Responding to Maternal Substance Use

Dixie Morgese

Helena Girouard

OBJECTIVES

- Identify key issues associated with maternal substance use
- List three policies to consider when working with mothers and caregivers impacted by substance use.
- List six mitigation intercepts to improve response to maternal substance use

Key Issues

- Significant increase in maternal substance use since 2005.
- Increase in substance related maternal death.
- Impact on pregnancy and infant health.
- High number of child removal rates associated with parental substance use.
- Stigma associated with substance use disorder – impacts engagement and outcomes.
- Multiple systems of care need to be coordinated.

Data Trends for Central Florida Counties

Figure 1.1 All Drug-Involved Emergency Department Visits for Central Florida Counties by Quarter for 2024, Rate per 100,000, Adults (18 years and older)

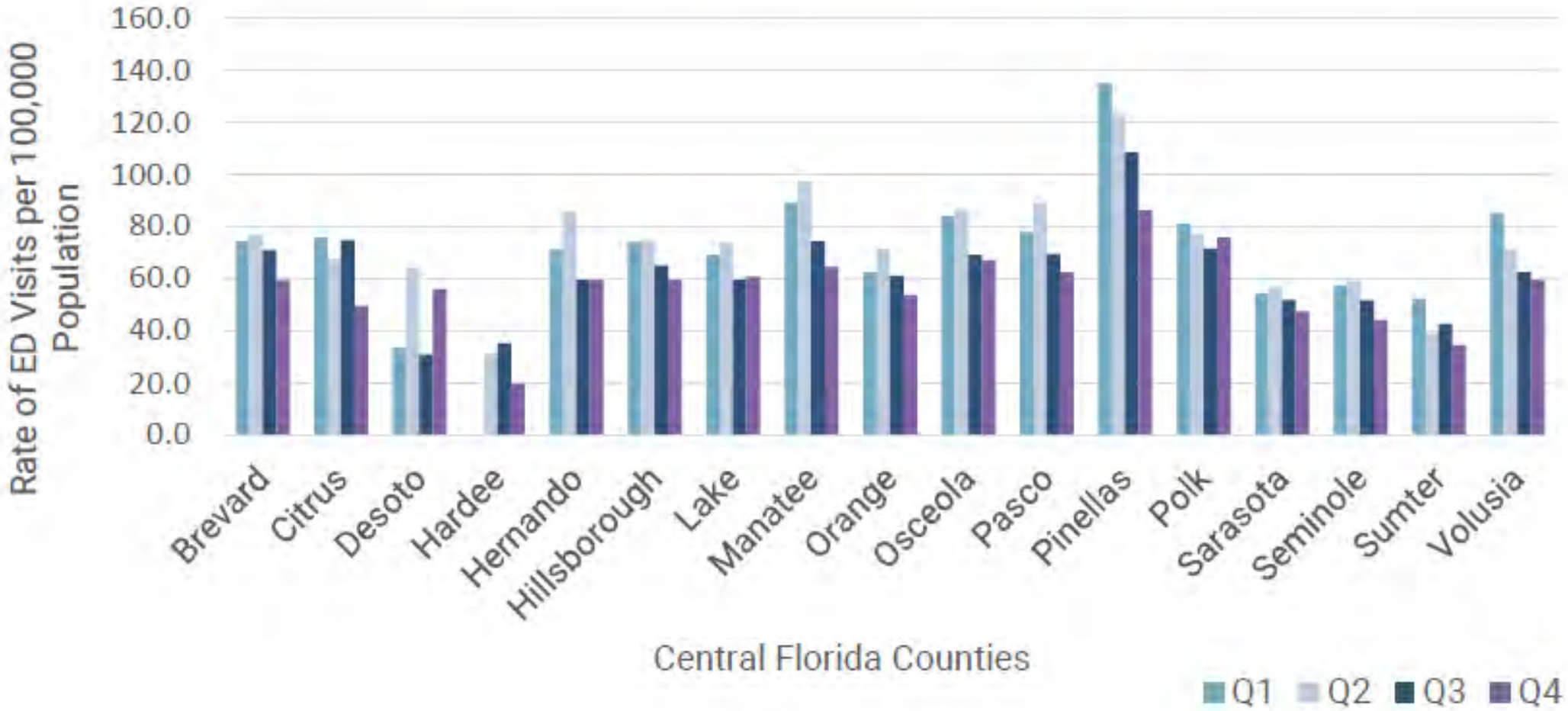
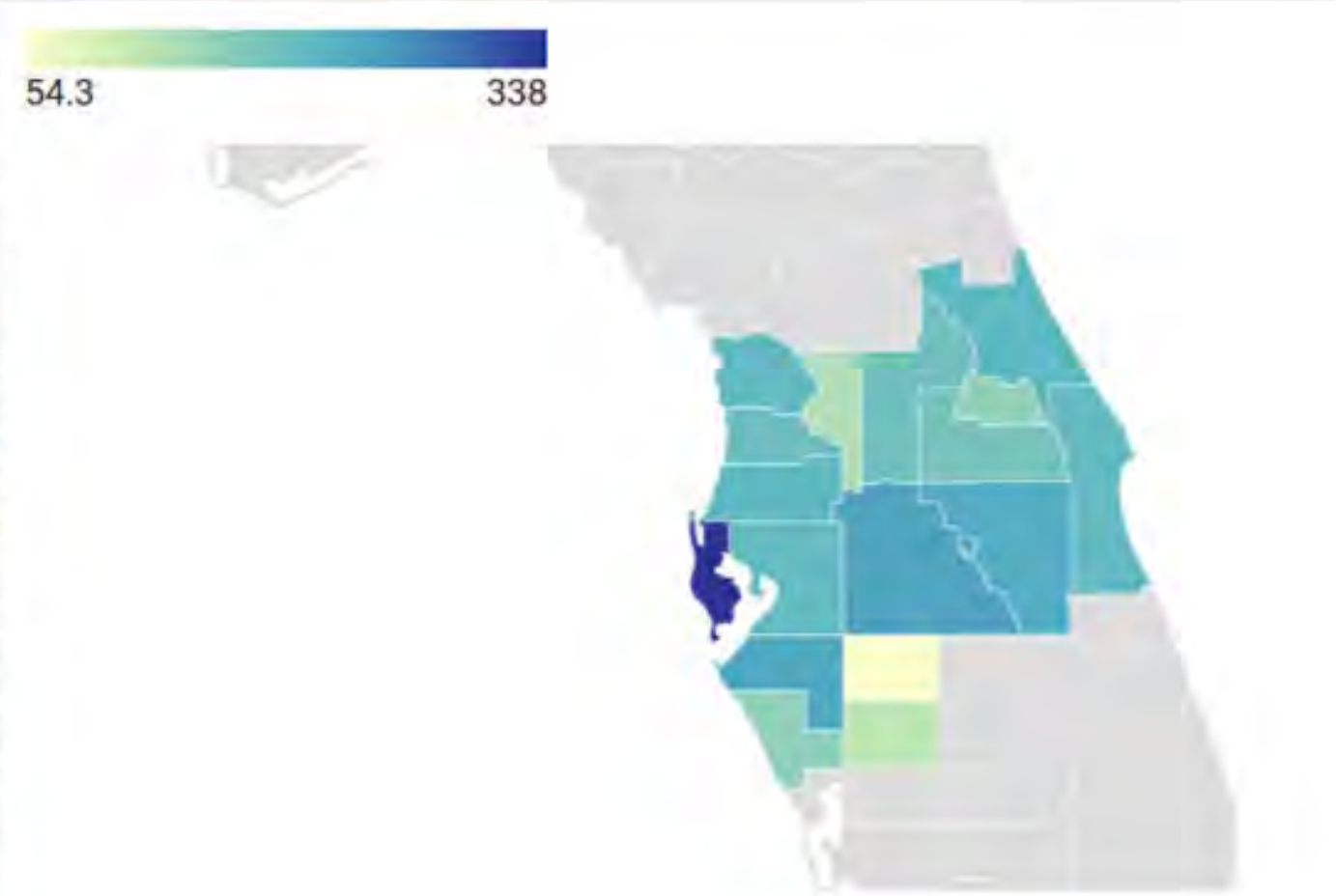
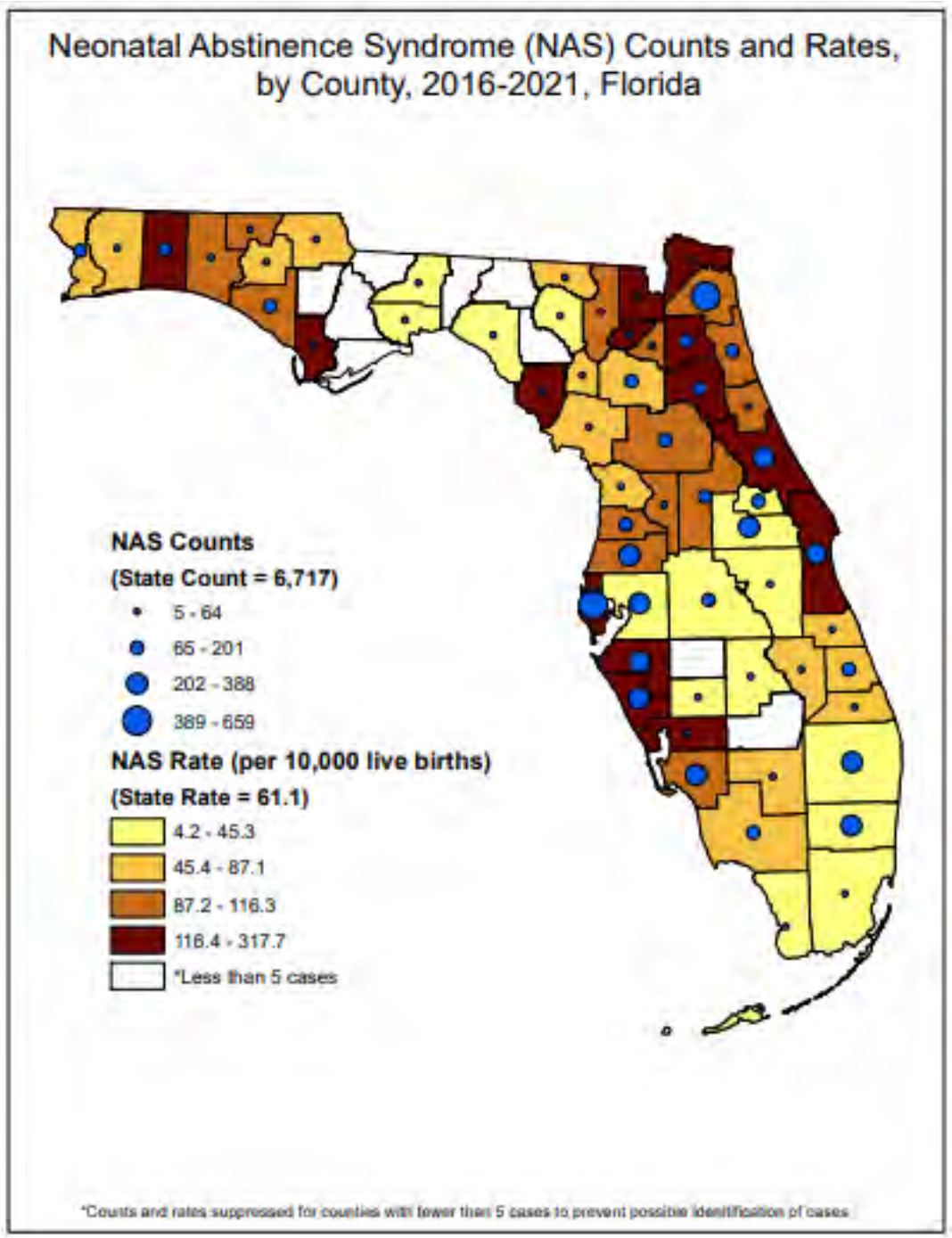


Table 1.1, Figure 1.2 All Drug-Involved Emergency Department Visits for Central Florida Counties for 2024, Rate per 100,000, Adults (18 years and older)

County	Count	Rate
Brevard	1349	209.5
Citrus	351	210.6
DeSoto	43	119.5
Hardee	14	54.3
Hernando	430	202.1
Hillsborough	3201	208.5
Lake	833	196.2
Manatee	1039	235.6
Orange	2757	187.4
Osceola	1012	231.2
Pasco	1359	214.7
Pinellas	3250	338.0
Polk	1980	242.0
Sarasota	751	160.1
Seminole	771	159.2
Sumter	201	132.6
Volusia	1261	213.6



Data provided by the Florida Department of Health (2024)



Neonatal Abstinence Syndrome (NAS)

- Indicator for maternal substance use
- New subcategory – NOWS – Neonatal Opioid Withdrawal Syndrome
- Data spans from 2016 – 2021
- Compiled through the DOH Birth Defects Registry Surveillance
- Majority in a Medicaid Managed Care Plan – need re-connection soon after the birth
- Cases are typically referred to NICU and hospital staff contacts DCF.
- There may be complicated dynamics in the NICU environment where care coordination could be very helpful.

HERNANDO

NAS Count under 201
Rate 87.2-116.3/10,000 live births

Hernando County Children Removed to Foster Care During October 2021 through September 2022	Count	Rate	State Rate	Rank (high=1 to low=67)
Total Removals to Foster Care	98	26.1 per 10K	26.0 per 10K	45
Average Monthly Removals to Foster Care	8.2	2.2 per 10K	2.2 per 10K	45
Reentries to Foster Care	26/98	26.5%	19.8%	13.5
Reentries to Foster Care within 12 months of Previous Discharge	13/98	13.3%	7%	10.5
Removals for Neglect	29/98	30%	58%	65.5
Removals for Caretaker Drug or Alcohol Use	65/98	66%	50%	18.5
Removals for Physical Abuse	10/98	10%	13%	41.5
Removals for Caretaker Inability to Cope	6/98	6%	17%	51
Removals for Inadequate Housing	6/98	6%	18%	54
Removals for Incarceration	8/98	8%	8%	35
Removals for Child Behavior	2/98	2%	2%	26
Removals for Abandonment	5/98	5%	12%	46
Removals for Sexual Abuse	1/98	1%	4%	45.5
Removals to Non-Relative Foster Care First Setting	16/54	30%	35%	43.5
Removals to Relative Foster Care First Setting	36/54	67%	61%	23.5

CITRUS

NAS Count under 201
Rate 87.2-116.3/10,000 live births

Citrus County Children Removed to Foster Care During October 2021 through September 2022	Count	Rate	State Rate	Rank (high=1 to low=67)
Total Removals to Foster Care	89	38.1 per 10K	26.0 per 10K	31
Average Monthly Removals to Foster Care	7.4	3.2 per 10K	2.2 per 10K	29
Reentries to Foster Care	17/89	19.1%	19.8%	34.5
Reentries to Foster Care within 12 months of Previous Discharge	4/89	4.5%	7%	48
Removals for Neglect	28/89	31%	58%	63.5
Removals for Caretaker Drug or Alcohol Use	58/89	65%	50%	22
Removals for Physical Abuse	6/89	7%	13%	52.5
Removals for Caretaker Inability to Cope	3/89	3%	17%	58
Removals for Inadequate Housing	5/89	6%	18%	54
Removals for Incarceration	8/89	9%	8%	31
Removals for Child Behavior	0/89	0%	2%	53.5
Removals for Abandonment	7/89	8%	12%	31.5
Removals for Sexual Abuse	7/89	8%	4%	10.5
Removals to Non-Relative Foster Care First Setting	12/49	24%	35%	54
Removals to Relative Foster Care First Setting	34/49	69%	61%	19.5

LAKE

NAS Count under 388 cases
Rate 87.2-116.3/10,000 live births

Lake County Children Removed to Foster Care During October 2021 through September 2022	Count	Rate	State Rate	Rank (high=1 to low=67)
Total Removals to Foster Care	176	24.1 per 10K	26.0 per 10K	49
Average Monthly Removals to Foster Care	14.7	2.0 per 10K	2.2 per 10K	49
Reentries to Foster Care	17/176	9.7%	19.8%	60.5
Reentries to Foster Care within 12 months of Previous Discharge	4/176	2.3%	7%	54.5
Removals for Neglect	66/176	38%	58%	57
Removals for Caretaker Drug or Alcohol Use	111/176	63%	50%	24
Removals for Physical Abuse	16/176	9%	13%	44
Removals for Caretaker Inability to Cope	8/176	5%	17%	53.5
Removals for Inadequate Housing	18/176	10%	18%	42.5
Removals for Incarceration	7/176	4%	8%	51.5
Removals for Child Behavior	0/176	0%	2%	53.5
Removals for Abandonment	18/176	10%	12%	22
Removals for Sexual Abuse	6/176	3%	4%	35.5
Removals to Non-Relative Foster Care First Setting	34/101	34%	35%	33.5
Removals to Relative Foster Care First Setting	67/101	66%	61%	26

SUMTER

NAS Count under 64 cases
Rate 87.2-116.3/10,000 live births

Sumter County Children Removed to Foster Care During October 2021 through September 2022	Count	Rate	State Rate	Rank (high=1 to low=67)
Total Removals to Foster Care	23	23.1 per 10K	26.0 per 10K	51
Average Monthly Removals to Foster Care	1.9	1.9 per 10K	2.2 per 10K	51
Reentries to Foster Care	7/23	30.4%	19.8%	9
Reentries to Foster Care within 12 months of Previous Discharge	0/23	0%	7%	63
Removals for Neglect	7/23	30%	58%	65.5
Removals for Caretaker Drug or Alcohol Use	8/23	35%	50%	58
Removals for Physical Abuse	1/23	4%	13%	59
Removals for Caretaker Inability to Cope	8/23	35%	17%	7.5
Removals for Inadequate Housing	0/23	0%	18%	63.5
Removals for Incarceration	5/23	22%	8%	5
Removals for Child Behavior	1/23	4%	2%	12
Removals for Abandonment	3/23	13%	12%	15
Removals for Sexual Abuse	0/23	0%	4%	57
Removals to Non-Relative Foster Care First Setting	3/15	20%	35%	57
Removals to Relative Foster Care First Setting	12/15	80%	61%	10 8

Urgent PAMR Message to Providers and Hospitals

Obstetric providers and hospitals are the first health care contact for most mothers with Opioid Use Disorder (OUD) and need to lead the effort to screen, assess, and refer these mothers as well as providing for their obstetrical needs.

Florida PAMR Findings:

- Opioid Use Disorder (OUD) is a life-threatening chronic condition and is dangerous to pregnant and postpartum women.
- The rate of Florida women with OUD identified at delivery admission quadrupled from 0.5 per 1,000 deliveries in 1999, to 6.6 in 2014.[1] Use of illicit opioid and related drugs is now increasing as prescription opioids are becoming more restricted.[2]
- Drug-related deaths are the leading cause of death to mothers during pregnancy or within one year afterwards in 2017, accounting for 1 in 4 of these deaths in Florida. There are now as many maternal drug-related deaths as deaths due to traditional causes of maternal mortality. 75% of maternal drug-related deaths occur after the baby is born and the mother has been discharged.[3]

Risk Factors:

- Stigma and bias by the public and by health professionals make it very difficult for patients to discuss their condition and get help. Getting treatment during pregnancy and continuing afterwards are key to maternal survival and healthy families.[4]
- More than 30% of women with OUD have underlying depressive disorders that complicate patient care during pregnancy and postpartum.[5]
- Women with OUD who decide to stop medication-assisted treatment are at high-risk of relapse and potentially fatal consequences.[6]
- Loss of Medicaid or other health care benefits after delivery (such as, through loss of infant custody) may result in reduced access to

PAMR Recommendations:

Prenatal Care and Screening

- Screen all pregnant women for OUD during prenatal care and at the time of delivery using a validated verbal or written screening tool: NIDA Quick Screen, 5P's, or CRAFFT. Using only biological testing for opioids and other drugs is not recommended.[6]
- Assess patients' prescription history though the Prescription Drug Monitoring Program (PDMP), preferably during the first prenatal visit.
- Be prepared to counsel women regarding opioid use during pregnancy and postpartum in a non-judgmental way. Tools such as SBIRT (Screening, Brief Intervention, Referral to Treatment) have been developed to help.[6]
- If a provider is unable to provide care for women with OUD, direct referral to another prenatal care provider or clinic to assure complete and compassionate care of the mother is essential.[6]
- A plan of safe care should be developed during prenatal care with input from all involved including prenatal care providers, community support services, and medication-assisted treatment providers.[6]

Referral and Treatment

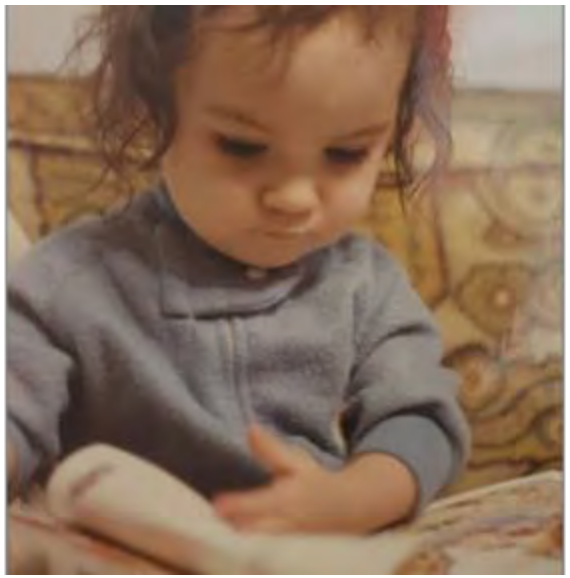
- Provide direct referrals for medication-assisted treatment and/or other community support services. Connecting and supporting treatment with rehabilitation specialists is essential to maintaining these patients in obstetrical care.[7]

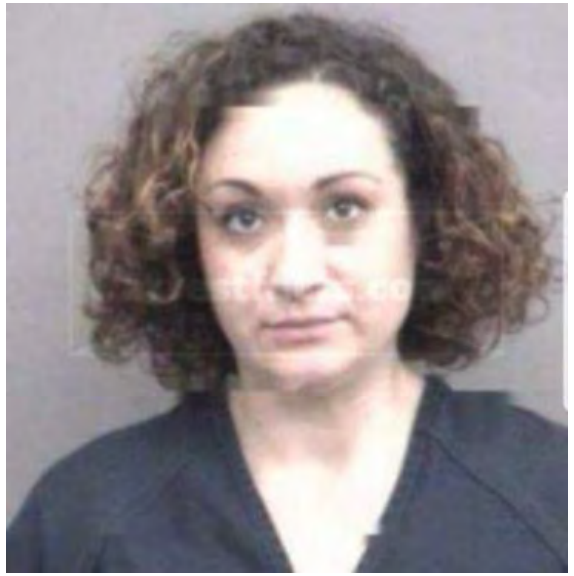
Florida

WHAT DOES MATERNAL SUBSTANCE USE LOOK LIKE?

- People with substance use disorder do not fit a profile.
- Multiple barriers may prevent women from disclosing substance use.
- The misconception that substance use requires highly specialized approaches may interfere with access to care and engagement.
- Substance use is one of many conditions that women may have during pregnancy.
- Acceptance, kindness, support, and positive interactions are very important attributes direct service workers bring to their work to engage and support motivation for women with substance use disorder to feel safe enough to seek and accept help.

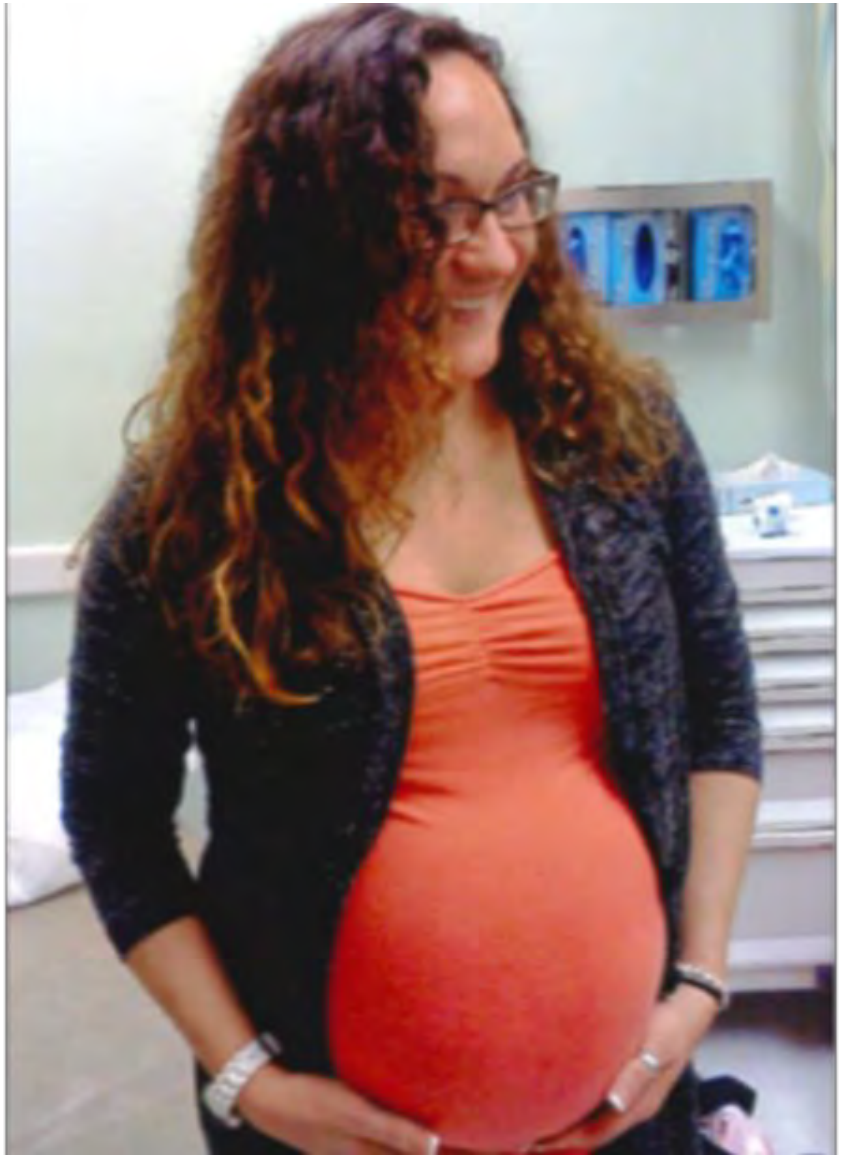
Helena’s Story

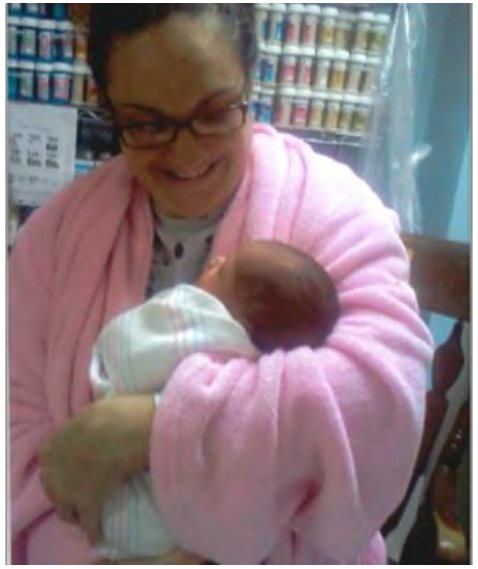




32 Weeks

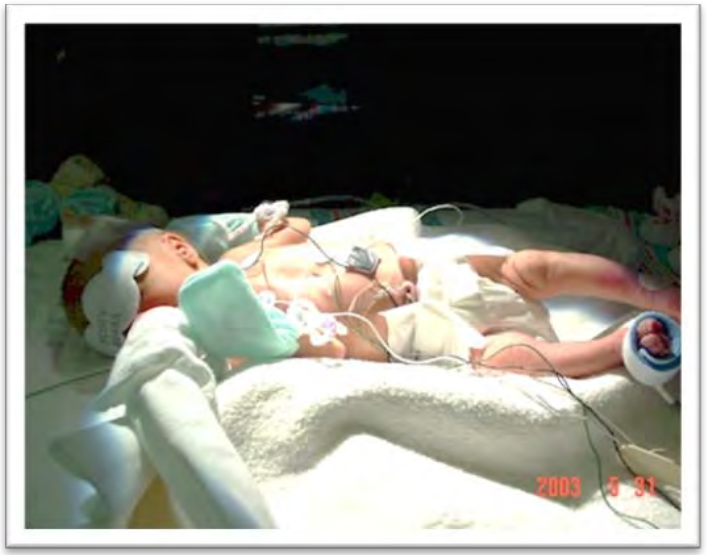
I found my smile.



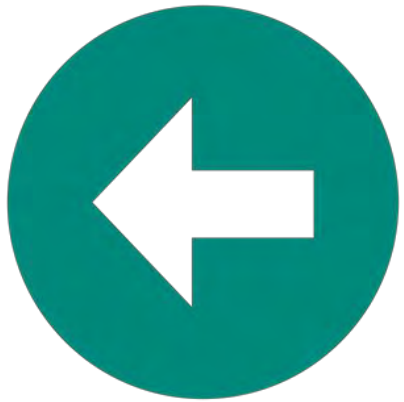


Medical Challenges

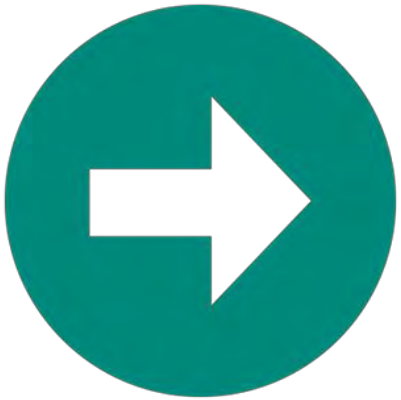
- Hepatitis C
- Hypertension
- Cord wrapped around her neck
- Placenta detaching
- Emergency C-Section
- Drop Foot
- Spinal Patch
- Back to treatment



What could have happened



What actually happened



Last Mugshot

- 2 weeks post-partum
- Healthy Start Care Coordinator stayed connected in jail
- Incarcerated 71 days
- 3 counties
- Pumped breastmilk 3 times a day

The Real Work Begins – Care Coordination supports continuum

- 11 Months Intensive Inpatient Residential Treatment – Care Coordination continues
- 14 Months Transitional Housing
- 2 Jobs
- Full Time Student
- Harvoni
- Internship at Healthy Start

DAYTONA STATE COLLEGE

thrive by five

HAWAI'I PACIFIC UNIVERSITY

One Voice for Volusia
Connecting Our Community

Florida HEALTH
Volusia County

FLAGLER COLLEGE

PRITZKER
Children's Initiative

Baby Steps

National Collaborative for Infants & Toddlers™

20/20 mom
GOVERNMENT AGENCY Fellowship

LIVE LOVE LIFE
Healthcare & Compassion For Everyone

CHALLENGES & BARRIERS

Challenges

- Policy misalignment with best practices
- Employee safety and retention
- Training to support confidence and supervision of direct service staff
- Engagement and retention of families
- DCF involvement
- Health and safety risk for families
- Ability to meet established/contractual outcomes for agencies

Barriers

- Fear (fear of “system” by families, staff safety, unknown, potential liability, not being able to provide adequate support)
- Stigma – language and perceptions that characterize substance use as dark and dangerous
- Access to residential treatment – some communities have limited services available
- Inability to trusting service staff
- Unit billing models with little context

POLICY CONSIDERATIONS CAPTA & CARA

- **CAPTA** –Child Abuse Prevention and Treatment Act – Keeping Children and Families Safe Act reauthorized CAPTA and provides requirement for hospitals to report substance exposed newborns to child welfare.
- **CARA** - Comprehensive Addiction and Recovery Act of 2016, reauthorized in 2021 – resulted in additional language associated with Plans of Safe Care and service delivery strategies.
- **RCO's** – Recovering Communities – policy provided language and funding to establish peer established and peer-run organizations to support formal peer recovery specialists to utilize in addressing substance use disorder.

CARA ACT 2016 Reauthorized in 2021

Comprehensive Addiction and Recovery Act of 2016

- Aimed to prevent and treat opioid and methamphetamine addiction and overdose
- Removed term “illicit” from the description of substance use/exposure for pregnant women
- Included provision for plan of safe care for the mother and the infant
- Requires each state ensure plan of safe care be documented in the NCANDS system

Reauthorization (CARA 2.0 & 3.0) of CARA 2021

- Authorized funding for:
  - Training and employment for substance use professionals
  - Support for coalition building
  - National infrastructure for recovery support services
  - Expansion of treatment for pregnant and post partum women
  - High quality recovery housing
  - Expansion of MAT

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES – CFOP NO. 170-8

- Plan of safe care for infants affected by prenatal substance use.
- DCF staff make referrals to home visiting “if the family accepts services.”
- Differentiates a plan of safe care from a DCF Safety Plan.
- References the legal authority as CAPTA and CARA and includes provisions associated to exposure criteria, inclusion of the mother or caregiver in the plan of safe care and requires attending providers to identify and refer exposed infants to early intervention, remediation, and prevention services.

SB 7016 & SB 7018 “LIVE HEALTHY” FLORIDA LEGISLATION

- Expands the term perinatal provider to include Healthy Start Care Coordinators, Community Health Workers, Midwives, and Doulas
- Expands definition of “Post Partum” to include a period of one year after a pregnancy
- Other provisions that support health care innovation through public and private partnerships and health care education

PLAN OF SAFE CARE/SUPPORTED CARE

MOTHER

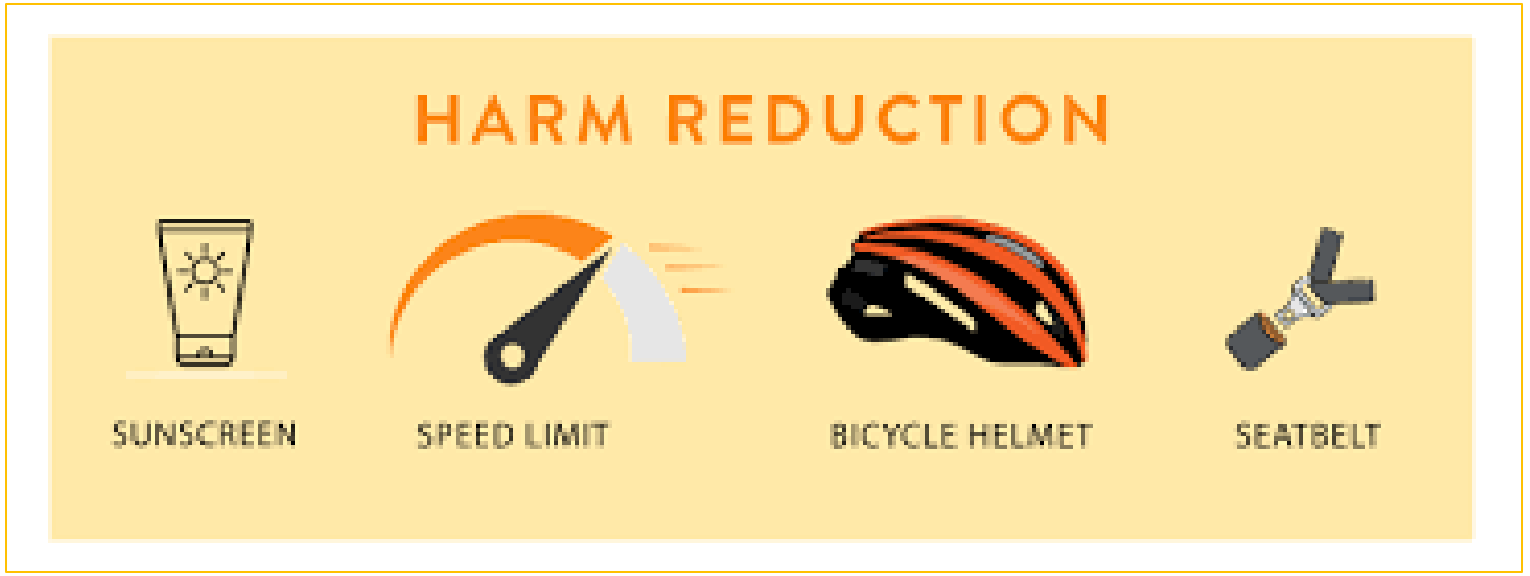
- Documentation of history
- Safe housing
- Safe relationship(s)
- Safe children
- Health care
- Pregnancy and Post partum plan
- Safe self-care – harm reduction/treatment/peer support
- Support system

INFANT

- Documentation of exposure
- Medical care
- Safe housing/environment
- Safe relationship(s)
- Safe sleep
- Perinatal/Pediatric Care
- Early Intervention Screening
- Attachment & nurturing
- Safe and attentive care

Multi-disciplinary Team Approach

WHAT IS HARM REDUCTION?



We use strategies every day aimed at lowering the risk of harm to ourselves and those around us.

HARM REDUCTION FOR SUBSTANCE USE

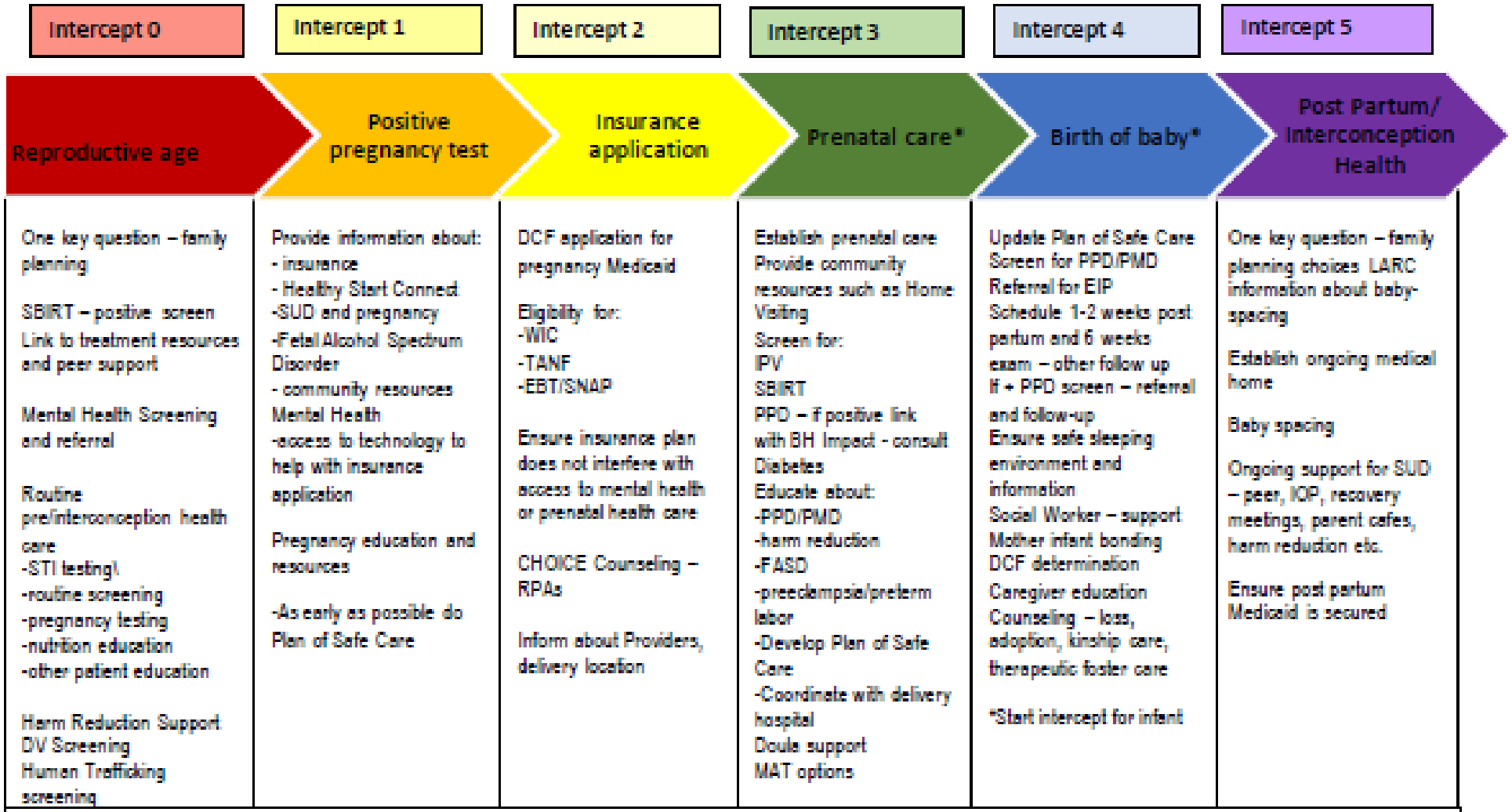
MEDICATION ASSISTED TREATMENT (MAT)

The use of medication as a harm reduction strategy for people with substance use disorders that can mitigate significant risk for negative health outcomes such as sepsis, endocarditis, Hepatitis B & C, HIV, staff infection/MRSA, overdose and suicide.

- **Methadone** - Methadone is a synthetic opioid agonist that eliminates withdrawal symptoms and relieves drug cravings by acting on opioid receptors in the brain—the same receptors that other opioids such as heroin, morphine, and opioid pain medications activate
- **Buprenorphine** – Semisynthetic mixed partial agonist opioid receptor modulator that is used to treat opioid addiction in higher dosages, to control moderate acute pain in non-opioid-tolerant individuals in lower dosages, and to control moderate chronic pain in even smaller doses. (Subutex, Buprenex, Subsolve, Temgesic, Cizdol, Norspan, Butrans)
- **Naltrexone** is an opioid antagonist that works by preventing any opioid drug from producing rewarding effects such as euphoria. Brand name Vivitrol®

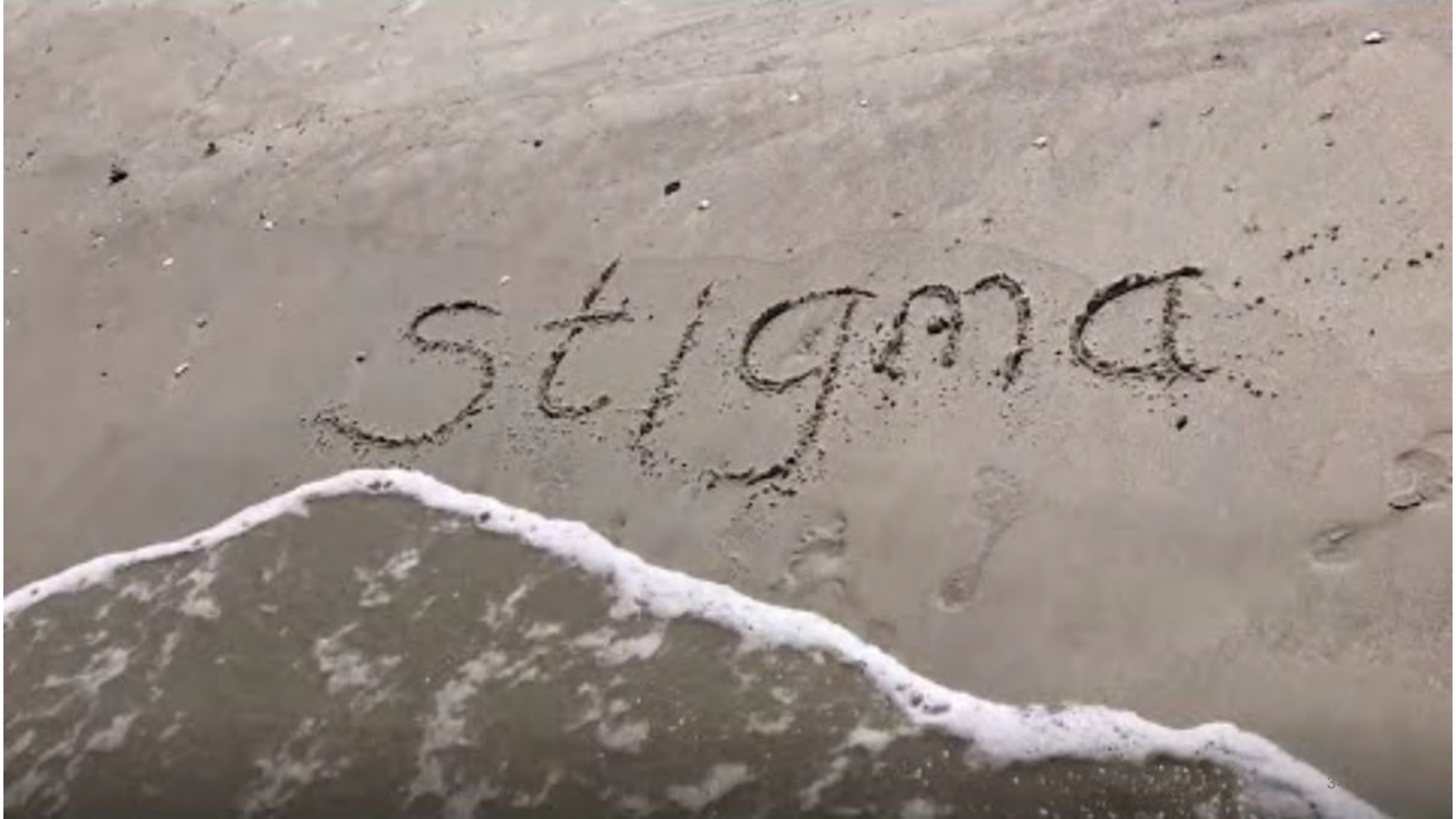
OTHER RISK MITIGATION APPROACHES FOR FAMILIES WITH SUBSTANCE USE DISORDER

- Helping to build Protective Factors to offset historical and recent adverse experiences (trauma and stress)
- Help parents focus on Positive Childhood Experiences (PCEs)
- Use motivational engagement to support positive choices and positive parenting decisions
- Assist with child care for mutual benefit – respite for parent/caregiver and routine and interactive activities with infants and young children
- Parent-Child attachment information and therapy

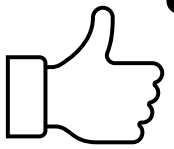


Best Practices: Mental health screening, trauma history, medical history, substance use history including alcohol, tobacco use history and overdose history, identifying, addressing healthy relationships/IPV, interconception health access, determine current or previous trafficking history, determine social determinant of health needs and resources – education, housing, access, legal, etc.

* If fetal loss – provide grief support, genetic counseling if indicated, substance use disorder support, pain management as needed, mental health support, continue to intercept model interconception health. If infant removed, provide grief support, PPD consult, Plan of Safe Care, ongoing support

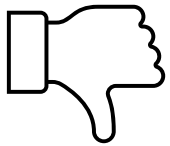

stigma

Stigma and Recovery-oriented language



Let's Say....

- ✓ Substance Use Disorder
- ✓ Person with substance use disorder/has substance dependence
- ✓ Person in recovery/remission
- ✓ Not engaged
- ✓ Medication is a treatment
- ✓ Return to use
- ✓ Positive urine screen
- ✓ Intoxicated/Impaired
- ✓ Distressed, agitated
- ✓ Person disagrees
- ✓ Resourceful
- ✓ Recovery residence



Instead of saying...

- X Substance abuse, drug habit
- X Addict, junkie, druggie, alcoholic, suffering from addiction
- X Ex-addict, abstinent, clean
- X Non-compliant
- X Drug Replacement
- X Relapse, fell off the wagon, out there
- X Dirty urine/dirty drug test
- X Drunk, stoned, wasted, three sheets to the wind
- X Crazy, shot out, feeling some kind of way, losing it
- X Denial
- X Manipulated
- X Sober house, halfway house

https://www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

WORKFORCE DEVELOPMENT AND SUPPORT

Development

- Training
- Reflective practice
- Policies associated with safety and client care
- Forms and processes to guide staff

Support

- Reflective Supervision
- MOU with DCF, hospitals, DV shelters, treatment centers, recovery housing, harm reduction and peer support
- Multidisciplinary staffing

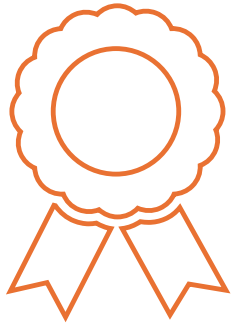
SYSTEMS – INFANTS AND CHILDREN

- Plan of Safe Care/Supported Care
- Eat, Sleep, Console
- Dr. Harvey Carp – Happiest Baby on the Block
- Pediatric Services – address all concerns identified in NICU or other clinical services at the time of birth
- Early Head Start
- Infant Mental Health - PCP
- Medicaid – Managed Care Plan, CMS, Healthy Kids – payer source for clinical services
- Developmental Services – Early Steps
- Department of Children and Families - supports
- Foster Care – when assigned/placed
- Other – substance use disorder – residential treatment that includes infants and children

SYSTEMS – BIO MOM & CAREGIVERS

- Plan of Safe Care
- Treatment Centers for Substance Use – MAT, outpatient, residential, women & infants, detox
- Breastfeeding safely and successfully
- Psychosocial Counseling – trauma
- Department of Children and Families
- Domestic Abuse and Human Trafficking
- Peer services
- Medical – physician, hospital, insurance, dental, interconception, post partum, developmental*
- Legal/Judicial-child support, disability application, other
- Post Partum Depression
- Housing and homeless services
- Healthy Start/Healthy Families
- Nurse-Family Partnerships, Parents as Teachers

BEST PRACTICES



- DCF – supported call when needed
- Foster Care – comfort calls, connect to bio parents
- Reflective Practice
- Peer Support
- Wellness Recovery Action Planning (WRAP)
- Harm Reduction – training and resources
- Behavioral Health Impact consultation with prenatal provider
- Multidisciplinary Staffing
- Trauma awareness and responsive care – intersection between trauma and substance use
- Protective Factors Framework and related activities
- Positive Childhood Experiences (PCEs)
- Healthy Outcomes from Positive Experiences (HOPE)
- Perinatal mental health

INTERACTING WITH DCF

- Memorandum of Understanding
- Internal Policies and Procedures
- Integrated training and staffing
- Coordinated supported care (Plan of Safe Care)
- Reflective Review
- Coordination with Foster/Kin ship Care – comfort call
- Parent Partners/Peers

- Anticipatory activities with family – informed consent
- Review local interpretation of DCF
- Emphasize the voluntary nature of program participation
- Use of Motivational Interviewing
  - Supported Call
  - Support for families
  - Guardian ad litem

PROTECTIVE FACTORS

- Family Resilience – be strong and flexible
- Practical/Concrete Support – everybody needs help sometimes
- Social Connections – positive friends and mentors
- Caregiver Knowledge of Child Development – being a parent is part natural and part learned – how do we know what our children should be mastering and when?
- Social and Emotional Competence of Children – children need help communicating

POSITIVE CHILDHOOD EXPERIENCES

Positive Childhood Experiences questions asked how often the respondent:

1. Felt able to talk to their family about feelings
2. Felt their family stood by them during difficult times
3. Enjoyed participating in community traditions
4. Felt a sense of belonging in high school
5. Felt supported by friends
6. Had at least two non-parent adults who took genuine interest in them
7. Felt safe and protected by an adult in their home

Questions?

REFERENCES

- https://www.myflfamilies.com/kids/news/plan-safe-care
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5673148/
- https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/healthy-start-docs/index.html
- https://nhvrc.org/what-is-home-visiting/
- https://www.flcourts.gov/Resources-Services/Office-of-Family-Courts
- https://health.usf.edu/publichealth/research/chiles/fpqc/more
- https://emotionsanonymous.org/
- https://naflorida.org/
- https://www.floridahealth.gov/diseases-and-conditions/birth-defects/neonatalabstinencesyndromenas.html
- https://smartrecovery.org/
- https://www.fadaa.org/page/Resource_Center
- https://flbhimpact.org/
- https://www.postpartum.net/
- https://cssp.org/our-work/projects/protective-factors-framework/
- https://nida.nih.gov/sites/default/files/21349-medications-to-treat-opioid-use-disorder.pdf
- https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30403-8/abstract
- https://positiveexperience.org/
- https://store.samhsa.gov/sites/default/files/sma16-4923_0.pdf
- https://fosteringcourtimprovement.org/fl/
- https://www.flmomsmatter.org/workgroups
- https://peerrecoverynow.org/resource-library/rco-directory/
- https://www.floridiansforrecovery.org/what-we-do
- https://www.zerohourlifecenter.org/?lightbox=dataItem-k1z9ilqf__item-j9sd2p9n
- https://www.peersupportfl.org/wp-content/uploads/2020/07/Recover-Oriented-Community-Toolkit-7.23.20.pdf
- https://quality.healthfinder.fl.gov/
- https://namimarioncountyfl.org/support-and-education/support-groups/
- https://988lifeline.org/chat/
- https://www.flhrc.org/
- https://flmomshealth.org/
- https://ncsacw.acf.hhs.gov/files/safety-and-risk-tip-sheet-1.pdf
- https://health.usf.edu/publichealth/research/chiles/fpqc/more
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8669950/

LOCAL PEER or 24/7 SUPPORT RESOURCES

- Zero Hour Life Center 352.503.0071 Citrus, Marion, Hernando, Lake Counties
- NAMI Marion County 800.950.NAMI (6264) Chat nami.org/help
- https://flbhimpact.org/ 833.951.0296
- https://flmomshealth.org/ 833-TLC-MAMA (852-6262) Free 24/7 perinatal behavioral health support
- Narcotics Anonymous 24 hour hotline and meeting locator 844.623.5674
- Emotions Anonymous 651.647.9712
- Mental Health Hotline 988 or https://988lifeline.org/chat/
- https://www.postpartum.net/ 800.944.4773 #1 En Espanol #2 English Text “Help” to 800.944.4773 or Test En Espanol 971.203.7772

THANK YOU

Thank you for the work you do!!
REMEMBER
Be kind

- Show respect
- Say something positive
- Fear might be getting in the way
- People need to feel safe to share and change
- You may be the only one to tell someone they matter

DIXIE

DixieMorgese@Gmail.com
386.566.2605

HELENA

hg108202@gmail.com
386.868.7012