Substance Use Among Pregnant and Parenting People: Research and Interventions to Promote Wellbeing

Anna Austin, PhD
Assistant Professor, Department of Maternal and Child Health
Core Faculty, Injury Prevention Research Center
Outline

• Epidemiology and trends
  • Types of substance use in pregnancy
  • Opioid use disorders in pregnancy
    • Neonatal opioid withdrawal syndrome
    • Medication for opioid use disorder in pregnancy

• State prenatal substance use policies
  • Existing qualitative and quantitative evidence

• CAPTA legislation and plans of safe care
  • North Carolina Plan of Safe Care Quality Improvement Project

• Parental substance use and child safety and wellbeing
  • Child welfare involvement
Epidemiology and trends
Substance use in past month among pregnant people 15-44 years: National Survey on Drug Use and Health

*Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine and misuse of prescription stimulants, tranquilizers or sedatives, and opioids
Opioid use disorders in pregnancy

Opioid use disorder diagnoses per 1,000 delivery hospitalizations, 1999-2014

Data source: National Inpatient Sample (NIS) – national representative sample of hospital discharges in the U.S.

Haight et al. MMWR. 2018.
Opioid- and amphetamine-related deliveries

Data source: National Inpatient Sample (NIS) – national representative sample of hospital discharges in the U.S.

Medication for opioid use disorder (MOUD)

• MOUD is recommended, evidence-based treatment of opioid use disorder in pregnancy
  • Methadone or buprenorphine

• Benefits of MOUD for pregnant peoples’ and infant outcomes
  • Reduced risk of preterm birth and low birthweight
  • Improved prenatal care attendance
  • Reduce risk of overdose

Medication for opioid use disorder (MOUD)

- Among those with OUD in pregnancy, as duration of MOUD in pregnancy increased:
  - Risk of fatal or non-fatal overdose in pregnancy through 12 weeks postpartum decreased
  - Likelihood of continuing MOUD postpartum increased
  - Risk of preterm birth and low birthweight infants decreased

Specialized substance use disorder treatment programs for pregnant and postpartum people

- 23% of SUD treatment facilities had specialized programs for pregnant and postpartum people in 2018
- Services offered by facilities with specialized programs:
  - 44% buprenorphine
  - 24% methadone
  - 16% childcare
  - 51% intimate partner violence services
  - 69% housing assistance
  - 49% employment assistance

Data source: National Survey of Substance Abuse Treatment Services, 2018
Neonatal opioid withdrawal syndrome (NOWS)

• Withdrawal syndrome in newborns following discontinuation of in-utero exposure to opioids
  • Prescription opioids, medication for opioid use disorder (MOUD), illicit opioids (e.g., heroin)

• Range of signs and symptoms
  • Minor behavioral problems like feeding difficulties and high-pitched crying to major problems like seizures and failure to thrive
  • Variability in symptoms and severity of symptoms between infants and within infants over time

• Treatable
  • Pharmacological and non-pharmacological treatments (e.g., Eat, Sleep, Console Method)

Neonatal opioid withdrawal syndrome (NOWS)

Data source: National Inpatient Sample (NIS) – national representative sample of hospital discharges in the U.S.

Among mothers of infants diagnosed with NOWS:

- 60% had claims for MOUD or prescription opioids
  - 47% had claims for MOUD
  - 22% had claims for other prescription opioids
- Younger women and Black non-Hispanic women were under-represented among those with claims for MOUD in pregnancy
State prenatal substance use policies
State prenatal substance use policies

• Child abuse policies
  • 23 states and D.C. include prenatal substance exposure in definitions of child abuse and neglect in civil statues

• Mandated reporting policies
  • 26 states and D.C. require healthcare providers to report infants with suspected or confirmed prenatal substance exposure to child protective services
  • States frequently amend these policies

• Leading medical and public health organizations (APHA, AMA, ACOG, AAP) recommend against these types of policies

https://www.childwelfare.gov/topics/systemwide/laws-policies/state
https://www.apha.org/-/media/files/pdf/advocacy/briefs/170728_loertscher_7circuit.ashx
State prenatal substance use policies: Qualitative evidence

• Pregnant and postpartum people with substance use often experience stigma and judgement in healthcare encounters
  • Difficulty forming supportive, respectful relationships with healthcare providers is a barrier to consistent engagement in care
  • Empathy, communication, and inclusion in decision-making key to forming positive relationships

• Pregnant people with substance use often delay or avoid prenatal care and treatment due to fears of detection, role of healthcare providers as mandated reporters, and loss of infant custody
  • Fears amplified by child abuse and mandated reporting policies

• Child abuse and mandated reporting policies are perceived by pregnant people and healthcare providers as punitive

State prenatal substance use policies: Quantitative evidence

- State child abuse policies and mandated reporting policies associated with:
  - Decreased admissions to SUD treatment among pregnant people
  - Decreased receipt of MOUD among pregnant people with OUD
    - Medicaid expansion associated with increased receipt of MOUD among pregnant people with OUD, but only in states without child abuse policies
  - Later initiation of prenatal care, lower likelihood of adequate prenatal care, and lower likelihood of a postpartum visit among those with substance use in pregnancy

State prenatal substance use policies: Inequitable impacts

• Kentucky (625.050)
  • No petition may be filed to terminate the parental rights of a woman solely because of her use of a nonprescribed controlled substance during pregnancy if she enrolls in and maintains substantial compliance with both a substance abuse treatment or recovery program and a regimen of prenatal care as recommended by her healthcare practitioner throughout the remaining term of her pregnancy...

• Existing inequities
  • Lower availability of MOUD and other SUD treatment in rural areas
  • Black non-Hispanic and Hispanic pregnant people less likely to receive MOUD and other SUD treatment than white non-Hispanic pregnant people

Plans of Safe Care

- North Carolina Plan of Safe Care Quality Improvement Project
Federal legislation

- Child Abuse Prevention and Treatment Act (CAPTA)

1974
Passage of CAPTA

2003
Reauthorization of CAPTA, new provisions to address the needs of infants affected by prenatal exposure to illegal substances through “plans of safe care” and CPS notification

2010
Reauthorization of CAPTA, included provisions to address needs of infants affected by Fetal Alcohol Spectrum Disorder

2016
Comprehensive Addiction and Recovery Act (CARA) amended CAPTA, removal of word “illegal”, requirement to address needs of both infants and caregivers

2021
Reauthorization of CAPTA introduced, revised language and requirement for states to create separate systems for notifications for substance affected infants and reports for suspected maltreatment
Federal legislation: 2016 CARA amendments

- States receiving CAPTA funding required to have a law or statewide program that includes...

  "affected by substance use disorder, including alcohol use disorder"

Policies and procedures that address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that healthcare providers involved in the delivery or care of such infants notify child protective services system of the occurrence of such condition of such infants.

"develop a system for purposes of notifications required that is distinct and separate from the system used to report child abuse and neglect"
Federal legislation: 2016 CARA amendments

- States receiving CAPTA funding required to have a law or statewide program that includes...

  The development of a **Plan of Safe Care** to ensure the safety and wellbeing of such infant following release from the care of health care providers by
  - Addressing the health and substance use disorder treatment needs of the infant and affected caregiver
  - The development and implementation by the State of monitoring systems regarding implementation of the family care plan

  "...development of a **multidisciplinary family care plan** for the infant born with, and identified as being affected by, substance use disorder, and such infant’s affected family member or caregiver, to ensure the safety and wellbeing of such infant...including using a family assessment approach to develop each family care plan and addressing, through coordinated service delivery, the health and substance use disorder treatment needs of the infant and affected family member or caregiver"
North Carolina Plan of Safe Care

Health care providers involved in the delivery and care of infants

- Identify substance affected infants
- Notify CPS upon identification

County child protective services agencies

- Complete Plan of Safe Care
- Refer families to CMARC
- Make screening decision

Engage families in voluntary services

Care Management for At-Risk Children (CMARC)
North Carolina Plan of Safe Care Quality Improvement Project: Wake County, North Carolina

• Semi-structured interviews
  • Healthcare providers (i.e., social workers, nurses, physicians) at Wake County hospitals (N=7)
  • Intake, assessment, and in-home social workers at the Wake County Division of Social Services (N=14)
  • Care managers at Wake County Care Management for At-Risk Children (N=10)

• Key themes
  • Concerns about requirement for CPS notifications for all substance affected infants
    • Infant exposure to marijuana or MOUD in which there are no additional safety concerns
  • Referral form (i.e., plan of safe care) vague and often lacking important details
  • Need for guidance on what information can and should be shared across agencies
  • Concerns about the effectiveness of care management given that engagement is voluntary
    • Referral comes from CPS

North Carolina Plan of Safe Care Quality Improvement Project: Wake County, North Carolina

Substance exposure type among infants with a POSC notification to Wake County child protective services and screened-in for a maltreatment assessment, January 2018 – October 2019 (N=347)

- 70% Marijuana only
- 9% Cocaine only
- 3% Opioids only
- 8% Polysubstance
- <1% MOUD only
- <1% Other
- 9% Unknown, pending or negative
Service recommendations for infants with a Plan of Safe Care notification to Wake County Division of Social Services and screened-in for a maltreatment assessment, January 2018 - October 2019 (N=347)

- Marijuana only: 55% Services Not Recommended, 17% In Need of Services
- Cocaine only: 53% Services Not Recommended, 17% In Need of Services
- Opioids only: 60% Services Not Recommended, 20% In Need of Services
- Polysubstance: 56% Services Not Recommended, 26% In Need of Services
Parental substance use and child safety and wellbeing
Foster care entries attributable to parental drug use

Data source: Adoption and Foster Care Analysis and Reporting System

How does parental substance use impact CPS caseloads?

(1) Direct pathway – parental substance use increases the risk for child harm

(2) Indirect pathways – factors that co-occur with substance use increases the risk for child harm

(3) Role of mandated reporters – may be sensitized to the risks of substance use (increased media headlines, changes in policies) and be more likely to report

(4) The CPS system – may respond and record data differently based on the degree of substance use in the population
Foster care entries due to parental substance use by state Medicaid expansion and Medicaid coverage of methadone

Fig. 2. First-time Foster Care Entries due to Parental Drug Use Disorder by Medicaid Expansion Status and Methadone MOUD Coverage, 2007–2016. Source: State level data from the Adoption and Foster Care Analysis and Reporting System, 2007–2016 was used. Notes: A state is defined as an expansion state if the expansion year of the state is before 2016. Detailed categories of states were presented in Table A4; The three solid vertical lines represent three major times when states expanded Medicaid.
Summary

• Increases in documented substance use and substance use disorders in pregnancy

• Child abuse and mandated reporting policies are associated with reductions in receipt of essential care and treatment

• 2021 CAPTA Reauthorization may require states to develop and implement new processes related to plans of safe care
  • Stated purpose of “supporting the health and well-being of infants and their mothers rather than penalizing the family”

• Multiple pathways by which parental substance use may impact CPS caseloads
Thank you!

Anna Austin, PhD
anna.austin@unc.edu