Administrative system navigation by perinatal women with substance use disorder

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Abstract

As rates of perinatal substance use increase in prevalence and complexity, research continues to inform the design of pregnancy-responsive addiction treatment.[1-3] However, there continues to be unequal utilization of addiction treatment services by women and pregnant women specifically.[4]

A key determining factor in treatment engagement and outcomes may be the multi-public system involvement that is characteristic of perinatal women seeking recovery.[5] Perinatal women and parents with substance use disorder (SUD) are often involved in medical, judicial, child welfare, financial support, childcare, public housing, and other service systems.[5-9] Research is needed to understand more about the experience of perinatal women with SUD navigating complex service systems, and how bureaucratic design may be affecting their parenting and recovery outcomes.

Components of perinatal addiction services

Integrated addiction treatment models for perinatal women offer comprehensive medical and behavioral supports and services:

- Universal prenatal screening, brief intervention, and referral to treatment
- Perinatal medical services, including warm hand-offs to postpartum and pediatric care
- Addiction treatment counseling, mental health counseling, group therapy, and psycho-education
- Prescription of medications to treat mental health and substance use, including medications for opioid use disorder (MOUD) such as methadone and buprenorphine
- Peer recovery coaching and care management support
- Parenting skills support, home visiting, and dyadic intervention services

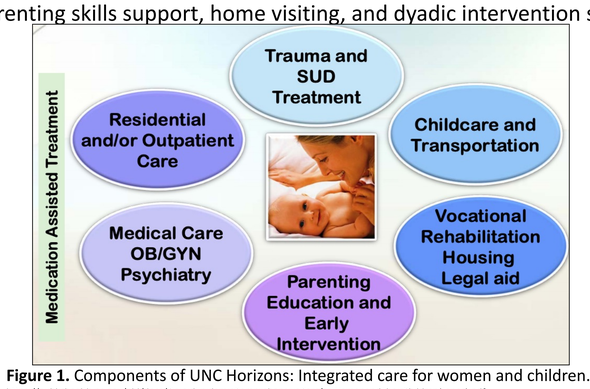


Figure 1. Components of UNC Horizons: Integrated care for women and children.
https://publichealth.nc.gov/phl/docs/OpioidEpidemicComprehensiveCareforWomenandTheirChildren(Jones).pdf

However, administrative system navigation supports are rarely included and difficult to sustain:

- Housing access and support in maintaining housing
- Legal record or criminal justice history resolution
- Acquisition of legal identification or driver's license
- Advocacy for custody, and access to childcare and parenting help
- Living wage employment and access to financial support

Perinatal substance use

Perinatal substance use and its consequences are persistent:

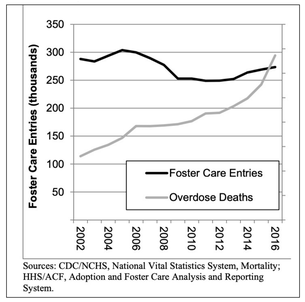
- Between 2010-2017, the national rate of Maternal Opioid-Related Diagnoses (MOD) increased from 3.5 to 8.2 cases per 1,000 delivery hospitalizations.[10]
- From 2000-2014, the North Carolina rate of maternal opioid misuse increased from 0.9 to 9.5 cases per 1,000 hospital deliveries.[11]
- In 2018, 9.0% of perinatal women in North Carolina reported drinking alcohol in the third trimester of their pregnancy.[12]
- Between 2010-2017, the national rate of Neonatal Abstinence Syndrome (NAS) increased from 4.0 to 7.3 per 1,000 birth hospitalizations.[10]
- In North Carolina, from 1999-2013, drug-related causes were responsible for 8.6% of maternal deaths.[13]

Involvement with multiple public systems

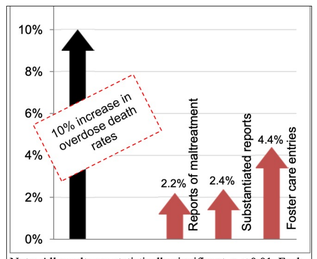
While more information is needed regarding the intersection between pregnancy, substance use, and public system involvement, indications suggest conflation of risk, including poverty, criminal justice system involvement, and child welfare system involvement

- Women made up 41.6% of all FY20 admissions to public community mental health and substance use services in North Carolina. Admissions of women in FY20 was 7.3% lower than in FY17.[14]
- In 2019, 18.3% of North Carolina residents lived below 125% of the Federal Poverty Level, including 27.7% of Black and 30.8% of Hispanic residents.[15]
- In 2019, 5.8 of children (<19) in North Carolina lacked health insurance.[16]
- Nationally, 80% of 2012 hospital discharges related to neonatal opioid withdrawal syndrome relied on Medicaid payment.[17]
- Nationally, in 2015-2016, more than half of people with Opioid Use Disorder (OUD) reported a history of criminal justice involvement.[18]
- Nearly 20% of pregnant women referred to addiction treatment in the U.S. in 2012 were referred by the criminal justice system.[19]
- Nationally, 83% of child welfare referrals related to prenatal substance exposure in 2019 were screened in for an investigation or alternative response.[20]

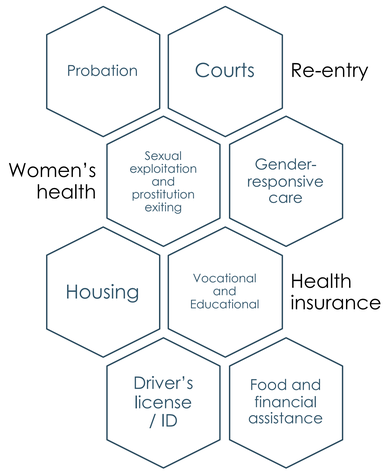
Figure 2. National association at the county level between overdose death rates and foster care entry rates, 2011-2016.[21]



Sources: CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.



Note: All results are statistically significant, $p < 0.01$. Each estimate is from a separate model, with sample sizes ranging from 14,539 to 14,560. Source: ASPE modeling.



Proposed qualitative study

In order to better understand the impact of public administrative system involvement on perinatal substance use disorder recovery, I propose a qualitative analysis of current bureaucratic barriers and inefficiencies.

Aims:

1. To document, through a series of qualitative interviews, the experience of perinatal women with substance use disorder who have navigated bureaucratic systems while pursuing recovery, as well as the perspective of officials and providers who design and work within these systems.
2. To create a statewide administrative system map, with identified targets of potential innovation, including service consolidation, virtual access, braided funding, and inter-agency collaboration.
3. To formulate recommendations for policy and administrative innovations that center the lived experience of individuals in the organization of services.

Conclusions

As prevalence of perinatal substance use continues to rise, it is imperative for researchers, practitioners, and policy makers to think more broadly than targeted addiction treatment services to the larger system of administrative bureaucracy and how it can be better designed to facilitate positive parenting and recovery outcomes. Patient-centered research illuminates a productive strategy for outlining the impact of public system navigation on the recovery trajectories of perinatal women with SUD. System mapping and professional interviews will enable a sophisticated identification of realistic targets for simplification, coordination, and innovation. This proposed qualitative research study will incorporate patient voice and policy recommendations to achieve an important contribution to translational research efforts aimed at improving the long-term outcomes of women with SUD and their children.

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