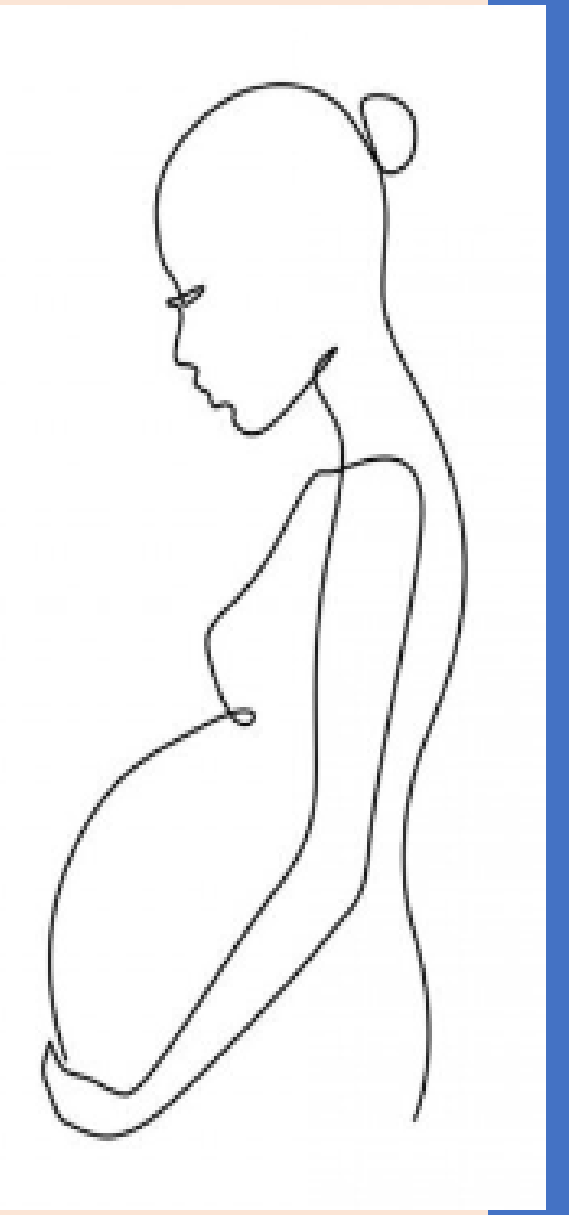
What to Expect When You're Expecting:

Exploring Prenatal Substance Use Policies and Navigation of MOUD During Pregnancy



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Department of Mental Health Law and Policy

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UNIVERSITY of SOUTH FLORIDA

Agenda

- Introduction
- Clinical experience
- Community-based research
- Navigation of treatment
- Maternal substance use policies
- Impacts of stigma
- Q and A

About myself

- Licensed Mental Health Counselor (FL)
- Behavioral Healthcare Researcher
- Assistant Professor at USF
- Maternal substance use treatment and policy

NYU
SILVER SCHOOL OF SOCIAL WORK

SCHOOL OF SOCIAL WORK
TULANE UNIVERSITY

BAY AREA BEHAVIORAL SERVICES

GAL
Guardian ad Litem
A POWERFUL VOICE FOR FLORIDA'S CHILDREN
FLORIDA GUARDIAN AD LITEM PROGRAM

Behavioral Sciences Training
BST
in Drug Abuse Research

My Background

Clinical Experience

Child and Family Therapist
- Foster and adoptive families

Substance Use Counselor
- Pregnant and postpartum clients

Licensed Mental Health Counselor (LMHC)

Parental substance use and recovery

Domestic violence and trauma

Family reunification

Attachment and attachment disorders

My Research

- Community-engaged research
- Focused on between-system collaborations
- Evidence based practices for maternal substance use and mental health
- Practices and policies that support equitable and supportive access to care
- Treatment navigation
- Therapeutic alliances
- Harm reduction
- Trauma-informed
- Feminist perspective
- Mixed methods

WHY THIS RESEARCH?

Life Saving

Listening to the community is effective

Storytelling is powerful

Mixed methods captures more

Navigating healthcare is hard

Improvements in education and training

What do we know so far?

- 40% of people with a lifetime substance use disorder are women (Wendell, 2013)
- 7% of women in the U.S. had used opioids during their pregnancy (CDC, 2019)
- 1 in 5 of those reported misusing opioids during their pregnancy

- 69% of women admitted to local jails met criteria for a SUD (ACOG, 2015)
- 26% experience OUD (Sufrin et al., 2020)

- preterm labor
- early onset of delivery
- withdrawal symptoms
- poor fetal growth
- NAS (neonatal abstinence syndrome) or NOWS
- miscarriage

(Johnson, 2018)

The recommended treatment for OUD during pregnancy is MOUD combined with prenatal care

39-50%

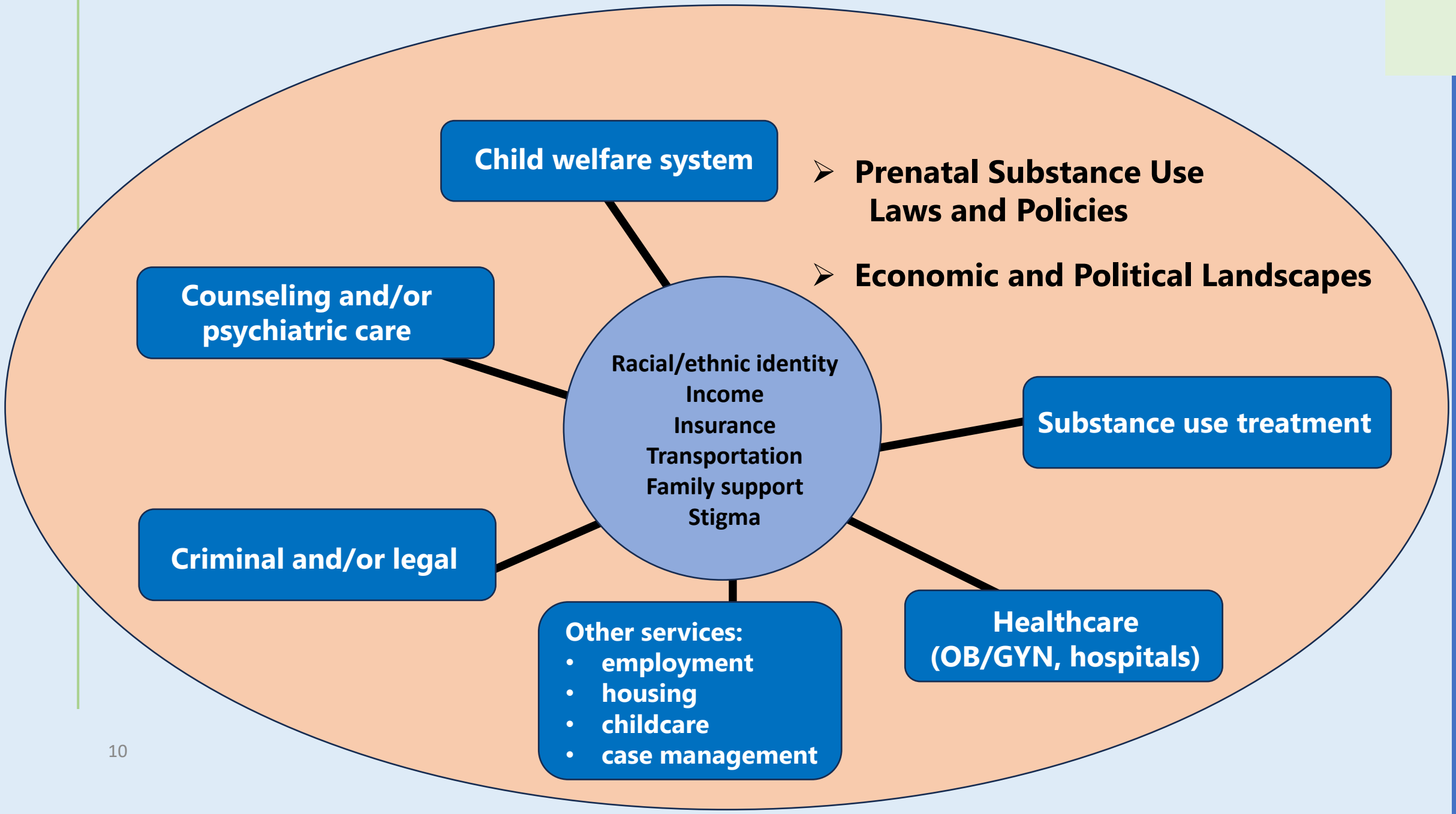
(ACOG, 2015; Jones, Finnegan, & Kaltenbach, 2012; Substance Abuse and Mental Health Services Administration, 2018; Short et al., 2018, Martin, 2015; Hand, 2017)

Treatment is complicated by stigma, fear of judgement, and competing demands of family/work

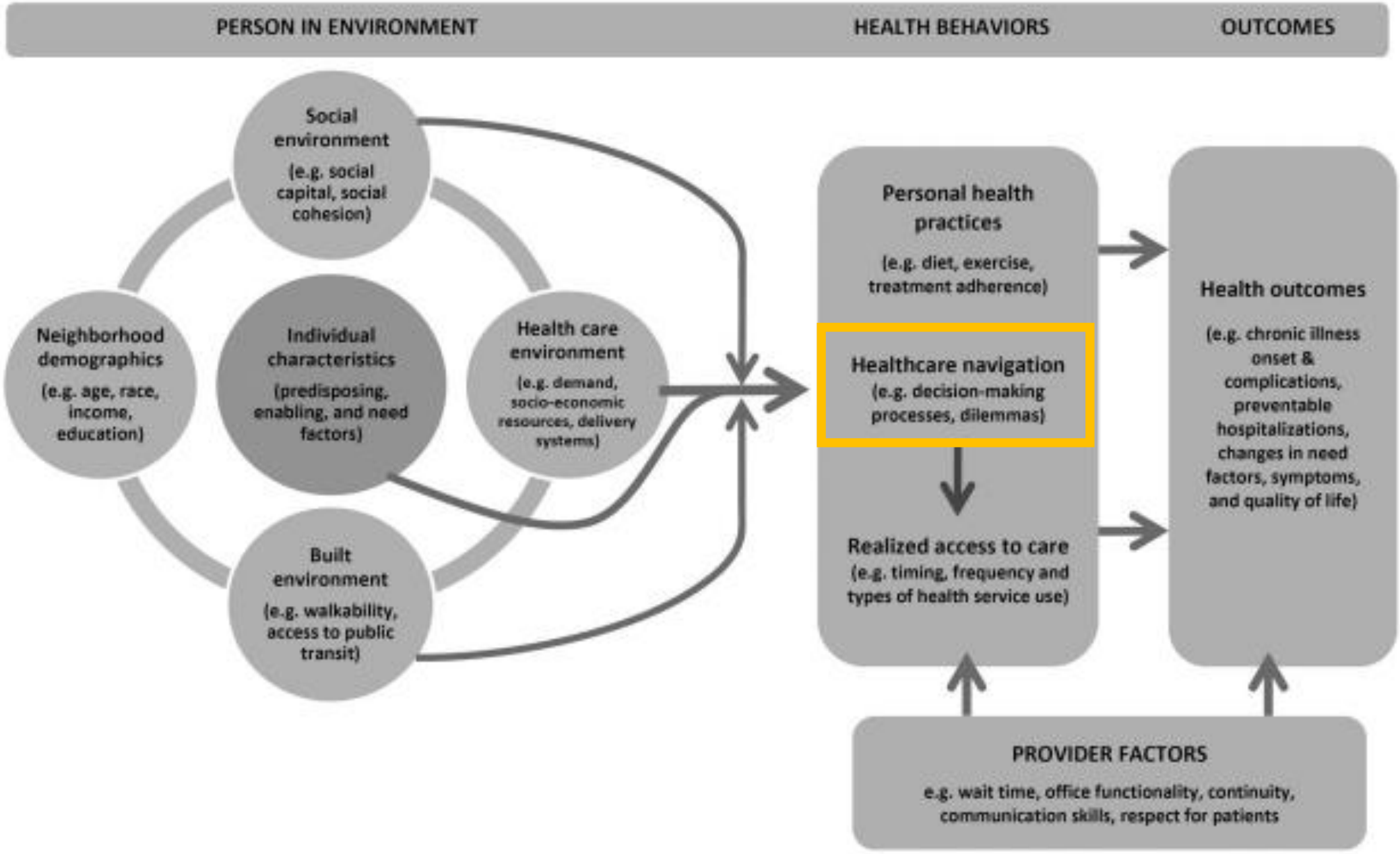
Women with SU tend to be more stigmatized than their male counterparts

Idealized depictions of motherhood

(Saunders et al., 2018; Brady & Randall, 1999; Kirtadze et al., 2013; Kulesza, Larimer, & Rao, 2013)


Child welfare system
Counseling and/or psychiatric care
Racial/ethnic identity
Income
Insurance
Transportation
Family support
Stigma
Substance use treatment
Criminal and/or legal
Other services:
• employment
• housing
• childcare
• case management
Healthcare (OB/GYN, hospitals)
➢ Prenatal Substance Use Laws and Policies
➢ Economic and Political Landscapes

BEHAVIORAL-ECOLOGICAL MODEL OF HEALTHCARE UTILIZATION AND NAVIGATION (RYVICKER, 2018)



SAMHSA
Substance Abuse and Mental Health Services Administration

GUTTMACHER INSTITUTE

GALLUP

1. Trends in Receipt of MOUD Among Pregnant Women in the U.S.
2. A Multilevel Analysis of Individual and State-level Factors Influencing MOUD Use
3. A Qualitative Exploration of the Experiences, Challenges, and Navigation of Treatment for OUD During Pregnancy

Research Question #1:

What are the annual nationwide and state level estimates of MOUD utilization among pregnant women experiencing OUD who are admitted to a federally funded treatment program from 2010 to 2018, and how do these estimates change over time?

Research Question #2:

Which referral sources are more likely to lead to MOUD use upon admission?

Research Questions #3:

How does MOUD use among pregnant individuals differ by age, race or ethnicity, employment status, and education?

Data and Sample

- **Treatment Episode Dataset-Admissions (TEDS-A)**
- **Admissions level secondary data**
- **2010 to 2018**

females

adults of reproductive age (18 to 49)

pregnant at admission

problematic use of heroin, methadone, or other synthetic opiates

Analysis

$$\frac{\text{pregnant females admitting to treatment with OUD who received MOUD as part of their initial treatment plan}}{\text{total pregnant females admitting to treatment with OUD}} = \text{Estimate of MOUD use}$$

Predisposing Factors

Other variables included:

- **age**
- **race/ethnicity**
- **education**
- **employment**

Comparison between MOUD and no MOUD

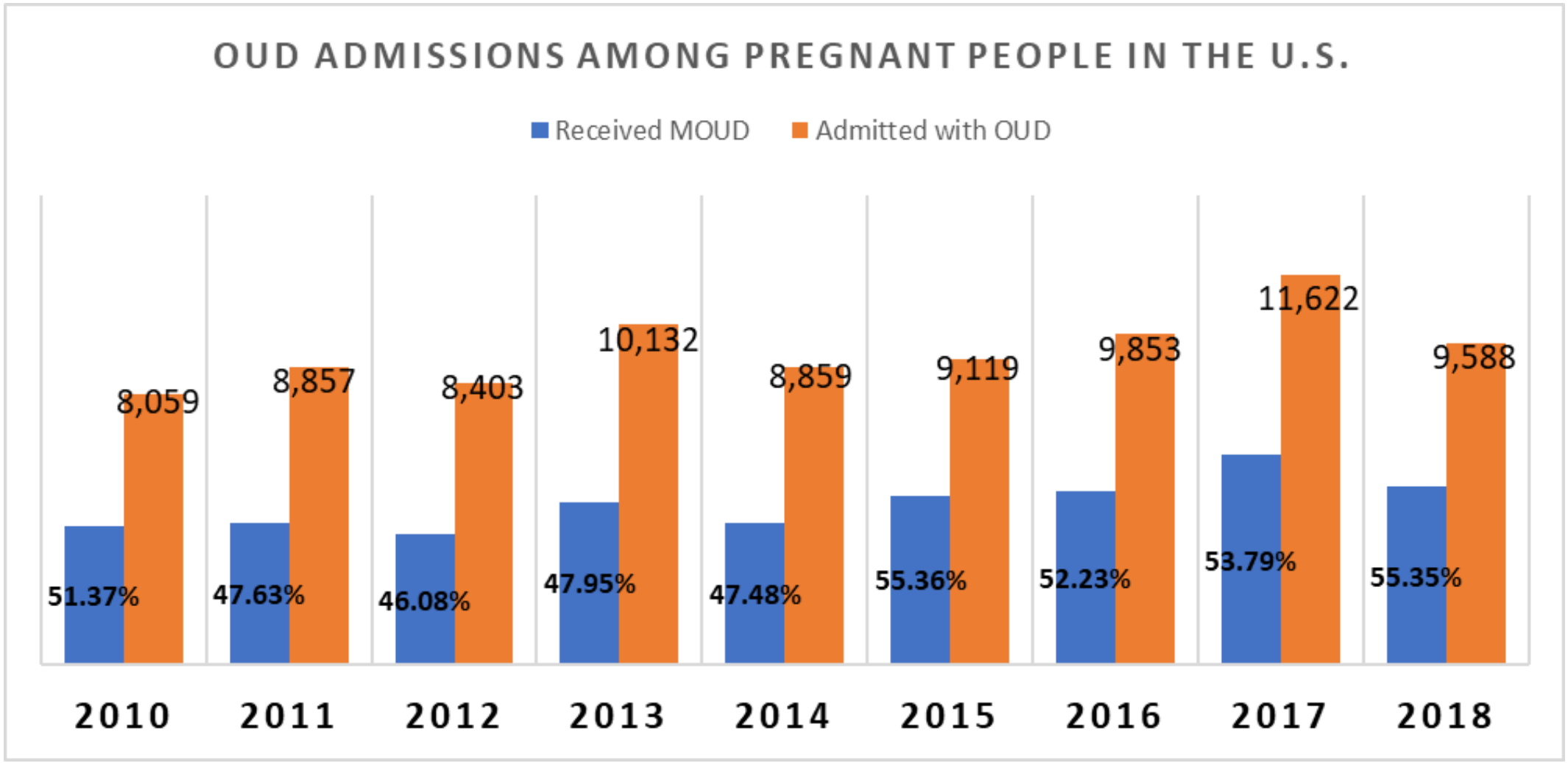
Enabling Factor

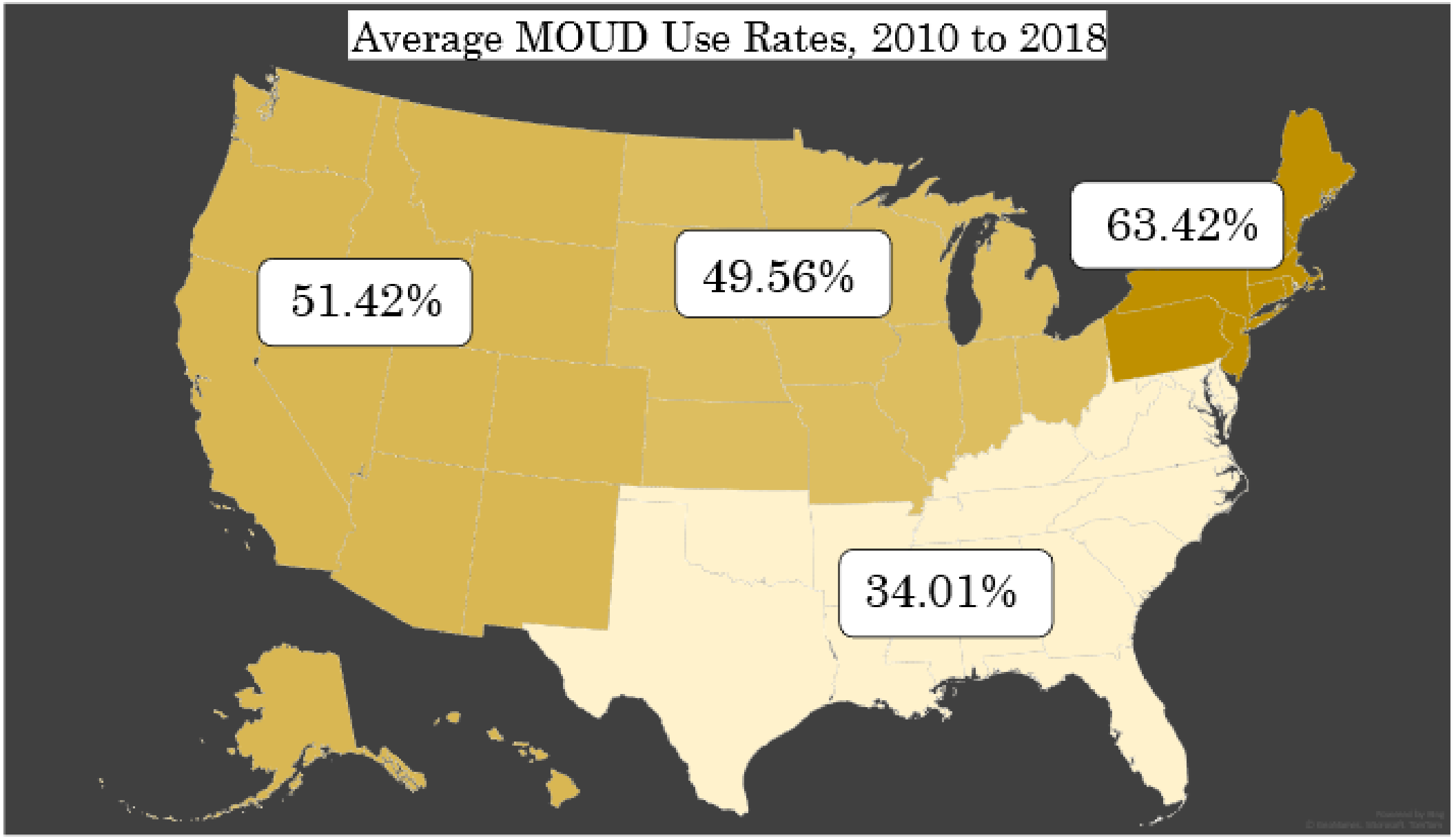
Referral sources:

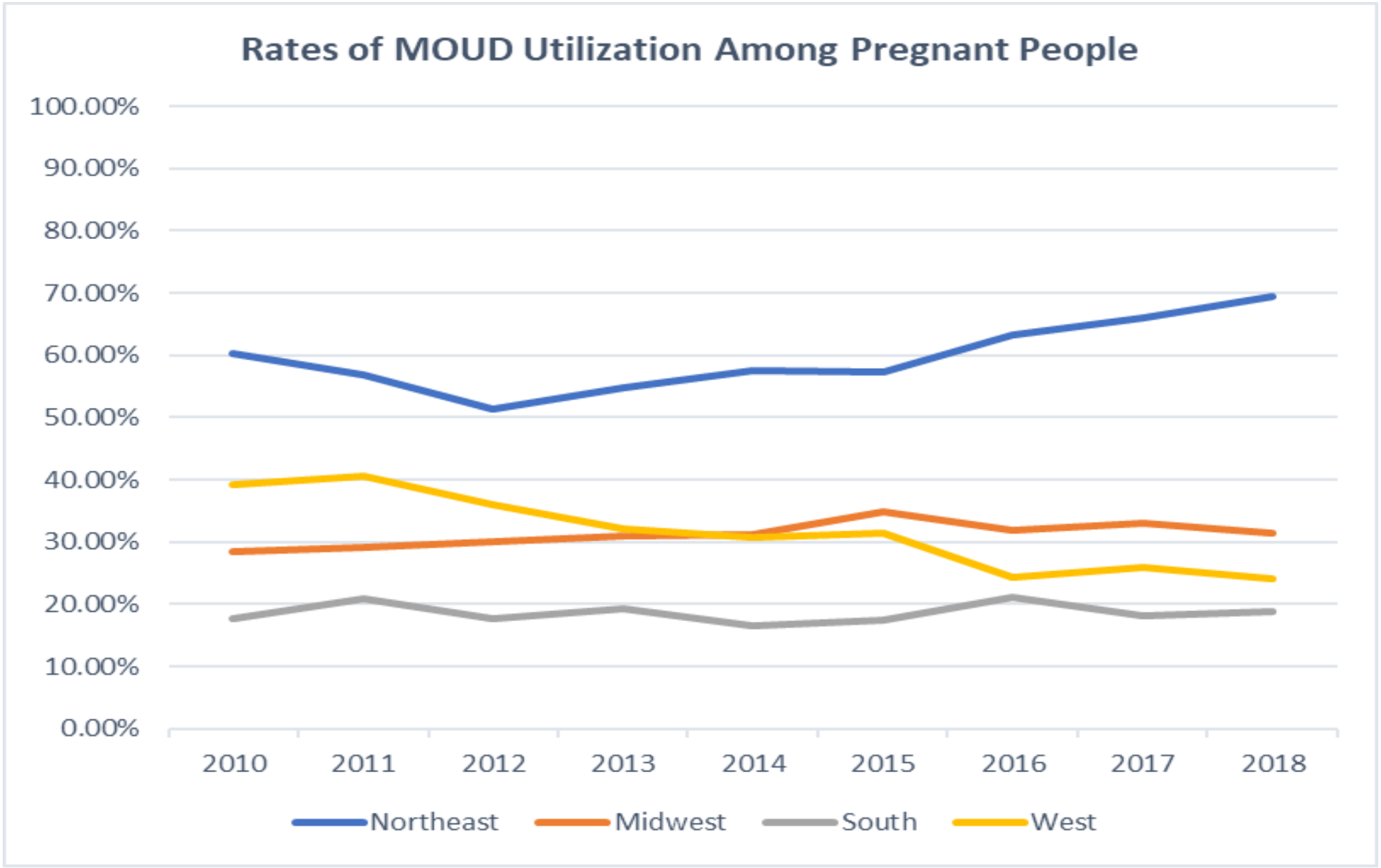
- **Individual or self-referral**
- **Another alcohol or drug use program**
- **Another healthcare provider**
- **Employer or EAP**
- **Legal or criminal justice referral**
- **Other community referral**

Results

- (N= 84,492)




Average MOUD Use Rates, 2010 to 2018
51.42%
49.56%
63.42%
34.01%


Rates of MOUD Utilization Among Pregnant People
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
2010
2011
2012
2013
2014
2015
2016
2017
2018
Northeast
Midwest
South
West

THOSE WHO RECEIVED MOUD

age 25 to 29	37.3%
white	80.6%
unemployed	39.1%
HS or GED	47.2%

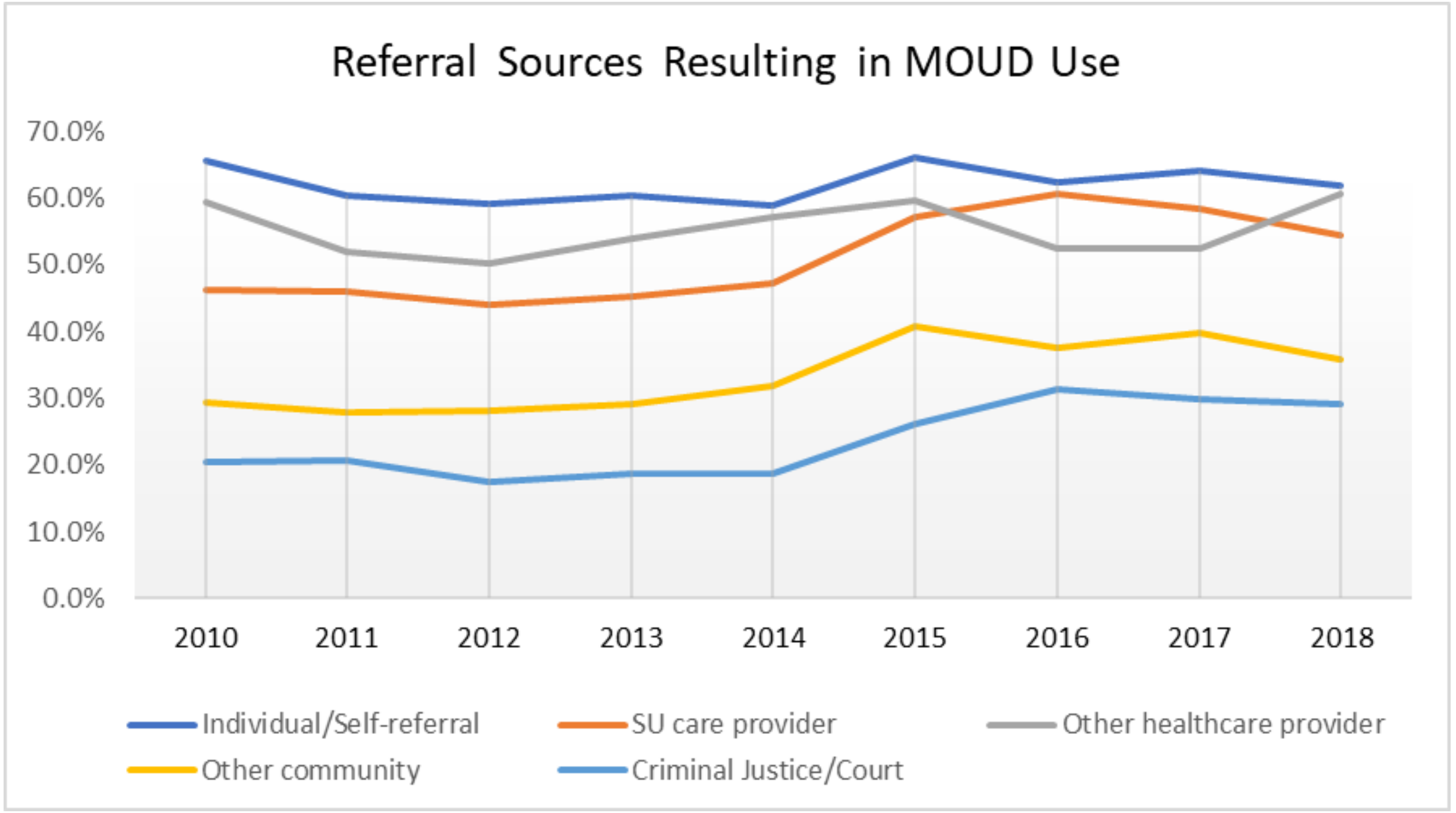
Maine	81.99%
New Mexico	76.31%
New Jersey	75.17%
Michigan	65.76%
Massachusetts	61.07%
Vermont	60.79%
Delaware	59.81%
Rhode Island	59.20%
California	58.82%
Connecticut	57.78%
New York	56.77%
Minnesota	56.74%

Maine	81.99%
New Mexico	76.31%
New Jersey	75.17%
Michigan	65.76%
Massachusetts	61.07%
Vermont	60.79%
Delaware	59.81%
Rhode Island	59.20%
California	58.82%
Connecticut	57.78%
New York	56.77%
Minnesota	56.74%

Mean = 50.58%

Florida = 42.89%

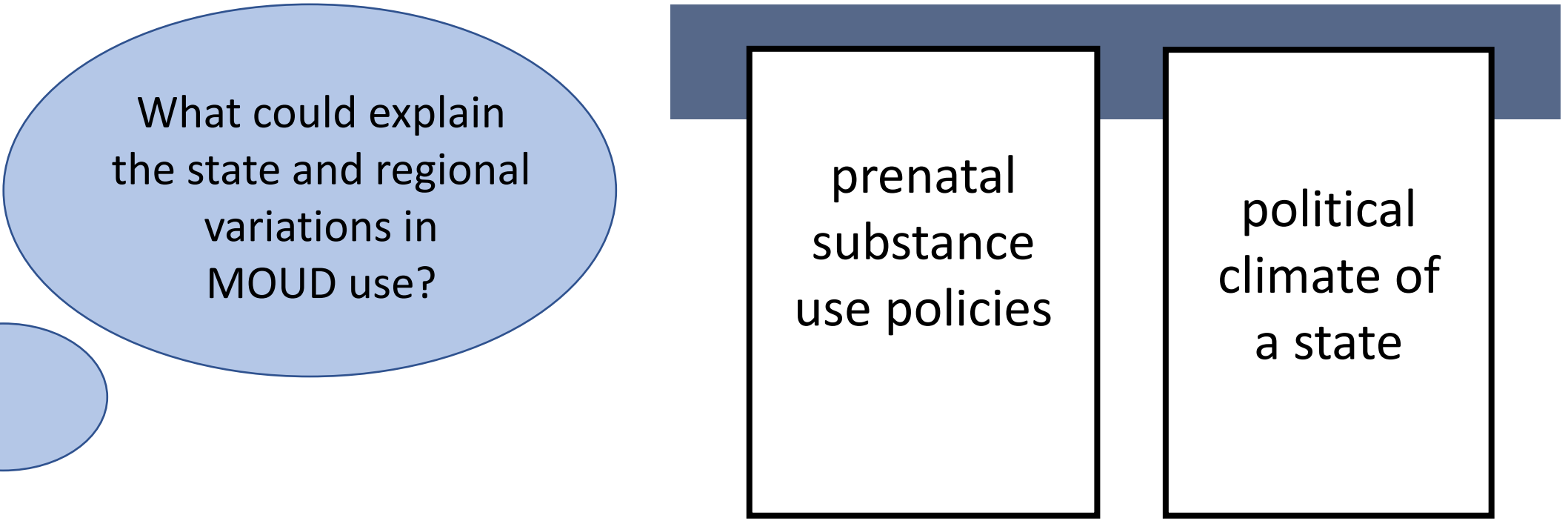
Median = 37.46%


Referral Sources Resulting in MOUD Use
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2010
2011
2012
2013
2014
2015
2016
2017
2018
Individual/Self-referral
SU care provider
Other healthcare provider
Other community
Criminal Justice/Court

Questions?

Prenatal Substance Use Policies Across the U.S.

What could explain the state and regional variations in MOUD use?



Prenatal Substance Use Policies

PUNITIVE POLICIES

24 states consider prenatal substance use to be child abuse

3 states consider it grounds for civil commitment

25 states require healthcare professionals to report suspected prenatal substance use

FACILITATIVE POLICIES

17 states have priority access for pregnant folks

10 states prohibit treatment programs from discriminating against pregnant folks

Women have been criminally charged in many states:

- **criminal child endangerment**
- **delivery of controlled substance via umbilical cord**
- **manslaughter**

Punitive policy efforts do not equate to increases in MOUD receipt

(Carroll, et al., 2021)

Between 2000 and 2015, more states implemented these punitive policies than supportive ones

Substance Use During Pregnancy | Guttmacher Institute

Research Question #1:

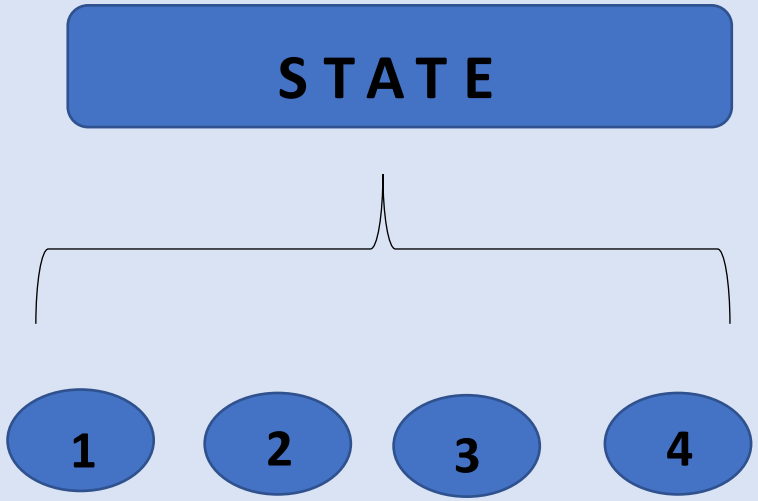
- What are the associations between MOUD receipt and the individual predisposing factors encountered by pregnant women entering substance use treatment (age, race, education, employment, referral source, and mental health)?

Research Question #2:

What is the extent to which state-level policies on prenatal substance use influence MOUD use among pregnant women in treatment for OUD?

analysis

nested data

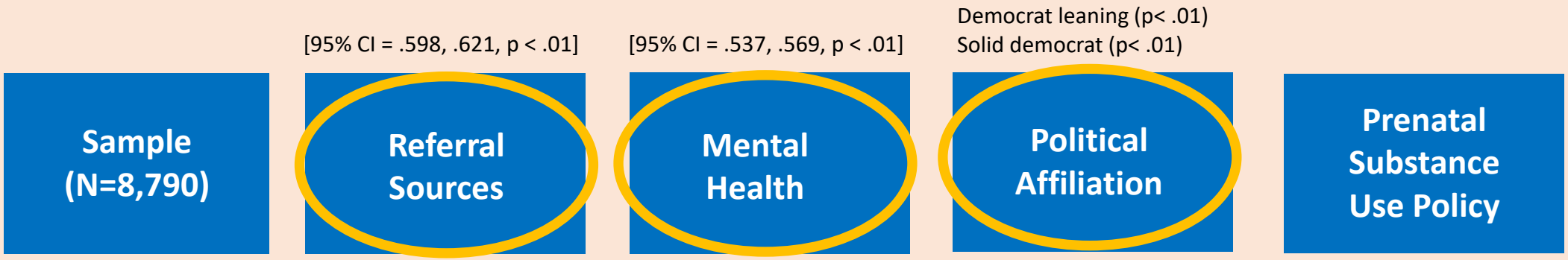


punitive policy
priority access policy
political climate of a state

age
race/ethnicity
education
employment
criminal justice referral
co-occurring disorder

- **Two-sample tests (proportions)**
- **Multilevel binary logistic regression**
- **For the year 2018**

Multi-level model Results



38.6% age 25 - 29

81.2% White

47.8% HS or GED

41.8% unemployed

Non-intensive outpatient setting

55% MOUD

45% did not

59% were self-referred

8% were referred by the criminal justice system

11% from another HC provider

Less likely to receive MOUD

47.21% had a co-occurring mental health disorder

More likely to receive MOUD

Democratic states associated with higher MOUD use

No evidence that either punitive policies or priority access policies had any association with MOUD

Policies were **not** the primary predictors of MOUD

MULTILEVEL REGRESSION MODELS

	MOUD Use								
	Model 1			Model 2			Model 3		
	(N= 8,787 from 45 states)			(N= 7,539 from 39 states)			(N= 7,539 from 39 states)		
	coefficient	SE	p	coefficient	SE	p	coefficient	SE	p
	-0.831	0.297	0.005						
predictors									
State level									
punitive policy				-0.186	0.450	0.679	-0.397	0.249	0.111
priority access policy				-0.188	0.461	0.684	-0.240	0.265	0.365
political affiliation									
republican leaning				-0.092	0.805	0.909	0.296	0.475	0.534
competitive				1.320	0.674	0.050	1.114	0.408	0.006
democrat leaning				2.237	0.755	0.003	2.170	0.456	0.000
solid democrat				2.261	0.631	0.000	1.861	0.399	0.000
Individual level									
criminal justice referral				-1.410	0.081	0.000	-1.411	0.081	0.000
co-occurring mental health				-0.240	0.062	0.000	-0.231	0.062	0.000
race									
Black				0.065	0.104	0.528	0.224	0.322	0.487
Asian or Pacific Islander				0.570	0.613	0.352	1.158	0.862	0.179
other single race				0.364	0.154	0.018	0.627	0.403	0.120
two or more races				0.322	0.165	0.051	0.559	0.369	0.130
chi squared				357.110			372.010		
ICC	0.521			0.296					

Questions?

Also let’s take a break from statistics…. ☺

Types of Stigma

1. Structural
2. Providers
3. Individual
4. Internalized
5. Criminal

https://youtu.be/PmP990MwEz4?si=oYgDV2itXOWBm8Qw

Experiences of MOUD

- Challenges faced by women in accessing substance use treatment or health care in general are amplified around the time of pregnancy, and may be complicated by stigma, fear of judgment, and competing demands from their family, health, or employment

- (Saunders et al, 2018)

Pregnancy can be an emotional time, especially if pregnancies are unwanted or unexpected, and women are at risk of feeling overwhelmed with the process of obtaining care, and may avoid seeking any help for substance use problems

(Latuskie et al., 2019; Roberts & Pies, 2010)

1. **What are the experiences of pregnant women as they seek, are referred to, and enroll in MOUD treatment during their pregnancy?**
2. **What are the main barriers and facilitators faced by pregnant women when receiving MOUD throughout their pregnancy?**

Study Design

- **Semi-structured interviews**
- **Formerly pregnant adults**
- **Experienced opioid misuse during pregnancy**
- **Received at least one MOUD during pregnancy**
- **Given birth in the past 2 years**

Interview protocol included questions about:

- Experiences of pregnancy
- Experiences of medication
- Seeking and enrolling in MOUD
- Social support
- Decision-making
- Substance use history
- Mental health services
- Child welfare involvement
- Changes related to COVID-19

RECRUITMENT

- From January to May 2022
- targeted at larger metropolitan areas
- Los Angeles, Tampa, New York City, Nashville
- chosen for their policy variations and varied MOUD access
- American Association for the Treatment of Opioid Dependence (Provider Locator)
- Private Facebook recovery groups for moms
- Craigslist

Data collection

- April 2022 to June 2022
- over the phone
- 30-45 minutes each
- $20 Amazon gift cards
- audio recorded
- sent to a third-party transcription services checked for errors

N=24

12 from NY and 12 from CA

Qualitative analysis

- **Thematic analysis**
- a method suitable for identifying, analyzing, and reporting patterns in the data, with rich description of it

- Deductive approach
  - (Braun & Clarke, 2006)

independently reviewed all transcripts and generated memos, initial thoughts and reactions to the transcripts, and a preliminary set of codes

in-depth analysis of the transcripts

memo writing

a more defined set of codes was developed

coding and thematic analysis in Dedoose

collated the codes into themes and created a thematic “map” of the data

selected excerpts to illustrate these themes

Qualitative Results

NAS

Seven infants treated for NAS
Seventeen were not

- **mean age = 25.6 years old**
- 91.7% Black (n= 22)
- 8.3% White (n= 2)

sample

referral source

54.2% referred by their prenatal doctor, primary care physician, a nurse, or a midwife (n= 13)

29.2% self-referred (n=7)

16.7% referred by family or friends (n=4)

Misuse of non-Rx opioids (n=18)
Misuse of Rx opioids for pain (n=6)

substance use

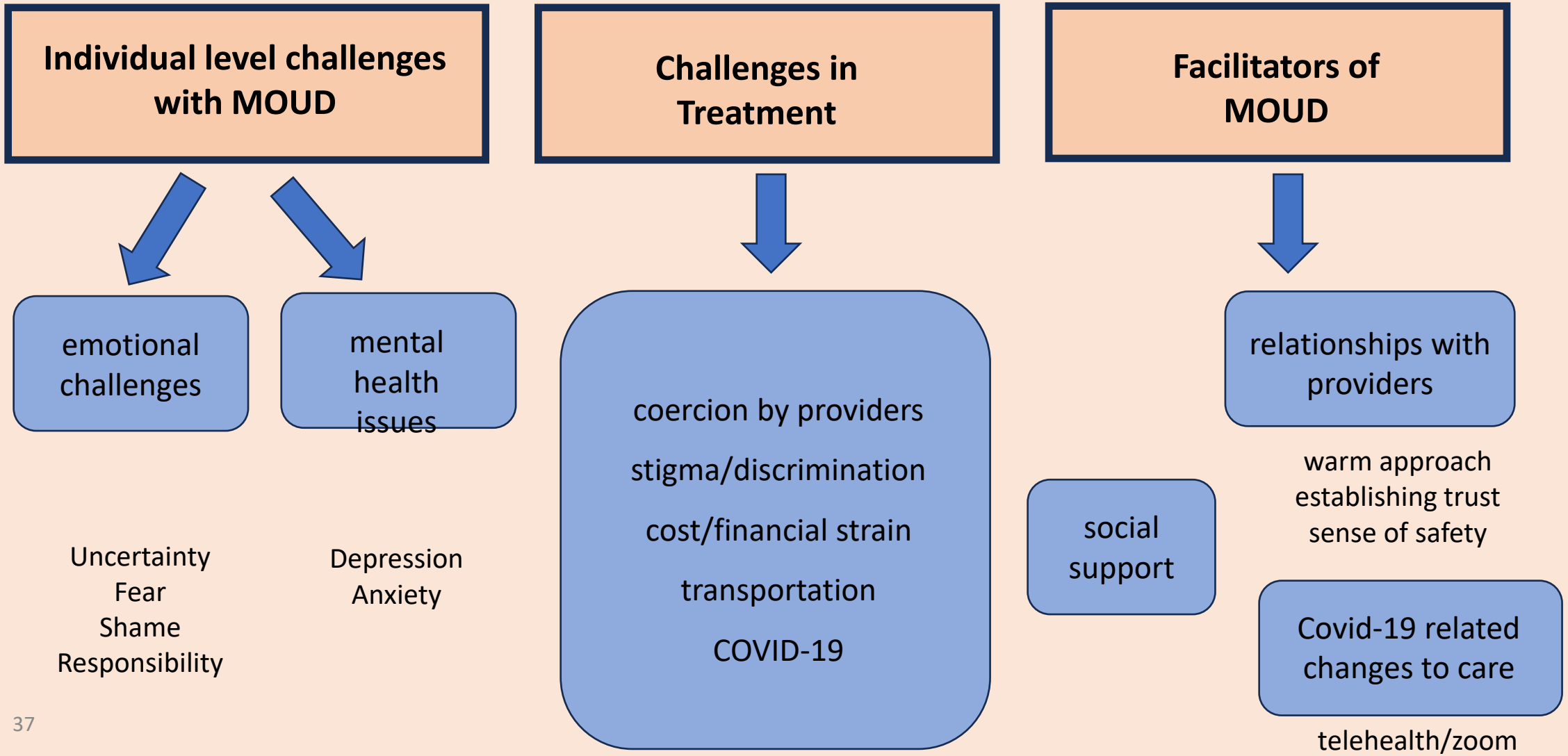
Child welfare involvement

Methadone (n=17)
Naltrexone (n=2)
Subutex (n=1)

treatment

17 no contact
7 at least one visit

Qualitative Themes



Uncertainty about MOUD

"My experience was one that – I thought I can't really explain it because I was nervous. I was scared that I didn't know what the outcome would be if I'm going to be [able to] hold the baby or not, because I just thought that I didn't know what it would be like. I don't know if my baby's going to be OK. I was taking so many medications and listening to what doctors' advice was like. I was nervous." (NY_12)

COVID-19 Related Challenges

"Everyone decided to stay indoors and everything. That also affected me. Also, financially because I think COVID affected everyone financially…For someone like me I was affected financially. At the same time, emotionally because you have a situation that you're dealing with, but when maybe you look at the news, you look all over, then you see people dying due to COVID, it affected me emotionally, I can say physically, financially, literally everything." (NY_05)

Provider Coercion

"but once I got there [treatment], he said to me, 'I want to treat you with methadone.' So he told me, 'That's what I want.' He wouldn't oppose me. He led me to the program where he gave me the methadone dose." (NY_09)

Relationships with Providers

- *"I guess I was nervous, but I met a nurse who was very friendly. She walked me to the doctor's office and it reduced my anxiety and I felt just this hope." … "they were very welcoming and very warm." (NY_07*)
- *"They give you accurate information because I felt like I didn't come out of that place with doubt. Because if you maybe go somewhere and you want to acquire information about a given product and they're able to explain this given product properly, then you decide, OK, I like to read, first, the information and I like to try this even further. So for me the information, they were very informative and they were very gentle while explaining everything, and taking me through each step, and for me that was what also made me decide to pick that given place." (NY_10)*

Conclusion

- The study found no evidence that punitive policies decrease MOUD or that supportive ones increased MOUD

- **Policies were not the primary predictors of MOUD**

- Criminal justice referrals and mental health were significant factors

What do providers need?

IMPLICATIONS

For policymakers:

- strengthen ties between legal and healthcare systems

For treatment:

- address logistical challenges
- promote collaborative systems of care
- programs that keeps families together

For providers:

- link clients with MOUD
- address stigma and discrimination for folks with substance use
- help pregnant clients to understand the laws and policies in their state, involvement with child welfare system

FUTURE RESEARCH

Technology based interventions

Provider level interventions

- shared decision making
- rapport and trust building
- **expectations** of the child welfare system

Mental health during post partum

Doulas

VIDEO:

https://youtu.be/q8Z2XO6WfyA?si=vakky9CK0C56UnJe

THANK YOU

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