, and restrictions on the use of medical information (Thomas et al., 2018). The implementation of these policies can span pre-conception through the postpartum period. Depending on the implementation of the various policies and protocols, their effectiveness, necessity, and appropriateness have been called into question (Azadi & Dildy Iii, 2008). Many of the existing policies rely on or include some form of screening, discussed below.

Within the literature there is some agreement related to the need to address substance use during pregnancy (e.g., Abel & Kruger, 2002; Price et al., 2018; Wright et al., 2016). However, there is an ongoing discussion regarding the most appropriate approach (i.e., universal vs. targeted/risk based) and the timing of the screening (e.g., Murphy-Oikonen et al., 2010; Price et al., 2018; Zellman et al., 2002). Further, there is little consensus on the use of punitive versus supportive approaches or the need to obtain consent when screening birthing individuals or their neonates (e.g., Abel & Kruger, 2002; Faherty et al., 2020; Foley, 2002; Price et al., 2018). In addition to a CPS referral, a positive screening can initiate referrals to treatment programs, supportive services such as parenting classes, and in-home visits as well as the allocation of entitlements such as mental health services, medical insurance, and housing (e.g., McCann et al., 2010). The current body of research provides minimal insight into providers' perspectives and the factors that influence compliance with screening protocols. Internal factors such as personal biases, stereotyping, and assumptions, coupled with external factors such as hospital policies and legislation, may influence providers' decision to comply with screening protocols (e.g., Benoit et al., 2014; Ellsworth et al., 2010; Kerker et al., 2004).

Screening Categories

Screening protocols are divided into two main categories: targeted/risk-based screening and universal screening. Targeted/risk-based screening protocols use an established list of criteria to determine which individuals will be screened for illicit substances (Oral et al., 2012; Oral & Strang, 2006; Pelham & DeJong, 1992; Zellman et al., 2002). Unlike targeted/risk-based screenings, universal screening protocols stipulate that all individuals should be screened for illicit substances (American College of Obstetricians and Gynecologists, 2017).

Screening, be it targeted/risk based or universal, can be completed by verbal or paper-based questionnaire, or specimens can be collected from either the pregnant individual or their newborn (Polak et al., 2019; Price et al., 2018). A variety of specimens have been used to screen for illicit substances; however, blood and urine screening are considered the gold standard (Carlberg-Racich & Mason, 2011; Price et al., 2018).

Barriers to Screening

Several barriers to the equitable implementation of perinatal illicit substance screening protocols exist. These include individual behaviors, such as compliance with protocols, personal beliefs, or explicit biases (Oral et al., 2012; Perlman et al., 2020; Terplan & Minkoff, 2017). Institutional barriers, related to the type of protocol adopted, also exist. For example, institutions which implement targeted/risk-based screen may place themselves at risk of only identifying a subset of their patient population. These practices result in the inequitable implementation of perinatal illicit substance screening protocols and may perpetuate biases and exacerbate disparities in screening.

Universal toxicology screening also has its challenges. Concerns over the limitations of immunoassays, institutional costs related to implementation, and high false positive rates all

present as barriers (Nelson et al., 2015; Newman, 2016). Lastly, screening tools are unable to isolate the impact that perinatal substance use has on perinatal health outcomes compared to the impact of other socioeconomic and environmental factors. This raises additional concern when considering either targeted/risk based or universal illicit substance screening (Giurgescu & Misra, 2018; Konijnenberg, 2015; Martin & Osterman, 2018; Perlman et al., 2020; U.S. Census Bureau, 2017, 2018).

Institutional Discrimination and Racism in Screening

Regardless of the type of screening protocol adopted (i.e., targeted/risk based or universal), systematic and institutional discrimination, racism, and bias can be found in perinatal illicit substance screening protocols and practices and in healthcare in general (Ellsworth et al., 2010; Kerker et al., 2004; Paltrow & Flavin, 2013; Raeside, 2003; Taylor, 2020). The media's persistent and harmful portrayal of Black and Hispanic birthing individuals and lower socioeconomic status birthing individuals as substance users has aided in the development of biased screening practices and stereotyping (Netherland & Hansen, 2016). Furthermore, the constant depiction of low income and birthing individuals of color as perinatal illicit substance users ignores the fact that there are similar rates of illicit substance use between Black, Hispanic, and white birthing individuals (Center for Behavioral Health Statistics and Quality, 2017).

When examining individual criterion, there are some inherent biases that may lead to the over identification of low-income and Black, Indigenous, and People of Color (BIPOC); these criteria are not specific to substance use but do correlate with specific racial or marginalized populations (Perlman et al., 2020; Son et al., 2018). Specific to targeted/risk-based screening, prior substance use, preterm labor, lack of prenatal care, prior involvement with child protective services (CPS), incarceration history, abruptio placentae, prior preterm birth, and domestic

violence are among the many risk factors used as screening criteria (Hansen et al., 1992; Rohan et al., 2011). Within current systems, more affluent individuals are able to avoid detection simply because they are white, privileged, and not plagued by some of the systemic and structural issues that are associated with being poor and under-resourced in the United States (Benoit et al., 2015; Netherland & Hansen, 2016).

Despite claims that universal screening can decrease racial disparities and increase equitable surveillance, these claims are not supported by the current body of evidence. Compared to white birthing individuals, Black birthing individuals are more likely to be reported despite similar positive screening results (Chasnoff et al., 1990; Roberts & Nuru-Jeter, 2011; Roberts et al., 2015). The discretionary use of screening protocols, even in settings with universal screening policies, has led to racial disparities in screening and reporting. This has also led to missed opportunities to engage birthing individuals about their illicit substance use practices.

Conclusion

Current research leaves many questions unanswered regarding the purpose of illicit substance screening during the postpartum period, the effectiveness of policies at achieving their stated objectives, and the evaluation of the intended and unintended consequences of screening. There is little information specific to understanding the purpose or intent of screening birthing individuals during the postpartum period. In order to evaluate its efficacy and potential benefits or harmfulness, clarification is needed as to whether illicit substance screening in the postpartum period is intended to detect substance use, improve outcomes, direct treatment, or something completely different. Future research is needed to explore provider and patient perspectives on the purpose of illicit substance screening during the postpartum period; the role screening plays

in determining maternal fit or ability; and how screening relates to referrals, reports, and treatment provision.

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Problem Statement

The significant rise in illicit substance use among birthing individuals in hospital settings, coupled with the ongoing opioid epidemic of the 2000s, has thrust perinatal illicit substance screening back into the spotlight. There has been ongoing debate regarding the type of screening (targeted/risk based vs. universal; (e.g., Gifford & Bearer, 2015; Hulsey, 2005; Price et al., 2018), the most appropriate policy approach (e.g., Abel & Kruger, 2002; Faherty et al., 2020; Tucker Edmonds et al., 2016; Wolff, 2011), and informed consent (e.g., Foley, 2002; Hulsey, 2005; Price et al., 2018). The current body of research fails to address the purpose and necessity of screening in the postpartum period (e.g., Price et al., 2018). Given the potential consequences of having a positive screening result (e.g., CPS involvement, stigma, and treatment), it is imperative to have a better understanding of the purpose and necessity of screening for illicit substances in the postpartum period. That said, the purpose of this study is to explore healthcare professionals' perceptions of the purpose and necessity of perinatal illicit substance screening in the postpartum period.

Research Question and Specific Aims

The purpose of this critical ethnography is to gain an in-depth understanding of the implicit purposes of perinatal illicit substance screening in the postpartum setting from the perspective of healthcare workers. By conducting this study as a critical ethnography, the results will shed light on the various purposes of perinatal illicit substance screenings, which are divided into three categories: intended, implied, or interpreted purposes. Additionally, this study could aid in exposing power relationships and call attention to issues of unfairness, injustice, and hidden agendas if they arise.

The central research question is: What are the implicit purposes of perinatal illicit substance screening in the postpartum period? The following specific aims are addressed in this study:

1. To describe the implicit purpose(s) of perinatal illicit substance screening in the postpartum setting from the perspective of healthcare workers, and
2. To explore the perceived influence of illicit substance screening in the postpartum setting,

The three-paper option was selected as the best way to present these research findings. Paper 1 presents social construction of a target population as a theoretical framework for understanding approaches to perinatal illicit substance screening. Paper 2 examines the implicit purposes of perinatal illicit substance screening at birth. Lastly, Paper 3 explores the perceived influences of perinatal illicit substance screening from the perspective of registered nurses and other healthcare providers. The term birthing individual will be used in reference to individuals who are capable of giving birth to neonates. The term 'woman or women' will be used when referencing a specific article, if that term was used by the authors.

Innovation and Significance

This dissertation addresses perinatal illicit substance screening by focusing on three major gaps in the literature. First, the time period under study is the postpartum period, whereas much of the existing research focuses on other pre-pregnancy and pregnancy time periods. Secondly, focusing on the purpose and impact of perinatal illicit screening instead of its validity or reliability represents a departure from existing research and provides an innovative way of addressing this topic. Insights gained from exploring the purpose and impact of such screening could be used to inform care delivery and influence policy design. The third area of innovation is

exploring the perceived purposes from the perspective of healthcare professionals. Doing so provides an in-depth understanding into how healthcare professionals perceive the purpose of screening, their behaviors and actions regarding the screening process, and their adherence to policies and protocols. Another area of significance is that registered nurses, nurse midwives, and advanced practice nurses make up nearly 90% (n=31, 86%) of the study population, which is a departure from previous research in this area. Lastly, by using a critical ethnographic approach, this study aids in exposing unspoken biases, ways of thinking, and assumptions that influence perinatal illicit substance screening practices in the postpartum period.

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Chapter II

Social construction of a target population: A theoretical framework for understanding policy approaches to perinatal illicit substance screening

**Social construction of target populations: A theoretical framework for understanding
policy approaches to perinatal illicit substance screening**

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Abstract

Perinatal illicit substance use is a public health issue. Current screening policies have significant consequences for birthing individuals and their families. Racial disparities exist despite targeted and universal screening policies and practices. Thus, new theoretical approaches are needed to investigate perinatal illicit substance use screening in hospital settings. The purpose of this analysis is to evaluate the social construction of target populations theory in the context of perinatal illicit substance use screening. Using the insights of this theory to interrogate the approaches taken by policymakers to address perinatal illicit substance use and screening provides the contextual framework needed to understand why specific policy tools were selected when designing public policy to address these issues. The analysis and evaluation of social construction of target populations was conducted using the theory description and critical reflection model.

Social construction of a target population: A theoretical framework for understanding policy approaches to perinatal illicit substance screening

The preoccupation with controlling the reproductive decisions of Black birthing individuals is etched in the very fabric of the United States (Roberts, 1999). There have been multiple attempts to deter such individuals from exercising reproductive autonomy (Roberts, 1999), which is defined as “having the power to decide about and control matters associated with contraceptive use, pregnancy, and childbearing” (Upadhyay et al., 2014, p. 20). The hypervigilance surrounding the reproductive decision making and criminalization of Black birthing individuals has and continues to thrive under the guise of legislation, policies, protocols, and socially constructed norms related to mothering and motherhood (Kim et al., 2020).

Perinatal illicit substance screening has been yet another mechanism challenging the reproductive autonomy of Black birthing individuals. Specifically, fear of the potential consequences of screening (e.g., prosecution, child removal, stigmatization, and coercive treatment) can influence these individuals’ reproductive health decisions. Their decision-making capacity and their power to control matters related to contraceptive use, pregnancy, and childbearing are diminished (Gregory, 2010; Stone, 2015).

On its surface, perinatal illicit substance screening may appear to be a protective mechanism. Screenings have been promoted to safeguard the health of babies and to guide care during the intrapartum and postpartum periods (Murphy-Oikonen et al., 2010). However, these policies and protocols have typically been based on unvalidated tools, implemented arbitrarily, using flawed designs targeted at a specific subset of the population (Miller et al., 2014; Ondersma et al., 2000). Apart from detecting substance use, these tools can also result in trauma

and contribute to health disparities and inequities: the exact opposite of health care workers' stated intentions.

To understand the driving forces behind the various approaches to perinatal illicit substance use and screening, this analysis begins with an account of the social construction of motherhood and the racialization and criminalization of perinatal substance use. This discussion is followed by a brief review of theoretical insights relevant to understanding how perinatal illicit substance use has been constructed and screening practices implemented.

Social construction of motherhood

Motherhood is frequently seen as a rite of passage or status. While it may shape the identity of some birthing and parenting individuals, this status remains unattainable for many (Roberts, 1997). A 'good mother' is understood to be submissive and dependent, to bear healthy and productive children, to act selflessly and put the needs of her children before her own, to be in a cisgender marriage, not to use licit or illicit substances, not to work outside of the home, and to be dedicated to caring for her family (Wood, 2013). The social construction of motherhood in the United States has largely been based on white, middle-class birthing individuals, and those who fail to meet such standards are shunned and considered bad mothers (Fouquier, 2011).

Conversely, a 'bad mother' is often depicted as cold, aggressive, overconfident, unattractive, working outside the home, putting their personal needs before those of their children, and incapable of raising productive citizens (Wood, 2013). Specific to perinatal illicit substance use, individuals who use substances while pregnant have been labeled as bad parents and stereotyped as disrespectful, untrustworthy, selfish, disinterested in prenatal care, incompetent, deviant, and focused solely on getting their next fix (Benoit et al., 2015; Miller, 2001). Their drug use is seen as breaking the "moral code" of motherhood and as compromising

the health of the fetus (Benoit et al., 2015). In addition, birthing individuals of color are rarely portrayed positively in mainstream media, instead being associated with perinatal illicit substance use, indirectly reinforcing the notion that Black, Indigenous, and people of color (BIPOC) are not good mothers (Johnston & Swanson, 2003). The perpetuation of the good mother/bad mother dichotomy, based on the experiences of white, middle-class women, puts low-income and BIPOC birthing individuals at a disadvantage and makes it extremely difficult, if not impossible, for these individuals or groups to achieve the social identity of a good mother (Fouquier, 2011).

Deserving motherhood

Society at large does not value or promote motherhood equally among birthing individuals. White birthing individuals have been encouraged to procreate, while Black birthing individuals have been systematically denied, discouraged, and even demonized for procreation, with the exception of forced procreation during slavery (Roberts, 1997, 1999; Springer, 2010). The simultaneous promotion of motherhood for some and its suppression for others raises the question, why should some people deserve motherhood while others do not? Some would argue that every birthing individual has the fundamental right to decide whether or not they want to parent, as a core element of reproductive justice. Melding reproductive rights with social justice discourse, the theory of reproductive justice shifts the conversation from “choice” to human rights (Ross & Solinger, 2017). The decision whether or not to have a child, the ability to parent in a safe and healthy environment, sexual autonomy, and gender freedom are all fundamental principles of reproductive justice (Ross & Solinger, 2017). However, given the history and political climate of the United States, BIPOC birthing individuals have not been provided with

reproductive justice. Instead, they have endured the racialization and criminalization of motherhood and perinatal substance use.

The Racialization and Criminalization of Perinatal Substance Use

The criminalization of perinatal illicit substance use garnered national attention in the 1970s and 80s as part of the war on drugs, in which illicit substance use was designated “public enemy number one” (Lassiter, 2015, p. 135). Although individuals of reproductive age have historically used both licit and illicit substances, crack cocaine took center stage in this moral panic, aided by mainstream media outlets (e.g., television, newspaper, and radio; Springer, 2010). With the help of popular media outlets, perinatal illicit substance use was not only criminalized, but also racialized.

During this period, images of the typical crack cocaine users flooded mainstream media alongside details of the drug’s devastating effects on children (Springer, 2010). Media were able to create a narrative about crack cocaine that led people to associate a specific location (urban communities) and identity (overwhelmingly Black individuals) as representing the epidemic. Media portrayals of substance use among BIPOC individuals reinforced the image of substance use as an experience tied to poor, ethnic communities, and the interpretation of such individuals as deviant, criminal, and deserving of punishment (Springer, 2010). The racialized depiction of crack cocaine led to the overestimation of its use among BIPOC people, helping shape popular opinion and guiding hospital policy development (Springer, 2010; Toscano, 2005).

Conversely, media often associate low-income white women with tobacco and alcohol use, while upper-class white women are rarely depicted as substance users (Springer, 2010). That said, the methamphetamine and opioid epidemics were associated with low income and middle-class white women respectively (Netherland & Hansen, 2016; Springer, 2010). Substance use

within white communities was and continues to be portrayed in the media as surprising, atypical, and deserving of compassionate care (Netherland & Hansen, 2016). This portrayal aligns with the historical denial of substance use among white people and reinforces the notion that white individuals who use substances are victims deserving of empathy rather than punishment (Netherland & Hansen, 2016).

Pregnant and postpartum BIPOC individuals have been the focus of many controversial cases surrounding efforts to criminalize perinatal illicit substance use. This can be seen in fetal protection laws, child abuse statutes, the misapplication of existing laws outside of their intended scope, biased protocols, discriminatory and discretionary screening practices, and patient–provider privacy breaches. Such practices have resulted in the prosecution and conviction of pregnant and birthing individuals, who may be accused of delivering substances to their fetus, child neglect, or even of murder after a stillbirth (Paltrow & Flavin, 2013). The criminalization of perinatal illicit substance use reinforces widely held beliefs about the behavior of pregnant and birthing individuals; serves as population control, by deterring procreation out of fear of prosecution; supports politicians’ political aspirations, by demonstrating a willingness to prosecute deviants; and distracts from the structural issues that contribute to poor birth outcomes, such as poverty and access to health care (Goodwin, 2017; Ocen, 2017; Schneider & Ingram, 1993).

Paltrow and Flavin (2013) conducted a landmark study that reviewed over 400 fetal protection prosecution cases, in which criminal or civil actions were taken against women using illicit substances during pregnancy between 1973 and 2005. They found that Black women represented more than half of the cases, and that low-income women, regardless of race, represented over 70% of cases reviewed. Incarceration, civil commitment, and mandated

participation in drug treatment programs were among the punishments levied against these individuals.

This criminalization of pregnancy sets a dangerous precedent, in that it allows for the behaviors, decisions, and actions of pregnant and birthing individuals to be subject to investigation and prosecution if they do not align with societal norms (Goodwin, 2017; Toscano, 2005). Further, it violates the human rights of bodily autonomy in life and death. Criminalizing pregnancy drastically reduces the options available to such individuals, pregnant or otherwise, as detection or disclosure can have significant consequences (Goodwin, 2017; Ocen, 2017; Paltrow & Flavin, 2013).

This paper explores how the social construction of target populations can be used to describe policy and protocol approaches to perinatal illicit substance screening. Specifically, these theories provide a framework for understanding the motivation behind policy design based on the social construction of target groups based on societal norms. Examining perinatal illicit substance screening in terms of the social construction of target populations, this paper describes how stereotypes have been used to shape policies that then result in discrimination and health disparities.

Methods

When determining how best to conceptualize perinatal illicit substance screening protocols, we considered intersectionality, critical race theory, reproductive justice, moral panic theory, and the social construction of target populations as theoretical approaches. While all of these perspectives deepen the understanding of this phenomenon, the social construction of target populations was chosen because of its structured approach to categorizing target populations, its ability to describe motivational factors influencing policy design, and its

predictive nature concerning the allocation of benefits or sanctions. Chinn and Kramer's (2018) model of theory description and critical reflection was used to analyze and critique theories of social construction of target populations.

The social construction of target populations

The social construction of target populations theory was originally developed in the 1980s by Schneider and Ingram to help explain how different factors or characteristics influence agenda setting, design, selection, implementation, and evaluation of public policy (Ingram et al., 2007; Schneider & Ingram, 1993). Unlike existing policy theories available at the time, the theory of the social construction of target populations emphasizes the significance of social constructions and the allocation of beneficial and punitive policies, the enduring effects of policies even when ineffective, and how changes in social constructions or institutions occur over time. Simply put, this perspective draws attention to the conditions under which policies are designed, who those policies affect, and how policy choices impact the target group (Ingram et al., 2007).

Schneider and Ingram (1993) distinguished four target populations or groups: advantaged, contenders, dependents, and deviants. Depending on individual group membership, policy and policy tools will be beneficial or burdensome, the individual will be viewed as deserving or undeserving, and the individual will have a high or low ability to mobilize politically (Table 2.1).

Policy tools

Policy tools are the features embedded in the policy that are used to motivate or coerce the target population to comply with a specific law, guideline, or desired behavior (Schneider & Ingram, 1990, 1993). Policy tools can shape and reinforce messages about what behavior is

desirable, which citizens are deserving or undeserving, who is subject to punishment, and what role the government should play to enforce these policies (Schneider & Ingram, 1993). Policy tools have been categorized as authoritative, incentivized, capacity, symbolic and hortatory, and learning (Table 2.2; Schneider & Ingram, 1990). Each policy tool puts forth a set of behavioral assumptions regarding what is needed to gain compliance from the target population (Table 2.2).

Fundamental elements of the social construction of target populations

Schneider and Sidney (2009) proposed nine fundamental elements of public policy: (1) defining the problem and goals, (2) allocating benefits and burdens, (3) identifying target populations, (4) establishing rules, (5) selecting tools, (6) implementing strategy, (7) social constructions, (8) justifying policy (explicit or implicit), and (9) assumptions (explicit or implicit). Policy design begins with identifying the issue to be addressed and establishing policy goals and the desired outcome(s). In defining the issue, policymakers identify a target population and select policy tools to solicit the desired outcome based on how the target population is socially constructed. Policymakers justify the selected policy approach and the allocation of benefits (e.g., social programs) or burdens (e.g., incarceration) based on the socially constructed target population. Establishing rules and implementation strategy overlap, in that policymakers focus on who gets what resources and when, in addition to evaluating the policy. Lastly, Ingram and colleagues (2007) described stated six propositions that demonstrate the interrelationship between theory concepts and overall purpose (Table 2.3).

Applications of the social construction of target populations

A broad range of qualitative and quantitative researchers have examined a wide variety of topics from the perspective of social construction of target populations (Fording et al., 2011; Owens & Smith, 2012; Pierce et al., 2014). The variety of methodological approaches taken to

examine different policy domains demonstrates the theoretical versatility of the social construction of target populations perspective.

Deploying the social construction of target populations

In this study, social construction of target populations theory is used to explore policy designs specific to perinatal illicit substance screening. It is important to mention that the target group for screening can be seen as unitary —birthing individuals—the theory has been modified to reflect four intra-target groups: white birthing individuals that adhere to social norms related to motherhood, BIPOC individuals that adhere to social norms related to motherhood, white birthing individuals that do not adhere to social norms related to motherhood, and BIPOC birthing individuals that do not adhere to social norms related to motherhood (Figure 2.1). Social norms include but are not limited to income, marital status, ability to care for and birth healthy children, and abstinence from illicit substances.

We do not subscribe to the notion of a single master category, as it is the convergence of multiple interlocking identities, environments, and institutions that shape individuals' experiences (Crenshaw, 1993). However, in this case there are some defining interlocking identities that result in placement within specific target populations, which has been reflected in our adaptation of the social construction of target populations theory in relation to perinatal illicit substance use and screening (Figure 2.1).

Target populations

White birthing individuals who adhere to social norms related to motherhood are members of the advantaged target population. Their placement within this group is based on a social construction of motherhood largely based on white middle-class birthing individuals (Fouquier, 2011; Springer, 2010). Those who meet or adhere to social norms related to

motherhood are able to avoid detection, not because they do not use illicit substances but because society is not suspicious of them (Netherland & Hansen, 2016).

Black, Indigenous and people of color who adhere to social norms related to motherhood are members of the contender target population. Their placement within this group is based on historical devaluation of their roles in motherhood and procreation, questions concerning their ability to parent, and the fact that the social construction of a good mother is Eurocentric (Roberts, 1997). Although policies targeting contenders tend to be burdensome, group members may achieve some level of protection if they are able to meet all other social norms. However, provider beliefs, discretionary screening practices, and institutional protocol criteria often result in BIPOC individuals undergoing perinatal illicit substance screening.

White birthing individuals who do not adhere to social norms related to motherhood are members of the dependent target population. Their placement within this group is historical; birthing individuals have long been viewed as dependents (Schneider & Ingram, 1993). Furthermore, white birthing individuals who use illicit substances have been viewed through a sympathetic lens; they are seen as just trying to meet the demands of motherhood and not (like birthing individuals of color) as moral failures. This pattern is consistent with each group's placement in the social construction of target populations theory (Netherland & Hansen, 2016).

Black, Indigenous and people of color who do not adhere to social norms related to motherhood are members of the deviant target population. Their placement within this group is based on the historical accounts of institutional surveillance, restricted reproductive autonomy, and the criminalization of BIPOC individuals who deviate from socially construction norms of motherhood (Roberts, 1997, 1999). Policies targeting the deviant population are punitive, harmful, and burdensome. Members of the deviant population will almost certainly undergo

screening, as they have very few protective measures. Having explained group membership and target populations, we now examine both the crack cocaine and opioid epidemics using the social construction of target populations theory.

The social construction of target populations and perinatal illicit substance use

The social construction of target populations theory can be used to explain both the design of screening policies and the actions taken against birthing individuals placed within different target populations. The crack cocaine and opioid epidemics demonstrate the relevance of the social construction of target populations for exploring actions taken against birthing individuals who use illicit substances; meanwhile, targeted, or risked-based screening is used to examine policy design.

Crack cocaine epidemic

Elected officials, the media, and flawed research contributed to sensationalism concerning crack cocaine use among Black birthing individuals and the impact of crack cocaine on the fetus or newborn (Hart, 2020; Netherland & Hansen, 2016; Omori, 2013). These individuals were demonized, labeled as unfit, charged with birthing damaged babies, and characterized as a blight on society—lacking the maternal instinct needed to safely care for their children (Netherland & Hansen, 2016; Toscano, 2005). The rhetoric used by elected officials and the media sought to punish individuals for their substance use and label them as deviant. These individuals were not cared for or regarded as people living with a disease in need of treatment or support (Netherland & Hansen, 2016). Sensational rhetoric about crack cocaine spurred a variety of policies to criminalize, prosecute, confine, or restrict the parental rights of Black birthing individuals who used crack cocaine while pregnant (Paltrow, 2005). The rationales behind such

punitive approaches centered on the protection and safety of innocent babies (Paltrow & Flavin, 2013).

These policy designs limited access to beneficial policies, such as substance use treatment (Ingram et al., 2007). Conversely, they promoted arrest and prosecution, coercion to seek treatment, child removal, institutional surveillance by government agencies (Paltrow, 2005; Paltrow & Flavin, 2013). These same policy approaches were seen with heroin, which was also largely constructed as an illicit substance used by Black individuals.

The rhetoric used to describe those who used crack cocaine and/or heroin, and the approach to address such use, is consistent with messaging related to members of the deviant population as defined by the social construction of target populations theory. Additionally, such authoritative or incentive policy tools and fear-based rationales were used to justify punitive policy designs, as the social construction of target populations perspective implies. The threat of negative consequences as a result of perinatal illicit substance use further reflects the social construction of target populations. In summary, this theoretical approach can be used to explain not only how this target population is socially constructed but also the rationale behind specific policies designed to penalize illicit substance use among Black birthing individuals and the consequences levied against them.

Opioid epidemic

The social construction of the opioid epidemic of the 2000s has been in sharp contrast to the ways the crack cocaine epidemic of the 1980s had been interpreted (Netherland & Hansen, 2017; Springer, 2010). Elected officials and the media largely constructed the opioid epidemic as a crisis among white suburban individuals (James & Jordan, 2018; Netherland & Hansen, 2016). In shifting the target group from Black birthing individuals to white suburban birthing

individuals, the target population classification, policy tools, rationales, and consequences for noncompliance have undergone corresponding shifts. White birthing individuals found to use illicit substances are members of the dependent target population and are viewed as sympathetic and deserving of support and resources.

The rhetoric used to describe the opioid crisis took a more therapeutic approach, compared to the punitive approach used for crack cocaine—it was described not as a moral failing but as a systemic failure and a disease deserving of medical treatment (James & Jordan, 2018). This shifting of the rhetoric surrounding the opioid epidemic aided in shaping the social construction of the target group as deserving and informed the national conversation about the policy designs that should target this group. In this case, supportive policies called for treatment and treatment programs, an approach not afforded to Black individuals during the crack epidemic (Netherland & Hansen, 2016).

Demands for institutional changes in regard to opioid prescribing practices among health care workers and within the pharmaceutical industry were loud and swift. Pharmaceutical companies were blamed, and their deceptive opioid marketing practices criticized. Culpability shifted from white suburbanites to health care providers, thus rendering white individuals who used illicit opioid substances as blameless victims (Netherland & Hansen, 2016). This denial of illicit substance use among white individuals is rooted in racism and oppression and serves as the rationale for a more sympathetic approach to the opioid epidemic. White illicit substance users are often depicted as helpless victims or hard-working individuals who use substances in order to meet the demands of everyday life (Netherland & Hansen, 2017).

The use of symbolic and hortatory policy tools by policymakers and elected officials is strategic, in that they perpetuate traditional beliefs related to whiteness and substances.

Consequences for substance use no longer centered on the carceral system and family separation; instead, white substance-using individuals are offered treatment and compassionate care (Netherland & Hansen, 2017). For example, buprenorphine and naloxone, a medication for treating opioid addiction, is often marketed toward white individuals (Netherland & Hansen, 2017). This medication can be prescribed from the privacy of an outpatient clinician office. This practice affords white individuals the opportunity to seek treatment while shielding them from public scrutiny, allowing these individuals to maintain a positive social image (Netherland & Hansen, 2017).

Targeted/risk-based screening

Regardless of the specific substance of focus (crack cocaine in the 1980s, heroin in the 1990s, and opioids in the 2000s), all of these epidemics have one element in common: illicit substance screening. Targeted and universal screening are the two most commonly used policies. Universal screening requires all birthing individuals to undergo screening, while targeted or risk-based screening is triggered based on a list of established criteria. A variety of specimens can be used for perinatal illicit substance screening, with urine being the most widely used specimen (Price et al., 2018). The next section is focused on targeted or risk-based screening criteria. More specifically, late entry into prenatal care and preterm birth are among the most frequently used screening criteria.

Late entry into prenatal care

Late entry into prenatal care is defined as the initiation of care in the third trimester of pregnancy (Kotelchuck, 1994). According to the National Center for Health Statistics, in 2019, late entry into prenatal care was highest among non-Hispanic Black women at 9.6%, followed by Hispanic women at 8.2%, and non-Hispanic white women at 4.5%. That said, individuals may

enter into prenatal care in the third trimester as a result of many factors, such as age, residency (i.e., rural vs. inner city), access to quality care, and insurance status, all of which are reflect socioeconomic status and are not necessarily an indication of substance use (Baer et al., 2019). The use of this criterion subjects BIPOC and low-income individuals to excessive scrutiny because of their inability to afford or participate in routine standards of care, ultimately penalizing poverty.

Preterm birth

In 2020, the rate of preterm births in the United States among Black women was 14.39%, compared to 9.83% among Hispanic women and 9.10% for white women (Hamilton et al., 2021). Substance use is just one of many risk factors for preterm birth; its impacts are difficult to separate from other risk factors such as structural racism, poor nutrition, use of licit substances (e.g., alcohol and tobacco), psychosocial factors (e.g., stress), and socioeconomic status (Goodwin, 2017; Ocen, 2017). The continued use of preterm birth as a screening criterion makes Black birthing individuals more susceptible to undergo screening, as preterm birth rates are nearly 1.5 times higher than those of Hispanic and white birthing individuals.

In examining these two commonly used screening criteria, it is clear that the advantaged target population is typically able to avoid screening—due to socioeconomic status, health-related protective factors, and privilege—thus insulating them from negative consequences or experiences. By contrast, contenders, dependents, and deviants are usually unable to avoid detection because these screening tools incorporate issues of socioeconomic status and health risk factors that often plague this population.

Clinical implications

Using the social construction of target populations as a lens revealed several clinical implications from an examination of perinatal illicit substance use and screening. The punitive nature of such screening is largely driven by who society has constructed as substance users; its consequences are counterintuitive to the goal of these policies, which are to improve birth outcomes. Although the behavioral assumptions around the use of coercive policy tools suggest that the target population will comply with the desired behavior (in this case, by ceasing to consume illicit substances), that has not been found to be true (Schneider & Ingram, 1990). In fact, the use of a punitive approach has been found to drive birthing individuals away from care, (Stone, 2015).

The contrasting approaches taken to the crack cocaine and opioid epidemics in the United States, which were heavily influenced by the social constructions of the target populations (Black individuals vs. white suburban individuals), draws attention to the ways historical misperceptions and stereotypes influence policy design. Clinical practice must take into account how substance use has been defined—as a self-imposed problem rather than a disease—and how resources have been allocated. With both the crack cocaine and opioid epidemics, the resources allocated were clearly inadequate to solve the problem. However, with the opioid epidemic, the language around the target population shifted, largely because of who was impacted. This change brought about an increase in the allocation of treatment options (i.e., buprenorphine and naloxone), some of which have traditionally been targeted toward white individuals (Lagisetty et al., 2019; Netherland & Hansen, 2016; Netherland & Hansen, 2017). These inequities in treatment options are the result of institutional and structural racism.

Incorporating screening criteria that is nonspecific to detecting substance use but highly correlated with individuals' socioeconomic status, race, and ethnicity allows for those who are not impacted by such constraints to be overlooked when assessing for perinatal illicit substance use. While white birthing individuals are provided privilege and protection based on screening criteria, BIPOC birthing individuals are not, which increases their potential exposure not only to screening but, more importantly, to the consequences of screening. Again, this inequity is the result of institutional racism.

Critique

The social construction of target populations theory is generalizable and has been used by both qualitative and quantitative researchers on a variety of topics (Fording et al., 2011; Pierce et al., 2014). While multiple concepts and their relationships lend complexity to these perspectives, they are highly accessible because they contain many empirical indicators that can easily be identified within the policy design process. Finally, insights from the social construction of target populations are critical to understanding the policy design process because policies made at the federal, state, local, and institutional (i.e., hospital) levels impact who has access to care, what treatments are available, how care is delivered, and how information is shared among institutions, factors that ultimately shape individuals' experiences of health care.

Limitations

Despite the theoretical versatility of social construction of target populations as a conceptual frame, key criticisms have been raised to it as well. A key criticism levied against the initial social construction of target populations theory was that upon its creation, little attention was paid to history and institutional power (Lieberman, 1995). Ingram and colleagues (2007) responded by stating that they viewed policy as an institution with deep-rooted historical

significance; in subsequent publications, they explicitly identified degenerative politics and professionalized politics as institutional cultures.

Another criticism of the social construction of target populations is that they do not account for multiple interlocking identities when determining placement within one of the four target populations or groups. Perinatal illicit substance use cuts across all races, ethnicities, and classes, yet BIPOC and low-income birthing individuals often experience perinatal illicit substance screenings policies differently than do white birthing individuals, despite similar rates of illicit substance use. That said, the social construction of target populations theory can still be used to understand why intragroup members experience policies differently depending on their social construction and group placement.

Conclusion

Due to the mounting concern about substance use among birthing individuals, illicit substance screening will remain an area of focus. Unless the influence of discrimination, racism, and biases in policy design and implementation are acknowledged, inequities will persist. The social construction of target populations provides the framework needed not only to gain insight into policy design but also to create pathways to pursue change. In this case, change will occur when the social constructions of substance use changes for everyone, not just specific intra-group members. The unique contribution of this study is that the social construction of target populations is understood in relation to the varied experiences of individuals with interlocking identities, who are members of different target populations but share a similar experience (i.e., substance use). Ultimately, this perspective provides another pathway to explore disparities in policy design.

Declaration of conflicting interests

The Authors declare that there is no conflict of interest.

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Table 2.1*Social Construction of Target Populations: Target Populations' Descriptions*

	Social Constriction	Political Power	Benefits Allocation	Burdens Allocation	Potential Group Members
Advantaged	Positive	Strong	Oversubscribed	Undersubscribed	Investors and Owners
Contender	Negative	Moderate	Sub-rosa	Symbolic and overt	Unions Polluting Industries
Dependent	Positive	Weak	Undersubscribed	Oversubscribed	Mothers Children Disabled
Deviant	Negative	Weak	Undersubscribed	Oversubscribed	Criminals Substance Users Gang Members

Adapted from Schneider, A., & Ingram, H. (1993). Social construction of target populations: Implications for politics and policy. *The American Political Science Review*, 87(2), 334-347.

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Table 2.2*Social Construction of Target Populations: Behavioral Assumptions of Policy Tools*

Policy Tool	Behavioral Assumptions of Policy Tools
Authority	Authority policy tools are most common policy tool and is often used in conjunction with other tools. Authority tools assume that target populations will comply because they want to obey laws without the need of a concrete incentive.
Incentive	Incentive policy tools rely on the use of incentives or sanctions to achieve the desired behavior. There are four sub-categories, all of which have different behavioral assumptions: <ul style="list-style-type: none"> • <i>Inducements</i> assumes that target populations will respond to positive incentives • <i>Charges</i> assumes that target populations will comply with establish guidelines or face sanctions • <i>Sanction</i> assumes that target population will comply to avoid more severe sanctions than those associated with charges • <i>Force</i> assumes that the target population will respond to the threat of punishment.
Capacity	Capacity tools assume that the target population would comply if they had the appropriate information and rely on education and training instead of the use of incentives.
Symbolic Hortatory	Symbolic and hortatory tools assume that the target population is self-motivated and will comply based on how policy tools align with their person beliefs and values.
Learning	Learning tools are used when insufficient information is known about the target population in terms of what would be the most effective approach at achieving the desired behavior.

Adapted from Schneider, A., & Ingram, H. (1990). Behavioral assumptions of policy tools. *The Journal of Politics*, 52(2), 510-529. <https://doi.org/10.2307/2131904>

Table 2.3*Social Construction of Target Populations: Theory Propositions*

Proposition	Summary
1	Emphasizes how policy designs allow for opportunities and signal how the government is likely to act and treat individuals in the community
2	Emphasizes how political power coupled with positive and negative social constructions influence the allocation of benefits and burdens.
3	Emphasizes how design elements such as tools and rationales vary depending on social construction and group power.
4	Emphasizes how policy makers create, reinforce, or perpetuate social constructions in expectance or disapproval of public acceptance.
5	Emphasizes how social constructions can change and public policy design can be a tool to assist with changing constructions.
6	Emphasize that differences in policy can be attributed to varying pattens of policy change

Adopted from Ingram, H., Schneider, A., & Deleon, P. (2007). Social construction and policy design. In P. Sabatier (Ed.), *Theories of the policy process* (pp. 93-128). Westview Press.

		Social Constructions	
		Positive	Negative
Political Power	Strong	<p>Advantaged</p> <p>White BIs (that adhere to social norms related to motherhood)</p> <p>High Control Benefits: Oversubscribed Burdens: Undersubscribed Deserving of Motherhood</p>	<p>Contender</p> <p>BIPOC BIs (that adhere to social norms related to motherhood)</p> <p>Low Control Benefits: Sub rosa Burdens: Symbolic and Overt Motherhood is questioned</p>
	Weak	<p>Dependent</p> <p>White BIs that do not adhere to social norms related to motherhood (i.e., low income, substance using, single, and young, etc.)</p> <p>Low Control Benefits: Undersubscribed Burdens: Oversubscribed Motherhood is accepted but may need supervision</p>	<p>Deviant</p> <p>BIPOC BIs that do not adhere to social norms related to motherhood (i.e., low income, substance using, single, and young, etc.)</p> <p>No Control Benefits: Very undersubscribed Burdens: Very Over subscribed Not deserving of motherhood</p>

BI = Birthing Individuals; BIPOC= Black, Indigenous, People of Color
Adapted from Schneider, A., & Ingram, H. (1990). Behavioral assumptions of policy tools. *The Journal of Politics*, 52(2), 510-529. <https://doi.org/10.2307/2131>

Figure 2.1

Target Populations of Birthing Individuals Informed by the Social Constructions of Target Populations

Chapter III

Exploring the Implicit Purposes of Illicit Substance Screening in the Intra- and Postpartum Periods

Exploring the Implicit Purposes of Illicit Substance Screening in the Intra- and Postpartum Periods

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Abstract

Objective: By 2016 more than 40 states had enacted substance use and pregnancy policies. Some of these policies utilize information generated from performing screening at the hospital level. For the purposes of this paper screening refers to the process of evaluating the absence, presence, or use of licit or illicit substance via self-report, verbal or written questionnaires, or toxicology screening. Screenings can be universal, in that everyone is screened, or targeted/risk-based, in which screening is triggered by the absence or presence of specific criteria. The goal of this critical ethnographic research study is to describe the implicit purposes of illicit substance use screening in the acute care postpartum period from the perspective of healthcare workers, primarily registered nurses.

Methods: This study used a qualitative, critical ethnographic research design within the contexts of the social construction of target population theory. Participants were recruited from birthing hospitals throughout the United States. A purposive sample of 36 healthcare workers providing care to birthing individuals in the acute care intrapartum and postpartum periods was recruited. Data were collected using individual interviews, participant observations, field notes, and interdisciplinary team meeting observations both in person and virtually.

Results: Eight themes reflect healthcare workers' perceived purpose of why screening occurs at birth: connecting patients with resources; assessing risk/safety; managing care; engaging with social service agencies; surveillance; reinforcing institutional racism; preventing government intervention; and fulfilling a legal, moral, or ethical duty.

Conclusion: The purpose of this critical ethnography was to explore the implicit purposes of perinatal illicit substance screening in the acute care postpartum setting. Findings from this study suggest that the perceived implicit purpose(s) of perinatal illicit substance screening varied along

a spectrum from supportive to punitive. The supportive implicit purposes identified can be accomplished without screening, which leads us to believe that screening is not necessary in providing care to this population.

Keywords: postpartum, substance use, screening, purpose, healthcare workers, pregnancy, policy

Exploring the Implicit Purposes of Illicit Substance Screening in the Intra- and Postpartum Periods

In the mid-1970s, Massachusetts was the first state to enact substance use and pregnancy policies, which outlined reporting requirements and defined substance use as child abuse/neglect (Thomas et al., 2018). By 2016, more than 40 states had enacted substance use and pregnancy policies (Thomas et al., 2018). These policies have been categorized as supportive, punitive, or a mixture of both and include civil commitment; limits or allowances for prosecution, priority, or coercive treatment; warning notifications; reporting requirements; and defining substance use as child abuse and neglect (Paltrow, 2005; Thomas et al., 2018). Policies targeting substance use and pregnancy initially began as punitive and then shifted towards a more supportive policy environment, ultimately settling into a mixed policy environment that includes both punitive and supportive policies (Thomas et al., 2018).

Many of these state level policies respond to information gained from hospital-based screening of birthing individuals for the absence or presence of substances. These policies include but are not limited to self-reporting, verbal or written questionnaires, and use of biological specimens (i.e., urine or meconium toxicology) (Klawans et al., 2019; Price et al., 2018; Wright et al., 2016) These policies are categorized as universal, in which all patients are assessed, or target/risk based, in which the absence or presence of specific criteria determine if someone undergoes screening (Klawans et al., 2019; Price et al., 2018; Zellman et al., 2002). For the purposes of this paper, screening is defined as the process of evaluating the absence, presence, or use of illicit substances via self-report, verbal or written questionnaires, or toxicology screening. Illicit substance screening can be done at any time during the perinatal

period. For the purposes of this study, we focused on the postpartum period, which is defined as the inpatient intrapartum period through the inpatient postpartum period.

While research has been conducted regarding different screening approaches (Coleman-Cowger et al., 2018; Cook et al., 2017; Jos et al., 1995; Klawans et al., 2019; Miller et al., 2014; Wexelblatt et al., 2015), the use of biological specimens (Price et al., 2018), policy approaches and trends (Faherty et al., 2019; Faherty et al., 2020; L. Scott et al., 2019; Thomas et al., 2018), ethical issues in screening (Perlman et al., 2020; Price et al., 2018; Roberts & Nuru-Jeter, 2011; Terplan & Minkoff, 2017), and prosecutorial actions taken against birthing individuals (Paltrow & Flavin, 2013), little to no research has been done exploring the implicit purpose(s) of screening. Screening requirements are vague and have led to a wide range of policies and beliefs (e.g., mandated reporter requirements) (Bishop et al., 2017). This ambiguousness makes it difficult to ascertain the explicit purpose of screening. That said, exploring the implicit purposes of screening provides insight into how healthcare providers have interpreted screening policies. The purpose of this paper is to describe the implicit purpose(s) of perinatal illicit substance screening in the postpartum setting from the perspective of healthcare workers working in acute care hospitals throughout the United States.

Methods

Study Design

Critical ethnography was the methodological approach utilized in this study. Critical ethnography expands on ethnography by highlighting the importance of incorporating both a critical and political lens into the research (Thomas, 1993). This methodology also seeks to uncover cultural norms and ideologies (Thomas, 1993). Further, critical ethnography strives to better understand the culture surrounding practices, purpose of such practices, and possible

alternatives to the current processes. This study was reviewed and granted exempt status by the University of California San Francisco Institutional Review Board.

Study Setting

This study took place at birthing hospitals located in the Midwestern, Southern, and Western regions of the United States, with observations taking place at one high-risk acute care facility in the Western region of the United States.

Study Sample

Healthcare workers employed in acute care intra- and postpartum settings were recruited via institutional listservs, flyers, face-to-face conversations, direct emails, and social media and blog postings. Purposive and snowball sampling were used to recruit study participants. A study modification was submitted and approved midway through the study to expand the target population to include the pediatric care team and nursery staff caring for newborns.

For inclusion in the study, participants had to be at least 18 years of age or older; able to read and speak English; care for birthing individuals or their newborns in the acute care labor and delivery or postpartum settings; and provide informed consent. Participants who did not meet these inclusion criteria were not enrolled in the study.

Data Collection

Data collection began in September of 2020 and concluded in February of 2021. Data were collected through one-on-one semi-structured interviews, document analysis, formal and informal in-person and virtual observations, and field notes. When determining the sample size for this study, the research team considered the scope of the study, nature of the topic, quality of the data, and study design (Morse, 2000). Participants were enrolled until data saturation was reached. Saturation was defined as the point in which new information was no longer being

generated, informational redundancy was occurring, and/or a sufficient number of codes or themes had been developed to sufficiently describe the phenomenon of interest (Faulkner & Trotter, 2017).

Participants who met the inclusion criteria were asked to participate in interviews lasting between 45 to 90 minutes, and baseline demographic information was collected. The initial interview guide was revised to include important topics and content raised by the participants. Interview questions included a focus on both the healthcare workers' own practices and the practices of others. Interviews were audio recorded on an encrypted device, transcribed verbatim, and deidentified. After initial review of the transcripts, it was determined that follow-up interviews and focus groups were not necessary as data saturation had been achieved.

In addition to the interview and participant observations, study participants were asked to provide a copy of their institutional protocol regarding perinatal illicit substance screening. A content analysis of these documents was conducted. Lastly, data were collected via prolonged formal and informal observations at one institution both virtually and in-person. Due to COVID-19 restrictions, both in-person and virtual observations were completed based on a list of approved observational opportunities from the observation site. Field notes were written after the observations and used to inform the data analysis by providing context and meaning to the information collected during interviews and observations, allowing for a deeper understanding of perinatal illicit substance screening. Labor and delivery and postpartum units within the birth center as well as interdisciplinary team meetings served as observation settings. The interdisciplinary team meetings focused on patient care, implementation of screening protocol, staff training, and screening protocol revision.

Data Analysis

Line-by-line data analysis was conducted using Braun and Clarke's (2006) method of thematic analysis. Using an iterative process starting with familiarizing oneself with the data the lead author sifted through the data generating codes. Themes were identified, reviewed, and named; and a written report created. In evaluating the trustworthiness of this study Tracy's (2010) eight "Big Tent" criteria for excellent qualitative research will serve as the evaluation framework.

Once a relevant and significant topic was selected based on existing gaps in the research, reflexivity and journaling aided in achieving rigor and sincerity (Tracy, 2010). Incorporating multiple data sources and utilizing thematic analysis assisted with achieving data triangulation, credibility, and resonance (Tracy, 2010) Prior to the start of the study approval from the University of California, San Francisco Institutional Review Board was obtained.

The purpose of this critical ethnography was to explore the purpose of perinatal illicit substance screening in the postpartum period. During data collection and analysis, the lead author reflected on how the lack of experience in maternal-child health, as well as, personal and professional relationships served as barriers or facilitators when engaging with study participants. All criteria for excellent qualitative research were met (Tracy, 2010)

Results

A total of 36 healthcare workers—22 registered nurses, seven midwives, two nurse practitioners, one obstetricians/gynecologist, one lactation consultant, and one pediatric resident—participated in this study. One participant reported a dual role, and another declined to provide their occupation. One interview was eliminated after further analysis as the participants' answers focused perinatal illicit substance screening in the clinic setting. The study population was predominately women (n=35, 97%), white non-Hispanic (n=17, 47%) or Black/African

American (n=12, 33%), age 35 or older (n=25, 69%), and had six or more years of experience in their current occupation (n=30, 83%; Table 3.1). Three participant clusters were identified, one in the South and the other two in the Western region of the United States. A participant cluster is defined as three or more participants from the same institution participating in the study.

Together these hospitals represented both public and private institutions caring for a diverse patient population in terms of race, ethnicity, insurance status, and resources (Table 3.1). The number of births per year varied, with some institutions reporting over 5,000 births per year. The use of an illicit substance screening policy was reported by 83% of the participant population, with universal screening being the most common. The majority of participants (n=18; 53%) reported that they had received training on the screening policy prior to use, with over 80% (n=29) of participants reporting feeling moderately to extremely comfortable with administering screening policies.

Several commonalities were observed during participant interviews and observations regarding the purpose of illicit substance screening during the postpartum period. These commonalities or themes, presented below, focused on connecting patients with resources, assessing risk/safety, managing care, fulfilling a legal and moral duty, engaging with social service agencies (i.e., child protective services [CPS]), preventing government intervention, surveillance, and institutional racism. The themes are discussed in terms of the type of purpose—perceived, interpreted, or implied—purpose at the institutional level (Table 3.2). The definition of each of the purposes are as follows. The perceived purpose centered around the healthcare workers' general understanding of the purpose of perinatal illicit substance screening. The interpreted purpose focused on healthcare workers' personal beliefs regarding such screening. Lastly, the implied purpose referred to the unspoken yet suggested purpose of screening.

Perceived Purposes

Connecting Patients with Resources

During several interviews, participants described the purpose of screening as a way to connect birthing individuals with resources. These resources encompassed food, housing, financial assistance, baby care essentials (e.g., a car seat, crib, and diapers), and treatment (substance use or mental health). Resources were offered to patients based on a needs assessment conducted by either social workers or CPS. This needs assessment was primarily triggered by a positive substance screening. In the excerpt below, a labor and delivery nurse described the breadth of services that are available to not only the birthing individual but to their newborn as well:

I think the purpose of screening is to identify those mothers and those newborns that are high risk for needing extra services. I think that it's kind of all encompassing; if we find a mother that [is] screening positive for anything, you know, maybe they just need more education. Maybe they need connection with social work, leading them to WIC or food stamps. Making sure they have appropriate housing, they have a safe place for baby to sleep, [a] car seat to take their baby home with. If they need help with mental health services in general or their addiction, I feel like that whole family unit is going to need support and services.

A positive screening seemed to be the catalyst for conducting an in-depth needs assessment. Several participants shared that if the substance screening was negative, no further actions were taken, and patients were often left to initiate the conversation about the need for additional resources themselves. In such cases, it was assumed that the absence of substance use indicated that the patient was not in need of additional support. Along that same line, some

participants acknowledged how positive or negative screening results are associated with the absence or presence of substance use, which can be problematic as some screening methods can be inaccurate (i.e., verbal screening or urine toxicology) or have a short window of detection (i.e., urine toxicology). A midwife shared how negative urine toxicology is often associated with no substance use, which is not always accurate:

Clinicians rely on this u tox [urine toxicology] because people feel uncomfortable talking about substance use. I think clinicians rely on a u tox either way. If its negative, people are like, “Great, it’s negative. That means this person isn’t using.” Which is not true at all. It’s a point-of-care test. It only tells us like a short window of exposure, generally if somebody used substances within the last 5 days. But yet we treat a negative test as like, “Great, this person doesn’t need [help] anymore. We don’t need to talk about substance use anymore, like they are not using. This one negative test tells us they’re not using.” Similarly, a positive test doesn’t tell us anything about whether or not a person has a substance use disorder.

It is important to acknowledge that although connecting patients with resources emerged as a theme, there was definitely some hesitancy to screen among some of the participants due to the fact that patients were not always connected with resources, there were inadequate resources available, or the resources that were available did not meet the needs of the target population. A lactation nurse shared the following regarding the adequacy of resources:

That's where we have struggled for years. We have been trying to do some sort of screening. since I came into the position. I've [been] here [since] 2012 and the pediatricians would say, “what good does it do to identify them if I have nowhere to send them, there's no help”. There's not enough help out there for these people. So now we've

just labeled them, and society has looked at them this way putting maybe more stress on them, and there's nowhere to send them.

Assessing Risk/Safety

The safety and protection of the newborn was of particular concern among study participants. During field observations and interviews, participants shared stories of newborns that had been dropped, neglected, or even killed, which served as justification for the need to perform illicit substance screening. A registered nurse recounts how two newborns of birthing individuals recently started on methadone were smothered by their parent and the lasting impact that it can have on healthcare providers:

We've had two cases that I know of since I've been working in the NICU, [the baby was] discharged home to parents that were thought to be in an okay place in their recovery. [They were] started on methadone while in the hospital in postpartum, we're on a stable dose, and then the baby was discharged to them. In both cases it was like SIDS events, the parent was sedated more or less from whatever they had taken and had smothered the baby. That kinda lives in some of the nurses, those kinds of memories. So, when they see similar cases and people behaving [in] similar ways, they tend to be a little bit more protective. Like [is it] really safe for the baby.

Among a substantial portion of participants, the safety of the newborn was paramount. The safety of the birthing individual was primarily described as a secondary concern, if mentioned at all. That said, there were some participants that prioritized the care of the birthing individual. When asked to describe what concerns they may have in regard to illicit substance use, the obstetrician-gynecologist shared concerns that shifted the focus from substance use to the care experience, life circumstances, and possible treatment for the birthing individual:

Honestly, the first thing that pops into my mind is I worry about how the woman is going to be treated. If it's [screening] going to jeopardize how [the] pediatrics team interacts with her and what they do with the baby, that whole CPS train. The other piece is wanting to help her with whatever life circumstances that are prompting drug use, assessing where she is in wanting to stop using, and what resources [are] available for her.

Similar to the theme of connecting patients to resources, there was hesitation among healthcare workers to describe the purpose of illicit substance screening in terms of assessing safety. Some participants felt that there were several factors that could compromise the safety of the baby after discharge and that singling out substance use could not account for those other factors. A nurse midwife recalled growing up in a home that they described as unsafe, not because of illicit substance use but because of mental illness:

My personal experience, like I grew up in a not totally safe home, but it wasn't because of substance use. It was because of mental illness. And I think that's why this particular issue is really hard for me personally, because I feel like...substance use is such a dumb way to determine whether a home is safe... And I do think that's true a little bit of like wanting to get people well and like helping people get into recovery if they're ready for it. The thing that drives most people is like, are these babies going to be safe? Because we as a society care more about babies than women, and, and it's almost like the moms are considered a lost cause.

Just as participants shared stories of newborns being dropped and neglected, they also shared stories of the trauma that birthing individuals experienced as a result of being screened. One labor and delivery nurse shared a story about a patient who was on the verge of having their

baby ripped from their arms, a story that was also shared with me by two different staff members on different occasions while conducting in-person observations:

When I left the other night, CPS was in her room, and they were talking about calling security to remove the baby from her arms. We had been encouraging her to do skin to skin and bond with her baby for three days. Then all of a sudden there's somebody in there telling her security's gonna forcefully remove your child from your arms, which was not the message I have been receiving as the person managing the floor. It just felt horrible and really unfair to the patient.

Managing Care

Care management—primarily of the newborn—in the immediate postpartum period was another theme that developed during data analysis. Participants spoke about needing to be prepared in case something happened during the birthing process or in the postpartum period. Participants felt that illicit substance screening served as an assessment tool that could assist with ruling in or out potential causes in the event that something were to happen to the neonate, such as the need for resuscitation or other symptoms associated with neonatal abstinence syndrome. In this excerpt a registered nurse talks about the purpose of screening at the time of birth:

I think there's also an emphasis on drug screening in the hospital because if it's in the mom's system, it's in the baby system and [the] first couple of hours after birth are hugely important times of transition for the newborn... You have a lot of medical issues that can occur with the baby. I think that's why there's such a huge emphasis of seeing what's in the moms. You need to know what's in the baby and are better prepared to care for that.

Care management was a prominent theme among study participants. That said, when participants were questioned about how care was initiated, most shared that care was symptom

triggered, and neonates were treated based on symptoms and not necessarily because of a positive screening. In this quote a registered nurse shares how screening may now be necessary at birth and proposed screening be done earlier in pregnancy.

Would doing a urine tox [toxicology] at the very moment that the patient [is] in labor. Do we really need that information at this point to help or better the labor? Not necessarily, but by having that information, it may help the outcome of the baby once the baby is born.... Mom will progress and have the baby anyway with or without a tox [toxicology]. So, do we need one? No. For educational purposes, me personally, I believe they need one early in the prenatal care, to know where mom is, what she's doing with this pregnancy, but do we need one when she comes in for labor? No, unless there's a problem going on.

Interpreted Purposes

Fulfilling a Legal, Moral, or Ethical Duty

Among some study participants, there was a belief that healthcare workers had a legal, moral, or ethical duty to perform illicit substance screening. The rationale behind this belief was that healthcare workers have a duty to ensure that the birthing individual is capable of caring for the needs of the newborn as well as ensuring the safety of the home environment. Similar to the themes of connecting patients with resources and assessing risk/safety, a positive screening triggered the need for additional investigation, while healthcare workers are obligated to ensure the safety of all their patients, these providers felt the duty to do so was greater for those using illicit substances. A labor and delivery nurse spoke with resolution when describing the purpose of screening: Much of the discussion of legal duty centered around mandated reporting of illicit

substance use or legal requirements. In this excerpt a registered nurse talks about upholding their duty by screening and reporting and the potential impacts to them and their patients:

I feel like I was paid to do a job. Even though it [screening and reporting] may have a bad outcome, where maybe it's breaking up this family unit, they're all part of me doing my job. So, for me that's kind of like the ethical thing for me [to do]. I'm a nurse, I'm doing the right thing. That's what I'm supposed to do. Even though I may feel bad or sad about it, I'm still gonna do my job. I have to think about that potential of if I don't report it, if I don't pass this [information along] and there is a bad outcome. I would feel horrible that I stood around and didn't do anything, [I] didn't fulfill my responsibility to the patient because the mother is the patient to me, and the newborn is the patient to me. And sometimes there may [be] conflict in those situations, but I have to do my job.

The belief among healthcare providers that they have a legal, ethical, or moral duty to implement specific tasks begs the questions who and how are these duties determined, how are they communicated, and what influences one's adherence. While beyond the scope of this paper, this issue does warrant greater discussion.

Engaging with Social Service Agencies

Engaging with social service agencies, specifically social workers, and CPS, was another theme that developed during participant interviews and observations. In this theme, a positive screening served as the trigger to initiate engagement with social services agencies. Participants talked of social workers performing assessments, the need to provide documentation of the presence or absence of illicit substance use, and child welfare agencies and social workers making determinations regarding maternal fitness and family separation after conducting investigations initiated by screening results. A postpartum nurse working in lactation described

how making determinations regarding maternal fitness was out of their scope of practice and more in line with the role of CPS:

I've always kind of felt like it's not our [job]; it is our [duty] to observe and facilitate a safe care plan. But I don't think we should have the ultimate decision. Who has had the ultimate decision is CPS? I view CPS as like beyond the hospital. We don't have any authority or decision to make whether this baby and mom stay together or not.

Often patients would undergo multiple illicit substance screenings despite disclosing use or having a previous positive result on file. When asked why patients are rescreened after disclosure or detection, a pediatric resident mentioned that institutional policies guided their work and described feeling powerless in their ability to change institutional policy:

One's word is not enough; you need this factual data point. I don't agree with that, but it is because it is a protocol, like, who are you to override that chain? As a resident, I feel like we work in a system that is broken and there is hierarchy in it. I don't have the power to change a protocol. I'm just not that high up in the totem pole and don't do that. So yes, I can advocate for my patient. I can empower them to do the right thing. I can set them up for success, but I can't change a protocol. I get stuck in the hard place of saying, like, "We have to do this. It is hospital policy." But that never feels right. And never feels great. And it feels unfair sometimes.

Preventing Government Intervention

Although discussed with substantially less frequency, some participants mentioned that screening could serve as a protective measure to prevent engagement with social services agencies. This midwife shared the following:

I think that patients that have a history similar to hers, my experience has been that they want to prove [to] the system that they are not [using], that they have changed. They've changed and been in recovery, and therefore they will do this. I've experienced this before, patients that say, "I want you to screen me all the time because I do not want CPS showing up again."

Implied Purposes

Surveillance

Another theme that developed was the use of illicit substance screening to surveil birthing individuals. Among participants, the need to surveil birthing individuals tended to center on widely held social and cultural norms and beliefs surrounding desirable and undesirable behavior, and expectations of birthing individuals. When asked their thoughts on the emphasis on birthing individuals' behavior and not so much on their partners' behavior, this midwife stated:

My opinions are because women's bodies are more controlled in and our society, and specifically pregnant women's bodies. Pregnant women don't have full ownership of their bodies in our society because [of] fetal health. Once someone's pregnant, the health of the fetus comes ahead of the health of the mother. Partners are not seen as primary parents. I think...for the most part, since the majority of partners [who] are in our facility...are men, it's not expected. Like, they're not under the same scrutiny.

To get a deeper interpretation of the purpose of screening, participants were asked their opinion about whether or not illicit substance screening was about safety or control. A midwife made the following statement:

Do we really care about children? Because we're not even addressing poverty. If at the root we're not, we don't really care about children. Then this whole thing is a little bit of a sham. You know, it's all a little bit of a ruse. It's absolutely about control. It's about control of your production. It's like control of who has, you know, back to the reproductive justice principles, who can have a baby, who can decide not to have a baby, and who can raise a baby in a thriving community. Those are absolutely linked to this conversation about, about urine toxicology testing... You can't have white supremacy in the United States without control of the production.

Reinforcing Institutional Racism

When asked to describe who was most likely to get screened, many participants shared individuals who were Black, Indigenous, and people of color (BIPOC); unhoused; had limited or no prenatal care; were low income (including white individuals); had mental illness; and had a history of substance use were most likely to be screened. Furthermore, participants described how race/ethnicity, class, and type of institution influenced specific interventions. When asked to describe the typical patient screened at their institution, a nurse practitioner shared the following:

Affluent whites are never screened, even if you suspect it. At a private hospital the doctor would be like, "No, she doesn't need to be screened." Even though you think that something's probably going on, they'll blow that off really quick. Um, Spanish, usually at a private hospital, always screened...The only place that kind of discriminated against it [race] was probably the private hospital.

There was one element that remained consistent in many if not all the themes, which was fear. The common fears included that a newborn might be harmed or neglected by their parent, that birthing individuals might birth unhealthy newborns, that a critical assessment might be

missed, that there would be repercussions for not screening, that the illicit substance use would have a negative impact on the infant, and lastly that newborns would be sent home to unsafe families. These fears, that are often associated with specifically the use of illicit substances ignores the fact that birthing individuals and newborns can have bad outcomes in the absence of illicit substance use. Perinatal illicit substance screening has been weaponized against BIPOC individuals and is rooted in this belief that the potential risk of illicit substance use far outweighs other socioeconomic influences on the health of the birthing individual and child.

Discussion

The aim of this paper was to explore the implicit purposes of perinatal illicit substance screening, specifically in the postpartum period, from the perspective of healthcare workers. Eight themes developed during data analysis that were categorized as the perceived, interpreted, or implied purpose (Table 2). Perceived purposes included connecting patients with resources, assessing risk/safety, and managing care. The interpreted purposes included fulfilling a legal, ethical, or moral duty; engaging with social services; and preventing government intervention. Lastly, the implied purposes included surveillance and institutional racism. While there were eight themes emerged from the data, the discussion will focus on assessing safety/risk, managing care, and fulfilling a legal, ethical, or moral duty, as those were the most prominent themes. Study participants described the most commonly screened birthing individual as BIPOC, low income, unhoused, single, or those experiencing observable signs of mental health issues. This is the lens through which the identified themes are examined.

The need to ensure the safety of newborns, particularly those born to Black birthing individuals, reflects how the image of Black motherhood has been constructed to represent these mothers as incapable of caring for their children. Access to basic necessities has less to do with

one's ability to provide care for the newborn and instead reflects who society deems worthy of motherhood. Unfortunately, negative stereotypes are often associated with Black motherhood (Roberts, 1992, 1997). These harmful images, despite being an inaccurate depiction of Black motherhood, often prompt suspicion of Black birthing individuals, resulting in additional scrutiny and their maternal fitness being questioned more often than white birthing individuals (K. Scott et al., 2019).

Managing care, particularly care of the newborn, was also a prominent theme among participants. Participants spoke of wanting to be prepared and minimizing delays in delivering care to the newborn if complications such as symptoms associated with neonatal abstinence syndrome or the need for resuscitation were to arise in the postpartum period. That same level of concern was not afforded to the birthing individual, although some study participants did acknowledge this disparate treatment of the birthing individual.

This disregard or lack of concern for the birthing individual harkens back to culpability and who society deems to be at fault for substance use. Babies are perceived as innocent victims dependent on the birthing individual, thus are deserving (Kameg, 2020). This was evident in this study by the level of concern participants expressed in wanting to be prepared to care for the baby as well as the desire, some participants would even argue duty, to ensure safety beyond the hospital setting. While the deservingness of treatment for children was automatic, that has not been the case for all perinatal substance users historically (Netherland & Hansen, 2017; Springer, 2010). Deservingness of treatment, which relies on the detection or absence of substances via screening, is determined based on race and class as evidenced by the approaches, description, and imagery associated with the crack, methamphetamine, and opioid epidemics (Cobbina, 2008; Netherland & Hansen, 2016; Netherland & Hansen, 2017; Springer, 2010).

Participants spoke of having a legal, moral, or ethical duty to ensure the safety of the newborn. One would assume that this duty would extend to all of their patients; however, that was not the case. Consistent with existing research, affluent white women were able to avoid detection and screening altogether because of their social status and providers' beliefs as to who uses substances (Benoit et al., 2014; Netherland & Hansen, 2016). During the interviews, participants described universal screening as a way to reduce disparities in screening. However, according to Roberts and Nuru-Jeter (2012), the implementation of a universal screening protocol for alcohol and drug use did not decrease the disparities in reporting Black newborns exposed to substances to CPS compared to white newborns.

Limitations

Several limitations were noted. The use of both purposive and snowball sampling could have resulted in selection bias. Although we were able to recruit and enroll participants from three of four geographical regions, most of the participants came from the Western United States ($n = 30$). Having such a significant portion of the participant population come from one region can bias the results due to geographical perceptions of perinatal illicit substance use. The inclusion of alternative observation opportunities (virtual vs. in person) may have influenced the information shared by participants. A core element of critical ethnography is conducting observations in one's natural environment. Due to COVID-19, observations were conducted both in person, when permitted, and virtually at one institution. It can be challenging to participate in an observational role within a virtual environment. In the virtual setting, participants are more aware of outsiders, which may alter their behavior, disclosure, or engagement compared to being in their natural setting (i.e., the hospital unit). Lastly, birthing individuals were not included in the study. Registered nurses primarily shared the experiences of birthing individuals, although

their personal biases either for or against screening could have influenced the details they chose to disclose.

Implications

In addition to the previously stated purpose, the results of this study also serve as a call to action to those who develop and/or implement perinatal illicit substance screening policies in hospital settings. Deeper reflection is needed in regard to interrogating the cultural norms and beliefs, be they institutional or societal, that influence policy and protocol design and the effectiveness of meeting the stated purposes. By taking an in-depth look at these policies, one can explore the necessity of screening, extent of its interconnectedness to systems beyond the healthcare arena, and the social hierarchies that result in the disparate treatment and marginalization of certain populations, with the goal of implementing a more equitable screening process.

Conclusion

In this study, the implicit purposes of perinatal illicit substance screening were examined and determined to serve several functions. It is clear that additional research is needed to explore potential alternatives to the current screening processes. Given the potential repercussions beyond pregnancy, it is critical that policy makers and institutions have a well-defined understanding of the purpose of perinatal illicit substance screening and how said results are used. That said, several of the more supportive implicit purposes identified (i.e., managing care, connection to resources) can be accomplished without screening which leads us to believe that screening is not necessary in providing care to this population.

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Table 3.1*Demographic Characteristics of Study Participants*

	Number	%
Gender		
Male	1	3
Female	35	97
Race*		
Black or African American	12	33
White, non-Hispanic	17	47
Ethnicity		
Hispanic or Latino	2	6
Multiracial (Race and/or Ethnicity)	5	14
Age		
18-24	1	3
25-34	10	28
35-49	11	30
50-64	12	33
65+	2	6
Education		
Associate Degree	4	11
Bachelor's Degree	12	33
Master's Degree	18	50
Doctorate Degree	2	6
Marital Status		
In a relationship	7	19
Divorced	6	17
Married	16	45
Single	7	19
Occupation		
Registered Nurse	22	61
Lactation Consultant	1	3
Midwife	7	19
Nurse Practitioner	2	5
Physician	1	3
Pediatric Resident	1	3
Dual role**	1	3
Declined to state***	1	3
Years of experience		
Less than a year	1	3
1-5 years	5	14
6-10 years	5	14
11-15 years	7	19
16+ years	18	50

	Number	%
Geographic Location		
Northeast	--	--
Midwest	1	3
South	5	14
West	30	83
Type of Institution		
Public	30	83
Private	6	17
Institutional screening protocol for illicit substances		
Yes	30	83
No	3	8.5
Unsure	3	8.5
Trained on institutional screening protocol		
Yes	18	53
No	13	38
N/A	3	9
Type of Screening		
Universal	16	57
Targeted/Risk-based	10	35
Both Targeted/Risk-based	1	4
Unsure	1	4
Comfort level with screening tool		
Extremely comfortable	10	28
Moderately comfortable	19	54
Slightly comfortable	2	6
Neither comfortable not uncomfortable	2	6
Slightly uncomfortable	1	3
Moderately uncomfortable	1	3
Extremely uncomfortable	0	--

*Race/Ethnicity self-reported by participants

**One participant reported being both a nurse practitioner and registered nurse

Table 3.2*Implicit Purposes: Categories and Themes*

Category	Definition	Theme
Perceived Purpose	Healthcare workers' general understanding of the purpose of perinatal illicit substance screening	<ul style="list-style-type: none"> • Connecting patients with resources • Assessing risk/safety* • Managing care*
Interpreted Purpose	Healthcare workers' personal beliefs regarding such screening	<ul style="list-style-type: none"> • Fulfilling a legal, ethical, or moral duty* • Engaging with social services • Preventing government intervention
Implied Purpose	Unspoken yet suggested purpose of screening.	<ul style="list-style-type: none"> • Surveillance • Institutional racism

*Reflects a prominent theme

Chapter IV

**The Perceived Influences of Perinatal Illicit Substance Screening from the Perspective of
Healthcare Stakeholders**

The Perceived Influence of Perinatal Illicit Substance Screening from the Perspective of Healthcare Stakeholders

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Abstract

Objective: To describe the perceived influences of perinatal illicit substance screening on birthing individuals from the perspective of healthcare workers.

Design: A critical ethnography was conducted within the context of the social construction of a target population policy theory.

Setting: Healthcare providers who provided care for birthing individuals were recruited from hospitals located in the United States.

Participants: Participants included registered nurses, midwives, physicians, and pediatric residents ($N = 36$) providing care to birthing individuals in the intrapartum and postpartum periods. Stakeholders were defined as healthcare workers who designed and/or implemented perinatal illicit substance screening policies.

Methods: Data were collected using semi-structured interviews and both in-person and virtual observations.

Results: Negative experiences were reported among most healthcare stakeholders. Participants reported that perinatal illicit substance screening was subject to both provider bias and institutional racism, resulting in institutional surveillance, child separation, and the criminalization of birthing individuals.

Conclusion: Data from this study highlight the perceived influences of perinatal illicit substance screening. Considering the perceived influence of illicit substance screening, institutional policy makers should evaluate the utilization of illicit substance screening and its results. Due to the harm influences associated with perinatal illicit substance screening, the use of such screening should be eliminated. Future research is needed to explore how to move beyond the current

methods used to assess for illicit substance use and how to investigate the perceived purpose of perinatal illicit substance screening from the perspective of the birthing individual.

The Perceived Influence of Perinatal Illicit Substance Screening from the Perspective of Healthcare Stakeholders

In 2019, there were 3.7 million births in the United States (Martin et al., 2021). Many of those births, approximately 98%, occurred in a hospital setting (MacDorman & Declercq, 2019). Hospitals provide access to specialized care, trained staff, and resources (Larsen, 2016). This access is extremely important if any complications for the birthing person or infant are to arise. However, hospitals also have institutional policies and protocols that are often avoided in other birth settings (MacDorman & Declercq, 2019). Perinatal illicit substance screening is one such policy. Depending on the institutional policy, birthing individuals may undergo either universal screening (i.e., mandatory for all individuals) or targeted/risk-based screening (i.e., based on specific risk factors).

The sensationalism of crack cocaine in the 1980s, media depictions of crack cocaine-exposed babies, and the initiation of the war on drugs spurred a variety of policies aimed at perinatal illicit substance use (Dailard & Nash, 2000; Faherty et al., 2020; Flavin & Paltrow, 2010; Lassiter, 2015; Saunders et al., 2018; Springer, 2010). Thomas et al. (2018) conducted a seminal study examining trends in individual drug and pregnancy policies as well as policy environments (punitive, supportive, or mixed). They found that from 1974 to 2016, the number of substance use pregnancy policies surged from just two policies in the state of Massachusetts to at least one policy each in 43 states. During this time period, fluctuations in the policy environment were also noted. As of 2016, the majority of states with drug and pregnancy policies had a mixed policy environment. This means that policies are both supportive and punitive (Thomas et al., 2018). However, additional research is needed to investigate the effects of such policies on their implementation in hospital settings (Thomas et al., 2018).

Many concerns about the intent of perinatal illicit substance screening remain unanswered in the current body of research including the influence of such policies on the healthcare institution, healthcare providers, and birthing individuals. This article builds on the study conducted by Thomas et al. (2018) by investigating the influence of perinatal illicit substance screening in the postpartum period on the healthcare institution and the birthing individual from the perspective of healthcare providers. This work is part of a larger critical ethnography that seeks to gain an in-depth understanding of the purpose and necessity of perinatal illicit substance screening at birth.

Methods

Study Design

For this research study, a critical ethnographic design was utilized, which provided an opportunity to conduct an in-depth review of policies and practices influencing perinatal illicit substance use screening and to engage in participant observation and interviews. Exploring this phenomenon through a critical ethnographic lens allowed the research team to take a deep dive into uncovering what screenings are, what they represent (implicit and explicit), and what they could be (i.e., a shift in how screenings are used and/or viewed (Madison, 2012)). The University of California San Francisco Institutional Review Board reviewed this study and granted it exempt status.

Setting

Participants were recruited from both public and private birthing hospitals throughout the United States. These institutions ranged from small, rural hospitals to large, urban ones. The institutions represented by the study sample cared for an inclusive patient population in terms of race, ethnicity, insurance status, and resources.

Study Sample

Purposive and snowball sampling were used to recruit healthcare providers caring for birthing individuals and their neonates in the acute care intra- and postpartum settings. In addition, various methods were engaged to promote the study nationwide, such as online list serves, emailed flyers, in-person conversations, social media platforms, and organizational blog posts. A modification was submitted and accepted to expand the target population to include pediatric and nursery healthcare providers in response to participant interviews.

In order to participate in this study, participants had to be at least 18 years of age, be able to read and speak English, care for birthing individuals or their neonates in the acute care labor and delivery or postpartum environments and give informed consent. If study inclusion requirements were not met, the potential participant was notified, and an invitation to participate was not offered. Participants who met the inclusion criteria and agreed to participate were enrolled in the study.

Data Collection

Data collection occurred over a five-month period from September 2020 to February 2021. Semi-structured interviews, archival data analysis, and in-person and virtual observations were used to collect data. The interview domains were purpose, impact, role, screening, institutional/structural racism, and stigma/personal bias. Participants that consented to participate in the study were interviewed for no more than 90 minutes. Revisions to the interview guide were made throughout data collection to reflect issues posed by previous participants (Table 4.1). Audio recorded interviews were transcribed verbatim, with the exception of any identifiable information, which was redacted. Based on data analysis, no follow-up interviews were deemed necessary as data saturation had been achieved. Due to COVID-19 restrictions, field observations

were conducted both in person and virtually at one observation site. The observational setting included all units in a family birth center and departmental meetings. Field notes were written after the observations and used to inform the data analysis, as well as reflective journaling.

Data Analysis

Braun and Clarke's (2006) method for thematic analysis provided the analytic framework needed to gain a comprehensive understanding of perinatal illicit substance screening. Using an iterative process involving line-by-line data analysis, the lead author examined the data, generating codes, and identifying themes. At the conclusion of the study a written report was produced. Participant observations, interviews, and field notes were examined, with the lead author noting similarities and discrepancies in the responses.

To achieve trustworthiness, this study employed Tracy's (2010) eight "Big Tent" criteria for excellent qualitative research. Utilizing principals of rigor and sincerity (i.e., reflexivity and journaling), and incorporating elements of data triangulation, credibility, and resonance (e.g., multiple data sources and thematic analysis) assisted with establishing trustworthiness. Additionally, focusing on existing gaps in research (e.g., implicit purposes and perceived influence of screening) this study provides a relevant and significant contribution to this area of research (Tracy, 2010). Prior to the start of the study approval from the University of California, San Francisco Institutional Review Board was obtained.

The purpose of this critical ethnography was to explore the implicit purpose of perinatal illicit substance screening in the postpartum period. During data collection and analysis, the lead author reflected on their positionality and how it influenced engagement with participants and the lens used to interpret data. This study addresses all of the criteria for excellent qualitative research (Tracy, 2010).

Results

The study enrolled a total of 36 participants, with registered nurses representing 61% of the total study population (Table 4.2). Midwives, nurse practitioners, obstetricians/gynecologists (OB-GYNs), lactation consultants, and a pediatrics resident comprised the remaining members of the enrolled participants. The study population was predominately married (n=16, 44%), women (n=35, 97%), white non-Hispanic (n=17, 47%), Black/African American (n=12, 33%), age 35 or older (n=25, 69%), and bachelors or masters prepared (n=30, 83%) with six or more years of experience in their current occupation (n=30, 83%; Table 4.2). Upon further analysis, one interview was eliminated as the participant's experience was outside the area of focus. Among the institutions with illicit substance screening protocols, universal screening was the most common (n=16, 57%) followed by targeted/risk-based screening (n=10, 35%). Three participants provided a copy of their institutional policy; these archival data served as historical or background information to gain more insight into perinatal illicit substance screening.

There were five themes that developed during data analysis related to the perceived influence: (1) denial of basic services, (2) institutional bias in screening, (3) reproductive autonomy infringement, (4) criminalization of substance use, and (5) stigma. The following paragraphs detail the influence of perinatal illicit substance screening on the birthing individual and healthcare institution from the perspective of healthcare workers, primarily registered nurses.

Denial of Basic Services

In the postpartum setting, there are some basic standards of care that all birthing individuals should receive, barring any extenuating circumstances. Participants identified the promotion of breastfeeding, skin-to-skin contact, rooming-in with the newborn, and allowing the birthing individual to stay at the hospital after discharge when their newborn remained

hospitalized as basic standards of care. During data analysis it became evident that birthing individuals were denied routine care not because of medical necessity but because illicit substance use was suspected, detected, or disclosed. The issue of breastfeeding came up repeatedly during data collection. Participants reported that the initiation of breastfeeding was frequently delayed pending illicit substance screening results. The excerpt below reflects how a maternal child clinical nurse educator and lactation consultant was prohibited by a physician from fulfilling their duties regarding breastfeeding support because of the patient's history of substance use:

The physicians will not allow us to, they actually write orders that the mom can't [breastfeed], she has used drugs. Now, if she still chooses to breastfeed and put that baby to breast, I can't go in there and snatch her baby off her breast, of course. But if a doctor writes that she can't breastfeed because of her history of drug use, and we've had some who were positive for marijuana and it stays in, like they would tell them they couldn't breastfeed for 30 days. But if the physician writes the order, she can't breastfeed. That ties my hands, and I can't go in and assist her with breastfeeding.

Despite the protests and significant gains surrounding breastfeeding, one participant, who worked as a labor and delivery, postpartum, and newborn intensive care unit nurse, shared how there is a lack of enthusiasm for ensuring the breastfeeding rights of birthing individuals who use illicit substances:

We will care about protecting breastfeeding rights, right? We were all over it. You know, I should be able to breastfeed wherever I want to breastfeed—on the Zoom camera while I'm in my class—but that same passion isn't there to protect that mom or give that mom help or that unborn child that is being affected by drug use. That same passion isn't there.

Institutional Bias in Screening

The use of screening criteria that are not specific to detecting perinatal illicit substance use was commonly reported among participants during interviews and in the screening protocols provided by participants. Participants stated that prenatal care, preterm birth, placental abruption, behavior of the birthing individual, and adherence to care plan (i.e., diagnostics test, procedures, etc.) determined by the healthcare team were among the criteria mentioned that could result in a urine toxicology being performed and/or engagement with social services. Although urine toxicology is common in the hospital setting, screening criteria vary from institution to institution. A postpartum nurse recalled some of the “triggers” or screening criteria that could prompt a urine toxicology screening, and if positive for illicit substances, a social worker consultation:

No prenatal care, if the parent is already in the system [those are] trigger[s]. If the parent they come in acting out, they know they’re on something. That is a trigger, you know?

There’s a number of other triggers, there’s a lot. And that’s what triggers the social provider to get involved. Even if they deliver pre-term, the social providers [are] involved. ’Cause they want to know what’s going on, you know?

In addition to prior history and a lack of engagement in prenatal care, participants described how certain characteristics and stereotypes have resulted in patients being screened for illicit substances. A midwife recalled how patients’ physical appearance and behavior often resulted in increased scrutiny of the birthing individual:

If we had patients who [are] acting funny, like if they came in they smelled a certain way, like marijuana, or if they had red eyes or dilated pupils or just had erratic behavior and the doctor had some kind of inkling to test them

Not all of the hospitals that participants worked at had a standardized screening tool, which meant that screening criteria and who would undergo screening was left up to the sole discretion of the provider. In regard to performing perinatal illicit substance screening in the absence of an established protocol, one participant, who worked in labor and delivery, postpartum, and the newborn intensive care unit, recalled providers arbitrarily making decisions to perform screenings based on history and suspicion:

If they said that they had prior use or admitted to current use, or if the provider felt that there were behaviors, if you will, subjective behaviors that they felt like they may be using...they could order the test. But there was no standard, if you will, there was no standard between providers or a tool that was being used. It was truly based on the individual providers.

Reproductive Autonomy Infringement

During data analysis it became apparent that suspicion of the birthing individual was often preceded by a disagreement between the patient and healthcare provider in terms of care management or the refusal of the birthing individual to comply with treatment recommendations. An obstetrician-gynecologist attending physician shared how healthcare institutions are structured to maintain power over patients and those who refuse treatment recommendations and tests raise suspicion among healthcare providers:

I know [I'm] focusing a lot on this urine tox, but it's such a charged thing. If they agree, and something shows up, then we'll use it against them. If they decline, then we totally use that against them. We're like instantly suspicious if they, and this is not just with u tox, but...when people decline what we recommend, like we get so suspicious of them. What are they hiding? What's wrong? Cause it's like, they're not letting us have power,

and I feel like our system is set up for like the medical providers to have power over the patient.

Participants reported that when patients exercised their autonomy and did not agree with the treatment recommendations such as test proposed by the healthcare team, not only did those actions prompt suspicion that the patient was hiding something, but this led to providers taking actions to circumvent the patients' decision. Participants spoke about routinely violating patients' autonomy and not obtaining consent to perform toxicology screening via urine or other specimens collected from the birthing individual's newborn if the birthing individual declined to provide a specimen for testing. When asked to about what happens when someone screens positive, a registered nurse shared the following:

So, the pediatric team, which I just don't agree with this, but they say that they can do a u tox [toxicology] on the baby without [the] mother's consent if there is [a] concern. They did that with this patient. They [pediatric team] went and put a urine bag on this baby without telling her [the birth parent], and then she took it off.

Criminalization of Substance Use

Some participants spoke very passionately about the criminalization of perinatal substance use and its impacts to the birthing individual. A nurse midwife recounted the following experience when reflecting on the criminalization of birthing individuals and how hospitals have been complicit accomplices in criminalizing perinatal substance use by collaborating and sharing information with agencies outside of the healthcare institution:

U-toxing women against their consent and then reporting them to the police. I'm sure that's still happening today, and I know of some cases, but that was totally acceptable in

the eighties and nineties. I think there's like this long history of criminalizing and demonizing pregnant people who are using illicit substances.

The legacy of criminalizing perinatal illicit substance use and the impact that it has on the birthing individual was mentioned by numerous participants. Stories of how birthing individuals have been arrested, stigmatized, and traumatized by urine toxicology results were shared. A midwife shared the harmful impact of criminalization and how it impacts disclosure and trust.

I think it [urine toxicology] is harmful. If our goal is to have people access prenatal care, we should listen to people and understand the[ir] circumstances...If we just trust people, we might get a little further than having standards of care that cause a lot of fear for individuals, especially if there's been generational trauma around drug testing and criminalization of family members and community... [There are] particular populations that have been greatly harmed by policies criminalizing addiction in the United States and that impacts how folks access care and trust [healthcare workers]. When we [healthcare workers] automatically start [with] I don't trust you and I need [to screen you] to confirm that I can trust you, that it's harmful.

Stigma

The issue of stigma was present throughout many if not all of the interviews. In these data, stigma has two subcategories: stigma associated with the birthing individual and stigma associated with the type of substance used (i.e., licit vs. illicit). Participants generally described stigma associated with birthing individuals' substance use in terms of expectations associated with the social construction of motherhood and the ability of the birthing individual to meet such standards. A pediatric resident stated the following in terms of stigma or bias associated with birthing individuals being labeled as substance users:

I think the biggest one that comes to mind is that when mothers use substance in pregnancy, there's a stigma that—or a stereotype or bias, whatever you want to call it, acknowledging those are all slightly different—that that mother is not able...to safely take care of their child. And I think that is a hundred percent wrong but can be a label that a mother might hold onto and be very traumatized by or affected by. There are plenty of mothers who, you know, they have, they, yes, they use substances prenatally, but they have a baby, and it completely changes their life.

The qualities or characteristics that were associated with perinatal illicit substance users were often contradictory to the social construction of motherhood and reflected a negative image. When asked to describe the regional culture associated with perinatal illicit substance use, this labor and delivery nurse from the southern region of the United States stated the following:

It's frowned upon to be honest with you. Living in the Bible belt, that's what it boils down to. So, a lot of these parents have a “religious relationship”, and our nurses are in the same boat. So, they are like that's frowned upon because we're so conservative. So, I think that the culture is, that's against God or it's a shame, or, selfish... She was just thinking about herself, not thinking about what the outcome would be with that infant. I've worked in different States, I've had the opportunity to see [the difference]. I think because [in] more liberal cities, it wasn't a “sin”. I [wasn't working] in such a conservative area versus here. It's very conservative, very Baptist, very Pentecostal way of seeing things.

During the interviews it became apparent that participants made a distinction between the use of licit and illicit substances. Participants shared a wide range of opinions regarding the stigma associated with the use of illicit versus licit substances, which ranged from substances

being described as “gateway drugs” to the addictive nature of various substances to the potential risk for harm (i.e., overdose), but most frequently stigma was associated with the legal status of the substance. The obstetrician-gynecologist in the study described how stigma is highly associated with illegal substances and used cannabis as an example of how perceptions can change:

I think just stigma runs deep and [goes back] to something being deemed illegal. Like even cannabis when it was illegal, which wasn't a long [time] ago, it's been in my career that it's changed. Some people were like, “Oh, she smoked cannabis.”-Or probably it was even called marijuana- “She uses marijuana, you know?” Now that it's not illegal anymore, now that it's legal, there's just a different charge and how it gets talked about. It's like, even though there actually may be some impact on pregnancy, there's way less stigma now. Nothing has changed. It's still cannabis, but it went from being illegal to legal.

Discussion

There are several healthcare stakeholders that are involved with creating, implementing, or undergoing perinatal illicit substance screening. Birthing individuals are critical stakeholders in terms of perinatal illicit substance screening as they are subjected to the various policies and protocols implemented by policy makers and healthcare institutions, particularly in the hospital setting.

Healthcare providers are also an integral stakeholder in respect to perinatal illicit substance screening as they are charged with implementing, collecting, interpreting, delivering results, and/or making referrals depending on their position (e.g., registered nurse, midwife, or physician). Without the cooperation of healthcare providers, hospitals would not be able to

implement such policies. Hospitals are also stakeholders in the perinatal illicit substance screening process as executive leadership is often tasked with developing institutional protocols.

The experiences shared by participants brought up several issues that are entrenched in the overall discussion of the purpose and necessity of perinatal illicit substance screening, mainly concerning the continued use of policies that have been found to be harmful and discriminatory. Many of the perspectives shared spoke to the detrimental effects that perinatal illicit substance screening can have on the birthing individual. These experiences reinforce the findings of previous research that has examined perinatal illicit substance screening. Those who are suspected of or have used illicit substances while pregnant are targeted for punishment and criminalization, stigmatized, subjected to discretionary screening practices, and have their autonomy compromised, and as a result they may delay care in order to avoid detection (Goodwin, 2017; Kerker et al., 2004; Paltrow, 2005; Roberts, 1991; Stone, 2015).

Given that the stated purpose of perinatal illicit substance screening is to identify those individuals who have used illicit substances and develop a safe plan of care for them (Pub. L. No. 114-198, § 524, 2016), these negative experiences are not an intended consequence of such screening. Further, beneficial policies targeting this group are often insufficient and tend to use coercion as a means of achieving the desired behavioral outcome (Schneider & Ingram, 1993).

The threat of incarceration, increased involvement with social services, and child removal as well as coercion to seek treatment to avoid these outcomes are policy tools that have been levied against birthing individuals who use illicit substances in an attempt to force compliance (Abel & Kruger, 2002; Flavin & Paltrow, 2010; Paltrow, 2005; Paltrow & Flavin, 2013; Roberts, 1991). The participants of this study not only confirmed that these experiences were occurring in their respective institutions, but they also highlighted the fact that such punitive approaches to

perinatal illicit substance use is contributing to health disparities while simultaneously failing to deter perinatal illicit substance use. According to the social construction of target populations theory, this indicates a policy failure. This was quite evident in regard to breastfeeding. The practices described further perpetuate inequities and disparities already experienced by communities of color, particularly Black birthing individuals, and present additional barriers to accessing critical breastfeeding support and other perinatal resources (Asiodu et al., 2017; Robinson et al., 2019).

The social construction of target populations provides a framework for understanding not only how disparities and institutional racism are reinforced through policy design, but also how policies remain enforce despite their inability to solve the targeted issue. Highlighting the experiences of intragroup members is a novel application of the social construction of target populations but harkens back to intersectionality. Utilizing the theory in this fashion demonstrates bias practices in policy design and implementation based on group membership, which works to advantage some and disadvantage others.

The experiences shared by the study participants were not unique. Discretionary screening practices and non-adherence to institutional protocols among healthcare providers have been and continue to be an issue. Consistent with what our participants reported, Ellsworth et al. (2010) found that Black mother–newborn pairs were more likely to be screened even when there was no evidence of meeting screening criteria. Healthcare providers are not precluded from having implicit biases. In fact, it has been found that not only do healthcare providers have implicit biases similar to the general population, but these implicit biases also tend to reflect positively towards white birthing individuals and negatively towards Black birthing individuals,

and these biases can influence clinical decision making and treatment recommendations (FitzGerald & Hurst, 2017; Hall et al., 2015; Penner et al., 2014).

Social norms and the persistent exposure to images put forth by the media about specific groups of people—in this case depictions of who uses illicit substances while pregnant—aid in shaping these implicit biases (Penner et al., 2014). Healthcare providers can harbor an implicit bias that makes them less likely to screen white individuals for illicit substance use because these individuals are viewed as less likely to participate in criminal or deviant behavior. Discretionary screening based on implicit biases is rooted in racism and further exacerbates health disparities and inequities (Hall et al., 2015; Kerker et al., 2004).

Birthing individuals found to have used illicit substances while pregnant are generally criminalized. Screening results have served as the trigger for initiating reporting of the individual to social services and/or law enforcement agencies as well as prosecutorial proceedings typically related to child neglect or fetal protection laws (Paltrow, 2005; Paltrow & Flavin, 2013; Prindle et al., 2018; Roberts et al., 2015). Criminalizing the birthing individual only works to further stigmatize this population, driving them further into the shadows and away from care (Patrick & Schiff, 2017; Roberts & Nuru-Jeter, 2010). Criminalizing perinatal illicit substance use serves as a method to gain compliance through the use of punishment and as a warning to other birthing individuals that if they are caught breaking societal norms or using illicit substance, then they may be subject to prosecution, child removal, increased surveillance by governmental agencies, and/or coercion to seek treatment (Ingram et al., 2007; Schneider & Ingram, 1990).

Birthing individuals found to have used illicit substances tended to be stigmatized as they are deemed to have violated social norms or engaged in illegal activities (Benoit et al., 2014; Roberts, 1991; Springer, 2010; Terplan et al., 2015). This stigma aids in justifying punitive

approaches and harsh consequences (e.g., prosecution, child removal, or civil commitment) targeting birthing individuals (Flavin & Paltrow, 2010; Lester et al., 2004; Paltrow, 2005; Paltrow & Flavin, 2013; Schneider & Ingram, 1993). Such stigmas have been found to have a negative impact on health-seeking behavior and care engagement (Flavin & Paltrow, 2010; Stone, 2015; Terplan et al., 2015), consistent with the findings of this study.

Lastly, hospitals and healthcare in general can be a source of pain and trauma to BIPOC individuals (Elias & Paradies, 2021). The manifestation of institutional racism in terms of perinatal illicit substance screening is apparent in the compliancy and willingness of institutions and healthcare providers to continue to use a diagnostic tool that has been found to discriminate against and disadvantage BIPOC individuals (Elias & Paradies, 2021). By maintaining such policies and practices, perinatal illicit substance screening has resulted in the reproductive oppression of BIPOC individuals while privileging white birthing individuals (Taylor, 2020). In addition to reproductive oppression, institutional racism has resulted in social isolation, criminal justice involvement, and poor health outcomes for BIPOC individuals and their infants (Davis, 2019; Elias & Paradies, 2021; Lollar, 2017; Stone, 2015; Taylor, 2020).

We must reexamine and reimagine how healthcare is delivered, as policies at the local, state, and federal levels translate into policies at the institutional level. Furthermore, healthcare institutions must acknowledge how racism, discrimination, and suboptimal care have led to distrust among BIPOC individuals. This distrust is only further exacerbated when institutions rely on discriminatory policies to confirm or deny the presence of something instead of building relationships that foster disclosure, investing in evidence-based services that are patient and family centered, and acknowledging and actively working to minimize the effects of implicit biases among healthcare providers (Darke & Burns, 2012; Patrick & Schiff, 2017).

Limitations

This study had a number of limitations that should be noted. Selection bias may have arisen from the use of purposive and snowball sampling. Although 36 participants were recruited and enrolled from three geographic regions across the United States, the majority of participants were from Western states. This could lead to a bias based on geographic perceptions of perinatal illicit substance screening. Another limitation of this study was that birthing individuals were not interviewed or included in this study. Instead, the experiences shared were from the perspective of healthcare workers, primarily registered nurses. That being said, having such a significant sub-population allowed for a deep understanding of perinatal illicit substance screening from the perspective of registered nurses. Lastly, virtual observations may have limited data collection. Participants may be more aware of observation in the virtual space compared to natural settings, which may inhibit disclosure or influence behavior. This limitation was mitigated by incorporating both virtual and in-person observations.

Implications

The results of this study can be used by policy makers, decision makers, and stakeholders who establish and/or adopt perinatal illicit substance screening policies to delve further into the cultural and social values that are shaping institutional policies. By delving further into these strategies, we can reveal their necessity, the degree to which they are intertwined with processes outside of healthcare, and the political dynamics and social hierarchies that culminate in disparate treatment and marginalization of BIPOC individuals. We expect that by exposing the disparate effect of these policies and protocols, this analysis may result in the alteration of current policies and protocols as well as the development and implementation of new policies.

Conclusion

Evaluating the perceived influences of policies and protocols is a critical step in the policy design and implementation process. This study helps to shed light on the perceived influences of perinatal illicit substance screening from the perspective of healthcare workers involved in or impacted by screening. By exploring the influence of screening, hospital decision makers will be able to use this information to evaluate whether or not the purpose of the policy or protocol has been achieved, identify unintended consequences of implementation, and revise policies in order to achieve the stated purpose or to minimize harm. That said, this study has identified several harmful perceived influences of illicit substance screening. Due to the potential harm associated with perinatal illicit substance screening, the use of such screening should be eliminated.

In order to move forward with a more positive and supportive approach, the social construction of individuals who use illicit substances while pregnant and substance use in general need to be changed. Social constructions can and do change. The social construction of cannabis, which was once considered a “gateway drug” and associated with criminal activity, is now widely accepted for its medicinal purposes, is legal for recreational use in many states, and is a growing industry for entrepreneurs. Once society truly acknowledges that illicit substance use while pregnant cuts across all races, ethnicities, and classes and is influenced by larger systemic issues, then and only then will we begin move past the need to perform such screening.

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Table 4.1*Interview Guide*

Domain	Question
Introduction	<p>Tell me a bit about yourself so that I can get a better sense of who is in the room.</p> <p>Can you describe the patient population that you serve?</p> <p>*Can you describe your patient population compared to your staff?</p> <p>What is the current screening process at your institution?</p>
Stigma/ Personal Bias	<p>When illicit substance use is suspected or confirmed, what do you think about?</p> <p>What are some of your concerns?</p> <p>Do you have the same thoughts about of alcohol and/or tobacco? Why or Why not?</p> <p>*Cannabis is in a gray zone. It's legal in some states and not in others. Does your institution screen for it? Do you have the same concerns about cannabis use?</p>
Role	<p>What is your role in the screening process?</p> <p>Tell me about the last time that you performed a screening.</p> <p>*How has screening changed over your career?</p> <p>*Do you think healthcare providers should be collaborating with outside organizations such as CPS?</p> <p>In a month how often do you perform perinatal illicit substance screening?</p> <p>Are there meetings to discuss these perinatal illicit substance screening policies? Cases that happen on the unit?</p>
Purpose	<p>Can you describe what happens when a patient screens negative? When they screen positive?</p> <p>What is the purpose of screening?</p> <p>*If the purpose is to guide care, why are referrals made to outside organizations such as CPS.</p>
Institutional/ Structural Racism	<p>*Do you think disparities exist in screening (can be in design or implementation)? Why or why not?</p> <p>Why do you think screenings continue to be performed?</p> <p>Based on your personal experience, describe the most commonly screened individual at your institution.</p> <p>One commonly used justification for screening is that it can help improve birth outcomes for the current pregnancy. With that in mind, why do you think patients are screened specifically at the time of birth?</p> <p>What are some advantages and disadvantages of the screening protocol used at your institution?</p> <p>What relevant information is not captured about your patients using your current institutional screening tool?</p> <p>*If it was determined that the screening criteria used disproportionately identified a subset of your patient population, would that change your mind about whether or not disparities exist or whether that specific criterion should be used?</p>

Domain	Question
Impact	<p>*When someone presented in labor and through the postpartum in-patient period is a few days, but the repercussions of screening can impact the patient much longer, what are your thoughts on that?</p> <p>What type of impact do you think screening is having on your patients? Has anyone ever disclosed anything to you or have you witnessed anything?</p>
Screening	<p>*Describe the culture on your unit when it comes to perinatal illicit substance use</p> <p>Do you feel that there is an alternative to the current screening process? If so, please describe.</p> <p>*If there is known substance use, why continue to perform urine toxicology?</p> <p>*Why do you think there is so much emphasis on urine toxicology screening over other methods?</p> <p>*Any test that we perform as healthcare professionals has a margin of error, u-tox included. Knowing that this could result in a false positive or a false negative does it change your thinking about the test? Reliance on the results?</p>
Other	<p>*When perinatal illicit substance use is an issue, how do you think maternal fitness is determined?</p> <p>*Are there adequate resources available for those who want treatment?</p> <p>*What is the role of the birthing individual's partner in the screening process? Are they screened?</p> <p>*What substances can you actually treat?</p> <p>*Based on your geographic location (regionally), what is the culture around perinatal illicit substance screening? What is the culture at your worksite?</p> <p>*Why is there so much focus on the birthing individual?</p> <p>*As healthcare providers how can we reconcile the maternal-fetal conflict when developing a plan of care?</p> <p>*Some would consider substance use a disease with other chronic disease we simply ask patients have they been diagnosed with anything, why do we need proof of substance use? Why not just ask, like we do with other chronic disease?</p>

*Not part of the original study guide

Table 4.2*Demographic Information of Study Participants (n=36)*

	Number	%
Gender		
Male	1	3
Female	35	97
Race*		
Black or African American	12	33
White, non-Hispanic	17	47
Ethnicity		
Hispanic or Latino	2	6
Multiracial (Race and/or Ethnicity)	5	14
Age³⁶		
18-24	1	3
25-34	10	28
35-49	11	30
50-64	12	33
65+	2	6
Education		
Associate Degree	4	11
Bachelor's Degree	12	33
Master's Degree	18	50
Doctorate Degree	2	6
Marital Status		
In a relationship	7	19
Divorced	6	17
Married	16	45
Single	7	19
Occupation		
Registered Nurse	22	61
Lactation Consultant	1	3
Midwife	7	19
Nurse Practitioner	2	5
Physician	1	3
Pediatric Resident	1	3
Dual role**	1	3
Declined to state***	1	3
Years of experience		
Less than a year	1	3
1-5 years	5	14
6-10 years	5	14
11-15 years	7	19
16+ years	18	50

	Number	%
Geographic Location		
Northeast	--	--
Midwest	1	3
South	5	14
West	30	83
Type of Institution		
Public	30	83
Private	6	17
Institutional screening protocol for illicit substances		
Yes	30	83
No	3	8.5
Unsure	3	8.5
Trained on institutional screening protocol		
Yes	18	53
No	13	38
N/A	3	9
Type of Screening		
Universal	16	57
Targeted/Risk-based	10	35
Both Targeted/Risk-based	1	4
Unsure	1	4
Comfort level with screening tool		
Extremely comfortable	10	28
Moderately comfortable	19	54
Slightly comfortable	2	6
Neither comfortable not uncomfortable	2	6
Slightly uncomfortable	1	3
Moderately uncomfortable	1	3
Extremely uncomfortable	0	--

*Race/Ethnicity self-reported by participants

**One participant reported being both a nurse practitioner and registered nurse

***Participant did not indicate their occupation when completing the demographic survey

Chapter V

Conclusion

Conclusion

Perinatal illicit substance screening is a complex issue that can have negative repercussions on the birthing individual and their family well beyond the pregnancy in which the screening was performed. The consequences of screening include birthing individual's questioning their own maternal fitness, social isolation, exacerbated health inequities and disparities, institutional surveillance, family separation, prosecution, coercion to seek treatment, discrimination, and stigmatization (Davis, 2019; Elias & Paradies, 2021; Lollar, 2017; Roberts, 1997; Stone, 2015; Taylor, 2020). Using a critical ethnographic lens, the authors described what illicit substance screenings are in terms of policy tools and design, explored what illicit substance screenings represent and their purpose, and revealed the impact of said screenings from the perspective of healthcare providers.

Patriarchal ideology, racism, and moral panic set the stage for perinatal illicit substance policies to perpetuate and thrive (Benoit et al., 2015; Johnston & Swanson, 2003; Roberts, 1991, 1992; Wolff, 2011). The social construction of motherhood is depicted as a white middle-class woman who is virtuous, selfless, submissive, and bears healthy children (Fouquier, 2011; Roberts, 1992; Springer, 2010; Wood, 2013). This narrow construction of motherhood allows society to question reproduction among anyone who falls outside of this description. In particular, Black motherhood has been scrutinized and challenged, with BIPOC birthing individuals often being used to represent "bad mothers" (Johnston & Swanson, 2003; Wood, 2013). The moral panic around "bad mothers" and other social deviants reproducing is rooted in their perceived threat to the white, patriarchal social structure of our society and how these "bad mothers" may jeopardize the balance of power. Policy, be it public or institutional, has been used to maintain this balance.

The social construction of target populations theory was used to explain what perinatal illicit substance screenings are and the rationale behind their design. Simply put, perinatal illicit substance screenings represent tools that policy makers and elected officials use to reinforce social norms. While any birthing individual can undergo illicit substance screening, the rationale for doing so has changed, as seen with both the crack cocaine and opioid epidemics. In accordance with the social construction of target populations theory, the approach to the crack cocaine epidemic was punitive, which was reflective of substance users' negative social construction. Black birthing individuals whose motherhood had already been devalued and demonized became the face of the crack cocaine epidemic. As such, the approach to address perinatal crack cocaine use was punitive, and the consequences were incarceration and family separation. The opioid epidemic, which is widely depicted as affecting white individuals, has seen a very different approach. White individuals who use illicit substances are viewed as victims, and treatment is often offered instead of punishment.

The implicit purposes can be categorized as perceived, interpreted, or implied. The perceived purpose reflected a general understanding of the purpose of perinatal illicit substance screening and included connecting patients with resources, assessing risk/safety, and managing care. The interpreted purpose focused on how individuals internalize such screening, and it included engaging with social services; fulfilling a legal, moral, or ethical duty; and preventing government intervention. Lastly, the implied purpose reflected unspoken aspects of screening that can be influenced by widely held societal beliefs and values, which included reinforcing institutional racism and surveillance to assess compliance.

There was agreement among providers regarding the necessity of illicit substance screening. Some participants felt that screening could be useful in the management of care if all

other differential diagnoses had been ruled out but there were still clinical concerns. Other participants felt it was acceptable to screen everyone with or without restrictions on how the results would be used. A subset of the participant population felt that verbal screening should be the only type of screening used. Overall, screening was viewed as having some utility.

In terms of alternatives to perinatal illicit substance screening, participants spoke of working to undo the harms caused by institutional racism in an attempt to rebuild trust and increase disclosure among BIPOC patients. Participants discussed how changing the language used to engage with patients might improve this process. The use of standardized practices and eliminating biased screening criteria were among the other alternatives mentioned. Currently, much of the concern related to perinatal illicit substance use is driven by concern for the child, whether it be care management or safety issues. Participants spoke of moving beyond concern for just the neonates to include the birthing individuals, their partners, support persons, and other socioeconomic aspects (i.e., housing and access to food), as parenting is not done in isolation.

Team Lily, located at Zuckerberg San Francisco General Hospital, is one such program. Team Lily is a transformative program involving a multidisciplinary care team that provides wrap-around services to pregnant and postpartum individuals impacted by mental illness, substance use, incarceration, intimate partner violence, or housing insecurity. Team Lily provides a variety of services such as pregnancy counseling, mental health, addiction, and case management services, which can be initiated at any point during one's pregnancy. Since its inception, Team Lily has been able to support pregnant and birthing individuals' transition into recovery, has prevented family separations by facilitating entry into treatment, has coordinated housing, and has decreased the utilization of emergency services among participants.

In conclusion, this dissertation sought to understand the implicit purposes of perinatal illicit substance screening in the postpartum period. Substance use among birthing individuals is a controversial issue, and there are many opinions regarding the most appropriate approach to address this issue. The social construction of target populations theory and critical ethnography provided the perfect framework for examining illicit substance screening because of its racial, social, and political undertones. The use of the social construction of target populations to highlight the experiences of intragroup members impacted by the same phenomena, in this case illicit substance use, was a novel approach to the use of theory. By using this approach, we can see how policies are used to reinforce institutional and structural racism.

Although some of the implicit purposes were described as supportive, the potential for harm far outweighs any potential benefits, in part due to the perceived influences of screening, being it at the individual (i.e., provide bias) or institutional (e.g., policy, hospital, etc.) levels. We must eliminate the use of routine perinatal illicit substance screening because its use is reinforcing institutional racism and discrimination. Additional research is needed to identify alternatives that will minimize racial and ethnic disparities while providing family-centered care.

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Appendix

Appendix A

Human Research Protection Program Institutional Review Board Outcome letter

(Original)



University of California
San Francisco

Human Research Protection Program Institutional Review Board (IRB)

Expedited Review Approval No Continuing Review

Conducting Research During the COVID-19 Public Health Outbreak: Please visit the Interim UCSF Policy on Human Subjects-Related Research Visits at San Francisco Campuses during COVID-19 Outbreak, which can be found at <https://research.ucsf.edu/interim-ucsf-policy-human-subjects-related-research-visits-san-francisco-campuses-during-covid-19> to determine whether and how this Policy may affect this IRB approved or exempt study.

Principal Investigator

Ifeyinwa Asiodu, PhD, RN, IBCLC

Co-Principal Investigator

Norlissa Cooper

Type of Submission: Initial Review Submission Packet
Study Title: Substance Use, Pregnancy, and Screening at Birth
IRB #: 20-29925
Reference #: 281023
Committee of Record: Parnassus Committee
Study Risk Assignment: Minimal

Approval Date: 07/22/2020

Regulatory Determinations Pertaining to this Approval:

This research is not subject to HIPAA rules.

A waiver of the requirement to obtain a signed consent form is acceptable for this study because, as detailed in the application, the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

The waiver applies to some subjects, as detailed in the application.

This submission was eligible for expedited review as:

Category 5: Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis)

Category 6: Collection of data from voice, video, digital, or image recordings made for research

purposes

Category 7: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

IRB Comments:

All changes to a study must receive UCSF IRB approval before they are implemented. Follow the [modification request](#) instructions. The only exception to the requirement for prior UCSF IRB review and approval is when the changes are necessary to eliminate apparent immediate hazards to the subject (45 CFR 46.108(a)(3)(iii), 21 CFR 56.108(a)). In such cases, report the actions taken by following these [instructions](#).

Expiration Notice: As a study qualifying for expedited review under the revised Common Rule, this study will not expire. You will not be required to submit continuing review reports to the IRB. However, this study remains under the oversight of the IRB and it may request periodic updates on the status of the study. You are still required to submit modifications, adverse events and protocol violations.

In addition, you are required to submit a [study closeout report](#) at the completion of the project.

Documents Reviewed and Approved with this Submission:

Consent Documents

Study Consent Form			
Title	Version #	Version Date	Outcome
Substance Use Pregnancy Perinatal Screening Consent Electronic V2.1	Version 1.5	07/22/2020	Approved
Substance Use Pregnancy Perinatal Screening Practices Consent Paper	Version 1.2	07/21/2020	Approved

Other Study Documents

Study Document			
Title	Version #	Version Date	Outcome
Substance Use Pregnancy Perinatal Screening Practices Bill of Rights V2	Version 1.1	05/06/2020	Approved
Substance Use Pregnancy Perinatal Screening Practices Focus Group Interview	Version 1.0	05/06/2020	Approved

Guide			
Substance Use Pregnancy Perinatal Screening Practices Demographics Questionnaire	Version 1.0	05/06/2020	Approved
Substance Use, Pregnancy Perinatal Screening Practices Individual Interview Guide	Version 1.0	05/06/2020	Approved
Substance Use, Pregnancy Perinatal Practices Eligibility Screening	Version 1.0	05/06/2020	Approved
Substance Use, Pregnancy Perinatal Practices Letter of Support	Version 1.0	05/06/2020	Approved
Substance Use, Pregnancy Perinatal Practices Recruitment Flyer	Version 1.0	05/06/2020	Approved
Substance Use, Pregnancy Perinatal Practices Screening Tool	Version 1.0	05/06/2020	Approved

For a list of all currently approved documents, follow these steps: Go to My Studies and open the study – Click on Informed Consent to obtain a list of approved consent documents and Other Study Documents for a list of other approved documents.

San Francisco Veterans Affairs Medical Center (SFVAMC): If the SFVAMC is engaged in this research, you must secure approval of the VA Research & Development Committee in addition to UCSF IRB approval and follow all applicable VA and other federal requirements. The UCSF IRB website has more information.

Appendix B

Human Research Protection Program Institutional Review Board Outcome letter (Modification)



University of California
San Francisco

Human Research Protection Program Institutional Review Board (IRB)

Expedited Review Approval

Principal Investigator

Ifeyinwa Asiodu, PhD, RN, IBCLC

Co-Principal Investigator

Norlissa Cooper

Type of Submission: Submission Correction for Modification Form
Study Title: Substance Use, Pregnancy, and Screening at Birth

IRB #: 20-29925
Reference #: 296650
Committee of Record: Parnassus Committee
Study Risk Assignment: Minimal

Approval Date: 10/15/2020 _____

All changes to a study must receive UCSF IRB approval before they are implemented. Follow the [modification request](#) instructions. The only exception to the requirement for prior UCSF IRB review and approval is when the changes are necessary to eliminate apparent immediate hazards to the subject (45 CFR 46.103.b.4, 21 CFR 56.108.a). In such cases, report the actions taken by following these [instructions](#).

Conducting Research During the COVID-19 Public Health Outbreak: Please visit the Interim UCSF Policy on Human Subjects-Related Research Visits at San Francisco Campuses during COVID-19 Outbreak, which can be found at <https://research.ucsf.edu/interim-ucsf-policy-human-subjects-related-research-visits-san-francisco-campuses-during-covid-19> to determine whether and how this Policy may affect this IRB approved or exempt study.

Expiration Notice: The iRIS system will generate an email notification eight weeks prior to the expiration of this study's approval. However, it is your responsibility to ensure that an application for [continuing review](#) approval has been submitted by the required time. In addition, you are required to submit a [study closeout report](#) at the completion of the project.

Documents Reviewed and Approved with this Submission:

Consent Documents

Study Consent Form			
Title	Version #	Version Date	Outcome
Substance Use Pregnancy Perinatal Screening Consent	Version 1.8	10/10/2020	Approved

Electronic V4			
Substance Use Pregnancy Perinatal Screening Practices Consent Paper	Version 1.4	07/21/2020	Approved

For a list of all currently approved documents, follow these steps: Go to My Studies and open the study – Click on Informed Consent to obtain a list of approved consent documents and Other Study Documents for a list of other approved documents.

San Francisco Veterans Affairs Medical Center (SFVAMC): If the SFVAMC is engaged in this research, you must secure approval of the VA Research & Development Committee in addition to UCSF IRB approval and follow all applicable VA and other federal requirements. The UCSF IRB [website](#) has more information.

Appendix C

Consent form (electronic)

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO CONSENT TO BE IN RESEARCH STUDY (Electronic)

Study Title: Substance Use, Pregnancy, and Screening at Birth

This is a research study, and you do not have to take part. The Research Projector Director is Dr. Ifeyinwa Asiodu, is an Assistant Professor in the Family Health Care Nursing Department. The Co-Principal Investigator, Norlissa M. Cooper Ph.D., will explain this study to you. If you have any questions, you may ask the researcher.

You are being asked to take part in this study because you have experience caring for individuals giving birth in the postpartum inpatient setting.

In this study, the researchers are doing a interviews and focus groups to learn more about healthcare providers' experiences with perinatal illicit substance screening in the postpartum setting. This is an unfunded student project. About 60 people will participate in this study.

What will happen if I take part in this study?

If you agree, the following procedures will occur:

First, you will be "screened" using a list of questions to find out if you can participate in the study.

If the screening shows that you can be in the main part of the study and you choose to continue, this is what will happen next:

You will be asked to participate in an interview in-person or virtually. This interview would be scheduled at a mutually agreeable date and time. In this interview you would be asked questions about what you feel is the purpose and necessity of perinatal illicit substance screening. This interview would last 90 minutes and will be audio taped. If a follow-up interview is needed it will last 60 minutes and will be audio taped. After the interview(s), someone will type into a computer a transcription of what is on the tape and remove any mention of names. The audiotapes will then be destroyed. Notes may be taken during the interview. The notes will not contain your name and will be kept confidential.

A group of people will be interviewed for about two hours in a private office or virtually. You will be asked to describe your experiences with perinatal illicit substance screening. A sound recording of the conversation will be made. After the interview, someone will type into a computer a transcription of what's on the tape and will remove any mention of names. The sound recording will then be destroyed. All transcripts will be password protected. Notes may be taken during the focus group. The notes will not contain your name and will be kept confidential.

You may be observed while you are at work or during work meetings (in-person or virtually). Notes may be taken during these observations. The notes will not contain your name and will be kept confidential.

How will my information be used?

Researchers will use your information to conduct this study. Once the study is done using your information, we may share it with other researchers so they can use it for other studies in the

future. We will not share your name or any other personal information that would let the researchers know who you are. We will not ask you for additional permission to share this de-identified information.

Are there any risks to me or my privacy?

Some of the survey questions may make you feel uncomfortable or raise unpleasant memories. You are free to skip any question. We will do our best to protect the information we collect from you. Information that identifies you will be kept secure. The survey itself will not include details that directly identify you, such as your name or address. Please do not put this information on your survey. The completed surveys will be kept secure and separate from information that identifies you. Only a small number of researchers will have direct access to completed surveys. If this study is published or presented at scientific meetings, names and other information that might identify you will not be used.

During focus groups you and the other people in the group will be asked to use only first names during the group session. You will also be asked not to tell anyone outside the group what any particular person said in the group. However, the research team cannot guarantee that everyone will keep the discussions private.

Authorized representatives from the following organizations may review your research data for the purpose of monitoring or managing the conduct of this study:

- Representatives of the University of California
- UCSF School of Nursing research faculty and graduate student researchers may review deidentified research records for data analysis and teaching purposes

Are there benefits?

There is no benefit to you. The focus group and interview results will be used for research.

Can I say “No”?

Yes, you do not have to complete a survey. If you choose not to be in this study you will not lose any of your regular benefits, and you can still receive medical care from UCSF. Choosing not to be in the study will not affect your employment.

Are there any payments or costs?

In return for your time, effort and travel expenses, you will be paid a maximum of \$90 for taking part in this study. You will receive a \$30.00 gift card at the beginning of the interview, focus group, or follow-up interview.

Who can answer my questions about the study?

You can talk with the study researcher about any questions, concerns, or complaints you have about this study. Contact the study researcher Norlissa Cooper at (510) 331-4155.

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the office of the Institutional Review Board at 415-476-1814.

CONSENT

PARTICIPATION IN RESEARCH IS VOLUNTARY.

Click here to download a copy of the [Consent](#) and [Bill of rights](#)

Please indicate below whether you consent or do not consent to participate in this study. **Please select all that apply.**

- I DO consent to participate in this study, I want to participate I the focus groups
- I DO consent to participate in this study, I want to participate I the interviews
- I DO consent to participate in this study, I want to participate in a follow-up interview
- I **DO NOT** consent to participate in this study

Please type your first and last name and birthdate below

Appendix D

Consent form (paper)

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO CONSENT TO PARTICIPATE IN A RESEARCH STUDY (Paper)

Study Title: Substance Use, Pregnancy, and Perinatal Screening Practices

Research Project Director/ Co-Principal Investigator:	Ifeyinwa Asiodu, PhD, RN, IBCLC Assistant Professor in the Family Health Care Nursing Koret Way, Rm 431E UCSF Box 0606 San Francisco, CA 94143 Phone: 415-476-1426; e-mail: Ifeyinwa.Asiodu@ucsf.edu Norlissa Cooper, PhD, MS, RN Phone: (510) 331-4155; e-mail: norlissa.cooper@ucsf.edu
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This is a research study about illicit perinatal substance screening practices at the time of birth. A member of the study team will explain this study to you. This study will be supervised by Dr. Ifeyinwa Asiodu.

DETAILED STUDY INFORMATION

This part of the consent form gives you more detailed information about what the study involves. Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask any member of the research team.

You are being asked to take part in this study because you are/have experience caring for individuals giving birth in the postpartum inpatient setting.

Why is this study being done?

The number of birthing individuals who report substance use and newborns that have health issues because of exposure to substances has increased. The purpose of this study is to learn more about the need and purpose of perinatal illicit substance screening among healthcare providers that work in the birthing setting. Also, this study will explore alternatives to screening.

Who pays for this study?

This study is not funded by an external agency, institution, group, or foundation. Internal funding for participant gift cards and other study materials will be provided by the study Co-Principal Investigator, Norlissa Cooper, PhD, MS, RN

How many people will take part in this study?

There will be approximately 10-15 people per focus group. Interviews will be one-on-one. Observations will focus on one person interacting in their environment. Approximately 60 people take part in this study.

What will happen if I take part in this research study?

If you agree, the following procedures will occur:

First, you will be “screened” using a list of questions to find out if you can participate in the study.

If the screening shows that you can be in the main part of the study and you choose to continue, this is what will happen next:

You will be asked to participate in an interview in-person or virtually. This interview would be scheduled at a mutually agreeable date and time. In this interview you would be asked questions about what you feel is the purpose and necessity of perinatal illicit substance screening. This interview would last 90 minutes and will be audio taped. If a follow-up interview is needed it will last 60 minutes and will be audio taped. After the interview, someone will type into a computer a transcription of what is on the tape and remove any mention of names. The audiotapes will then be destroyed. Notes may be taken during the interview. The notes will not contain your name and will be kept confidential.

A group of people will be interviewed for about two hours in a private office or virtually. You will be asked to describe your experiences with perinatal illicit substance screening. A sound recording of the conversation will be made. After the interview, someone will type into a computer a transcription of what's on the tape and will remove any mention of names. The sound recording will then be destroyed. All transcripts will be password protected. Notes may be taken during the focus group. The notes will not contain your name and will be kept confidential.

You may be observed while you are at work or during work meetings (in-person or virtually). Notes may be taken during these observations. The notes will not contain your name and will be kept confidential.

Study location:

There will be a few study locations. Focus groups will meet the interviewer in a predetermined place, such as an office space or meeting room in a library or virtually on a predetermined date. Field Observations will happen at your work site or in work meetings in-person or virtually. Interviews will take place at a mutually agreeable private place, such as a meeting room in a local library or virtually.

How long will I be in the study?

Participation in the study will take no more than four hours, with a total of one interview and one focus group. The interview and focus group will be held on a separate days.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell someone on the research team or staff person right away if you wish to stop being in the study.

Also, a member of the research team may stop you from taking part in this study at any time if he or she believes it is in your best interest, if you do not follow the study rules, or if the study is stopped.

What side effects or risks can I expect from being in the study?

- Some of the focus group discussion questions may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to leave the group at any time.

- Some of the people in the focus group may have opinions that differ from yours which may make you feel uncomfortable or upset. You are free to leave the focus group at any time.
- For more information about risks and side effects, ask a member of the research team.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, the information that you provide may help health professionals better understand/learn more about perinatal illicit substance screening practices at the time of birth and potential influence future screening protocol development.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you. You will not lose any of your regular benefits, and you can still get your care from our institution the way you usually do. Choosing not to be in the study will not affect your employment.

How will my information be used?

Your information will be used to conduct this study. Once the study is done using your information, we may share your information with other researchers so they can use it for other studies in the future. We will not share your name or any other personal information that would let the researchers know who you are. We will not ask you for additional permission to share this de-identified information.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Authorized representatives from the following organizations may review your research data for the purpose of monitoring or managing the conduct of this study:

- Representatives of the University of California
- UCSF School of Nursing research faculty and graduate student researchers may review deidentified research records for data analysis and teaching purposes

During focus groups you and the other people in the group will be asked to use only first names during the group session. You will also be asked not to tell anyone outside the group what any particular person said in the group. However, the research team cannot guarantee that everyone will keep the discussions private.

Are there any costs to me for taking part in this study?

There are no cost associated with taking part in this study.

Will I be paid for taking part in this study?

In return for your time, effort and travel expenses, you will be paid a maximum of \$90 for taking

part in this study. You will receive a \$30.00 gift card at the beginning of the interview, focus group, or follow-up interview.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way. You will not lose any of your regular benefits, and you can still get your care from our institution the way you usually do.

Who can answer my questions about the study?

You can talk to any member of the research team about any questions, concerns, or complaints you have about this study. Main study contact, Norlissa Cooper, RN, PhD at (510) 331-4155. If you wish to ask questions about the study or your rights as a research participant to someone other than the research team or if you wish to voice any problems or concerns you may have about the study, please call the Institutional Review Board at 415-476-1814.

CONSENT

You have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in the study's focus groups, you should sign below.

Date Participant's Signature for Consent

Date Person Obtaining Consent

If you wish to participate in interview, you should sign below.

Date Participant's Signature for Consent

Date Person Obtaining Consent

If you agree to be contacted later for a follow-up interview, you should sign below.

Date Participant's Signature for Consent

Date Person Obtaining Consent

Appendix E

Participant bill of rights

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
EXPERIMENTAL SUBJECT'S
BILL OF RIGHTS

Study Title: Substance Use, Pregnancy, and Screening at Birth

The rights below are the rights of every person who is asked to be in a research study. As an experimental subject I have the following rights:

- 1) To be told what the study is trying to find out,
- 2) To be told what will happen to me and whether any of the procedures, drugs, or devices is different from what would be used in standard practice,
- 3) To be told about the frequent and/or important risks, side effects, or discomforts of the things that will happen to me for research purposes,
- 4) To be told if I can expect any benefit from participating, and, if so, what the benefit might be,
- 5) To be told of the other choices I have and how they may be better or worse than being in the study,
- 6) To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study,
- 7) To be told what sort of medical treatment is available if any complications arise,
- 8) To refuse to participate at all or to change my mind about participation after the study is started. This decision will not affect my right to receive the care I would receive if I were not in the study,
- 9) To receive a copy of the signed and dated consent form,
- 10) To be free of pressure when considering whether I wish to agree to be in the study.

If I have other questions I should ask the researcher or the research assistant. In addition, I may contact the Institutional Review Board, which is concerned with protection of volunteers in research projects. I may reach the committee office by calling: (415) 476-1814 from 8:00 AM to 5:00 PM, Monday to Friday, or by writing to the UCSF Human Research Protection Program, Box 0962, 3333 California St., Ste. 315, San Francisco, CA 94143.

Call 476-1814 for information on translations.

Appendix F

Focus group interview guide

Substance Use, Pregnancy, & Perinatal Screening Practices Focus Group Interview Guide

I. Introduction

Hello. My name is Norlissa Cooper and I am a Doctoral Candidate at the University of California San Francisco. Thank you for agreeing to participate in this study. As a reminder, the purposes of this study are to investigate perinatal screening practices at the time of birth.

Participation in this study is voluntary, you have the right not to answer questions and/or withdraw from the study at any time. The interview will be audio recorded. During the interview, you may stop to take a break at any time. Do you have any questions for me right now?

II. Centering Exercise

III. Focus Group Questions

1. Several people identified [insert theme] as the purpose for substance screening. Based on your experience is this an accurate description of the purpose? Why or why not?
2. Several people identified [insert theme] as the necessity for substance screening. Based on your experience is this an accurate description of the purpose? Why or why not?
3. [insert theme] were identified as impacts of screening. Can you tell me how the impacts reflect or align with the purpose or intent of screening?
4. Based on [insert number] interviews the most commonly screened birthing individual was [insert description], Why do you think this group was screened more often when compared to other individuals?
5. When asked about disparities in screening, people stated [insert responses] in regard to the continued used of screening.
 - When you hear these justifications, what comes to mind?
 - How would you group or categorize these responses?
6. Some people indicated on the questionnaire that they are part of [insert organization]. How does your intuitional policy align with position statements regarding substance screening issued by [insert organization].?

IV. Conclusion

Before we end today, is there anything else that you would like to share with me that I have not yet asked you about or that we haven't discussed? Thank you for participating in this focus group. I appreciate your willingness to share your experiences with me.

Probes:

Tell me more about...

Tell me about a time when...
Can you say more about that?
What was that like for you?
Can you describe that experience in detail?
It sounds like you're saying

Appendix G

Demographic questionnaire

Substance Use, Pregnancy, & Perinatal Screening Practices Demographics Questionnaire

Initials: _____

Last two digits of birthdate year: _____

Gender:

- Male
- Female
- Trans male/Trans man
- Trans female/Trans woman
- Genderqueer/Gender non-conforming
- Different identity (please specify):

Age:

- 18-24
- 25-34
- 35-49
- 50-64
- 65+

Race/Ethnicity:

- American Indian or Alaskan Native
- Black or African American
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- Asian
- White, non-Hispanic
- Two or more

Highest Level of Educational Attainment:

- Trade/technical/vocational Training
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Doctorate Degree
- Other (please specify):

Marital Status:

- Divorced
- In a relationship
- Married
- Separated
- Single
- Widowed

Are you a member of any professional organizations such as the Association of Women's Health, Obstetric and Neonatal Nurses or the American College of Obstetricians and Gynecologists.

Please specify:

Employment Status:

- Employed
- Retired
- Student
- Currently not employed
- Other (please specify):

Occupation:

- License Vocational Nurse
- Midwife
- Physician
- Registered Nurse
- Resident/Intern
- Other (please specify):

Number of Years in this Occupation:

- Less than a year
- 1-5 years
- 6 -10 years
- 11-15 years
- 16+ years

Type of institution employed/studying at:

- Public
 - Private
 - Other (please specify):
-

Does your institution have a screening protocol for alcohol?

- Yes No Unsure

If yes, is this protocol

- Universal (Everyone is screened)
- Targeted/Risk-based (Screened based on criteria)
- Both Universal and Targeted-Risk-based
- Unsure

Does your institution have a screening protocol for tobacco?

- Yes No Unsure

If yes, is this protocol

- Universal (Everyone is screened)
- Targeted/Risk-based (Screened based on criteria)
- Both Universal and Targeted-Risk-based
- Unsure

Does your institution have a screening protocol for illicit substances?

- Yes No Unsure

If yes, is this protocol

- Universal (Everyone is screened)
- Targeted/Risk-based (Screened based on criteria)
- Both Universal and Targeted-Risk-based
- Unsure

Did you receive training on these screening tools prior to using them?

- Yes
- No
- N/A

Rate your familiarity with the screening protocols used at your institution.

- Not at all familiar
- Slightly familiar
- Moderately familiar
- Very familiar
- Extremely familiar

Rate your comfort level with administering such screening protocols

- Extremely comfortable
- Moderately comfortable
- Slightly comfortable
- Neither comfortable or uncomfortable
- Slightly uncomfortable
- Moderately uncomfortable
- Extremely uncomfortable

During the last month how often did you perform illicit perinatal substance screening at the time of birth?

- Never
- Once
- Twice
- Three times
- Four or five times
- More than five times

In the last six months how often did you perform illicit perinatal substance screening at the time of birth?

- Never
- Once
- Twice
- Three times
- Four or five times
- More than five times

Appendix H

Individual Interview Guide

Hello. My name is Norlissa Cooper and I am a Doctoral Candidate at the University of California San Francisco. Thank you for agreeing to participate in this study. As a reminder, the purposes of this study are to investigate perinatal screening practices at the time of birth.

Participation in this study is voluntary, you have the right not to answer questions and/or withdraw from the study at any time. The interview will be audio recorded. During the interview, you may stop to take a break at any time. Do you have any questions for me right now?

As a reminder screening refers to the use of paper, verbal, or urine toxicology screening performed at the time of birth.

I. Interview Questions

Introduction

1. Tell me a bit about yourself and your role on the care team?
2. Can you describe the patient population you serve?
3. What is the current screening process at your institution?

Stigma/Personal Bias

1. When illicit substance use is suspected or confirmed, what do you think about? What are some of the concerns?
2. Do you have the same thoughts or concerns about alcohol and/or tobacco? Why or Why not?
3. Cannabis is in a gray zone. It's legal in some states and not in others. Does your institution screen for it? Do you have the same concerns about cannabis use?

Role/Purpose/Necessity

1. What is your role in the screening process?
2. What is the purpose of screening?
3. How has screening changed over your career?
4. Tell me about the last time that you performed a screening?
5. Can you describe what happens when a patient screens negative? When they screen positive?
6. When someone presented in labor and through the postpartum in-patient period is a few days but the repercussions of screening can impact the patient much longer, what are your thoughts on that?

Institutional/Structural Racism

1. Do you think disparities exist in screening (can be in design or implementation)? Why or why not? why do you think screenings continue to be performed?
2. Based on your personal experience, describe the most commonly screened individual at your institution.
3. One commonly cited justification for screening is that it can help improve birth outcomes for the current pregnancy. With that in mind, why do you think patients are screened specifically at the time of birth?
4. What are some advantages and disadvantages of the screening protocol used at your institution?
5. What relevant information is not captured about your patients using your current institutional screening tool?
6. If it was determined that the screening criteria used disproportionately identified a subset of your patient population, would that change your mind about whether or not disparities exist or whether that specific criterion should be used?

Impact

1. What type of impact do you think screening is having on your patients? How you practice?

Other

1. Describe the culture on your unit when it comes to perinatal illicit substance use
2. Do you feel that there is an alternative to the current screening process? If so, please describe.
3. If there is known substance use, why continue to perform urine toxicology?
4. Why do you think there is so much emphasis on urine toxicology screening over other methods?
5. Any test that we perform as healthcare professionals has a margin of error, u-tox included. Knowing that this could result in a false positive or a false negative does it change your thinking about the test? Reliance on the results?
6. When perinatal illicit substance use is an issue, how do think maternal fitness is determined?
7. In a month how often do you perform perinatal illicit substance screening?
8. Are there meetings to discuss these perinatal illicit substance screening policies? Cases that happen on the unit?
9. Can you describe your patient population compared to your staff?

10. Are there adequate resources available for those who want treatment?
11. What is the role of the birthing individual's partner in the screening process? Are they screened?
12. If the purpose is to guide care, why are referrals made to outside organizations such as CPS.
13. What substances can you actually treat?
14. Based on your geographic location (regionally), what is the culture around perinatal illicit substance screening?
15. Do you think healthcare providers should be collaborating with outside organizations such as CPS?
16. Why is there so much focus on the birthing individual?
17. As healthcare providers how can we reconcile the maternal-fetal conflict when developing a plan of care?
18. Some would consider substance use a disease with other chronic disease we simply ask patients have they been diagnosed with anything, why do we need proof of substance use? Why not just ask, like we do with other chronic disease?

II. Conclusion

Before we end today, is there anything else that you would like to share with me that I have not yet asked you about or that we haven't discussed? Thank you for participating in this interview. I appreciate your willingness to share your experiences with me.

Probes:

Tell me more about...

Tell me about a time when... Can you say more about that? What was that like for you?

How did that make you feel?

Can you describe that experience in detail? It sounds like you're saying . . .

Appendix I

Eligibility screening script

Substance Use, Pregnancy, & Perinatal Screening Practices Eligibility Screening Telephone Consent Script

Hello, my name is Norlissa Cooper, I am a doctoral student from the University of California, San Francisco.

I'd like to tell you about a research study looking at perinatal substance screening practices at birth, and then ask you a few questions to see if you are interested and eligible to participate in the study.

We are asking you to be in this study because you have experience caring for birthing individuals in the labor and delivery and/or postpartum setting.

We are doing this study because we want to find out more information about screening practices and the perceived purpose of screening at the time of birth.

People who volunteer to be in this study will be asked to participate in one interview and one focus group.

The study will take place in either Oakland, CA or San Francisco, CA and will take approximately four hours to complete.

We will do our best to keep all of your information confidential. However, we cannot guarantee total privacy.

Being in this study is optional, and if you decide to participate, you can stop being in the study at any time.

I would like to ask you some questions to find out if you are able to participate in the study. Is that okay?

It is important to know that you are not joining the study simply by answering these questions. If we find that you are eligible to participate, and you want to learn more, then we can make plans to give you more information about the procedures and risks before you decide to join the study.

Would you like to answer some questions to see if you are eligible for the study?

At the end of the discussion, after the screening:

I'd like to give you two phone numbers to write down. If you have questions about this study, you can contact Norlissa Cooper at (510) 331-4155. If you have questions or concerns about this phone call or about your rights as a research participant, you can call the UCSF Institutional Review Board at 415-476-1814. Thank you for your time and consideration.

Appendix J

Recruitment flyer



Research Volunteers Needed

Study looking at Substance Screening at the Time of Birth



Norlissa Cooper, Doctoral Candidate, MS, RN from the University of California, San Francisco School of Nursing is looking for volunteers for a study looking at perinatal illicit substance, alcohol, and tobacco screening at the time of birth

If you have worked or currently worked in labor and delivery or postpartum care, we want to talk to you.

Study Requirement?

- At least 18 years old
- Care(d) for birthing individuals in the labor and delivery or postpartum setting
- Speak and read English

What will you have to do? Participate in:

- One interview
- One focus group

What will you get?

- A \$30.00 gift card per interview/focus group

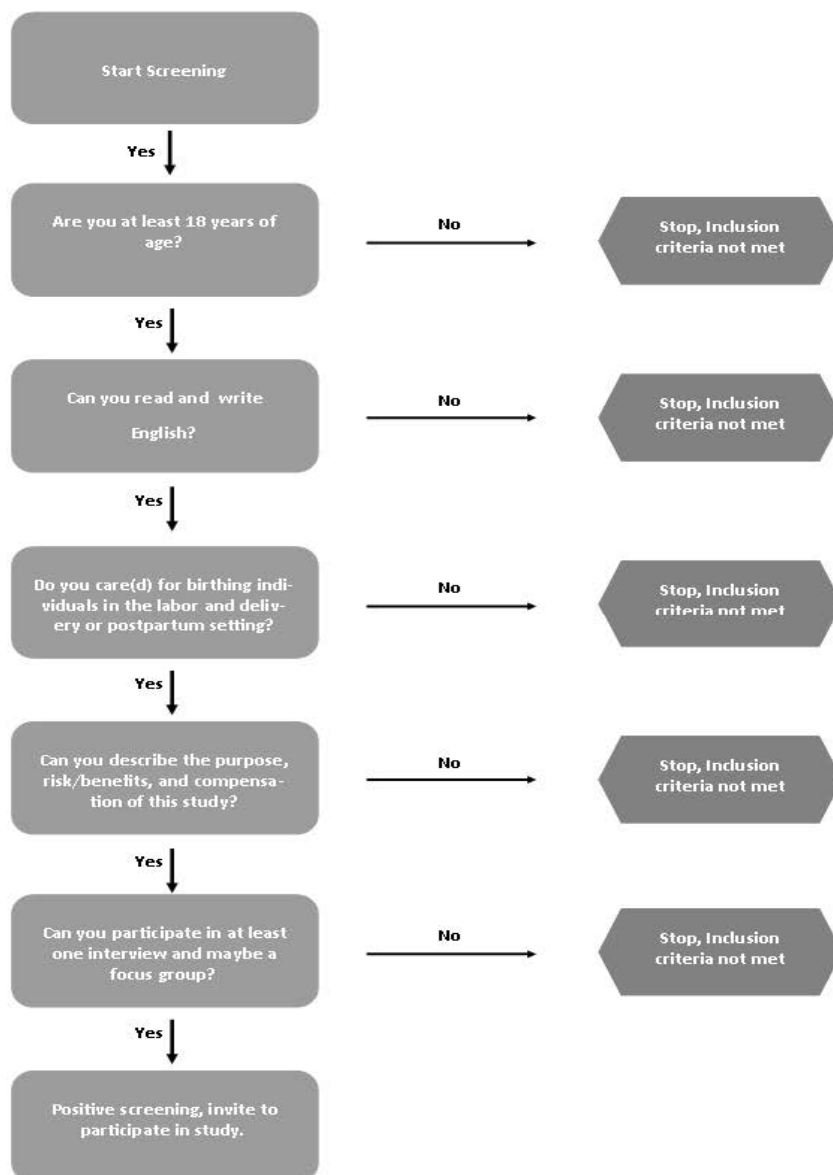
If you want to join or have questions, call/text Norlissa Cooper at (510) 331-4155 or email her at norlissa.cooper@ucsf.edu.

Thank you.

Appendix K

Screening tool

Substance Use, Pregnancy, & Perinatal Screening Practices Study Eligibility Screening Tool



University required forms

UCSF School of Nursing Proposed Publications for the Dissertation

Form A

(This form should be completed when the Dissertation Committee meets to approve the dissertation proposal)

Date: April 20, 2020

Student Name: Norlissa Cooper

Dissertation Chair: Dr. Ifeyinwa Asiodu

Dissertation Title: Substance use, pregnancy, and perinatal screening practices

Paper #1

Content area or focus: Literature Review

Proposed authors: Dr. Ifeyinwa Asiodu³, Norlissa Cooper¹, Dr. Audrey Lyndon²,
Dr. Ruth Malone², Dr. Monica McLemore¹, Dr. Sarah Roberts¹

Potential journal: TBD

Anticipated date for submission: July 2021

Paper #2

Content area or focus: Perceived purpose and necessity of screening

Proposed authors: Dr. Ifeyinwa Asiodu, Norlissa Cooper, Dr. Audrey Lyndon,
Dr. Monica McLemore, Dr. Sarah Roberts

Potential journal: TBD

Anticipated date for submission: June 2021

Paper #3

Content area or focus: Alternatives to screening

Proposed authors: Dr. Ifeyinwa Asiodu, Norlissa Cooper, Dr. Audrey Lyndon,
Dr. Monica McLemore, Dr. Sarah Roberts

Potential journal: TBD

Anticipated date for submission: July 2021

Dissertation Committee Chair Signature: _____

UCSF School of Nursing Proposed Publications for the Dissertation

Form B

(This revised version of Form A should be completed by April 1st of the year of graduation, when a draft of the entire dissertation is submitted to the Dissertation Chair)

Date: April 16, 2021

Student Name: Norlissa Cooper

Dissertation Chair: Dr. Ifeyinwa Asiodu

Dissertation Title: Illicit Substance Use, Pregnancy, and Perinatal Screening Practices

Paper #1

Content area or focus: Policy approaches to perinatal illicit substance use

Proposed authors: Dr. Ifeyinwa Asiodu, Norlissa Cooper, Dr. Audrey Lyndon,
Dr. Monica McLemore, Dr. Sarah Roberts

Potential journal: Policy, Politics, and Nursing Practice

Anticipated date for submission: July 2021

Paper #2

Content area or focus: Implicit purposes screening

Proposed authors: Dr. Ifeyinwa Asiodu, Norlissa Cooper, Dr. Audrey Lyndon,
Dr. Monica McLemore, Dr. Sarah Roberts

Potential journal: BMC Pregnancy and Childbirth

Anticipated date for submission: May 2021

Paper #3

Content area or focus: Alternatives to screening

Proposed authors: Dr. Ifeyinwa Asiodu, Norlissa Cooper, Dr. Audrey Lyndon,
Dr. Monica McLemore, Dr. Sarah Roberts

Potential journal: TBD; International Journal of Childbirth or Journal of Perinatal and Neonatal
Nursing

Anticipated date for submission: June 2021

Dissertation Committee Chair Signature: _____

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