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Pregnant Women with Substance Use Disorders Deserve Plans of Safe Care

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Approximately 340,000 infants are affected by prenatal exposure to illicit drugs annually.[1] This number should not be surprising given that misuse of prescription and illicit drugs has been a growing population health problem for years. Alcohol and other drugs have played an increasing role in child removals in recent years, raising concerns about the lasting impacts of substance use on parents and their children for generations to come.

KEY TAKEAWAYS

- Maternal substance use is a critical U.S. population health issue.
- Approximately 340,000 infants are prenatally exposed to illicit drugs annually.
- Parental drug or alcohol use is a contributing factor to 35% of child removals annually.
- Plans of Safe Care are a necessary tool to give mothers autonomy and dignity in addressing their substance use preparing for their new role as a parent.

In response to this public health crisis, the federal government issued Public Law 114-198: Comprehensive Addiction and Recovery Act Section 503 in 2016, requiring the development of Plans of Safe Care (POSC) for women with substance use disorders. The act encourages social workers and hospitals to develop comprehensive plans with mothers prior to hospital discharge with the goals of increasing mental, emotional, and physical wellbeing and reducing prenatal exposure to substances.

This brief summarizes trends on substance use among pregnant women, risks for children, and the role of Plans of Safe Care in reducing these risks.

Growing Rates of Pregnant Women Who Use Substances

About 1 in 9 women report drinking alcohol during pregnancy, and about 1 in 3 of them engage in binge drinking.[2] Of the nearly 4 million annual U.S. births, about 11.5% of infants are born with prenatal exposure to alcohol, and about 8.5% are born with exposure to illicit drugs.[3] Substance use during pregnancy has led to a rapid increase in the number of babies born with a physical dependence on opioids—otherwise known as neonatal abstinence syndrome (NAS)—with rates increasing 82% between 2010-2017.[4] During this same timeframe, the number of mothers with opioid-related diagnoses documented at delivery increased by 131%.[3] These numbers are likely to increase given added stressors associated with COVID-19. Moreover, while opioids (especially fentanyl) continue to be a major problem, stimulant use (e.g., cocaine and methamphetamine) has been increasing, making this a critical period to intervene with pregnant women with SUDs.

Consequences of Parental Substance Use during Pregnancy

Infants with prenatal substance exposure are at risk of developing Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Syndrome Disorder (FASD), birth complications, low birth weight, and respiratory problems.[5] Prenatal substance exposure can also lead to long-term deficits in physical, cognitive, and emotional development and functioning.[6] These outcomes can have long-lasting consequences for wellbeing.

In addition, substance use during pregnancy can increase the risk of child removal from the parents. The incidence of parental alcohol and other drug use as a contributing factor for child removal in the United States nearly doubled between 2000 and 2016, going from 18% to 35%. Forty-one percent of all removals were among children under the age of five, and 17.5% of those children were under the age of one.[1]

Children of parents with substance use disorder are at greater risk of physical abuse, neglect, domestic violence, and inadequate follow-up for infants after hospital discharge.[5] Most infants born to mothers with active substance use face multiple risk factors for removal within their first year of life. These experiences often put children at risk of longer foster care stays and make them less likely to be reunified with their biological parents.

Child removal also has negative consequences for the mother. Research examining the impact of child removal shows that mothers typically experience an acute, immediate psychosocial crisis followed by enduring and cumulative negative consequences. These consequences include escalating substance misuse, high risk sexual behavior, and feelings of family disconnection.[7] While removal is often imperative to the safety of the child, failing to engage the mother in appropriate therapeutic services may exacerbate the negative behaviors that could increase time to reunification.[8]

Plans of Safe Care

In 1974, Congress passed Public Law 93-247: Child Abuse Prevention and Treatment Act (CAPTA), the aim of which was to provide funding for programs to prevent, identify, and treat child abuse and neglect. In 2003, CAPTA was amended to reauthorize programs under the act and to create new conditions for states to receive grants. The law was again amended in 2010 to clarify the definition of substance-exposed infants and add Fetal Alcohol Spectrum Disorder.

As our understanding of addiction has evolved, so has our understanding of the needs of mothers with substance use disorders. In 2016, Congress enacted Public Law 114-198: Comprehensive Addiction and Recovery Act (CARA). The goal of CARA was to increase treatment access and preventative services. CARA also required the development of Plans of Safe Care for newborns "born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Spectrum Disorder (FAS)."[3] These updates to CARA also included new guidelines for data reporting which stipulates that each state reports: 1) the number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FAS, 2) the number of infants for whom a POSC was developed, and 3) the number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.[3] In New York State, the responsibility to report these mandated data falls to hospitals. Hospital staff are required to notify the Office of Children and Family Services and complete a Plan of Safe Care if the mother is: 1) in treatment for a substance use disorder and being prescribed or being administered an addiction medicine by a health care provider, 2) under the care and treatment of a health care provider for chronic pain and taking opioids as prescribed, 3) taking benzodiazepines as prescribed by a health care provider, or 4) taking medical marijuana as directed by a registered practitioner. [3]

Plans of Safe Care are designed to ensure the safety and wellbeing of an infant with prenatal substance exposure by immediately identifying their safety, health, and developmental needs. The plans are also intended to provide physical and mental health and substance use disorder treatment and support to the affected parents or caregivers, which includes referrals to appropriate services and resources. For the plans to be successful, parents and caregivers should work in collaboration with healthcare providers and other professionals, or agencies involved in providing care to the affected infant and family. Ideally, these plans are developed prior to birth using a cross-system, collaborative approach, fully addressing the needs of the infant and the family.

<u>What Should be Included in Plans of Safe Care?</u>

Plans of Safe Care should be uniquely tailored to the needs of each mother and her specific circumstances. They should

be designed to meet both short-term and long-term needs of the family with the goal of strengthening the family and keeping the child safe. Some of the things that may be included in a Plan of Safe Care are:

- Substance use assessment and linkage to treatment services
- Referrals to medical and mental health services (outside of substance use treatment)
- Assistance with obtaining safe and stable housing
- Delivery plan: transportation to hospital, toiletry and clothing for the hospital stay
- Instructions on the infant's special care needs (especially if the baby is born diagnosed with NAS or FAS)
- Guidance to ensure safe sleeping arrangements
- Vocational training for mothers
- Comprehensive and coordinated social services (e.g., referrals to Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), locating baby equipment and clothing, and securing daycare).

The Federal Government Must Take the Lead

The implementation of Plans of Safe Care has lacked uniformity across the country. Instead of a centralized approach to implementation, roll out and enforcement has been left up to individual states. Currently, only 33 states have laws and policies that require state agencies to develop Plans of Safe Care, leaving significant room for national expansion. For Plans of Safe Care to be effective, the federal government must take the lead in enforcing state implementation, compliance, data collection, and reporting. Additionally, state agencies need to work together more closely to ensure a clear message on the importance of Plans of Safe Care in the healthcare provider and hospital setting. Furthermore, while mandating Child Services be notified when a baby is born substance exposed allows for some data collection, data collection efforts must be strengthened. Limited data availability and not requiring further post-hospital discharge follow-up hinders the ability to further evaluate the success of Plans of Safe Care and their impacts on mothers and their babies.

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