The Intersection of Motherhood and Substance Use Disorder

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Discussion Topics…

- What is SUD?
- What is motherhood?
- What are ACES?
- Prevalence of SUD in women and motherhood
- Impact of SUD?
- What can we do about this...Treatment approaches
  - Treating together / Family Centered Treatment
    - What does this look like?
    - Outcomes and successes
    - Challenges

Defining Substance Use Disorder

- DSM V:
  - A Substance Use disorder involves patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects.
  - 3 Levels of Severity
    - At Risk: If a person has one symptom
    - Mild SUD: If a person has 2-3 symptoms
    - Moderate SUD: If a person has 4-5 symptoms
    - Severe SUD: If a person has 6 or more symptoms;

DSM V Criteria for SUD diagnosis:

- 1. Use more of a substance that intended or suing for longer than you meant to.
- 2. Inability to cut down or stop using
- 3. Experiencing intense cravings or urges to use the substance
- 4. Tolerance: Needing more of the substance to get the desired effect
- 5. Withdrawal: developing illness like symptoms when discontinuing use
- 6. Spending more time obtaining, using and recovering from substance use
- 7. Neglecting responsibilities at home, work or school
- 8. Using despite substance causing relationship issues
- 9. Giving up important or desirable social ot recreational activities
- 10. Using in risky setting that could be dangerous
- 11. Continuing to use despite problems developing in physical and mental health

- **A person can be diagnosis with an SUD after meeting two or more of these criteria**

Defining Motherhood

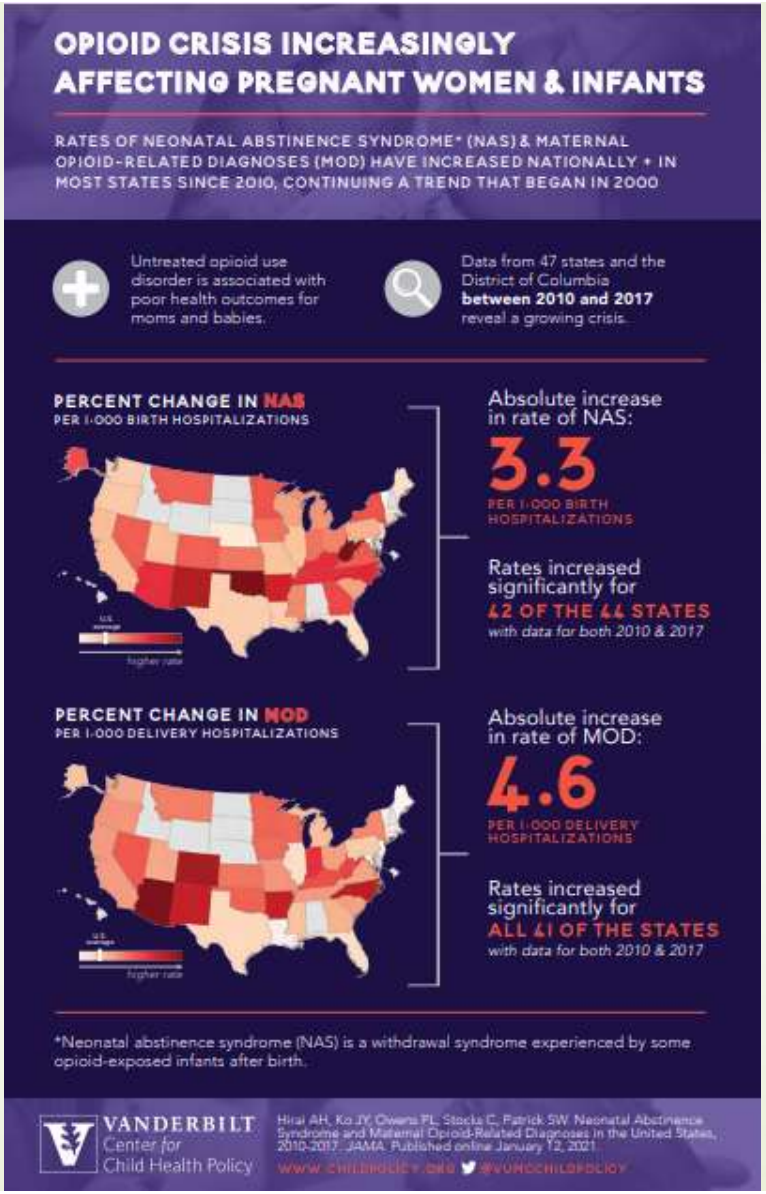
- Any woman who is pregnant or has been pregnant in her lifetime
  - For the sake of this presentation we will be discussing those individuals who are pregnant or have children under the age of 18yrs old.

Prevalence of SUD in Women

- 2021: 21,793 women died in the US due to drug overdose
  - 1,250 of those deaths were in TN
    - That is about 3.4 women per day!
- 1 in 3 people with an SUD are women however less than 1 in 5 of people in treatment are female. (World Drug Report, 2020)

WHY?

- According to the World Health Organization it is estimated that women with an SUD have a lifetime prevalence rate of intimate partner violence of 40-70% compared to 14-35% in the general population.
- Stigma of substance use is greater for women than men.
- Concerns about caring for children.
- Increased prevalence of being in a relationship with drug using partner
- Less likely to have family support
- Increased presence of co-occurring disorders.
- Fear of prosecution for substance use during pregnancy.
- Fear of losing custody of child(ren).


OPIOID CRISIS INCREASINGLY AFFECTING PREGNANT WOMEN & INFANTS
RATES OF NEONATAL ABSTINENCE SYNDROME* (NAS) & MATERNAL OPIOID-RELATED DIAGNOSES (MOD) HAVE INCREASED NATIONALLY + IN MOST STATES SINCE 2010, CONTINUING A TREND THAT BEGAN IN 2000
Untreated opioid use disorder is associated with poor health outcomes for moms and babies.
Data from 47 states and the District of Columbia between 2010 and 2017 reveal a growing crisis.
PERCENT CHANGE IN NAS
PER 1,000 BIRTH HOSPITALIZATIONS
Absolute increase in rate of NAS:
3.3
PER 1,000 BIRTH HOSPITALIZATIONS
Rates increased significantly for
42 OF THE 44 STATES
with data for both 2010 & 2017
PERCENT CHANGE IN MOD
PER 1,000 DELIVERY HOSPITALIZATIONS
Absolute increase in rate of MOD:
4.6
PER 1,000 DELIVERY HOSPITALIZATIONS
Rates increased significantly for
ALL 41 OF THE STATES
with data for both 2010 & 2017
*Neonatal abstinence syndrome (NAS) is a withdrawal syndrome experienced by some opioid-exposed infants after birth.
VANDERBILT Center for Child Health Policy
Hirai AH, Ko JY, Owens PL, Stocks C, Patrick SW. Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the United States, 2010-2017. JAMA. Published online January 12, 2021.

Maternal Mortality

- US has the highest maternal mortality rate of 11 high income countries and is the only country to see this rate continue to rise.
- African American women are 5 times more likely to experience the leading causes of maternal death.
- 2020: 36% of all pregnancy associated deaths were related to substance use in the state of TN

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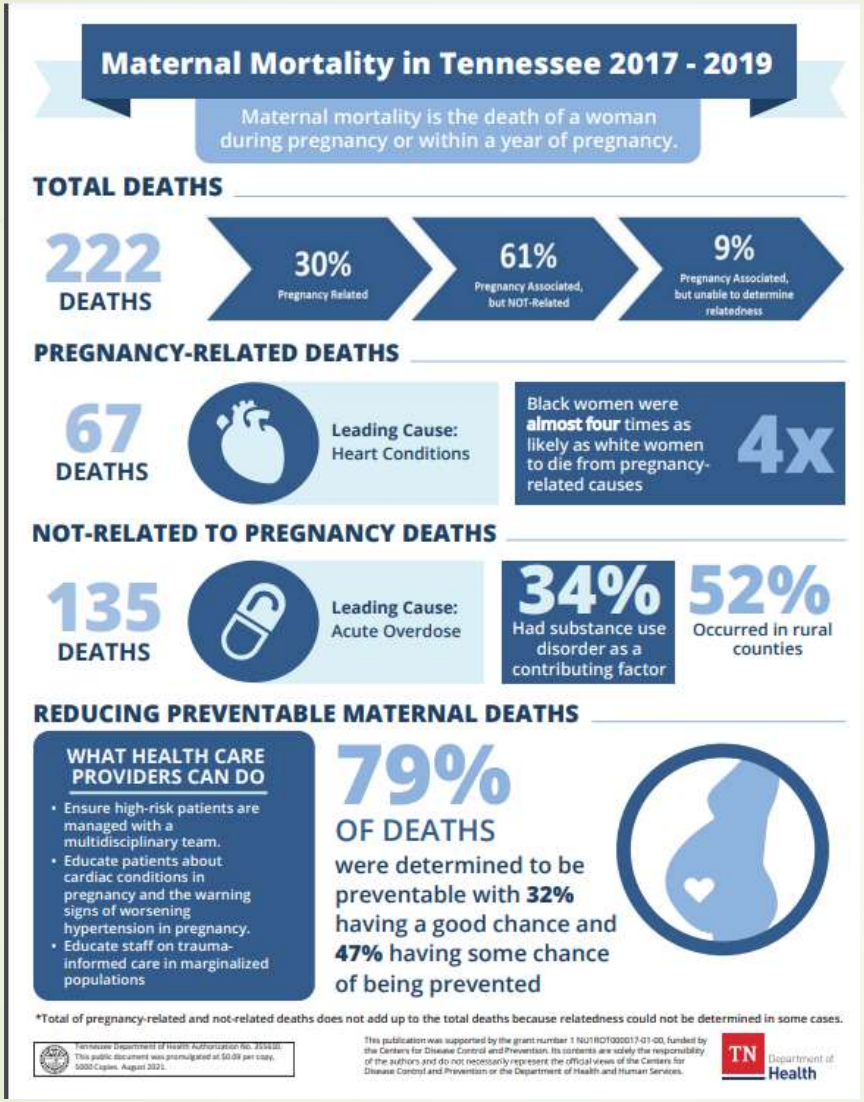
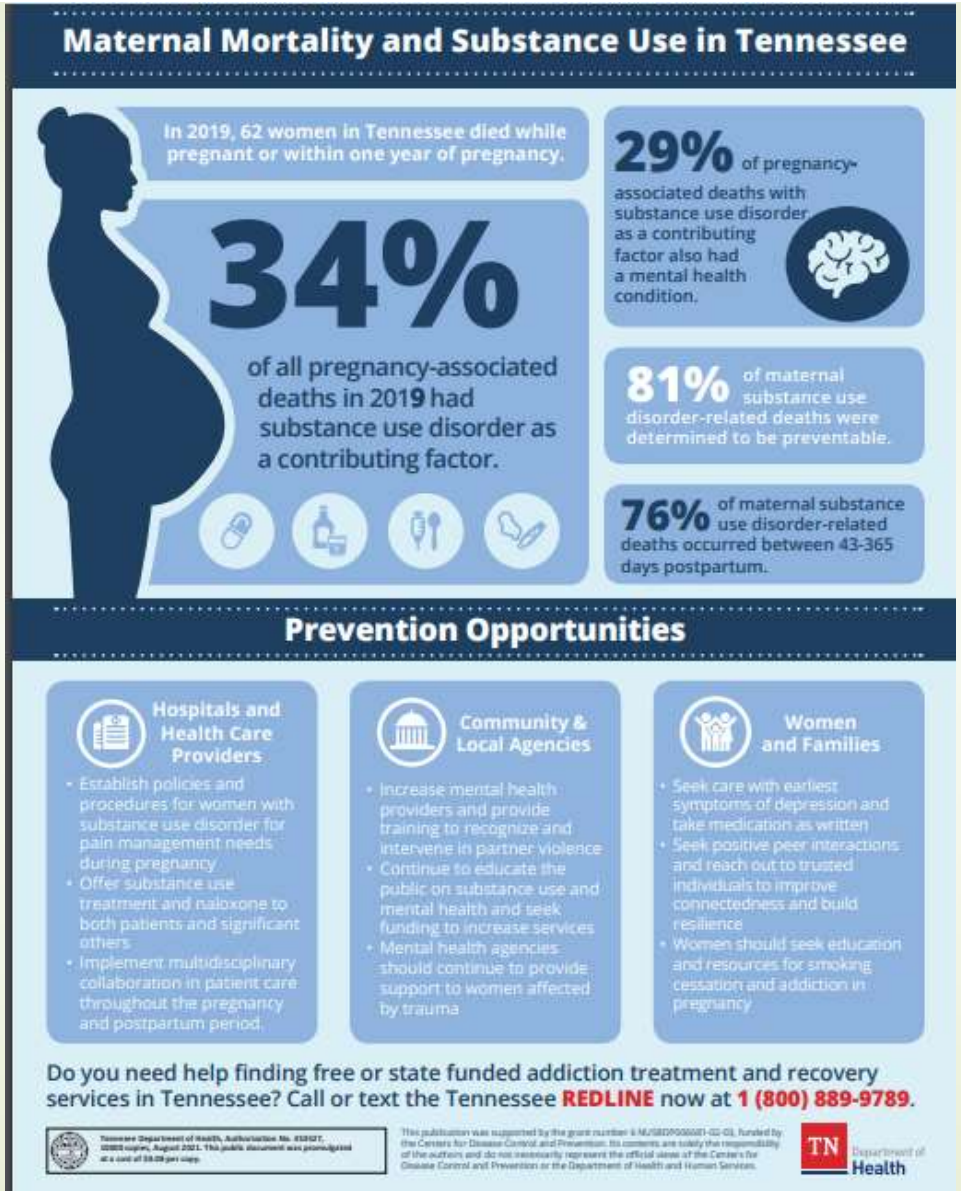
- 2022: 1,808 children entered into DCS custody in TN; many due to substance exposure


Maternal Mortality in Tennessee 2017 - 2019
Maternal mortality is the death of a woman during pregnancy or within a year of pregnancy.
TOTAL DEATHS
222
DEATHS
30%
Pregnancy Related
61%
Pregnancy Associated, but NOT-Related
9%
Pregnancy Associated, but unable to determine relatedness
PREGNANCY-RELATED DEATHS
67
DEATHS
Leading Cause:
Heart Conditions
Black women were almost four times as likely as white women to die from pregnancy-related causes
4x
NOT-RELATED TO PREGNANCY DEATHS
135
DEATHS
Leading Cause:
Acute Overdose
34%
Had substance use disorder as a contributing factor
52%
Occurred in rural counties
REDUCING PREVENTABLE MATERNAL DEATHS
WHAT HEALTH CARE PROVIDERS CAN DO
• Ensure high-risk patients are managed with a multidisciplinary team.
• Educate patients about cardiac conditions in pregnancy and the warning signs of worsening hypertension in pregnancy.
• Educate staff on trauma-informed care in marginalized populations
79%
OF DEATHS
were determined to be preventable with 32% having a good chance and 47% having some chance of being prevented
*Total of pregnancy-related and not-related deaths does not add up to the total deaths because relatedness could not be determined in some cases.
Tennessee Department of Health Authorization No. 359630. This public document was promulgated at $0.09 per copy, 5000 Copies. August 2021.
This publication was supported by the grant number 1 NU1ROT000017-01-00, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.
TN Department of Health


Maternal Mortality and Substance Use in Tennessee
In 2019, 62 women in Tennessee died while pregnant or within one year of pregnancy.
34%
of all pregnancy-associated deaths in 2019 had substance use disorder as a contributing factor.
29% of pregnancy-associated deaths with substance use disorder as a contributing factor also had a mental health condition.
81% of maternal substance use disorder-related deaths were determined to be preventable.
76% of maternal substance use disorder-related deaths occurred between 43-365 days postpartum.
Prevention Opportunities
Hospitals and Health Care Providers
• Establish policies and procedures for women with substance use disorder for pain management needs during pregnancy
• Offer substance use treatment and naloxone to both patients and significant others
• Implement multidisciplinary collaboration in patient care throughout the pregnancy and postpartum period.
Community & Local Agencies
• Increase mental health providers and provide training to recognize and intervene in partner violence
• Continue to educate the public on substance use and mental health and seek funding to increase services
• Mental health agencies should continue to provide support to women affected by trauma
Women and Families
• Seek care with earliest symptoms of depression and take medication as written
• Seek positive peer interactions and reach out to trusted individuals to improve connectedness and build resilience
• Women should seek education and resources for smoking cessation and addiction in pregnancy
Do you need help finding free or state funded addiction treatment and recovery services in Tennessee? Call or text the Tennessee REDLINE now at 1 (800) 889-9789.
TN Department of Health

Adverse Childhood Experiences

- Study first conducted at Kaiser Permanente between 1995 and 1997.
- Included over 17,000 patients (Southern California) who complete a physical and a confidential survey about their childhood experiences and current health and behaviors.
- Data was then analyzed to determine the relationship if any between early life events and health and behaviors in later life.

Defining ACEs

- Adverse Childhood Experiences:
  - Potentially traumatic experiences that occur between childhood and age 17
  - Environmental aspects of a child's that can impact their sense of safety, stability and bonding such as:
    - Substance Use Problems
    - Mental Health Problems
    - Parental Separation or household members being incarcerated

  - Impact of ACE's
    - Linked to chronic health problems, mental illness and SUD in adolescence and adulthood.
    - According to the CDC a 10% reduction in ACE's in North America could equal a $56 billion annual savings in economic and social costs.
    - Women and several minority groups are at greater risk of experiencing 4 or more types of ACEs.
    - Toxic Stress caused by ACEs can negatively impact a child's brain development, immune system and stress response affecting their ability to focus, make decisions and learn.
    - The prevention of ACES would result in:
      - 1.9 million fewer heart disease cases
      - 21 million fewer cases of depression

Center for Disease Control, 4/2022

Preventing ACEs

Preventing ACEs	
Strategy	**Approach**
Strengthen economic supports to families	•Strengthening household financial security •Family-friendly work policies
Promote social norms that protect against violence and adversity	•Public education campaigns •Legislative approaches to reduce corporal punishment •Bystander approaches •Men and boys as allies in prevention
Ensure a strong start for children	•Early childhood home visitation •High-quality child care •Preschool enrichment with family engagement
Teach skills	•Social-emotional learning •Safe dating and healthy relationship skill programs •Parenting skills and family relationship approaches
Connect youth to caring adults and activities	•Mentoring programs •After-school programs
Intervene to lessen immediate and long-term harms	•Enhanced primary care •Victim-centered services •Treatment to lessen the harms of ACEs •Treatment to prevent problem behavior and future involvement in violence •Family-centered treatment for substance use disorders

Center for Disease Control, 4/2022

SUBSTANCE-EXPOSED INFANTS & THE U.S. CHILD WELFARE SYSTEM

The *U.S. CHILD WELFARE SYSTEM* was **not** set up to meet the complex needs of families affected by **substance use disorder.** Recent federal changes have made *IMPROVEMENTS*, but more progress & funding are needed.

FROM 2011 TO 2017:
The number of infants entering the U.S. foster care system grew *BY NEARLY* **10,000**

Overall Foster Care Removals & Parental Substance Use Removals
for Infants less than 1 year old in U.S. Foster System

At least 1/2 of U.S. foster care placements for infants are associated with **parental substance use**

Rate of Infants (<1 year) in Foster Care per 1000 Live Births

In 2016, changes to the Child Abuse Prevention & Treatment Act **(CAPTA)** required "Plans of Safe Care" be inclusive of the needs of family/ caregivers of substance-exposed infants.

In 2018, the SUPPORT Act amended CAPTA to provide **clearer guidance** and authorize a new state grant program to help implement "Plans of Safe Care."

Clinicians should consider a more **active role** in shaping how these policies are implemented.

Patrick, SW, Frank, RG, McNeer, E, Stein, BD. Improving the Child Welfare System to Respond to the Needs of Substance-Exposed Infants. Hospital Pediatrics. Supported by NIDA K23DA038720 & R01DA045729

www.childpolicy.org • @VUMCchildpolicy • Play with the data at childpolicy.org/childwelfare

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Policies that Punish Pregnant Women for Substance Use *linked to* More Newborns Experiencing Drug Withdrawal

The opioid crisis increasingly affects pregnant women & infants:

women w/ opioid use disorder diagnosis at delivery: **4x** increase from 1999-2014

newborns experiencing drug withdrawal after birth: **7x** increase from 2000-2014

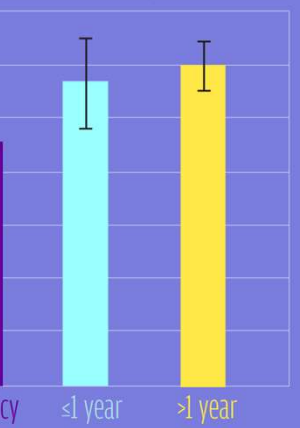
***State policies** can punish pregnant women for substance use by:*

- criminalizing substance use *in* pregnancy
- considering it grounds *for* civil commitment
- considering it child abuse *or* neglect

Examining 4.6 million births in 8 states from 2003-2014, our research found that:

***More infants are born experiencing drug withdrawal** in states w/ policies that punish pregnant women for substance use:*

Annual Rates of NAS* per 10,000 Births



46 *in states with* **NO punitive policies**

57 *in states with* **policies in effect for ≤1 year**

60 *in states with* **policies in effect for >1 year**

*Punitive policies **aren't beneficial** for women or infants:*

Punishing pregnant women for substance use discourages them from seeking **prenatal care** and **substance use treatment**

Policymakers should focus on public health approaches that ***bolster prevention & expand access to substance use treatment*** among pregnant women.

*Neonatal Abstinence Syndrome (NAS) is a withdrawal syndrome experienced by some opioid-exposed infants after birth

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Treating them together… Family Based Services

- **Simultaneously focuses on increasing the mother child relationship, increasing parenting skills and building skills to manage the disease of addiction in a therapeutic treatment environment.**

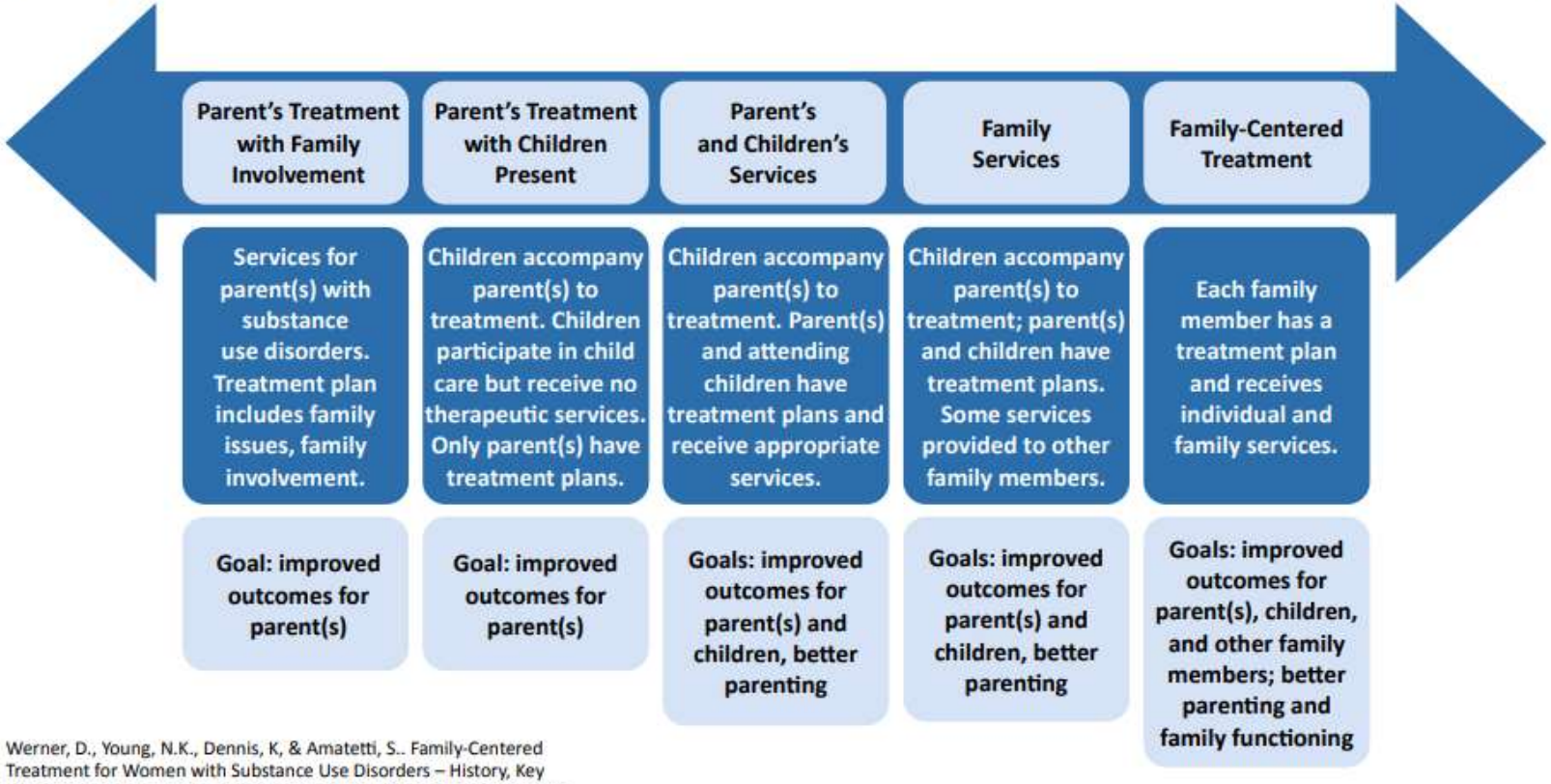
- How does this differ from traditional SUD treatment:
  - The focus is on the woman's identity as a mother, individual and the role she plays in her family rather than just an individual.
  - Children are present and are part of the treatment plan.
  - Uses the opportunity to learn and practice recovery skills while parenting with the support of staff.
  - Parenting groups and individual sessions are a required and an essential part of treatment.
  - Often partner with the Department of Children's Services and other community agencies.
  - Additional assessments are given such as: Parenting, trauma and childhood developmental and trauma assessments.
  - So much more…

Family Centered SUD Treatment: Removing Barriers

- Women will often chose to not enter treatment due to not being able to bring their child or having a safe place for their child to live while in treatment.
- Children are often reunited with mothers on admission day.
- Gender specific treatment prevents women from avoiding treatment due to do past trauma with males.

- Removes the shame and stigma of being a mother who has a SUD by joining a community of mothers with a SUD.
- Includes a parenting component which many would traditionally need to seek from another provider in a different location.

Continuum of Family-Based Services



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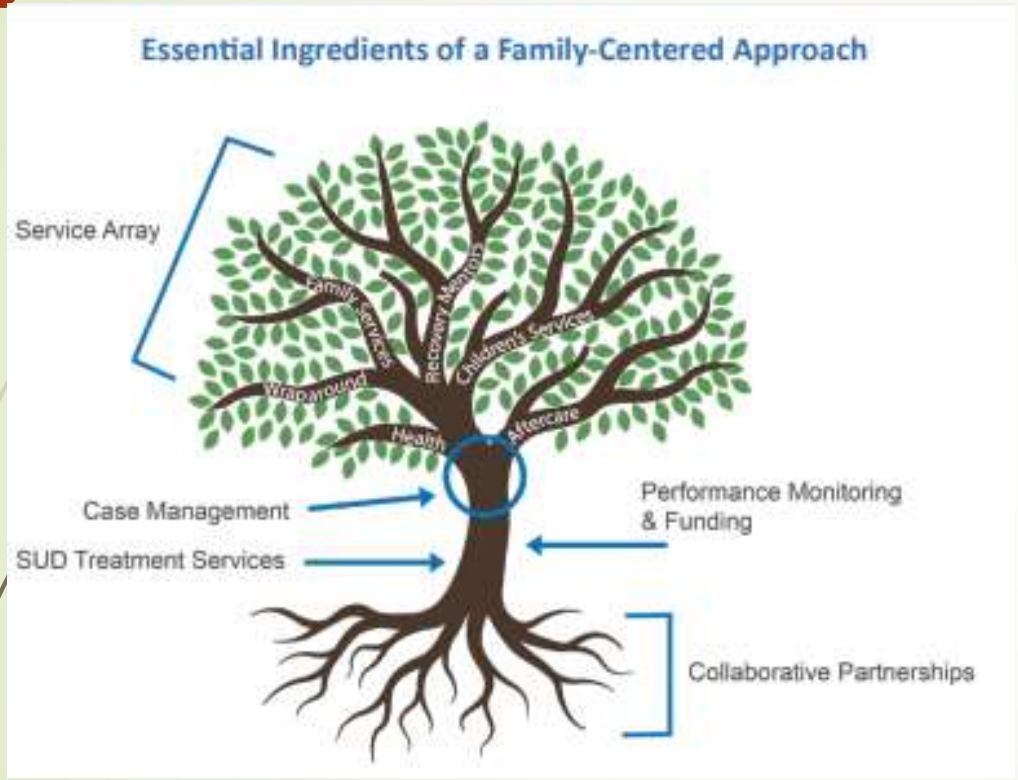

1. Collaborative Partnerships
2. Adequate and Flexible Funding
3. Performance Monitoring
4. Intensive Coordinated Case Management
5. High Quality Substance Use Disorder Treatment
6. Comprehensive Service Array
    1. Family Center Service Planning
    2. Evidenced based parent-child program and parenting education
    3. Therapy
    4. Children's Services to address developmental needs, trauma, education, etc.
    5. Linkage to support services such as: Legal Aid, vocational support, education, transportation and housing, etc.

Outcomes and Successes

- Increased treatment retention and reduced substance use rates.
- Decrease risk of child abuse.
- Increased rates of reunification and positive permanency outcomes
- Improved parenting attitudes
- Improved psychosocial and family functioning for children, parents and family members.
- Improved child development and behavioral outcomes.

- **"Studies of residential treatment programs for parenting women with SUDs found that women living with their infants had the highest level of treatment completion rates and longer stays in treatment compared to women who did not have their children with them." (Clark et al., 2006)**

Challenges for treatment providers…

- Seriously can you get that baby to stop crying during group!
- There are so many moving parts to a family.
- Toddlers are fast and frustrating!
- Correcting parenting styles/techniques… "If I can't spank them they will never listen"
- More space is needed.
- Liability and risk increases.
- So many doctors appts… Children get sick all the time!
- Etc.

References

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