11-21-2025

Differential Substance Use Screening Approaches Among Medical Providers Based on Pregnancy Status

Ericka L. Suarez-Vella
Walden University

Walden University

College of Allied Health

This is to certify that the doctoral dissertation by

Ericka L Suarez-Vella

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mark Arcuri, Committee Chairperson, Psychology Faculty
Dr. Delinda Mercer, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Abstract

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by

Ericka L Suarez-Vella

MS, San Jose State University, 2009

BS, San Francisco University, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

November 2025

Abstract

Exploring medical providers' role in relation to pregnant individuals who use substances is critical. Understanding how screening practices and provider biases influence addiction treatment referrals based on pregnancy status can help address several key issues, including potential disparities resulting from provider bias. It can ensure fair referral practices, promote equitable access to treatment, and ensure timely intervention resulting in better health outcomes. It can influence changes to policy and procedure among healthcare and judicial establishments, ultimately improving the relationship between providers and patients. The purpose of this study was to explore how medical providers' screening practices of substance use in pregnancy and personal biases influence addiction treatment referrals. The design of this study employed a qualitative approach and utilized thematic analysis. The theoretical foundation was social constructivism theory. Participants reported a high degree of consistency in screening for alcohol and drug use in pregnancy. Participants indicated that referrals, rather than screenings, are influenced by social stigma. Participants demonstrated awareness of their biases and described intentional efforts to build trust and reduce stigma in their practice. A need to explore the impact of diagnostic language on stigma and care was identified, as well as a need to address postpartum support, evaluate integrated care models, and assess the effectiveness of community education and outreach in reducing stigma around substance use in pregnancy. The positive social change implication of this study is that it supports systemic changes that reduce stigma, improve access to care, and promote healthier outcomes for pregnant individuals and their families.

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Dedication

I dedicate this dissertation to my son, who at only five years old has been my life's biggest teacher and most incredible gift. I also dedicate this to my husband, whose love and never-ending support made this academic dream a reality. I also dedicate this to my parents, whose countless sacrifices gave me the opportunities they never had, and to my grandmother, who planted a seed that has now grown into a genuine love for knowledge and personal growth. I also thank her for showing me the value of faith and its incredible power even in the darkest of times.

Acknowledgments

I want to express my deepest gratitude to Dr. Mark Arcuri and Dr. Delinda Mercer; their constant guidance and support served as the fuel needed to accomplish this monumental accomplishment in my life.

Table of Contents

List of Tables v

Chapter 1: Introduction to the Study 1

Introduction 1

Background 2

Problem Statement 3

Purpose of the Study 4

Research Questions 5

Theoretical and/or Conceptual Framework for the Study 6

Nature of the Study 8

Assumptions 8

Scope and Delimitations 9

Limitations 9

Significance 10

Summary 10

Chapter 2: Literature Review 11

Introduction 11

Literature Search Strategy 12

Theoretical Foundation 15

Literature Review Related to Key Variables and/or Concepts 16

Effects on the Fetus 16

Effects on the Mother 20

Barriers (Healthcare/Personal/Legal/Stigma) 22
Screening Tools 32
Treatment Options 33
Social/Cultural Factors 36
Overview/Critique of Research 37
Summary and Conclusions 39
Chapter 3: Research Method 40
Introduction 40
Research Design and Rationale 40
Role of the Researcher 41
Methodology 42
Participant Selection Logic 42
Instrumentation 42
Procedures for Recruitment, Participation, and Data Collection 43
Data Analysis Plan 46
Issues of Trustworthiness 47
Ethical Procedures 49
Summary 50
Chapter 4: Results 51
Introduction 51
Setting 52
Demographics 53

Data Collection 55
Data Analysis 57
Theme 1: Societal Views on Substance Use in Pregnancy 58
Theme 2: Organizational Impact on Clinical Practice 59
Theme 3: Personal Beliefs of Medical Providers 61
Theme 4: Approaches to Screening and Assessment 62
Theme 5: Referral and Treatment Processes 64
Theme 6: The Patient-Provider Relationship 65
Theme 7: Legal Considerations 67
Theme 8: Recommendations for Change 69
Evidence of Trustworthiness 72
Results 73
Summary 77
Chapter 5: Discussion, Conclusions, and Recommendations 78
Introduction 78
Interpretation of the Findings 79
Theme 1: Societal Views on Substance Use in Pregnancy 79
Theme 2: Organizational Impact on Clinical Practice 80
Theme 3: Personal Beliefs of Medical Providers 81
Theme 4: Approaches to Screening and Assessment 81
Theme 5: Referral and Treatment Processes 82
Theme 6: Patient-Provider Relationship 83

Theme 7: Legal Considerations 83

Theme 8: Recommendations for Change..... 84

Limitations of the Study.....87

Recommendations.....89

Implications.....90

Conclusion 91

References.....93

Appendix A: Marketing Forms (Sample Email).....110

Appendix B: Semistructured Interview Questions 111

Appendix C: Themes and Participant Quotes.....113

List of Tables

Table 1. Search Engines and Terms Used to Conduct Research 14

Table 2. Participant Demographics..... 54

Table 3. Summary of the Key Themes and Illustrative Quotes (*N* = 10) 71

Table 4. Themes and Participant Quotes…….113

Chapter 1: Introduction to the Study

Introduction

Despite public awareness of the effects of substance use in pregnancy, the statistics show continued problems. Substance use disorders among women are rapidly becoming more prevalent, leading to an increase in pregnancy-related deaths (Smid et al., 2020). The National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022a) reported a 9.4% use rate of substances by pregnant women, highlighting a failure by the government to address a serious social problem adequately. Current medical practices and available interventions for substance use share the goal of harm reduction and abstinence. However, current approaches fail to acknowledge substance use in pregnancy as a chronic medical condition that can manifest across a woman's life span.

The responsibility, blame, and stigma are often placed on women, while legislative and organizational changes that could facilitate accurate detection and treatment are overlooked. Pregnant women who use substances are a marginalized group facing persecution without meaningful government involvement. The stigma experienced during pregnancy negatively affects the quality of medical and social care received and contributes to treatment underutilization.

The purpose of this study was to explore current screening practices of substance use in pregnancy and potential personal biases held by medical providers when working with women with substance use disorders in pregnancy, as they hold a unique position in this social problem. The study is divided into several sections, including an extensive

literature review, research methods, results, and a concluding discussion on the implications of the results and their potential to stimulate future research.

Background

The research on substance use in pregnancy has focused mainly on the role of women, emphasizing personal and psychosocial barriers. However, research has not sufficiently addressed the role of the medical community and its impact on this social problem, resulting in fragmented information for public awareness. Studies have identified inconsistencies in screening practices among medical providers (Hostage et al., 2020). Additionally, in situations when substance use is present, less than two-thirds of pregnant women receive adequate treatment (Lynch et al., 2021). Part of this problem may be attributed to organizational barriers faced by medical providers, including competing priorities, time constraints, and a lack of clear protocols, which result in inconsistent clinical practices, inadequate training, and limited awareness of treatment options (Oni et al., 2019).

In addition, personal beliefs about substance use in pregnancy may also play a key role and interfere with clinical practice. Differences among medical provider attitudes, beliefs, and stigma toward pregnant women with substance use disorders demonstrate more empathetic and supportive approaches among those who view substance use as a chronic disease compared to those adhering to the moral model, which links addiction to personal failings (Trainor, 2022).

In this study, I focused on potential discrepancies in screening practices for substance use and possible personal biases within the healthcare community. This

knowledge gap has the potential to create meaningful change in the way these women are viewed and treated. The study has the potential to shift responsibility away from solely women while highlighting how the government and organizations can address this issue comprehensively. There is a need for this study, as the emotional, financial, and social costs are too heavy to continue sustaining without immediate change. Current legal and organizational policies, procedures, and practices do not support Nancy Reagan's platform of "just say no." The disconnect between policy and practice needs to be addressed, which could result in fewer punitive policies that have not been effective and greater clinical competence among medical providers in detecting, educating, and treating these women in an individually tailored, compassionate, and integrative manner.

Problem Statement

Substance use during pregnancy is a social issue that requires attention not only from the medical and psychiatric communities but also from increased government awareness to address this public health concern. Pregnancy is a crucial period in a woman’s life, which can be further complicated by untreated substance use. Therapeutic and rehabilitative methods for substance use are essential for supporting the safety of both mother and child during the prenatal and postnatal periods.

Unlike previous studies that focused on the psychosocial barriers faced by women with substance use disorders during pregnancy, I explored discrepancies and inconsistencies in clinical practice and potential biases among medical providers. Increased support, education, and training for medical providers may increase their

confidence and consistency in screening for substance use in pregnant and parenting women, resulting in more accurate and timely medical intervention.

Studies have shown that substance use can significantly impair a woman's ability to parent and has been linked to incidents of interpersonal partner violence (IPV; Cully et al., 2021); therefore, this issue affects several social spheres. Although I did not examine the commitment of medical providers to their patients, I did note discrepancies in clinical practice. The current body of literature does not adequately address how the role of medical providers and the variability in screening practices affect the assessment, treatment, and rehabilitation of women with substance use disorders during pregnancy. Medical providers are well-positioned to facilitate multidisciplinary collaboration, ensuring effective treatment. Past research has focused on the personal and psychosocial barriers faced by women during this critical period; however, the problem extends beyond these individual factors.

Until healthcare leaders and legislation can better understand the phenomenon of substance use in pregnancy, women, their unborn children, their families, and society will continue to suffer. The information generated from this study may provide guidance and resources for medical providers, whose primary objective, as stated in their oath, is not to harm patients.

Purpose of the Study

In this qualitative study, I examined how variations in screening practices and personal biases among medical providers may influence referrals to addiction medicine treatment based on pregnancy status. I also investigated whether pregnancy status affects

referral decisions and explored how screening practices and negative attitudes or personal biases regarding substance use contribute to this process.

Research Questions

The following research questions (RQ) and subquestions (SQ) were used to guide the study:

RQ1: How do medical providers screen and assess alcohol and substance use in pregnant women?

$SQ_1$1: What factors guide medical providers' decisions regarding treatment referrals for pregnant women who report alcohol and substance use?

$SQ_1$2: How do organizational policies and legislative requirements impact screening practices for alcohol and substance use in pregnant women?

RQ2: How do medical providers' attitudes and societal expectations influence their approach to pregnant women who use substances?

$SQ_2$1: In what ways do personal biases and societal expectations shape medical providers' clinical practices when working with pregnant women who use substances?

$SQ_2$2: How does the social construction of substance use in pregnancy influence medical providers' screening and referral practices?

$SQ_2$3: What changes to current practices or policies do medical providers believe would improve care for pregnant women with substance use issues?

Theoretical and/or Conceptual Framework for the Study

I used social constructivism theory (Berger & Luckmann, 1966) as its framework. Social constructivism theory explains how knowledge, norms, and values are constructed through social processes, with everyone in society participating in this construction (Berger & Luckmann, 1966, p. 15). Such knowledge guides conduct in everyday life and is interpreted subjectively by society. Over time, this knowledge becomes internalized, habitual, and predictable. In this context, understanding society's views on substance use as deviant and the roles assigned to women is crucial, as these intersecting factors may influence practice due to habituated behaviors based on societal knowledge. Women with substance use during pregnancy experience stigma through derogatory labels such as "junkie" and "bad mother," which lead to stereotypes and discrimination, further ostracizing them. Women who use substances during pregnancy have overlapping identities and social categories, contributing to significant challenges and creating compounded forms of discrimination and stigma that may affect their ability to seek support.

The research questions were based on several assumptions regarding the experiences of medical providers and the care provided to pregnant women with substance use disorders, specifically that medical providers lack consistency in screening practices and that personal negative attitudes may contribute to the type of treatment these women receive.

Oni et al. (2019) completed a comprehensive literature review and found seven key barriers that medical providers face when screening for alcohol and substance use in

pregnancy. The barriers experienced by medical providers which may affect consistent screening practices included: competing work priorities and time constraints resulting in screening for substance use becoming a low priority in the day to day task completion; not feeling skillful and lacking clear protocols of how to screen pregnant women for alcohol and other substances, providers feeling uncomfortable asking about alcohol and substance use due to insufficient rapport with the patient, providers not wanting to seem judgmental, feeling worried about false disclosure, feeling uncertain about the consequences of alcohol and substance use in pregnancy and finally feeling uneasy about screening for alcohol and substance use since many felt this would bring anxiety and guilt to their patient.

Another study identified barriers pregnant women experienced to adequate substance use treatment in relation to medical providers. Barnett et al. (2021) found that a lack of awareness of treatment options, along with judgmental attitudes and staff who lacked understanding and empathy, created significant barriers. Some women felt this resulted in mistrust and led to disengagement from treatment. Social constructivism theory emphasizes that knowledge and understanding are constructed through social interactions and cultural contexts (Berger & Luckmann, 1966). Using this framework, I examined data representing women with substance use disorders in pregnancy and medical providers, with the goal of gaining a deeper understanding of this social problem and its impact on the treatment of these women.

Nature of the Study

In this qualitative study, I used a research design that includes semi-structured interviews. Cohen and Crabtree (2006) noted that semi-structured interviews provide clear instructions while allowing flexibility to follow topical trajectories, which results in reliable and comparable qualitative data. Because the study's questions were exploratory, semi-structured interviews are appropriate; this approach provides structure while allowing the flexibility needed for follow-up questions to enrich the data.

Data was collected from medical providers, preferably those in obstetric care; those medical providers not associated with the care of pregnant women struggling with substance use were excluded. The data was collected from 10 participants through a series of semi-structured interviews. The interviews were conducted either virtually or in person, at the participant's request. Participants were audio-recorded using the recording option on Zoom and via voice memo for face-to-face interviews. Data was analyzed using qualitative data analysis software (NVivo).

Assumptions

Current research has highlighted the need for accurate and timely identification of substance use during pregnancy. The American College of Obstetricians and Gynecologists (2012) identified the need for comprehensive, coordinated, evidence-based, trauma-informed care that is individually tailored and delivered to women struggling with substance use during pregnancy in a compassionate and non-punitive manner. However, a widening gap remains between policy and practice regarding the care these women receive. Several states have adopted punitive policies, and limited

access to quality care persists. Research suggests that medical providers may be required to work quickly and efficiently, which can increase the impact of organizational barriers (American College of Obstetricians and Gynecologists, 2012). Addressing substance use during pregnancy requires legal and organizational entities to collaborate to remove barriers beyond an individual woman's control to effect meaningful change.

Scope and Delimitations

I focused on the medical community and its role in the care provided to pregnant women struggling with substance use. Without comprehensive, timely, and effective treatment, substance use during pregnancy is likely to remain prevalent. I examined medical providers who care for pregnant women with substance use issues and excluded providers who do not work with this population. For this qualitative study, I explored the individual experiences of medical providers who treat pregnant women with substance use. The findings may also be relevant to other medical specialties, including psychiatry.

Limitations

A significant limitation, as with any qualitative study, is that the results may not be statistically representative of the larger medical community. However, in-depth analysis and exploration of common themes can inform future research. To address transferability, I maintained detailed records of the research process to ensure transparency and replicability. I continuously engaged with the data to identify discrepancies or outliers in the findings, which helped refine and strengthen the conclusions.

Significance

This study is significant because it provides insights that may help policymakers increase access to resources and education for medical providers, which can improve consistency and competency in screening practices. These insights may also help reduce stigma and improve care for women and their unborn children.

Summary

The current body of literature presents a misguided picture of substance use in pregnancy for society and does not adequately address the role of medical providers in the assessment, treatment, and rehabilitation of pregnant women. The purpose of this study was to investigate how various screening practices and potential personal biases among medical providers may impact the care these women receive. This qualitative study is intended to inform those in power and who have the capacity to create meaningful change to improve detection and treatment for women who are pregnant and struggling with substance use. In Chapter 2, I provide a comprehensive review of the current literature on this topic and present an argument for why this study is necessary.

Chapter 2: Literature Review

Introduction

Substance use during pregnancy is a multifaceted issue requiring an understanding of not only individual factors but also systemic barriers and provider practices. While the effects on maternal and fetal health have been well-documented, stigma and structural inequities continue to hinder equitable and effective care for these women. I explored discrepancies and inconsistencies in clinical practice and potential biases held by medical providers when treating women with substance use disorders in pregnancy.

Substance use in pregnancy is a growing concern and social issue. Previous research on this topic has focused heavily on the role of women and the personal psychosocial barriers they face; however, this is not a complete and accurate picture. Addressing a woman's role and potential solutions to these issues are only one part of a complex social concern. Previous research has not adequately identified how differing clinical practices and potential provider bias may contribute to and sustain this social issue. Martin et al. (2020) studied unmet treatment needs among reproductive-age women and found that fewer than 13% of pregnant women and 9.3% of parenting women who reported substance use received treatment. The authors also found that pregnant and parenting women, especially African American and Latino women, were significantly less likely to receive treatment despite being identified as a high-risk population.

Few substance-using women are screened, referred, and offered interventions for substance use (Lynch et al., 2021). A discrepancy exists between policy and practice for

pregnant women struggling with substance use, and potential differences in clinical practice and personal biases regarding substance use in pregnancy may affect medical providers' decision-making processes when determining treatment for this vulnerable population.

In this chapter, I build upon existing literature to explore critical barriers, including stigma and provider bias, and highlight evidence-based strategies to improve care delivery for this population. The goal is to inform the reader of what the literature has established regarding substance use in pregnancy. in this section, I provide the foundation necessary to accurately understand the societal impact of substance use in pregnancy. I also focus on the effects of substance use on the fetus, the effects of substance use on the mother, the individual and organizational barriers experienced by these women, the available screening resources, and the current treatment options.

Literature Search Strategy

The literature review involved multiple searches across several databases, including EBSCO, ProQuest, PubMed, and Google Scholar. The searches covered the years 2015-2024 and used keywords such as *addiction, illicit substance use (alcohol, cannabis, opioids, stimulants), illicit drug use/misuse, pregnancy, postpartum, expectant mother, detection, linkage, screening practices, interventions/treatment for alcohol and drug use, barriers, medical providers (doctor/obstetrician), effects on fetus, punitive policies, psychosocial and cultural factors, stigma,* and *judgement*. Limits included scholarly and peer-reviewed articles. Additional sources included gray literature from Google, Wikipedia, and ChatGPT. Data on statistics, policies, and best care practices

were also gathered from organizations such as the American College of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control and Prevention (CDC), SAMHSA, the National Institute on Drug Abuse, and the World Health Organization (WHO; See Table 1).

Table 1

Search Engines and Terms Used to Conduct Research

Search engine & databases	Search terms
Google Scholar	Addiction, substance use, illicit drug use, alcohol, cannabis, opioids, stimulants, pregnancy, detection, linkage, resources, expectant mother, treatment interventions, treatment for alcohol and drug use, barriers to services, medical/health providers, doctor, obstetrician, effects on fetus, punitive policies, stigma and judgement
PubMed	Drug use/misuse, substance use, Pregnancy, postpartum, effects on mother, effects on child, legal consequences.
ProQuest	Screening practices, psychosocial, culture, BICOP
EBSCO	Mother, state laws, child abuse, interventions for drug use in pregnancy, barriers endorsed by medical providers, health outcomes for women.
Gray Literature	
Google.com	Screening tools to detect illicit drug use, Treatment options for illicit drug use, states with policies condemning illicit drug use in pregnancy
Wikipedia	Cannabis, opioids, stimulants, teratogenic, social constructivism theory, theory of cognitive development.
ChatGPT	Treatment options for illicit drug use in pregnancy.

Theoretical Foundation

The theoretical foundation for this study was social constructivism theory by Berger and Luckmann (1966). Berger and Luckmann argued that society is a product of human creation and interaction, a concept they referred to as habitualization. Habitualization explains how frequently repeated actions become established patterns, allowing them to be conducted in the future with greater ease and efficiency. This concept holds significance in the context of this study because it highlights the influence of social constructs surrounding substance use. Over time, members of society have constructed stigmas and perceptions regarding substance use, reinforcing habitual patterns of thought and behavior. When individuals encounter substance use in pregnancy, these pre-existing societal patterns may significantly influence how they respond to pregnant women with substance use disorders. Society often regards substance use as negative and undesirable; as this perspective is perpetuated by individuals, it becomes a "habit." When this perception is applied to pregnant women, the same habituation can influence responses due to socially constructed roles for women.

Along with Berger and Luckmann's (1966) concepts, Vygotsky's (1978) theory of cognitive development is significant for this study as it also highlights the fundamental role of social interaction in the development of acquired knowledge. According to Vygotsky, social interaction is crucial for cognitive development, and individuals acquire knowledge through collaborative dialogue and interaction with parents, teachers, and peers. Vygotsky argued that language is the primary tool through which cultural knowledge is transmitted. The significance of Vygotsky's theory of cognitive

development for this study lies in the idea that language becomes internalized and plays a crucial role in both thought and behavior.

Yu (2023) identified how policies and laws enacted during the War on Drugs have created a negative bias surrounding addiction and have negatively affected particularly vulnerable patient populations, such as women with substance use disorders during pregnancy. Societal bias toward punitive rather than rehabilitative approaches to addiction remains an ongoing barrier and leads many individuals to avoid health care due to fear and retaliation. Stigma often becomes embedded in personal beliefs and practices (Avery et al., 2019), which can be counterproductive to addressing this social issue. Exploring current attitudes and practices may facilitate real and meaningful changes in practice.

Literature Review Related to Key Variables

Effects on the Fetus

Substance use during pregnancy has several negative consequences for both the mother and the developing fetus. The consequences to the fetus vary depending on the specific substance. I did not provide an exhaustive review of all the effects of every type of substance; rather, I focused on the most common substances used during pregnancy, including alcohol and cannabis (see Chang, 2020), as well as opioid and stimulant use, which have shown a significant increase in exposure among pregnancies in recent years (see Haight et al., 2018).

According to the National Survey on Drug Use and Health (SAMHSA, 2022), it is estimated that the rate of alcohol use in pregnancy is 11% for pregnant women between

the ages of 15 to 44 in the United States. The negative effects associated with alcohol use during pregnancy are highly preventable with early identification and linkage to treatment. Currently, neither the American College of Obstetricians and Gynecologists (ACOG, 2012), the WHO (2014), nor the CDC (2024) recommends any use of alcohol during pregnancy, as there is no known safe level of alcohol consumption during this period. Research has yet to determine an exact dose-response relationship between the amount of alcohol consumed prenatally and the potential damage caused to the fetus (May et al., 2018). Additionally, other factors may influence the effects on the fetus, including the pattern of maternal drinking, maternal and fetal genetics, socioeconomic variables, and ethnicity (Chang, 2020). Alcohol is a teratogen and can interfere with fetal development, leading to birth defects, such as damage to the heart, kidneys, bones, hearing, neurodevelopmental disorders, and fetal alcohol spectrum disorders (FASD; Chang, 2020).

Although cannabis is legal for recreational and medical use in many states, it remains illegal (both recreational and medical) elsewhere, including Idaho, Wyoming, Kansas, and Tennessee (Legal Clarity, 2025; Marijuana Policy Project, n.d.). Data from the National Survey on Drug Use and Health Report (SAMHSA, 2020) found a 5.2% cannabis use rate among pregnant women ages 15-44 in the United States. Over the past 20 years, there has been an increase in cannabis use among women of childbearing age (Silverstein et al., 2019). There is speculation that increased acceptance of cannabis use and decreased perceptions of its related harms may contribute to a rise in use (Silverstein et al., 2019). Current research on cannabis use and its effects on the fetus is not as robust

or clear as research on alcohol; in fact, the association between cannabis use during pregnancy and its effects on the fetus remains unclear (Gunn et al., 2016). The main psychoactive ingredient in cannabis, delta-9-tetrahydrocannabinol (THC), rapidly crosses the placental membrane and can bind to cannabinoid (CB) receptors of the fetal endogenous cannabinoid signaling system (ECSS), potentially altering neurodevelopment and resulting in neonatal morbidity (Metz et al., 2017). Other negative consequences related to cannabis use during pregnancy include decreased birth weight and increased neonatal intensive care unit admission for infants exposed to cannabis in utero (Oni et al., 2022a). As with alcohol, ACOG (2012) advises women who are pregnant or planning to become pregnant to avoid using cannabis and other cannabinoids.

The use of opioids in pregnant women has increased fourfold and is present in 3% of pregnancies (Ecker et al., 2019). Unlike alcohol and cannabis, opioid use during pregnancy is unique as it may occur in different contexts, including medical care and misuse. Infants born with prenatal opioid exposure are typically born smaller and may experience neonatal opioid withdrawal symptoms (NOWS; Chang, 2020). In addition to withdrawal, infants may experience disturbances in the gastrointestinal, autonomic, and central nervous systems, which can lead to irritability, poor sleep, poor feeding, congenital heart defects, neural tube defects, clubfoot (Levine & Woodward, 2018), respiratory distress, and seizures (Ryan et al., 2019). Opioid use can also result in fetal hypoxia, causing decreased oxygen levels to fetal tissue and reduced blood flow to the placenta, which can lead to stillbirth and neonatal death (Ayres-de-Campos, 2017).

Given the continued increase in stimulant substance use in pregnancy in recent years, it is important to highlight some of its adverse effects on both child and mother. For this study, stimulant substance use that is legally prescribed by a medical provider to treat attention problems during pregnancy will not be explored. Stimulant substance use in pregnancy has been associated with teratogenic effects on the fetus, stillbirth, preterm birth, low birth weight, and smaller head circumference (Cestonaro et al., 2022). In addition, children born into mothers who use stimulants may experience issues with growth and development and have been linked to cognitive and behavioral problems later in life (Maranella et al., 2022). Stimulant substance use in pregnancy can also affect maternal health, including poor overall health (i.e., higher risk of preeclampsia/hypertension), resulting from poor diet, poor access to prenatal care, poverty, stress, and psychological disorders, which can indirectly affect fetal health (Graves et al., 2021). A major concern regarding stimulant use during pregnancy is that, although pregnancy can serve as a motivator to abstain or reduce use, women are often less likely to engage in or remain in treatment (Blandthorn et al., 2017).

Neither the ACOG, WHO, nor the CDC supports the use of any substances during the prenatal period due to well-documented effects on the fetus, nor does it have any evidence to support a safe level of use in pregnancy (American College of Obstetricians and Gynecologists, 2012; World Health Organization, 2014; Centers for Disease Control and Prevention, 2024). These agencies also recommended early universal screening and the use of validated measures annually and within the first trimester to increase effective care to women who use substances in pregnancy. The effects of substance use during

pregnancy are preventable and treatable; however, health systems should support universal screening using validated measures for every woman of childbearing age.

Effects on the Mother

As discussed previously, substance use in pregnancy is a social problem, substance use continues to increase, and these trends have not only been associated with increased drug-related deaths among nonpregnant women (VanHouten et al., 2019) but have also been linked to drug-related deaths during pregnancy and postpartum, making overdose the leading cause of maternal death in the United States (Goldman-Mellor & Margerison, 2019). Substance use in pregnancy within the medical community is seen as a chronic medical condition requiring integrated care to address not just the pregnancy, but also the substance use. The effects on women who are pregnant and experiencing substance use are numerous. A well-documented effect experienced by these women is stigma. For these women, the fear and stigma of being judged is a barrier for both accessing services and for disclosure (Stone, 2015).

The problem faced by women who are pregnant and abusing substances is multilayered and includes self-stigma, social stigma, and structural stigma (Hatzenbuehler, 2016). In addition, stigma related to substance use in pregnancy is intersectional; not only does society view substance use as deviant behavior, but society also tends to have assigned rules for women regarding their role as mothers, which adds to the stress experienced. Motyka et al. (2022) explored the unique struggles faced by women with substance use disorders globally. The authors highlight that these women face significant barriers to treatment, including stigma, lack of gender-specific programs,

economic disadvantages, and inadequate access to healthcare. Additionally, sociocultural biases often exacerbate these challenges, particularly in countries where women hold a lower social status. In addition to advocating for gender-sensitive therapeutic facilities, comprehensive support systems that address reproductive and childcare needs, and culturally informed healthcare interventions, Motyka et al. (2022) emphasized the importance of educating medical providers and policymakers to ensure trauma-informed, empathetic care for women. The authors also identified the necessity for public education to destigmatize substance use and improve access to harm-reduction and rehabilitation services, as these efforts are key to creating meaningful systemic change. Destigmatizing substance use may result in positive changes for both society and the healthcare community, as both external and self-stigma have been shown to deter individuals from seeking help, often leading to delays or avoidance of effective treatment (Caris & Beckers, 2022).

These women also experienced fear related to the judicial system. Currently, 23 states have policies that define substance use during pregnancy as child abuse, and 25 states require mandated reporting for substance use during pregnancy (Guttmacher Institute, 2020). This fear of criminal prosecution often leads women to avoid seeking medical attention, which can result in untreated physical health issues. These women also experience personal guilt, shame, and worry about how others, including medical providers and those around them, will treat them. This can lead to isolation, decreased support, and may affect their mental health. Self-stigma can also affect a woman's

confidence and instill self-doubt and worry about the mother's ability to care for and provide for the infant.

Given the number of challenges faced by women who use substances in pregnancy, several agencies, including the ACOG, the American Academy of Pediatrics, CDC, and the SAMHSA, endorse supportive policies and denounce punitive policies for the treatment of pregnant women who use substances (Faherty et al., 2020). The goal for women with substance use disorders is access to comprehensive, coordinated, trauma-informed, family-centered, and compassionate care. Long-term outcomes of this approach have yielded cost-effective results, including decreased costs for neonatal intensive care services, shorter hospitalizations for the parent-infant dyad, and reduced costs associated with involvement in the judicial system (Weber et al., 2021).

Evidence indicates that comprehensive care models integrating addiction treatment with prenatal services can significantly improve outcomes for both mother and child (Barber & Terplan, 2023). The consequences of untreated substance use during pregnancy are profound, affecting both maternal and fetal health. These negative outcomes are preventable with timely and equitable interventions (Barber & Terplan, 2023; Merritt et al., 2022; Renbarger et al., 2022).

Barriers (Healthcare/Personal/Legal/Stigma)

At this point, there has been a review of the negative consequences faced by both the fetus and the pregnant woman who use substances during the gestational period; however, it is also important to consider which barriers play a role in this social problem. For this review, the focus will be on personal/psychosocial, legal, institutional, and

provider barriers, including stigma and the availability of educational training or its lack thereof.

Some of the personal psychosocial barriers faced by pregnant women who use substances include poly-substance use, history of sexual abuse, history of intimate partner violence, inadequate social support, poor nutrition, unstable housing, and co-occurring mental health disorders (SAMHSA, 2016, 2018). For those seeking treatment, additional structural barriers may include a lack of childcare, inadequate financial resources (Jackson & Shannon, 2012), and the type of insurance or lack thereof (Ranji et al., 2021). Studies have also highlighted transportation and access to integrated care systems as critical factors hindering treatment (Barber & Terplan, 2023; McCartin et al., 2022; Renbarger et al., 2022).

Other significant barriers include fear of losing custody of their children (Elms et al., 2018) and stigma associated with sexism and racism for women who are part of marginalized communities (Stringer & Baker, 2018). These barriers can also lead to decreased disclosure, which may also decrease the woman's chances of early identification, decreased awareness of the effects of substance use, and decreased awareness of treatment options. The numerous barriers may compel many women to avoid seeking care, increasing the likelihood of adverse maternal and fetal outcomes. Addressing these systemic issues requires policies that prioritize support over punishment and ensure equitable access to comprehensive care services (Oni et al., 2022; Renbarger et al., 2022).

Punitive policies and legal ramifications play a significant role in treatment access to pregnant women who use substances. In 2014, Tennessee (Tennessee Code Annotated § 39-13-107, 2014) was the first state to criminalize prenatal substance use. In 2018, Arizona (Arizona Revised Statutes § 8-533, 2018) and Kentucky (Kentucky Revised Statutes § 625.090, 2018) passed laws that identified prenatal substance use as grounds for termination of parental rights. The legal ramifications of disclosing substance use are too significant to bear, leading many to avoid seeking medical treatment. The fear of losing custody of their children is one of the most significant deterrents to disclosure. This fear is exacerbated by criminalization and mandatory reporting policies, which disproportionately affect marginalized populations (Oni et al., 2022; Renbarger et al., 2022). Rather than treating prenatal substance use as a criminal act, experts identify substance use in pregnancy as a chronic medical condition that requires integrated medical and substance use treatment (Patrick et al., 2020).

Several studies have identified the shortcomings of punitive policies. Although the claim by the legislature is that such policies create motivation to stop substance use and seek treatment, the reality is that punitive prenatal substance use policies do not decrease use and do not increase the rate of admission to treatment (Atkins & Durrance, 2020). Government leaders and policymakers must become informed and recognize that punitive policies criminalizing substance use during pregnancy are not effective; there needs to be a shift to reconceptualize prenatal and postnatal substance use not as a criminal act but as a public health concern. Several agencies, including the American

College of Obstetricians and Gynecologists, oppose such policies and have instead created guidelines for increased education, prevention, and community-based treatment.

Research has demonstrated a lack of benefit resulting from punitive policies, and an analysis of the current policies reveals the issue is complex and contradictory. Faherty et al. (2019) conducted a comprehensive review of state policies related to substance use during pregnancy; the findings indicated significant variation across the United States. While some states have prioritized treatment, including harm reduction, others support punitive policies that continue to be a barrier for pregnant women with substance use. A study by Stone (2015) focused on the State of Tennessee and its 2014 Fetal Assault Law, which criminalizes substance use in pregnancy. Supporters of this law argued it would result in decreased substance use in pregnant women; however, the study found it decreased prenatal care utilization and did not impact the rate of neonatal abstinence syndrome. Kozhimannil et al. (2019) explored the impact of Medicaid expansion on access to treatment for pregnant women with opioid use disorder. The study found that expanded Medicaid also increased access to medication-assisted treatment and resulted in better birth outcomes.

The contradictory policy approach underscores the need for government officials and policymakers to enhance their awareness and education on this social issue, as many policy decisions fail to fully account for its complexity, consequences, and potential societal impact. Schiff et al. (2022) examined how stigmatizing language and the type of opioid use affect public attitudes toward mothers with opioid use disorder and their newborns. Using a randomized vignette design, the study varied terminology (e.g.,

"addicted baby" vs. "substance-exposed newborn") and opioid type (e.g., injection heroin vs. prescription opioids) to assess stigma, punitive-blaming, and supportive attitudes among participants. Results indicated limited differences in attitudes based on language or opioid type. While participants supported recovery opportunities for mothers, they also blamed them, showing agreement with statements that mothers were "responsible" for their substance use and had "put their baby in danger." The findings of this study reveal cognitive dissonance, as respondents simultaneously endorsed both supportive and punitive views. The study highlights the persistence of stigma, which may hinder treatment engagement and contribute to the avoidance of care. This research emphasizes the complexity of public perceptions of substance use and the challenges in addressing stigma to foster better maternal and neonatal health outcomes.

The ever-growing problem of substance use in pregnancy has shed light on the need to modify traditional single-focus treatment approaches to a more interdisciplinary mode of delivering care to meet the unique needs of this vulnerable population, to mitigate the risks of substance use in pregnancy. Multidisciplinary treatment would require collaboration among obstetric specialists, addiction medicine specialists, psychiatrists, behavioral health providers, and social service agencies to improve outcomes for both the child and the mother (see Smid et al., 2020). Some of the services need to include, regular and consistent prenatal/postnatal care, including nutritional support and health education, substance use treatment which not only focuses on abstinence, but also, withdrawal management, medication assisted treatment and relapse prevention, behavior health treatment, including individual, group, family therapy and

medication management and finally social support in the form of housing, financial and legal assistance. The focus would shift from only focusing on the fetus and the prenatal period, where traditional abstinence-based approaches are championed, to one that prioritizes recovery-oriented treatment with an emphasis on harm reduction and treatment that carries into the postpartum period as the first year after giving birth can be a stressful time and stress has been linked to higher risk of relapse (American Society of Addiction Medicine Substance Use, 2017)). The key will be to understand these interventions and, through a collaborative process, make personalized treatment recommendations tailored to each patient's needs. Unfortunately, without this tailored approach, merely offering multiple treatment options will not be sustainable for most healthcare organizations and may lead to more problems related to access to care for these patients.

Legislation is not the only organizational barrier women with substance use disorders in pregnancy face; health care plays a significant part and can be a barrier in this public health concern. Every medical provider is required to take the Hippocratic oath at the onset of their career. This oath encourages them to do no harm and to prioritize the needs of their patients; however, policies, procedures, and personal attitudes can all serve as barriers to upholding this oath. Stigma associated with substance use during pregnancy remains a significant barrier to care.

Research demonstrates that implicit and explicit biases among medical providers negatively impact their interactions with women with substance use disorders. For example, Merritt et al. (2022) identified that stigmatizing beliefs among providers reduce empathy and contribute to limited access to quality care. Furthermore, provider attitudes

grounded in punitive models of addiction perpetuate fear and mistrust among patients, leading to decreased prenatal care engagement (Merritt et al., 2022; Renbarger et al., 2022). Efforts to educate medical providers about substance use disorders have been shown to reduce stigma; however, these efforts alone are insufficient to sustain meaningful change. Findings suggest that ongoing education, coupled with structural interventions, is necessary to address biases and improve provider-patient relationships (Barber & Terplan, 2023; Merritt et al., 2022).

The ACOG (2012) recommends consistent screenings, using validated measures at the first visit, yet this is not the practice in many settings. There are several barriers faced by medical providers including, competing priorities, time restraints, lack of adequate screening skills, clear protocols, relationship between medical provider and the pregnant woman, medical providers perceptions, under reporting or false/nondisclosure, inconclusive evidence regarding the risk of alcohol and other substances in pregnancy and concerns about guilt and anxiety (Oni et al., 2019). There appears to be a disconnect between policy and practice, an area that warrants further investigation for potential future research.

Potential personal beliefs, stigma, and discrimination on the part of medical providers also play a role in this public health issue. Previous studies have identified the effects of negative attitudes by medical providers as being a significant barrier to the screening of women who use substances in pregnancy, resulting in delayed care (Richelle et. al., 2022). The same cross-sectional study also found that anesthetists and emergency doctors have the most negative attitudes towards women with substance use disorders. In

contrast, psychiatrists have less of a negative attitude as compared to general practitioners; they also found that gender plays a role, with male medical providers disclosing more negativity towards pregnant women with substance use as compared to their female counterparts (Richelle et. al., 2022).

As mentioned earlier, Trainor (2022) examined medical provider stigma, attitudes, and beliefs toward pregnant women with substance use disorders. One thing not previously mentioned is that direct care nurses exhibited higher levels of stigma and more negative attitudes compared to doctors and social workers, who were generally more supportive. The differences identified in several studies regarding medical provider attitudes toward these women demonstrate a need for medical providers to receive education on the medical nature of addiction to reduce stigma in maternal healthcare settings.

In a qualitative study, Hoover et al. (2022) explored the experiences of stigma among patients with substance use disorders. They found that negative past healthcare experiences propagate a cycle of mistrust and stigmatization between patients and providers. The study found that medical chart documentation often perpetuated enacted stigma, influencing providers' perceptions and patients' anticipated stigma. The study emphasized the importance of integrating evidence-based treatments and non-stigmatizing practices into routine hospital care. It advocated for training medical providers on stigma reduction and using person-first, medically accurate language in documentation to enhance the quality of care and support for individuals with substance use disorders. These findings underscore the crucial role of systemic changes in reducing

stigma and enhancing patient-provider relationships within hospital settings. Systemic reforms that prioritize patient-centered care were also reviewed by Drossman & Ruddy (2020). The authors argued that administrative demands, time constraints, and over-reliance on technology have eroded the quality of patient care and diminished the "art of medicine". This shift has led to reduced face-to-face interaction, poor communication, and decreased physician satisfaction, ultimately impacting patient outcomes. The suggestions provided to improve effective patient-provider relationships include enhancing medical education to focus on communication skills and incentivizing practices that value meaningful patient engagement. They proposed integrating experiential learning techniques, such as role-playing and case-based training, to enhance provider competency in patient interactions. Additionally, the authors emphasized the importance of aligning reimbursement policies to reward cognitive skills and patient care over procedure-based tasks, which may lead to a cultural shift in healthcare that re-establishes the foundational principles of patient-provider relationships, benefiting both patients and providers.

The Health Stigma and Discrimination Framework (Stangl et al., 2019) identified the role of stigma in health care and conceptualizes effective responses to health-related stigma. This framework described how stigma affects the treatment of patients in healthcare settings and negatively impacts health outcomes, particularly when individuals are stigmatized due to certain conditions, including substance use disorders. According to this framework, stigma can reduce access to care, as individuals may delay or avoid care due to fears of judgment, discrimination, or mistreatment by medical providers. The

framework explained how stigma can reduce the quality of care patients receive, as medical providers may treat stigmatized patients differently, either consciously or unconsciously, leading to lower-quality care. Examples included holding biased attitudes, offering less empathetic treatment, or withholding necessary medical services due to prejudices about the patient's condition. Stigma can also affect the extent of patient disclosure, which may lead to incorrect identification of a condition and affect timely, effective treatment and care.

Women with substance use disorders in pregnancy may already be feeling shame, isolated, and distressed; therefore, this differential treatment can affect their mental and physical health, further isolate these women, and make it harder for them to access care in the future. According to this model, addressing this issue involves increasing education and awareness, supporting and advocating for policy changes, and investing in patient-centered care practices (Stangl et al., 2019).

Trust is a foundational element in effective healthcare delivery for women with substance use disorders. Research highlights the significance of provider traits, including empathy, competence, and the use of non-stigmatizing language, in promoting trust. Renbarger et al. (2022) found that women were more likely to disclose substance use and engage in treatment when they felt supported and respected by their medical providers.

Trauma-informed care, which emphasizes understanding and mitigating the effects of trauma on patient behavior, has been identified as a critical approach to reducing stigma and building trust. Training medical providers in this model can improve

maternal and child health outcomes by creating a safe and supportive care environment (Barber & Terplan, 2023; Renbarger et al., 2022).

Given the numerous barriers present within health care settings, increased awareness, training, education, and resources need to be prioritized if medical providers are to be responsible for the identification and treatment of women who abuse substances in pregnancy. Several studies have identified the effects of addiction medicine training on medical students' attitudes towards addiction. One study was able to demonstrate improvement in the students' perceptions of substance use and improvement in their belief that they had a good understanding of substance use and treatment (Ayu et al., 2022). Recommendations to address gaps in the current healthcare system included increased education and training on harm reduction strategies and medical treatment, increased education and training of alcohol use disorders and opioid use disorders, and expansion of current course content to include substance use curriculum (Muzyk et al., 2020). These recommendations may improve providers' ability to screen for substance use accurately and consistently in pregnancy and improve provider confidence in linking women to time-sensitive treatment.

Screening Tools

Another concern surrounding this issue, besides the lack of consistency in clinical practice of using validated screening measures to assess substance use and pregnancy, is the measures themselves. The ACOG recommends early universal screening of pregnant women for alcohol and substance use, as this is not typically disclosed without prompt, and recommends against using toxicology screenings. The

following are a few of the available screening measures for the screening of alcohol use: TWEAK (Tolerance, Worried, Eye-Opener, Amnesia, K/Cut Down) (Russell, 1994); T-ACE (Tolerance [number of drinks], Annoyance, Cut Down, Eye-Opener) (Sokol et al., 1989); CAGE (Cut Down, Annoyed, Guilty, Eye-Opener) ((Ewing, 1984), NET (Normal Drinker, Eye-Opener, Tolerance) (Fleming & Smith, 2004); AUDIT (Alcohol Use Disorder Identification Test) (Saunders et al., 1993); AUDIT-C (AUDIT Alcohol Consumption Questions) (Bush et al., 1998), and SMAST (Short Michigan Alcoholism Screening Test) (Selzer et al., 1975). The following screening measures are available for screening prenatal substance use: Substance Use Risk Profile-Pregnancy (SURP-P) scale (Kline et al., 2004), the proprietary 4P's Plus (O'Connor and C.A., 2006), and the Quick Screen-Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) (Saunders et al., 1993). Although it is recommended and there are established and accessible screening measures, research has also shown differences in validity, sensitivity, and specificity (Chang, 2020) in these tools.

Treatment Options

Besides accurate identification of substance use in pregnancy, there needs to be a system that facilitates linkage to effective treatment. Organizations like the ACOG and WHO have established evidence-based guidelines for managing substance use in pregnancy. The current treatments available for substance use in pregnancy include Behavioral Interventions, including Cognitive-Behavioral Therapy (CBT), Motivational Interviewing, Contingency Management, Trauma-Informed Care, and supportive therapy. These approaches aim to help pregnant women reduce or eliminate substance use through

behavioral change and support. Another option is Medication-Assisted Treatment (MAT): Methadone and Buprenorphine are two medications commonly used for opioid use disorder during pregnancy. These medications help stabilize withdrawal symptoms and cravings while reducing the risk of relapse. Additionally, medical care is essential; prenatal/postnatal care is crucial for monitoring both the mother's and the baby's health throughout pregnancy. Social Support and Rehabilitation Programs that address social, psychological, and medical needs, including housing assistance, nutritional support, parenting classes, and vocational training, should also be included. Most of this care cannot occur in a vacuum; interdisciplinary collaboration is recommended among healthcare and social service providers to deliver tailored care.

There are several ways in which these evidence-based treatment approaches can be tailored to the specific needs of this population. One thing to consider is how multidisciplinary teams can enhance their communication to achieve improved patient outcomes. Krans et al. (2019) found that ensuring consistent contact and communication among members of the multidisciplinary team can improve messaging to patients regarding their care and health outcomes. In addition, pregnant and parenting women should be invited to participate actively within the treatment team so they can gain ownership and accountability for their treatment and recovery plans. Another component of effective implementation is exploring and identifying trauma histories in the lives of these women. This is crucial because both historical and current trauma add complexities to substance use treatment, as trauma increases the risk of substance use relapse and overdose (Cleveland et al., 2020). Another consideration is the impact of medication-

assisted support in substance use treatment. The National Institute on Drug Abuse (NIDA, 2020) highlighted medication treatment in substance use disorders as an integral part of evidence-based treatment. As discussed, social service support is also needed for many of these women, given their limited financial and social resources. Klaman et al. (2017) described a wraparound model of care, which can include assistance with housing, transportation, childcare, and employment support to provide stability and improve treatment outcomes. For women experiencing mental health concerns, a dual treatment, dual diagnosis approach is necessary. Psychiatric comorbidities are common among pregnant and parenting women with substance use disorders (Aruado et al., 2017); therefore, access to mental health treatment is also essential. Finally, peer support can also play a valuable role. Fallin-Bennett et al. (2020) found that offering peer support specialists was associated with increased retention and recovery.

Addressing the complex needs of pregnant women with substance use requires a multi-pronged approach, some of which include:

- Policy Reform: There needs to be a shift from punitive to rehabilitative policies that prioritize treatment over criminalization (Oni et al., 2022; Renbarger et al., 2022).
- Provider Education: There needs to be consistent and continuous training programs available to medical providers to address implicit biases and the adoption of trauma-informed care models (Merritt et al., 2022; Renbarger et al., 2022).

- Integrated Care Models: There needs to be an expansion of access to co-located services that combine prenatal care, addiction treatment, and mental health support (Barber & Terplan, 2023; Renbarger et al., 2022).
- Language and Communication: medical providers need to adopt person-centered, non-stigmatizing language to reduce fear and build trust with patients (Barber & Terplan, 2023; Merritt et al., 2022).

Social/Cultural Factors

Another important area to discuss is that this complex issue involves the social, environmental, and cultural factors that influence the use and the likelihood of seeking treatment/support. Social Stress Theory (Aneshensel, 1992) indicated that social structures and inequalities lead to a higher risk of health problems and mental illness, including substance use disorders. Social Stress Theory highlighted that stress from these sources is not just individual, but rather social and shaped by an individual's environment, relationships, and position within society. When it comes to substance use in pregnancy, the social factors that may play a role in the maintenance of this social problem include poverty, lack of social/emotional support, trauma, including intimate partner violence, access to healthcare, and housing instability (Amaro et al., 2021). In addition, racism, stigma, and discrimination play a role, as previously discussed. Research around Black, Indigenous, and/or people of color (BIPOC) found that this population makes up a disproportionate number of the homeless population, has a lower educational attainment, lower income, and higher poverty rates (Rutan & Glass, 2018). In addition, BICOP women with opioid use disorder are significantly less likely to engage in

medication to treat addiction and less likely to remain consistent with a treatment regimen (see Schiff et al., 2020). Although treatment may be available to these women, lack of available support and limited economic resources are significant barriers unique to BICOP women.

Overview/Critique of Research

There are several aspects to highlight and critique regarding the current body of literature available on this social problem. The first concern related to the effects of substance use on the mother and fetus. Although established research indicated that substance use can result in serious medical, physical, and psychological problems for the mother and fetus, confounding factors, such as the type of substance, timing of ingestion, dose-response relationship, and biological and psychosocial variables, complicate providers' efforts to educate patients about possible risk factors. More research is needed to provide more precise guidance for both medical and non-medical providers.

The second concern pertained to where attention is focused within the research community. From the current research, there was a vast amount of data available regarding alcohol use and the numerous risks associated with it, yet much less is known for other substances, especially stimulants. This may be a funding issue; however, incomplete data can also lead to confusion and the dissemination of misguided information to the medical community.

The third concern, previously highlighted, related to the notion that most leading healthcare organizations with expertise in this field reject punitive practices. However, these organizations may not be as visible within the legislative branch, as many states

continue to support punitive policies for substance use in pregnancy, even though the data indicated that the intent of these policies is not being met. Most policies focus solely on the protection of the fetus or child and fail to provide policies to protect the mother. Most of these punitive policies see the mother as a mere vessel or a mere caregiver, but the truth is, these two cannot be separated; therefore, attention also needs to be given to women and their needs.

The fourth concern pertained to medical providers and the oath they take to do no harm. Although most of their time should be spent building rapport, trust, and demonstrating a deep and compassionate understanding of their patients' experience, bureaucracy within managed healthcare systems has led to less face-to-face time with patients and increased time spent on administrative tasks that often only serve the needs of the organization and not those of the patient.

The fifth critique involved the lack of available screening tools and the lack of consensus regarding which tool is most effective for each population. Without accurate detection, many providers rely on standard care practices, such as using the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5). However, this approach may be inefficient in distinguishing between effective and ineffective treatments (Kwako et al., 2019).

The final concern is built on previous points: data regarding treatment outcomes vary, as outcomes depend on the substance type and the intervention provided. Significant gaps in knowledge persist in this social issue, and additional research is needed to inform effective changes to current legal and medical practices.

Summary and Conclusions

The current research provides evidence of the effects of this social problem at the individual, organizational, and societal levels. Substance use in pregnancy can no longer be viewed as an individual, moralistic problem affecting only those with "poor self-control". Although the medical and psychiatric communities may view substance use in pregnancy as a chronic medical condition, requiring integrated medical care, many members of society have yet to recognize it as such. Individuals rarely face the stigma, shame, and fear experienced by these women with other chronic medical conditions, such as diabetes. Therefore, there is a need for increased awareness of the global impact of this issue and the collective responsibility to address it. Most of the current research highlighting personal and organizational barriers in the healthcare community is qualitative in nature, exploring personal experiences and attitudes.

The current study will focus on screening practices and personal attitudes of medical providers on substance use in pregnancy. The goal is to identify barriers, highlight facilitators, and provide increased awareness that may potentially lead to changes in organizational and legal policies surrounding this issue. This information can also be used to increase awareness regarding gaps in current treatment practices. This study aimed to support a transition away from punitive practices toward more person-centered, compassionate, and well-informed care. The focus of the next chapter will be on the design and format of the study.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to explore current screening practices used by medical providers for women who use substances in pregnancy and to examine personal attitudes held by these medical providers towards these women. In this chapter, I describe the approach and design of this study, as well as the methods and procedures used to collect and analyze the data. Ethical considerations and limitations of the study are also discussed.

Research Design and Rationale

A qualitative design was chosen as this study explored individual experiences held by medical providers who treat women with substance use in pregnancy. Using a qualitative design is appropriate because the exploration of this phenomenon can only be gathered through self-reported data. A semi-structured interview was chosen to examine current screening practices used by medical providers for alcohol and substance use in pregnancy and attitudes held by these providers towards substance use by pregnant women. A field test was conducted prior to the study's commencement to evaluate the interview questions and ensure their alignment with the study's topic.

The questions for this study include:

RQ1: How do medical providers screen and assess alcohol and substance use in pregnant women?

$SQ_1$1: What factors guide medical providers' decisions regarding treatment referrals for pregnant women who report alcohol and substance use?

SQ_12: How do organizational policies and legislative requirements impact screening practices for alcohol and substance use in pregnant women?

RQ2: How do medical providers' attitudes and societal expectations influence their approach to pregnant women who use substances?

SQ_21: In what ways do personal biases and societal expectations shape medical providers' clinical practices when working with pregnant women who use substances?

SQ_22: How does the social construction of substance use in pregnancy influence medical providers' screening and referral practices?

SQ_23: What changes to current practices or policies do medical providers believe would improve care for pregnant women with substance use issues?

Role of the Researcher

My role during this study was that of observer-participant. My main role was to observe participants; however, this was not a mere observational study. Therefore, I was required to participate and interact with potential participants to gather data related to their individual experiences, clinical practices, and personal beliefs. The participants were selected through a combination of convenience sampling and snowball sampling and were invited to participate in the study. I recruited them via my professional network. There may have been some chosen participants who also work at the same site as my current internship, although I do not have any authority over their job duties, and I do not work in the same department. My internship site is a large medical facility with multiple locations nationwide; however, as a coworker, I have access to some of the organization's

current policies and procedures. I documented the participant's personal experience and identified my affiliation within the organization. I remained present and open during the interviews to avoid making assumptions about organizational policies. Participants did not receive any incentives; the study relied solely on volunteer participation.

Methodology

I used a qualitative design and relied on self-reported data collected through semi-structured interviews. This approach is supported by Cohen and Crabtree (2006), who noted that semi-structured interviews provide clear instructions while allowing flexibility to explore relevant topics in depth.

Participant Selection Logic

I recruited participants using convenience and snowball sampling methods and invited them to volunteer for an interview, consistent with qualitative research practices (Creswell & Poth, 2018). I distributed an email that included a brief description of the study and my contact information. Individuals who were interested reached out to me directly to inquire about participation. When someone contacted me, I provided additional details about the study, answered any questions they had, and conducted a brief screening to ensure they met the study’s inclusion criteria. If they were eligible and agreed to participate, we scheduled an interview at a time that was convenient for them.

Instrumentation

For this study, I developed a semi-structured interview with standardized questions. Responses were audio-recorded using Zoom for virtual interviews and a voice memo application for in-person interviews. I analyzed the data using computer-assisted

data analysis software (NVivo). Although self-report methods may introduce social desirability bias (Edwards, 1957), this approach remained appropriate for the study's objectives.

Inductive coding was used for data analysis. Because this study was exploratory in nature, inductive coding was more suitable than deductive coding, as it allowed for a deeper exploration of a complex social problem and could capture the depth and richness of the data (see Saldaña, 2021). The research questions were designed to examine medical providers' personal experiences treating pregnant women with substance use disorders; thus, inductive coding was an appropriate method for organizing and analyzing the data. The coding process began with open descriptive coding to identify noteworthy elements from the interviews. A subsequent focused round of coding emphasized data aligned with the research questions. Additional rounds of coding added to the richness of the data. NVivo software was used to help organize and manage the large dataset. I served as the sole coder for this project.

Procedures for Recruitment, Participation, and Data Collection

As outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979), researchers must ensure that participants are treated as autonomous agents. Participation in this study was voluntary, and participants received detailed information about the study. The informed consent process included information about research procedures, the purpose of the study, potential risks, anticipated benefits, and a statement offering participants the opportunity to ask questions and withdraw from the research at any time. Data was

collected through semi-structured interviews and stored in a secure, password-protected digital file. All data was encrypted and coded to maintain privacy, with access limited to myself, the researcher, and faculty chairs. The raw data will be retained for the duration of the study and disposed of according to applicable regulatory requirements.

To ensure fairness in the selection of research participants, I sent an email to providers, inviting them to participate in this study. The sample consisted of volunteers. To address recruitment challenges, I partnered with the head of the obstetrics department at the medical facility. The department head forwarded the recruitment email to staff over the course of one month. Only medical providers who work with pregnant women were recruited to increase consistency and reliability.

Although there are no set rules regarding sample size in qualitative research (Ravitch & Carl, 2016), I considered several factors when deciding to recruit 10 participants. These considerations included the study's exploratory nature, research questions, chosen instrumentation, and available resources. The purpose of this study was to explore the individual experiences of medical providers treating patients who may be using substances during pregnancy. This deep exploration is one reason for a smaller sample size. The use of semi-structured interviews, which align with the research questions, allowed for an in-depth exploration of themes while keeping data collection and analysis manageable. Semi-structured interviews included both standardized questions asked to all participants and sub-questions that allowed customization of the interview process. Available resources, time constraints, competing priorities, and patient care demands also contributed to the decision to recruit 10 medical providers.

Additionally, my available time was a factor, as no external funding or resources were secured.

A participant sample of 10 was expected to yield data saturation. As I conducted and analyzed the interviews, I noticed recurring codes and themes emerging across participants. Many of the individuals described similar workflows, experiences, and perspectives, which indicated a level of consistency in the data. By the time I had completed the tenth interview, few new themes had emerged, and the responses were becoming increasingly repetitive. This suggested that data saturation had been reached, as additional interviews were unlikely to produce substantially new insights. I collected and analyzed data simultaneously. After each interview, detailed notes were used to compare new data with previous interviews to determine if new themes emerged. Through this process, theme repetition was completed after 10 interviews. The coding process also helped monitor data saturation, with codes tracked after each interview. Data saturation was determined to be met when no new codes were generated. In addition to monitoring themes and codes, I sought support from my research committee to obtain an external perspective once saturation is reached. If saturation was not achieved after 10 interviews with medical providers, data collection would have continued by recruiting additional participants using snowball sampling. If necessary, the inclusion criteria may also have been broadened to consider additional professions, such as mental health providers, addiction medicine specialists, and recovery services providers. Fortunately, data saturation occurred after 10 interviews.

Data Analysis Plan

As this study was exploratory in nature and relied on semi-structured interviews to capture the individual experiences of medical providers and their care practices when treating pregnant women with substance use, using thematic analysis was appropriate. Thematic analysis involves noting relationships, similarities, and differences in the data (Ravitch & Carl, 2016). One of the key benefits of this analysis is its flexibility. This study relied on semi-structured interviews, which can generate in-depth, rich data. Thematic analysis provided a systematic way to explore the data while maintaining the adaptability of the interview process. The use of thematic analysis also facilitated the identification of common themes, which highlighted similarities or differences in the data among participants. This type of analysis also helped to organize and manage data more efficiently. One of the reasons a semi-structured interview process was chosen for data collection is that it allows for flexibility and can produce rich data. Thematic analysis aligns with this, as it also allowed for the deeper exploration of individual participants' experiences using follow-up questions. Thematic analysis also contributed to increased reliability as it provides a guide to the coding process. I used software to interpret the data gathered from the interviews. There was a small fee for using NVivo, which I personally covered.

Inductive coding helped organize and analyze the data generated. It began with open, descriptive coding. The first round of coding identified things that stood out from the interviews. After that, a more focused second round of coding focused on the data that coincided with the research questions; additional rounds of coding were needed.

Using NVivo helped organize and manage the data. Given the limited resources, I was the sole coder. Having only one coder may increase the risk of bias, such as confirmation bias, and may make it more difficult to manage large amounts of data within time constraints. Having a single coder can also affect reliability, as there is no opportunity to increase inter-coder reliability by including a second coder, which could improve the chances of others replicating the study with the same consistency. This approach may also present validity challenges, as it limits opportunities to demonstrate transparency in the coding process. Although these were concerns, I remained the only coder.

The goal of exploratory qualitative studies is to accurately capture and reflect the individual experiences of participants; therefore, relying on a single coder can affect the accuracy of the data analysis. To mitigate these limitations, I engaged in peer review with the committee chair, kept a personal journal for reflection on potential biases and decision-making, and provided an audit trail to support transparency. Member checking was also used to ensure that participants' experiences were accurately captured and represented. As previously noted, using NVivo as a qualitative data analysis software (QDAS) helped manage and organize data systematically and maintain an audit trail (Ravitch & Carl, 2016).

Issues of Trustworthiness

Because this was a qualitative study focused on a specific issue and utilized a small sample size, the findings may not be statistically generalizable. However, future researchers could replicate this study with a larger sample to explore similarities and differences across studies. I upheld the principles described in the Belmont Report

(National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979), adhering to the principles of respect, beneficence, and justice.

To improve accuracy in the study, I had originally planned to use several strategies, including member checking, peer debriefing, and personal reflection. For member checking, the initial plan was to connect with participants after each interview to assess the accuracy of the collected data. This approach was intended to be efficient and respectful of participants' time, involving a brief follow-up to confirm that their views were accurately captured and to offer the opportunity to clarify any statements.

However, due to time constraints and the scheduling demands of both myself and the participants, I could not conduct member checking immediately following each interview as planned. Instead, I conducted member checking at the end of the data collection phase. I emailed each participant a copy of their interview transcript, inviting them to review the document for accuracy and to clarify or elaborate on any points as they saw fit. This allowed participants to confirm that their perspectives were represented accurately and provided a final opportunity to make any corrections or additions before analysis was finalized. While this differed from the original plan, it still served the intended purpose of enhancing credibility and ensuring that the data authentically reflected participants' experiences.

I successfully recruited my dissertation chairs and a clinical supervisor for debriefing. The purpose of this process was to share data and seek feedback regarding potential assumptions, interpretations, and personal biases. This external review

identified areas for improvement. I also engaged in personal reflection based on peer feedback and documented these reflections in a personal journal to maintain awareness of my role as a researcher throughout the study.

To enhance the dependability and confirmability of the study, I maintained an audit trail, which provided detailed documentation of the research process (e.g., data collection, coding, and analysis). This audit trail included accounts of decisions made during the research process, along with the reasons behind these decisions. As previously discussed, maintaining a journal helped document and identify personal biases and assumptions, with the goal of increasing personal awareness of potential impacts on the study and its outcomes.

Ethical Procedures

As described in the Belmont report (1979), the goal is to ensure participants are treated as autonomous agents. Participation in this study was voluntary, and although it imposed minimal risk on participants, it was essential that they were provided with adequate information about the study. This study ensured adherence to ethical guidelines and legal requirements in several ways, including providing informed consent before the start of all interviews, reviewing confidentiality at the beginning of every interview, and outlining its limits, which may include potential harm to self, harm to others, and activities. It was essential for participants to understand that, although I have ethical obligations as a researcher to their well-being, certain situations may arise that involve potential legal concerns. All participants were clearly informed not only about the consent to participate in this study, but also about the limits of confidentiality, before they

agreed to take part. Although clearly reviewing protocols of the study, reviewing informed consent, and reviewing limits of confidentiality can decrease disclosure, which may lead to legal and moral dilemmas for me, qualitative research is centered on relationships (Ravitch & Carl, 2016); therefore, it is important to balance and safeguard the participants of the study while recognizing my accountability in the research process.

I relied on ethical codes to guide my actions and decisions throughout this process; however, clear communication was essential at multiple stages of the research process. If a situation had arisen that could have led to legal ramifications, I would have taken certain steps before making any decisions. One source to consult is the institutional review board (IRB), as it may provide guidance on reporting protocols and ethical obligations. I could have also sought consultation from my clinical supervisor, peers, committee chairs, and even legal experts. In situations where confidentiality was not required, I monitored risks and consulted as needed during the study.

Summary

I used a qualitative design, appropriate for exploratory research (see Creswell & Poth, 2018). Semi-structured interviews were conducted to gain a deeper understanding of differing screening practices and potential personal biases within the medical community. Participants included medical providers who have contact with pregnant women who use substances during pregnancy; those who did not meet these criteria were excluded. 10 participants were recruited using convenience/snow sampling, and I analyzed the data using qualitative data analysis software.

Chapter 4: Results

Introduction

Substance use during pregnancy is a serious health problem. Addressing this issue requires focused attention, prioritization, and coordinated action from medical, psychiatric, and governmental organizations (ACOG, 2012; WHO, 2014). Pregnancy represents a unique opportunity for women struggling with substance use, as it is a medically significant timeframe and a critical period for both mother and fetus. The purpose of this qualitative study was to explore current screening practices used by medical providers for women who use substances during pregnancy and to examine providers' attitudes toward this population. I addressed two research questions: (a) How do medical providers screen and assess alcohol and substance use in pregnant women? and (b) How do medical providers' attitudes and societal expectations influence their approach to pregnant women who use substances?

In this chapter, I present the results of the thematic analysis. The report is organized as follows: setting, demographics, data collection, data analysis, evidence of trustworthiness, and results, all categorized by eight themes, followed by a summary. I employed both inductive and descriptive coding. The coding process was tedious and time-consuming, involving a total of three rounds before the emergence of themes. The themes included societal views on substance use in pregnancy, organizational impact on clinical practice, personal beliefs of medical providers, approaches to screening and assessment, referral and treatment processes, the patient-provider relationship, legal considerations, and recommendations for change.

The following are the questions applied to every participant to gain further understanding of the complex public health concern of substance use in pregnancy.

RQ1: How do medical providers screen and assess alcohol and substance use in pregnant women?

$SQ_1$1: What factors guide medical providers ' decisions regarding treatment referrals for pregnant women who report alcohol and substance use?

$SQ_1$2: How do organizational policies and legislative requirements impact screening practices for alcohol and substance use in pregnant women?

RQ2: How do medical providers ' attitudes and societal expectations influence their approach to pregnant women who use substances?

$SQ_2$1: In what ways do personal biases and societal expectations shape medical providers ' clinical practices when working with pregnant women who use substances?

$SQ_2$2: How does the social construction of substance use in pregnancy influence medical providers ' screening and referral practices?

$SQ_2$3: What changes to current practices or policies do medical providers believe would improve care for pregnant women with substance use issues?

Setting

At the time of data collection, all 10 participants were employed full-time by a managed healthcare facility. Many of the participants shared having significant clinical experience working with pregnant women. The average time among all participants was

9 years; the longest tenure reported by a provider was 19 years, while the shortest tenure was 2.5 years.

All interviews occurred in clinical or professional settings during routine work hours. Nine interviews were conducted via Zoom, and one in person. No unit closures, strikes, or acute organizational crises were reported by participants during the data collection window. Minor, brief disruptions (e.g., background noise) occurred in several virtual interviews, but did not affect the ability to complete them. All participants received full information about the nature of the study, and the researcher made efforts to create a safe and open environment to encourage disclosure and open dialogue (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

Demographics

For this qualitative study, 10 participants were interviewed, all of whom were employed full-time within a managed care healthcare organization at the time of their interviews. All participants identified as female. Two were medical doctors specializing in obstetric care in a women’s health clinic, two were clinical psychologists working primarily with pregnant women, and six were master's-level clinicians also working primarily with pregnant women. The final sample consisted of obstetricians, psychologists, and master's-level clinicians. Participants averaged 8.75 years of experience (range = 2.5–19 years).

Table 2

Participant Demographics

Participant	Gender	Professional role	Area of specialization	Years of experience
P1	Female	Master Level Clinician	Perinatal Mental Health	4 years
P2	Female	Clinical Psychologist	Perinatal Mental Health	13 years
P3	Female	Master Level Clinician	Perinatal Mental Health	6 years
P4	Female	Master Level Clinician	Perinatal Mental Health	4 years
P5	Female	Medical Doctor	Women's Health	18 years
P6	Female	Master Level Clinician	Perinatal Mental Health	9 years
P7	Female	Clinical Psychologist	Perinatal Mental Health	2.5 years
P8	Female	Master Level Clinician	Perinatal Mental Health	4 years
P9	Female	Master Level Clinician	Perinatal Mental Health	8 years
P10	Female	Medical Doctor	Women's Health	19 years

Data Collection

Walden IRB approval #03-11-25-0977807 was granted on March 11, 2025. Data was collected from May 2025 to June 2025. To maintain participant confidentiality, all identifying information was removed and replaced with generic labels. Participants were assigned participant identification codes instead of using their real names. Professional roles and descriptions were generalized to avoid a potential breach in confidentiality, especially in cases where unique job titles or specialties could reveal a participant's identity. Workplace names or geographic locations were also omitted in the reporting of findings.

All 10 participants completed their full interviews. This study relied solely on semi-structured, standardized interview questions as its only data collection method. The participants were recruited via a convenience/snowball sample. An email was sent out to potential participants with a description of the study. Those who agreed to volunteer were then verbally informed of the following information: research procedures, the purpose of the study, potential risks, anticipated benefits, and a statement offering the participant the opportunity to ask questions or withdraw from the research at any time. As the interview process continued, snowball sampling was also employed, as many participants were willing to ask their colleagues to participate.

Most interviews lasted between 30 minutes and 45 minutes, and each participant was given only one interview. At the beginning of each interview, informed consent, confidentiality, and its limits were reviewed. Participants were also advised that the

interview would be recorded and kept in a password-protected file with limited access to me and faculty chairs.

The interviews were audio-recorded using Zoom for virtual interviews and Voice Memo (an application on a mobile device) for in-person interviews. This was a deviation from the original plan, as TEAMS was the intended solution; however, Zoom was chosen to reduce the use of work-related resources. The interviews were transcribed using Microsoft Word to create verbatim transcripts for analysis. Most interviews were conducted virtually (one was conducted face-to-face), and both the participant and I were in a clinical setting at the time of the interview.

The data collection process took 5 1/2 weeks; the average number of interviews per week during this period was one to two. One variation that was not planned was the transcription of the interviews, although this was a tedious process, manual transcription was used for all 10 interviews. The original plan was to conduct all interviews virtually; however, one participant requested an in-person interview due to accessibility. Another unusual circumstance was that the use of transcription software was initially considered; however, due to limits on what software can be used, per academic institutional standards, manual transcription was chosen for increased accuracy.

As mentioned, all interviews were conducted in clinical settings to ensure a quiet and confidential environment. Yet, there were occasional disruptions, including background noise, but these did not seem to affect participants' ability to complete the interview successfully. No other significant disruptions or challenges were encountered

during the data collection period. Member checking occurred post-analysis via an emailed summary.

Data Analysis

Given the complexities of substance use during pregnancy, a thematic analysis was conducted to identify key patterns and themes within the data. Several themes emerged regarding provider practices in medical settings. The identified themes included societal views on substance use during pregnancy, organizational impacts on clinical practice, personal beliefs of medical providers, approaches to screening and assessment, referral and treatment processes, the patient-provider relationship, legal considerations, and recommendations for change. These themes collectively provide a comprehensive understanding of the challenges and opportunities within the medical community and society regarding perceptions and treatment of substance use during pregnancy.

Analysis proceeded in three cycles: (a) open descriptive coding conducted line by line, (b) focused coding to consolidate semantically related codes, and (c) theme generation. Across 10 transcripts, the first cycle yielded more than 90 open codes (e.g., barriers to using the tool, compassion, collaboration between departments, Child Protective Services, patient choice, support for harm reduction, changes in law regarding grave disability). Focused coding consolidated these into 12 categories (e.g., screening tools and practices; organizational facilitators and barriers; legal considerations; patient readiness; stigma and judgment; collaboration), which informed eight analytic themes. NVivo node frequencies were used descriptively (e.g., to indicate salience such as

collaboration between departments appearing in seven of 10 transcripts) without implying statistical inference.

During analysis, discrepant or nonconforming cases were documented (see each theme). These cases were retained to refine the definitions and boundaries of themes. No new codes emerged after the seventh interview, and this finding was confirmed by the 10th interview. The themes are presented in the following order: societal views on substance use during pregnancy, organizational impact on clinical practice, personal beliefs of medical providers, approaches to screening and assessment, referral and treatment processes, the patient-provider relationship, legal considerations, and recommendations for change.

Theme 1: Societal Views on Substance Use in Pregnancy

The first theme identified was societal views on substance use during pregnancy. This theme addresses RQ2, which explored how the social construct of substance use during pregnancy influences medical practice, specifically screening and referral practices. All participants described frequent public judgment toward pregnant patients who use substances. For example, P1 stated, “Quit judging. I feel like in society, people feel that if someone is pregnant, it gives them the right to comment.” P2 similarly noted, “People get petty, outraged, really upset,” and explained that this social scrutiny “shows up in clinic as shame and silence.” Several other participants described how these societal attitudes influence the treatment of pregnant patients, resulting in feelings of shame and guilt, which can lead to isolation and create unrealistic expectations regarding abstinence during this period.

Another important finding was the intersection between health care systems and legal systems. A disconnect was noted between legal statutes and medically advisable practices. For example, P9 stated, “Just because something is legal does not mean it is healthy for you.” Participants frequently referenced marijuana use as an example. In recent years, a cultural shift in marijuana use has occurred, likely because of legalization in many states.

Another finding was that most providers believed screening practices were adequate and consistent, and implemented to facilitate early detection and intervention. However, many reported that past negative experiences and societal scrutiny had affected the referral process. P1 shared, “I don't think it impacts the screening process because that's the same; however, it impacts the referral process. It impacts how receptive people are to treatment and further evaluation.”

Theme 2: Organizational Impact on Clinical Practice

The second theme to emerge was organizational impact on clinical practice. This theme addressed RQ1. Participants spoke extensively about screening practices. Eight of 10 participants shared that their organizations had systems in place to ensure consistency. P5 stated, “There are checks and balances in our organization where the ball does not get dropped.” Participants described policies that required every patient to be screened at every visit. P8 explained, “We'd rather cast a wide net and bring in a few people than miss them and have them fall through the cracks.”

Participants described how these organizational policies served to identify and screen for potential substance use in pregnant women. Many shared that screening was

expected to be completed 100% of the time and that this level of monitoring continued throughout the pregnancy. Nine of 10 participants reported feeling supported by their organizations, stating that policies and procedures "probably facilitate" (P4) their work and that "no administrative barriers" (P7) came to mind.

Participants also described a high level of training offered to support these policies. They reported that information was disseminated through formal training opportunities such as "annual CMEs, initial onboarding at time of hiring, and all staff meetings" (P1). One participant shared a different experience, stating they received "very minimal" (P3) basic training. Organizational facilitators (e.g., "team meeting, clinical consultation, OneNote, SharePoint") were also identified by two participants.

While most participants had not identified organizational barriers in their roles, they described barriers faced by patients. Five participants highlighted patient-level barriers (deductibles/insurance, stigma, readiness, bias). P2 also noted that insurance type, especially for those on Medi-Cal, could influence access to care. These barriers were described as limiting factors in effective treatment, even when organizational policies emphasized the urgency of treatment to reduce "duration of exposure during a critical developmental window" (P10).

Participants consistently supported universal screening. They expressed that when screening was missed, multiple attempts by multiple providers should be made. Most felt capable and supported regarding this expectation, due to clear messaging and consistent training. P7, however, expressed concern about pressure from their organization, stating, "The program sometimes places more pressure to push engagement, push outreach, more

than I'm comfortable with." This participant shared that while their role included educating and supporting women, they also believed, "It's always a personal choice." This participant emphasized a different perspective from most others, describing a view of patients as individuals capable of making their own decisions. They noted the tension between this view and institutional expectations.

Only one of 10 participants spoke directly to the idea that personal experiences might influence provider interactions with patients. P6 stated, "lived experiences impact our ability to work well with our patients." This participant noted that they saw value in organizations helping providers to "address our shadows," especially in the context of working with vulnerable populations.

Theme 3: Personal Beliefs of Medical Providers

The third theme to emerge was the personal beliefs of medical providers. This theme addressed RQ2. Eight of 10 participants acknowledged understanding the negative experiences faced by pregnant women who used substances. Many described how this knowledge influenced the way they viewed substance use and how they treated these women. All 10 participants expressed increased awareness of their own biases. P1 shared, "I think I am very self-aware of my own biases; it's a lot of self-awareness. I don't want my own belief system to come into those intakes."

Participants described wanting to take a more "compassionate" (P4) approach and emphasized being "gentle, nonjudgmental, nonpunitive, and supportive" (P2). Participants described efforts to move away from assumptions about substance use and parenting. P3 stated, "It's a positive drug test, it's not a parenting test." This quote

reflected a different way of thinking than the societal message often associated with prenatal substance use.

Participants also emphasized the importance of staying open and curious in their efforts to support women through recovery and treatment. Several described attempts to reframe substance use as "unconventional methods to treat their conditions" (P5). Participants discussed separating the behavior from the individual, and described substance use as a way to "cope" (P7) rather than as a personal flaw. One participant shared that before their exposure to this population, they held personal beliefs that contrasted those championed by the organization. For this participant, there was a conflict with their personal values, yet as this participant engaged more with these women, this dilemma became less of a hindrance, and they began to "have a different understanding of the why behind it" (P3).

Some participants voluntarily disclosed their own personal experiences with substance use. Most stated they had never used substances themselves and expressed that, in their personal lives, they "would never do those things" (P1). This added another layer to the findings, as many participants appeared to hold two belief systems: one that aligned with their role as a medical provider and another influenced by their position as members of society.

Theme 4: Approaches to Screening and Assessment

The fourth theme to emerge was approaches to screening and assessment. This theme addressed RQ1. Most participants described how their professional roles were clearly defined by the medical organizations in which they worked. They reported feeling

supported by their organizations to carry out practices related to the identification and treatment of substance use in pregnant women. Participants explained that their organizations played a significant role in establishing screening procedures, setting criteria, and providing training to support those standards.

Participants demonstrated a clear understanding of their responsibilities in the screening and assessment process. P10 explained, “Screening occurs with every pregnancy, almost 100% of the time. I would say I don't think anything is ever 100%, but at least 99%, pretty consistently.” Seven out of 10 participants shared feeling confident in using the available tools. Common responses included “very comfortable” (P4), “pretty comfortable” (P3), and “100% comfortable” (P9).

Participants identified a range of tools used in their practice, including the Clinical Intake, Patient Health Questionnaire (PHQ), Adult Outcome Questionnaire (AOQ), Prenatal Screening Questionnaire (PSQ), Urine Drug Screening (UDS), Early Start Questionnaire, and Physician Health Screening. Some also reported using more specific assessments, such as the CAGE questionnaire or tools related to mental health conditions. Seven participants reported using a standardized prenatal screening questionnaire plus UDS as indicated; three relied on clinic intake plus clinical judgment; one reported the CAGE in specific contexts.

One participant described how their organization tracked missed screenings and established benchmarks. They stated, “Our goal is less than 5%, and we’ve always been at less than 2% missed opportunities, so most of our pregnant moms are evaluated” (P6). Reasons given for missed screenings included time/documentation (two participants);

three participants cited patient discomfort with sensitive questions. Six out of 10 participants described the tools used for screening as "valuable" (P2, 3, 6, 9) and emphasized their role in supporting early identification and intervention.

Theme 5: Referral and Treatment Processes

The fifth theme to emerge was referral and treatment processes. This theme addressed RQ1. Participants described how their organizations structured the referral and treatment process for pregnant women who screened positive for substance use. 10 out of 10 participants reported that a formal referral system was in place. One participant stated, "We have a referral system; anybody who screens positive will meet with an early start specialist" (P10). Another participant shared, "When either the questionnaire is positive or the urine drug screening is positive, they are referred" (P2).

In addition to questionnaires and urine drug screenings, many participants noted the use of clinical criteria and tools such as the DSM-5 to assess acuity. P9 described their process as being "based on the DSM and clinical judgment."

Three participants described practices that extended beyond formal organizational procedures. These included personally initiating follow-up and outreach after an initial referral. P4 shared, "I usually do schedule a follow-up just to see because a lot of times they may not necessarily follow up with addiction medicine," and "We want to double-check that they actually linked and follow through with their treatment plan" (P1). This participant also stated, "until they are linked, we are going to follow up to ensure they are safe and getting the care they need" (P1). Once substance use was identified, participants reported involving specialists referred to as "early start specialists" to provide education,

support, and connection to treatment services. These specialists were described as playing a key role in assessing risk and facilitating referrals.

Participants also described an increase in outreach efforts following the identification of substance use. P7 noted, “There’s a lot of outreach.” Organizational alignment and communication appeared to be emphasized, with participants identifying tools such as “huddles, emails, monthly check-ins, OneNote, SharePoint” (P1) to help ensure consistent communication and adherence to procedures.

Although screening was described as occurring with nearly all pregnant patients, referral to addiction medicine treatment did not happen in all cases. Many participants shared that early support and brief interventions were often sufficient. Three participants shared referrals to addiction medicine specialty programs are rare and stated, “I haven’t had a lot of patients referred to addiction medicine,” (P10) while P2 shared, “Only a few, a small percentage of people, meet criteria.” These descriptions highlighted the structured nature of the referral process, while also showing how providers extended care through follow-up, outreach, and clinical judgment.

Theme 6: The Patient-Provider Relationship

The sixth theme to emerge was the patient-provider relationship. This theme addressed RQ2. Participants described the provider–patient relationship as a central element in their clinical work with pregnant women who used substances. Seven out of 10 participants spoke at length about the importance of building trust and maintaining a respectful, compassionate approach. Several highlighted the emotional and social challenges faced by these women, including shame, guilt, and societal judgment. P1

stated, “There is a shame connected to asking for help and seeking services”, P3 stated, “They feel a lot of judgment from society,” and P6 shared, “Due to stigma, they’ll often underreport.”

With this awareness, many participants described making conscious efforts to minimize judgment in their clinical practice. P2 shared, “I take a gentler approach. You want to have trust, it’s important to demonstrate dignity and respect, and make sure that people, regardless of their circumstances, still get treated with dignity and respect.” Participants described this relational approach as a key factor in successfully engaging patients in treatment.

While they acknowledged the existence of standards of care for assessing severity and determining interventions, they also noted the presence of a power dynamic between provider and patient. One way participants described addressing this was by emphasizing the patient’s right to make their own decisions. One participant explained, “At the end of the day, it’s your baby, your body” (P5). Others echoed this sentiment with statements such as, “It’s always about personal choice, I can do as much education and support as possible, but if you continue to use, that’s your personal choice” (P7).

Several participants expressed the difficulty of balancing concern for the health of the fetus with respect for the patient’s autonomy. P1 stated, “I don’t ever want to shame a patient, but I want them to understand their choices can have detrimental effects… I’m helping them make the most informed decision while still trying to stay non-judgmental.” Participants emphasized that beyond policies and procedures, the nature of care was shaped through ongoing interactions between provider and patient. These interactions

were described as grounded in mutual respect, compassion, and the desire to create a safe space for patients to engage in care.

Theme 7: Legal Considerations

The seventh theme to emerge was legal considerations. This theme addressed RQ1. Participants described a range of experiences regarding the role of law in their clinical practice. While many reported an understanding of their legal responsibilities, they also described challenges in translating written law into everyday decision-making. Three out of 10 participants shared that they prioritized medical care over legal consequences. P4 stated, “We are not going to think legal consequences, we're thinking of medical issues,” while P5 explained, “I'm not going to lie, I don't really follow with the policies, the laws. I am just going to do what I know is right for the patient, and that usually will probably coincide with laws and policies that have been made.”

Participants described discrepancies between written laws and how they applied those laws in practice. Many appeared to rely more on workplace norms and professional judgment than on specific legal statutes. P7 stated, “Can’t say I’m well-versed in the laws,” P8 shared, “I’m not necessarily up to date on every legislative requirement.” One participant expressed confidence in their organization’s oversight, stating, “That’s the nice thing about working for an organization, I know whatever we’re doing is going to meet criteria” (P4).

Participants frequently reported relying on organizational policies and procedures rather than consulting legal forums directly. Legal knowledge was often described as being integrated into practice through systems such as training, policies, and

communication within the organization. Statements reflecting low engagement with current law (e.g., P7) should be interpreted as reliance on organizational compliance structures rather than disregard for legal obligations.

Participants did, however, show a more consistent understanding in one legal area, mandatory reporting to Child Protective Services (CPS). Most understood that "If a pregnant individual is using, this does not mean that they have to get reported to CPS" (P7) and clarified, "Once the baby is born, the doctor is under legal obligation to report to CPS" (P9).

Two out of 10 participants discussed challenges related to cultural and legal changes, particularly around marijuana use. P2 noted, "Cannabis has honestly been the trickiest substance for most of us." Another described marijuana legalization as a shift that created new concerns in clinical care, explaining that "the legalization of marijuana was a big shift and a concern about how to address it with patients because it is a legal substance" (P6).

One participant mentioned upcoming changes to involuntary psychiatric treatment laws related to substance use. They referred to a law set to go into effect in 2025, with implementation delayed until 2026 in some counties. This law would make chronic substance use a qualifying condition for involuntary hospitalization. Most participants reported limited familiarity with the new law, which had not yet been implemented in the counties where interviews were conducted.

Overall, participants emphasized confidence in their role in providing care rather than enforcing laws. Several expressed that their focus was on treatment and patient support, not legal compliance.

Theme 8: Recommendations for Change

The eighth theme to emerge was recommendations for change. This theme addressed RQ1 and RQ2. Recommendations clustered into four areas: (a) language/diagnostic framing, (b) expanded services, especially postpartum, (c) multidisciplinary collaboration, and (d) community education. 10 out of 10 participants shared recommendations for changes they believed could positively impact the care and treatment of pregnant women who used substances. These suggestions emerged as participants reflected on their clinical experiences and the challenges their patients faced.

One area that participants discussed was the language used to describe substance use and its associated diagnoses. Several voiced concern that the current diagnostic terminology carried negative connotations, despite being intended to reflect a medical condition. P4 stated, “Probably the biggest thing I see offhand is the diagnosis we use to identify substance use disorder; it is already perceived as negative.” P4 also said, “Like mental health, substance use has to be normalized; this is all part of treating the whole person.”

Participants also proposed changes to treatment practices. While many described their outreach efforts positively, they also recognized the need to expand available services. P2 shared, “We need to expand services for this population.” Others highlighted gaps in support during the postpartum period. P8 explained, “Maternity leave works, but

compared to other countries, we are far behind. Our patients are not getting support in postpartum." This comment was made in the context of stressors associated with labor, delivery, and the transition into motherhood. P8 also stated, "They need to acknowledge this as a stressful time where women and babies need additional support to avoid relapses."

Two of 10 participants emphasized the importance of improving coordination and collaboration within clinical settings. P3 suggested, "More collaboration between departments and for the creation of a true multidisciplinary team."

Participants also addressed broader societal issues, including public understanding of substance use during pregnancy. They described a need for increased community education and outreach to reduce stigma. P1 stated, "We need to be able to go to canvas, local areas, and provide resources and support." P8 explained, "There's definitely a lack of education. I don't think there's a lot of public service announcements around how you can really set your baby up for success by actually stopping some of these things prior to becoming pregnant."

These recommendations reflected participants' hopes for improving not only clinical practices and systems of care, but also how society supports and understands pregnant women affected by substance use.

Table 3

Summary of the Key Themes and Illustrative Quotes (N = 10)

Theme	Illustrative Quote	Participants
Societal stigma	"People feel pregnancy gives them the right to comment."	P1, P2
Organizational support & barriers	"Checks and balances so the ball doesn't get dropped."	P5, P7, P8
Provider beliefs	"It's not a parenting test." "I try not to let my beliefs interfere."	P1, P3, P5
Screening practices	"Screening occurs almost 100% of the time."	P6, P10
Referral process	"Referral if UDS or screener is positive."	P1, P2, P4
Patient–provider dynamics	"There is shame in asking for help."	P1, P3, P6
Legal uncertainty	"I'm not well-versed in the laws."	P4, P7, P8
Need for systemic change	"We need to expand services and outreach."	P1, P2, P4, P8

Note. Full quotes and extended analysis are included in Appendix D.

Evidence of Trustworthiness

The original plan for credibility, as described in Chapter 3, included member checking, peer debriefing, and personal reflection. There were changes to the initial plan, where scheduled member checking was supposed to occur after each interview. However, due to time constraints and participant availability, member checking was conducted as a summary review after the thematic analysis phase. Participants were contacted via email and invited to review a summary of the findings to confirm that the interpretations accurately reflected their experiences. Seven of the 10 participants responded and confirmed accuracy, while three did not respond. No participants requested changes. The findings included contextualized participant quotes, allowing readers to assess transferability and interpretation. No new data was gathered from this process.

Regular meetings with the dissertation chair were conducted throughout the data analysis process to discuss emerging codes and themes. The purpose of these meetings was to seek feedback on potential assumptions, interpretations, and personal biases to enhance analytical rigor. Initial codes and themes were sent via email to ensure that they accurately reflected the collected data. Additional support was obtained in the form of tutoring from a private coder to facilitate the use of NVivo software. Although there was a small fee for the one-hour tutoring session, the support proved beneficial given the time and monetary investment required.

Throughout the data collection and analysis process, I kept a personal journal to critically and reflexively examine potential biases and positionality, as well as their influence on the interpretation of the data. After each journal entry, a period of reflection

was observed before reviewing the entry for accuracy. As the data remained unchanged, the reflections were also consistent.

Detailed notes were maintained for organizational and analytical purposes. Notes documented all coding decisions, theme development, and methodological changes to provide transparency in the analytical process. NVivo code reports were also used to track data. Although the original plan was to complete two rounds of coding, a third round was conducted because an additional round of coding was deemed necessary prior to theme development.

The first and second rounds of coding provided initial insights, but the initial codes lacked sufficient depth to accurately capture the complexity of participants' experiences. The second round resulted in deeper engagement with the data, more refined coding, and the identification of connections between codes. In the third round, themes began to emerge, and an iterative and reflexive approach to data analysis was adopted. Interpretations were linked to data excerpts in NVivo, and discrepant cases were retained and discussed in the Results.

Member checking, peer debriefing, and personal reflection were essential to ensuring that themes identified through thematic analysis were grounded in participants' narratives and not influenced by researcher bias. These strategies supported the trustworthiness of the study's results.

Results

For this qualitative study, two research questions guided data collection. The first research question was, How do medical providers screen and assess alcohol and

substance use in pregnant women? The second question was How do medical providers ' attitudes and societal expectations influence their approach to pregnant women who use substances? For the first research question, the specific themes that emerged from the data included Approaches to screening practices, Organizational impact on clinical practice, and patient-provider relationships.

For the first theme, there was a pattern in participant response; overall, the majority of participants shared that they use a mixture of formal assessment tools (e.g., PHQ, AOQ, PSQ, UDS, CAGE, Early Start Questionnaire, Physician Health Screening, and clinical intake) and informal questioning in their clinical practice. The consensus was that there is a range of available tools and that these are used consistently ("Screening occurs with every pregnancy, almost 100% of the time," P10). The findings also suggested that participants felt confident using these assessment tools ("very comfortable," "pretty comfortable," "100% comfortable", P3, P4, P9). While participants shared comfort and ease when using these tools, they also disclosed an awareness of barriers their patients face, including: insurance-related issues such as costly deductibles/insurance type, stigma, judgment, patients declining treatment, and provider bias (P2, P3, P4, P9).

Participants also highlighted the importance of trust-building in encouraging disclosure. Participants disclosed having a keen awareness of the challenges faced by their patients, which in turn influenced their practice. Participants emphasized the importance of adopting a gentler, more compassionate approach to foster dignity and respect for these women (P2). Although most participants felt strongly in the screening

and assessment efforts laid out by their organization, one participant shared a different viewpoint. P7 shared that they too want to support women struggling with drug use, yet they also felt the organization's push for ongoing outreach and detection efforts undermines a woman's autonomy. Although this was vastly different from the rest of the participants, P7 had a unique view of the situation. This may be related to several factors; however, it was not a matter of not wanting to do the work. It was more about treating the patient as a competent individual with the ability to make her own decisions about her body.

For the second research question, the specific themes that emerged from the data included: personal beliefs of medical providers, Societal views on substance use during pregnancy, and Legal considerations. For the first theme, participants shared a collective recognition of the challenges faced by pregnant women using substances (stigma, judgment, shame, guilt), which influenced their medical approach. Many shared that this resulted in compassionate, gentle, non-judgmental, non-punitive, and supportive (P2, P4) treatment. Most of the participants also recognized their own personal biases and described making conscious efforts to separate these from their professional responsibilities (increased self-awareness, P1). With this increased self-awareness, many participants described a move away from the dominant social discourse around substance use in pregnancy to a more complex issue, where the use and the person or their abilities are separate ("It's a positive drug test, not a parenting test", P3).

Participants also removed the blame from the women and described substance use in pregnancy, not as a personal flaw, but as a coping strategy meant to address something

deeper than just addiction (P5, P7). There was notable tension between personal values and professional roles. While many participants felt strongly about supporting women who struggle with substance use in pregnancy, several participants acknowledged personal opposition to personal substance use (P1). Participants, as discussed earlier, are aware of the public scrutiny these women face and the shame, guilt, and isolation they experience (P1, P2). Participants were open and forthcoming about the efforts made to support these women; they described the countless ways they screen and assess, yet even at a rate close to 100% in screening, they could not eliminate the stigma society places on these women, which then negatively affects referrals and patients' openness to treatment (P1).

Participants also described a discrepancy between medical advice and the legality of substances (specifically marijuana). They shared that this has led to confusion on both sides (“just because something is legal does not mean it is healthy for you”, P9). This cultural shift was significant for this study as it demonstrates how changing views on substances like marijuana can complicate medical care and influence an individual’s perceptions. When addressing the legality of this social issue, most participants emphasized their role as caregivers and not law enforcers. This was evident in how many participants described prioritizing patient care over strict legal adherence (P4, P5).

Many also shared that they preferred to rely on organizational policies, which they felt were in place to protect the patient, rather than investing time in in-depth legal understanding (P4, P5). Although participants shared concerns over the legalization of marijuana and upcoming changes to involuntary hospitalization, all understood their role

as mandated reporters (P7) and did not appear to feel ill-informed or equipped to carry this professional responsibility, as it is written in the law books.

Summary

Findings suggest largely consistent organizational expectations for universal screening, with some variation in tools, training depth, and perceived pressure (e.g., P3 minimal training; P7 concerns about outreach pressure). There was a consensus that societal influences do affect treatment utilization. Participants shared feeling competent and well supported in screening and assessment practices for substance use in pregnant women yet felt unable to adequately address poor treatment acceptance rates, which are directly influenced by society.

Providers' attitudes were indeed shaped by personal experience; however, that was not the only influence, other factors included organizational polices/procedures, societal stigma, and legal reporting obligations. Chapter 5 interprets these findings through the lens of Social Constructivism and the relevant literature, addresses limitations, and presents implications and recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore how medical providers' screening practices and personal biases influence referral decisions for addiction medicine treatment based on pregnancy status. I used a qualitative design, employing semi-structured interviews with medical providers. Thematic analysis was applied to interpret the interview data.

I assessed whether pregnancy status influences referral decisions and examined how personal attitudes, biases, screening practices, and societal expectations factor into those decisions. Two research questions guided the analysis:

RQ1: How do medical providers screen and assess alcohol and substance use in pregnant women?

$SQ_1$1: What factors guide medical providers' decisions regarding treatment referrals for pregnant women who report alcohol and substance use?

$SQ_1$2: How do organizational policies and legislative requirements impact screening practices for alcohol and substance use in pregnant women?

RQ2: How do medical providers' attitudes and societal expectations influence their approach to pregnant women who use substances?

$SQ_2$1: In what ways do personal biases and societal expectations shape medical providers' clinical practices when working with pregnant women who use substances?

$SQ_2$2: How does the social construction of substance use in pregnancy influence medical providers' screening and referral practices?

$SQ_2$3: What changes to current practices or policies do medical providers believe would improve care for pregnant women with substance use issues?

These questions were a guide in the study's exploration of both clinical practices and personal/organizational influences.

The study was grounded in social constructivism theory (Berger & Luckmann, 1966) and influenced by Vygotsky's (1978) cognitive development theory to explore how social context and cognition influence provider behavior. I conducted the study to address the importance of improving maternal healthcare. Change is linked to increased awareness and education. The results offer an opportunity to increase awareness, potentially reduce provider bias, and may inform changes to policy or practice regarding substance use in pregnancy, which could improve health outcomes for pregnant individuals and their fetuses. Findings are interpreted in relation to social constructivism and prior literature, followed by a discussion of limitations, recommendations, implications for positive social change, and a brief conclusion.

Interpretation of the Findings

Theme 1: Societal Views on Substance Use in Pregnancy

This theme aligns with prior research by Stone (2015), Hatzenbuehler (2016), and Motyka et al. (2022), who found that stigma, shame, and judgment deter pregnant individuals from seeking care. The participants in my study echoed this by highlighting that stigma, shame, and judgment are frequent public experiences for people who use

substances during pregnancy. Participants also shared that feelings of shame, guilt, and judgment can lead to isolation, which creates unrealistic expectations regarding abstinence. My findings extend the literature because participants described how societal judgment directly impacts the referral process, not just initial engagement. This impact may not have been fully explored in the existing literature, as the focus seemed to be more on initial screening. The participants, however, did not disconfirm that while some literature implies stigma may delay or prevent screening, they described screening as largely consistent (e.g., universal screening expectations; see P6, P10), while emphasizing that social stigma most directly affected referral receptivity.

Theme 2: Organizational Impact on Clinical Practice

This theme confirms prior research by SAMHSA (2016, 2018) and Barber and Terplan (2023), who identified a need for systemic, trauma-informed, and non-punitive care within obstetric and gynecologic settings. They also advocated investing in staff training, protocols, and infrastructure to reduce fragmentation in care, thereby improving patient trust and engagement. Participants in this study described strong organizational support systems, staff training, and integrated referral processes within their organizations. My findings extend the literature because participants provided insight into how organizations ensure compliance (e.g., OneNote, SharePoint, tracking missed screenings), which are practical tools not widely described in prior studies. One difference from prior studies is that participants in my study did not report organizational barriers; instead, the focus shifted toward patient-level and insurance-based barriers, unlike prior studies, which focused on systemic barriers. These results reflect one large

managed care context; other systems may report different levels of standardization and support.

Theme 3: Personal Beliefs of Medical Providers

This theme aligns with prior research by Merritt et al. (2022) and Richelle et al. (2022), who explored the impact of provider bias and highlighted how organizations can, through training and education, play a pivotal role in shaping provider attitudes and behaviors toward pregnant women with substance use. Most participants acknowledged their own biases and saw this as a reminder to act compassionately towards these women. My findings extend the literature, as it was found that providers often hold two belief systems: a professional and a personal one. This adds depth to the discussion of implicit/unconscious bias, as well as the possible role they play in this social issue. However, unlike prior literature, which frames provider attitudes as largely negative, this study's findings showed that many providers actively work to reduce judgment and stigma and have adopted harm-reduction approaches, which challenge this generalization.

These findings are more consistent with harm-reduction and non-punitive practice than with prior reports emphasizing negative provider attitudes, suggesting that organizational culture and training may moderate personal beliefs.

Theme 4: Approaches to Screening and Assessment

This theme aligns with prior recommendations made by major organizations, including the ACOG, CDC, and SAMHSA, which advocate universal screening. The participants commonly described universal screening policies with high perceived adherence. My findings extend the literature because, although organizations like the

ones mentioned previously do set standards of care, the participants in this study were able to provide real-world examples of how screening is implemented (e.g., multiple tools used, missed screening tracking, outreach attempts); this operational detail is not always reflected in the literature. One difference between the established literature and this study is that the literature notes inconsistent use of validated tools (Oni et al., 2019), whereas the findings of this study suggest consistency, with tool use being high for this group.

Theme 5: Referral and Treatment Processes

This theme supports prior research by Smid et al. (2020), who recommended interdisciplinary collaboration and identified a lack of coordination and fragmented care systems as barriers to effective treatment for individuals with substance use disorders. Participants in my study described the use of addiction medicine specialists and an early start program for individuals with substance use disorders as approaches to improve collaboration. My findings extend the literature by detailing follow-up and outreach practices, demonstrating that provider initiatives may extend beyond established protocols, an aspect not previously emphasized in research. A key difference is that previous literature assumed identification of substance use would lead to referral, but this was not the case in the present study. Not all positive screens resulted in specialty addiction referrals; providers frequently described brief interventions and monitoring as sufficient for many cases in this context.

Theme 6: Patient-Provider Relationship

This theme aligns with prior research by Hoover et al. (2022), who found that the presence of addiction consultation services in hospitals can reduce stigma and support patient dignity. Renbarger et al. (2022) also found that provider characteristics such as empathy, inclusion, reassurance, and expertise can build trust between providers and patients with substance use disorders. Participants in this study emphasized the importance of building trust and maintaining a respectful, compassionate approach in clinical practice. My findings extend the literature by addressing the power dynamic and patient autonomy that must be considered alongside fetal risk, a tension not always explored in previous studies.

Although this theme did not contradict prior research, participants challenged previous assumptions of intentional negative attitudes toward individuals with substance use disorders, as many reported actively engaging in intentional trust-building efforts with their patients. This theme underscores the constructivist perspective, suggesting that language and interaction help create a clinical environment conducive to disclosure and engagement.

Theme 7: Legal Considerations

This theme aligns with prior research by the Guttmacher Institute (2020) and Oni et al. (2022), who highlighted a legal landscape characterized by variation and ambiguity. These studies identified that punitive child-welfare approaches often coexist alongside supportive, treatment-oriented models, creating an environment of uncertainty that can contribute to fear regarding Child Protective Services involvement. Such ambiguity has

been associated with reduced disclosure, which may negatively impact both pregnant individuals and fetal health outcomes.

Participants in my study echoed these findings, noting inconsistencies between written laws and their interpretation or implementation in practice. My findings extend existing literature by revealing that participants often rely more on organizational policies than on a comprehensive understanding of legal statutes. This suggests a potential gap in legal literacy among providers. Unlike previous literature, which characterized providers as enforcers of legal compliance, participants in this study reported prioritizing patient care and relying on organizational policies and consultation for legal compliance, rather than independently monitoring statutory changes.

Theme 8: Recommendations for Change

This theme aligns with prior research by Smid et al. (2020) and Barber and Terplan (2023), who advocated for multidisciplinary care, education, and stigma reduction. Participants in my study recognized the need to expand available services and increase community education and outreach to reduce the stigma associated with mental health issues. My findings extend the literature because participants emphasized the importance of changing language, labeling, and terminology as areas for improvement. I also add to current knowledge by highlighting postpartum gaps, which are often overlooked in research focused on prenatal care. Unlike much of the current literature, participants in this group demonstrated substantial awareness of existing challenges and offered numerous suggestions to improve care for pregnant and postpartum individuals.

Interpreted through social constructivism (Berger & Luckmann, 1966), findings suggest that shared language (e.g., diagnostic labels), organizational routines (e.g., universal screening), and broader cultural narratives of good versus bad motherhood co-produce clinical realities. Providers' bias-awareness and intentional use of non-stigmatizing language reflect efforts to reconstruct interactional norms that invite disclosure and engagement. Reliance on organizational policy for legal compliance further illustrates how institutional scripts shape practice. Together, these social processes help explain why screening feels standardized, while referral receptivity varies according to the level of stigma.

Participants' belief systems are influenced by their professions and the medical establishments in which they work. Medical organizations play a significant role by establishing practices and workflows that reinforce societal perceptions of substance use in pregnancy and set standards for what constitutes a healthy pregnancy. These organizations develop procedures to increase oversight of pregnant individuals to mitigate risk and encourage abstinence, which aligns with societal expectations regarding healthy pregnancies. Social construction theory (Berger & Luckmann, 1966) provides a framework for examining how institutions, such as healthcare, use language and practices to establish systems of care that are shaped by organizational and provider influences rather than being fixed.

At the core of this study is the relationship between provider and patient and their social interactions and from a social constructivist (1966) lens, participant accounts highlighted the importance of provider and patient relationships that is built on mutual

respect, compassion, and safety. Vygotsky's (1978) theory of cognitive development highlights the fundamental role of social interaction in the development of acquired knowledge. The study highlighted the importance of social interaction on cognitive development.

A unique aspect of my study is the legal system's continuous evolution and adaptation to cultural shifts. Laws are not universal and are often influenced by several entities, including society, culture, and institutions. Although laws are written with the intention of providing clarity on how they are implemented, many participants shared that this is not always the case. Many understood their legal responsibilities to their patients and organizations; however, personal experiences have caused a shift in how they practice. Other factors affecting this include workplace norms, as well as personal and ethical values.

During the course of the interviews, participants discussed desired changes. The suggestions offered are significant, as they have the potential to reshape societal views and understanding of substance use in pregnancy. This potential shift could also influence future policies and procedures, supporting the social constructivist perspective (Berger & Luckmann, 1966). The stigma faced by pregnant individuals is not solely personal but is socially constructed through medical discourse, policy, and cultural narratives about pregnancy and substance use. These participant suggestions may help reconstruct societal perspectives and guide future policy and procedural changes.

Recommendations were consistent across roles and clustered into four main areas: language and terminology, postpartum support, multidisciplinary collaboration, and public education.

Limitations of the Study

Although multiple strategies were implemented to support the trustworthiness of my study, some limitations arose during execution that may have affected its credibility, dependability, transferability, or confirmability.

Regarding sample and context, all participants were employed within one large managed care system in California; all identified as female; and most were perinatal mental health clinicians or master 's-level providers, rather than solely physicians. These factors limit transferability to other systems, regions, provider compositions, and legal environments.

A limitation of my study was the use of convenience and snowball sampling, along with one-time interviews, this may have inadvertently favored participants with higher organizational alignment and greater bias awareness. Socially desirable responding may have shaped self-reports of "universal" screening. An additional limitation of using semi-structured interviews is that, since the study relied solely on interviews, no document review (e.g., policies, training materials) or electronic health record audits were conducted to triangulate self-reports.

A modification that occurred was a change in member checking. Originally, member checking was intended to occur after each interview, allowing participants to clarify or elaborate on their responses in real time. Due to time constraints and participant

availability, member checking was conducted after the coding process and theme development were completed. This modification is significant, as it may have reduced credibility by limiting participants' ability to influence or refine the initial coding process. Another limitation of member checking is that only seven out of 10 participants responded to the summary review email. The three missing responses are significant because these perspectives were not validated, which potentially limits the confirmability and completeness of the findings.

Another possible limitation is that there was only one coder. Although there was constant contact between me and my dissertation chair, who served as peer debriefer, having only one coder may have affected the dependability of the analysis. There were other issues with the coding analysis. Learning new software proved challenging, requiring additional effort and external support from a private tutor, which could have affected coding consistency during the initial analysis stage. The initial plan was to conduct two rounds of coding, yet after two rounds, a decision was made to conduct a third round, which resulted in stronger theme development. One possible explanation is that the data were not thoroughly explored, which may have affected the consistency of the analysis.

Given limited resources, I served as the only interviewer and coder; however, a detailed journal was maintained to help ensure an audit trail of decisions. Complete neutrality is unattainable in qualitative research, and researcher bias may have influenced the results. Rich quotes were included in the study to enhance transferability. However,

three out of 10 participants did not respond to the follow-up email after the analysis, which may have affected the transferability of the findings.

Recommendations

Based on the strengths and limitations of my study, several recommendations for future research have emerged. Participants provided an in-depth look at current practices and procedures and identified several areas that could positively affect the public health concern of substance use in pregnancy. Future research should examine how diagnostic language affects both provider attitudes and patient experiences. Many participants highlighted that, despite changes to diagnostic criteria that have reduced negative connotations and aligned with a medical model of care, the current terminology may still reinforce stigma in clinical settings. Future research could investigate the influence of diagnostic language on providers and its subsequent impact on care delivery and treatment outcomes.

Another recommendation focused on postpartum care and the lack of available support and resources. Goldman-Mellor and Margerison (2019) reinforced this idea, identifying the postpartum period as a time of increased vulnerability, specifically linking it to mortality due to overdose. The postpartum period offers a critical window for intervention; therefore, future studies should explore the specific needs of individuals with substance use histories during this period and use this information to increase support and resources.

Another recommendation was to investigate how the integrated care model functions. Many participants expressed a desire to see improved collaboration between

departments. Renbarger et al. (2022) and Barber and Terplan (2023) emphasized that integrated care is crucial for fostering trust and that providing multiple services in a single location (e.g., obstetric services, addiction treatment, mental health services, lactation consultation, social support, and legal services) can help reduce barriers and streamline care. Along the lines of integrated care, another recommendation is to increase public education to combat stigma and promote prevention. This is an area where future research could examine the effectiveness of community education programs related to substance use in pregnancy.

Implications

My study identified substance use in pregnancy as a serious social problem affecting several spheres, including individual, family, peer, workplace, and societal domains. At an individual level, my study's recommendations have the potential to improve trust between pregnant individuals with substance use disorders and medical providers. Increased trust can lead to consistent engagement, reduce self-stigma, and increase access to supportive care. Increased medical, mental health, and addiction medicine care has the potential to improve health outcomes for both pregnant individuals and fetuses.

At the family level, improved prenatal and postpartum care has the potential to promote better health outcomes, as well as stronger bonding and attachment between parents and infants. Increased support during the pre- and post-delivery periods may reduce stress, lower relapse rates, and decrease the need for child welfare or legal

involvement. This support could also help preserve families and reduce intergenerational cycles of trauma or substance use.

At an organizational level, improved multidisciplinary collaboration could enhance care coordination and communication, thereby creating efficiency across departments. Improved training could lead to a decrease in provider bias, and integrated health models that incorporate best practices could improve outcomes and reduce healthcare costs.

At the societal level, research demonstrates the need for a shift away from punitive policies and toward compassionate, evidence-based approaches for pregnant individuals with substance use disorders. Policy changes could support expanded postpartum services, harm-reduction programs, and community education, contributing to the destigmatization of substance use during pregnancy. Achieving a meaningful shift in language, social interaction, and shared social knowledge requires collaboration across multiple systems to address this issue.

Conclusion

A key finding of my study was that participants desire to provide compassionate care and are acutely aware of the severity of this situation, yet systemic barriers remain a concern. The stigma faced by women who use substances in pregnancy is a deterrent and multifaceted. Participants expressed a need to increase collaborative efforts among medical providers and described postpartum support as a critical period that requires increased focus.

Substance use in pregnancy is a serious social problem, and suggestions have been made with the potential to create a meaningful impact. My study highlighted changes to diagnostic language and increased efforts to educate the public, actions that could decrease stigma and increase public awareness. These findings underscore the need for change at both individual and societal levels. Providing compassionate, person-centered, multidisciplinary treatment is essential to ensure the health and safety of both pregnant individuals and infants.

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Appendix A: Marketing Forms (Sample Email)

Subject Line: Research Volunteer Opportunity

Subhead: You can contribute to improving the care of pregnant women struggling with drug use.

Hello,
My name is Ericka L Suarez-Vella, and I am a PhD student working on my dissertation and I need participants for my research study.

The goal of this study is to explore current screening practices for pregnant women with drug use.

Would you like to help?
To see if you are eligible, please read the requirements below:

Who Can Participate?

- Medical providers working with women who are pregnant.

Why You Should Participate:

- You can provide valuable insight into the clinical practice of screening for substance use in pregnancy which may lead to better clinical practice.

What to expect:

- You will be asked to take part in a 60-minute interview where you will be asked a set of questions pertaining to your clinical practice and views of substance sue in pregnancy.

This is voluntary and no monetary incentive is available for your participation.
If you meet these requirements and are interested in helping, sign up for the study by replying to this email. I will contact those who are interested in setting up our one-on-one interview.

Please let me know if you have any questions I could answer.
Thank you for helping to improve the lives of pregnant women.

Best,
Ericka L Suarez-Vella

Appendix B: Semi-structured Interview Questions

1. How long have you been in medical practice? Specifically, how long have you treated pregnant women?

2. What methods do you use to screen and assess alcohol and substance use in pregnant women?
    a) Can you describe your approach and any specific tools or frameworks you rely on?
    b) What training was offered by your organization, if any regarding the assessment tool, its administration and interpretation?
    c) How comfortable are you using this tool?
    d) How often are you using this tool?
    e) Do you notice barriers to using this tool consistently? If so, what are these?
    f) What do you do with the information generated from these types of assessments?
    g) How valuable do you find these assessments tools?

3. What factors influence your decisions when referring pregnant women who disclose alcohol or substance use for treatment?
    a) Could you share any specific considerations or criteria that guide your referrals.
    b) Once a patient is referred, is there follow up between you and the treatment team and if so, what is that process like? What is your role?

4. How do organizational policies in your place of employment affect your screening practices for alcohol and substance use in pregnant women?
    a) Can you share any specific examples or experiences that illustrate this impact?
    b) Do you find organizational polices useful in your decision making?
    c) What support is offered in your agency to help understand the why behind such policies?

5. How do legislative requirements in the state of California affect your screening practices for alcohol and substance use in pregnant women?
    a) Can you share any specific examples or experiences that illustrate this impact?
    b) What support is offered in your agency to help stay informed regarding state and federal requirements as a medical provider?

6. What are your personal opinions regarding substance use in pregnancy?

7. In what ways do your attitudes and societal expectations shape your approach to working with pregnant women who use substances?
    a) Can you provide specific examples of how these factors influence your interactions or decisions?

8. How do personal biases and societal expectations influence your clinical practice when working with pregnant women who use substances?
    a) Can you share specific experiences or examples that illustrate these influences?
    b) Do you incorporate personal reflection in your practice and if so, what does this look like?

9. In what ways do you think the social construction of substance use during pregnancy affects your screening and referral practices?
    a) Can you provide examples of how societal perceptions influence your approach?

10. What changes to current practices or policies do you believe would enhance care for pregnant women dealing with substance use issues?
    a) Could you share specific ideas or recommendations based on your experiences?

Appendix C: Themes and Participant Quotes

Table 4

Themes and Participant Quotes

Theme	Participant	Code	Quote
Societal views on substance use in pregnancy	P1	Society fosters shame, guilt, loss of resources and punishes	"Quit judging. I feel like in society, people feel that if someone is pregnant, it gives them the right to comment."
	P2	Society fosters shame, guilt, loss of resources and punishes	"People get petty, outraged, really upset… shows up in clinic as shame and silence."
	P9	Society does not affect screening; it affects the information women share	"Just because something is legal does not mean it is healthy for you."
	P1	Society does not affect screening; it affects the information women share	"I don't think it impacts the screening process because that's the same, however, it impacts the referral process. It impacts how receptive people are to treatment and further evaluation."
Organizational impact on clinical practice	P5	Checks and balance system	"There is a checks and balances in our organization where the ball does not get dropped."
	P8	Checks and balance system	"We'd rather cast a wide net and bring in a few people, than miss them and have them fall through the cracks."
	P4	Support from the organization	Policies and procedures "probably facilitates" their work.
	P7	Support from the organization	"No administrative barriers" came to mind.
	P1	Training	Training offered through "annual CMEs, initial onboarding at time of hiring, and all staff meetings."

Theme	Participant	Code	Quote
	P3	Training	Received “very minimal” training.
	P2, P3	Barriers not related to organization	Barriers include “crazy deductibles, stigma, judgment from society.”
	P9	Barriers not related to organization	Patients declining treatment.
	P7	Forced engagement dilemma	“The program sometimes places more pressure to push engagement, push outreach, more than I'm comfortable with.”
	P6	Buy in from clinical staff	“Lived experiences impact our ability to work well with our patients.”
Personal beliefs of medical providers	P1	Awareness of Bias	“I think I am very self-aware of my own biases, it's a lot of self-awareness. I don't want my own belief system to come into those intakes.”
	P4	Compassion for their situation	Aim to be “compassionate.”
	P2	Compassion for their situation	Emphasized being “gentle, non-judgmental, non-punitive, and supportive.”
	P3	Compassion for their situation	“It’s a positive drug test; it’s not a parenting test.”
	P5	Compassion for their situation	Reframe substance use as “unconventional methods to treat their conditions.”
	P7	Compassion for their situation	Described substance use as a way to “cope,” rather than as a personal flaw.
	P1	Do not believe in substance use in pregnancy	“would never do those things”
	P3	Compassion for their situation	“Have a different understanding of the why behind it”
	P10	Every woman is screened	“Screening occurs with every pregnancy, almost 100% of the

Theme	Participant	Code	Quote
Approaches to Screening and Assessment			time... at least 99%, pretty consistently."
	P4, P3, P9	Comfortable using organizational tools	Described feeling "very comfortable," "pretty comfortable," and "100% comfortable" with tools.
	P6	Every woman is screened	"Our goal is less than 5% missed screenings, and we've always been at like less than 2% missed opportunities."
	P1	Barriers to using available tools	"a lot of extra documentation."
	P2	Barriers to using available tools	"lack of online access, lengthy questionnaires, discomfort with answering sensitive questions."
	P2, P3, P6, P9	Screening tool is valuable	Tools described as "valuable."
Referral and Treatment Processes	P10	Clinical judgement, disclosure, positive UDS, positive screener can lead to hospitalization	"We have a referral system, anybody who screens positive will meet with an early start specialist."
	P2	Clinical judgement, disclosure, positive UDS, positive screener can lead to hospitalization	"When either the questionnaire is positive or the urine drug screening is positive, they are referred."
	P9	Clinical judgment, disclosure, positive UDS, positive screener can lead to hospitalization	"Based off of the DSM and clinical judgment."
	P4, P1	Clinical judgment, disclosure, positive UDS, positive screener can lead to hospitalization	Follow-up scheduled to ensure linkage to addiction medicine treatment.
	P7	Clinical judgment, disclosure, positive	"There's a lot of outreach."

Theme	Participant	Code	Quote
		UDS, positive screener can lead to hospitalization	
	P1	Collaboration between departments is essential	Use of "huddles, emails, monthly check-ins, OneNote, SharePoint" to support communication.
	P10	Addiction medicine treatment referrals are rare, but there is follow up	"I haven't had a lot of patients referred to addiction medicine."
	P2	Addiction medicine treatment referrals are rare, but there is follow up	"Only a few, a small percentage of people, meet criteria."
The Patient-Provider Relationship	P1	Barriers can include judgement, shame, stigma	"There is a shame connected to asking for help and seeking services."
	P3	Barriers can include judgement, shame, stigma	"They feel a lot of judgment from society."
	P6	Barriers can include judgement, shame, stigma	"Due to stigma, they'll often underreport."
	P2	Compassion for their situation	"I take a gentler approach… it's important to demonstrate dignity and respect."
	P5	Choice is on the patient	"At the end of the day, it's your baby, your body."
	P7	Choice is on the patient	"It's always about personal choice… if you continue to use, that's your personal choice."
	P1	Compassion for their situation	"I don't ever want to shame a patient, but I want them to understand their choices can have detrimental effects… I'm helping them make the most informed decision while still trying to stay non-judgmental."

Theme	Participant	Code	Quote
Legal Considerations	P4	Legislation	"We are not going to think legal consequences, we're thinking of medical issues."
	P5	Legislation	"I don't really follow with the policies, the laws. I just am going to do what I know is right for the patient."
	P7	Legislation	"Can't say I'm well-versed in the laws."
	P8	Legislation	"I'm not necessarily up-to-date on every legislative requirement."
	P4	Legislation	"That's the nice thing about working for an organization, I know whatever we're doing is going to meet criteria."
	P7	Child Protective Services	"If a pregnant individual is using, this does not mean that they have to get reported to CPS."
	P9	Child Protective Services	"Once the baby is born, the doctor is under legal obligation to report to CPS."
	P2	Legalization of cannabis	"Cannabis has honestly been the trickiest substance for most of us."
	P6	Legalization of cannabis	"The legalization of marijuana was a big shift and a concern about how to address it with patients because it is a legal substance."
Recommendations for Change	P4	Changes to diagnosis name	"The diagnosis we use to identify substance use disorder; it is already perceived as negative."
	P4	Changes to diagnosis name	"Like mental health, substance use has to be normalized, this is all part of treating the whole person."
	P2	Expansion of services	"We need to expand services for this population."
	P8	Expansion of services	"Maternity leave works, but compared to other countries, we

Theme	Participant	Code	Quote
			are far behind. Our patients are not getting support in postpartum."
	P8	Expansion of services	"They need to acknowledge this as a stressful time where women and baby need additional support to avoid relapses."
	P3	Increased collaboration	"More collaboration between departments and for the creation of true multidisciplinary team."
	P1	Increased community outreach	"We need to be able to go to canvas, local areas, and provide resources and support."
	P8	Increased community outreach	"There's definitely a lack of education. I don't think there's a lot of public service announcements around how you can really set your baby up for success by actually stopping some of these things prior to becoming pregnant."