Children's Hospital of Philadelphia
PolicyLab

Strategies to Improve Connections to Services for Families Affected by Perinatal Substance Use

Family & Community Health

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As Philadelphians wrestle with increasing morbidity and mortality related to substance use and substance use disorder (SUD), we must continue to call out the importance of applying a family-centered approach to birthing people affected by SUD and their infants.

Infants with prenatal substance exposure are at risk of withdrawal syndromes after birth (e.g., neonatal abstinence syndrome or neonatal opioid withdrawal syndrome), increased risk of hospitalization and death during infancy, and increased risk of neurodevelopmental challenges during childhood, while birthing people with SUD face a high and increasing risk of overdose in the postpartum period.

In an attempt to address some of these risks, federal policy mandates that infants identified as being affected by prenatal substance exposure, withdrawal, and/or a Fetal Alcohol Spectrum Disorder (FASD) be offered a "Plan of Safe Care" (POSC) that is meant to address the diverse needs of both the infant and their birthing parent. In addition, health care providers are mandated to make "notifications" regarding affected infants to child protective service (CPS) agencies, which differ from mandatory reports to CPS for concerns regarding child abuse or neglect. Pennsylvania guidance stipulates that "the notification of an infant born and identified as affected by substance use, withdrawal symptoms resulting from prenatal substance exposure, or FASD does not constitute a report of suspected child abuse in and of itself."

Following federal legislation enacted in 2016, jurisdictions have taken different approaches to POSC implementation, with varied results. Delaware's pilot POSC programming in 2018 indicated fewer than 10% of affected infants required foster care placement. In early years of assessment, while Connecticut's POSC implementation helped divert over half of infants with prenatal substance exposure from CPS involvement, over 91% of notifications for substance-affected infants in Wake County, North Carolina were screened in for a CPS maltreatment assessment. Meanwhile, very little is known about how birth parents perceive and experience the POSC.

In new research, we interviewed birth parents with SUD who were offered a POSC in the 18 months following implementation in Philadelphia County in order to understand their perceptions and experiences. We found that stigma, confusion, and fear of CPS involvement were pervasive, influencing caregiver attitudes toward health care providers and experiences with medications for opioid use disorder. Supportive connections that flow through and/or intersect with CPS may exacerbate fears around increased CPS surveillance and involvement, with the unintended consequence of decreased engagement with needed health care, endangering recovery and access to other supports.

The intent of a POSC is to improve the well-being of infants affected by prenatal substance exposure and support the well-being and recovery of their parents. Yet, our research suggests that in practice, POSCs may further marginalize this population by exacerbating fear and mistrust of health care providers and systems.

With an eye to how POSCs could better serve and support a family-centered approach for pregnant and postpartum people with SUD, we would recommend consideration of the following approaches:

First, family-centered, integrated wrap-around services are needed to support parents affected by SUD and their infants, including to promote engagement with SUD care.

SUD treatment programs serving birthing people should specifically address birthing and parenting needs, including easy access to child care, reproductive health care, and psychosocial support that promotes attachment and the well-being of both parent and baby. Expansion of in-home treatment models such as Family-Based Recovery or models that support parental mental health and reflective functioning could also improve engagement in treatment while allowing families to remain safely together in recovery.

Second, supportive, non-punitive approaches to notifications and POSC implementation should be distinct and separate from CPS and child maltreatment reporting pathways.

As stated by the Biden-Harris White House and the American Academy of Pediatrics, as well as other medical organizations, substance use during pregnancy in and of itself does not constitute child maltreatment, but represents an opportunity to support recovery and promote family well-being. Mandatory CPS contact related to any prenatal substance use may create a barrier to care engagement, with particular relevance for medications for opioid use disorder (MOUD).

Infants in the care of birth parents who are in stable recovery, including with MOUD, may have no greater safety risk than infants cared for by other adults with well-controlled chronic medical conditions or caregivers receiving non-MOUD SUD treatment. Examples of promising approaches that facilitate connections to supports while reducing CPS involvement include deidentification of notifications to CPS unless there is concern for child maltreatment, and partnering with trusted community-based organizations or public health agencies to develop new pathways to receive notifications and ensure service delivery.

Third, increased clarity is needed around substance types and circumstances that warrant a notification and POSC, as opposed to a child maltreatment report, with education of health care and social service providers on best practices for each situation.

For instance, explicitly naming types of substance use or misuse that should lead to either a report or notification can support education around substances that can result in withdrawal symptoms, and recommendations for how to manage illicit use or misuse during pregnancy.

Fourth, develop POSCs as early as possible to support and empower birth parents in their recovery throughout and beyond the perinatal period, including low-barrier access to SUD care.

Given the high prevalence of co-occurring mental health disorders among birthing people with SUD, early engagement and connections with mental and behavioral health supports are critical to ensure continued support following birth during the vulnerable postpartum period. Offering POSCs before or during pregnancy through early identification of reproductive age people who may be or become pregnant can expedite connections to material needs supports, physical and mental health care, perinatal services such as doula support and home visiting, and resources to address intimate partner violence. This approach also decreases stress at delivery and improves documentation of care engagement in the event the family becomes CPS-involved.

Finally, cross-sector data sharing and collection is needed to support rigorous evaluations of POSCs.

Although data is emerging regarding the impacts of POSCs on CPS involvement and health care engagement, little is known regarding their impacts on infant health and development, or birth parents' well-being and recovery. Recommended approaches include establishing a governance structure to formalize processes and communications across agencies and sectors, as well as more flexible data sharing agreements.

With worsening morbidity and mortality related to perinatal substance use, provider bias in perinatal and newborn drug testing, and the fear, stigma, and mistrust that many birthing people with SUD have regarding both health care and CPS, careful design and implementation of POSCs are critical. As the Pennsylvania Opioid Misuse and Addiction Abatement Trust distributes opioid settlement funds to counties for the purposes of prevention, recovery, and treatment of opioid use disorder, there is an opportunity to support maternal and

child health through improved POSCs. As policymakers consider how best to allocate and spend this funding as well as other funding streams, our research reflects the importance of elevating the lived experiences of those being served.

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