

Journal of Applied Research on Children: Informing Policy for Children at Risk

Volume 11
Issue 2 *Substance Use Prevention in the Era of COVID-19*

Article 6

2020

Community Readiness to Align and Better Support Families with Perinatal Substance Use Issues and the Impacts of the Covid-19 Pandemic on Progress

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Recommended Citation

Van Horne, Bethanie S.; Mandell, Dorothy; and Keefe, Rachael J. (2020) "Community Readiness to Align and Better Support Families with Perinatal Substance Use Issues and the Impacts of the Covid-19 Pandemic on Progress," *Journal of Applied Research on Children: Informing Policy for Children at Risk*. Vol. 11 : Iss. 2 , Article 6.

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Community Readiness to Align and Better Support Families with Perinatal Substance Use Issues and the Impacts of the Covid-19 Pandemic on Progress

Acknowledgements

We would like to thank the University of Baltimore's Center for Drug Policy and Prevention for their support of the needs and readiness assessment. We would also like to thank and recognize the many people who gave us their time, expertise, and insights for this project. It is because of their tireless work and determination that Houston has continued to make great strides in improving the system of care for families impacted by substance use issues.

Introduction

Maternal substance use is a significant and growing public health issue. In Texas and in other states, overdose after pregnancy is one of the leading causes of maternal mortality, with the majority of deaths involving opioids.¹ In general, women have been found to be disproportionately impacted by the opioid epidemic, experiencing more chronic pain, being prescribed more prescription pain medications and for longer periods of time, progressing to dependency more quickly, and having larger increases in overdose deaths than men.² Across a woman's lifetime, she is most likely to develop a substance use disorder (SUD) during her childbearing years.³ Results from the National Survey on Drug Use and Health indicate 5.4% of pregnant women reported using illicit substances and 9.9% reported heavy alcohol use while pregnant.⁴ The rates of pregnant women with opioid use disorder at delivery more than quadrupled from 1999 to 2014.⁵

Infants exposed to substances (e.g., alcohol, opiates, methamphetamines) prenatally are at greater risk for numerous short- and long-term consequences including increased rates of: stillbirth; low birth weight; physical, mental and behavioral problems; developmental delay; SUDs in adolescence; child maltreatment, and entry into the foster system as compared to their non-exposed peers.⁶ In 2019, 34% of all children in foster care in the US had parental substance use listed as a risk factor for the removal.⁷ In Texas, 68% of child welfare removals included parental substance use as a contributing factor.⁸

Pregnancy represents a uniquely vulnerable time for a woman—one in which she may be engaging more with healthcare providers and simultaneously may have an increased motivation to seek substance use treatment. Given the increased incidence of substance exposure, discrete window of opportunity, and potential for grave consequences for both mother and infant, increased attention has been placed on pregnant women with opioid use and other SUDs. Historically, SUDs, particularly for pregnant women, have been addressed through siloed efforts of treatment providers, healthcare, the judicial system, and law enforcement.⁹ Recently governments and agencies have begun to promote the use of multisector collaboration as best practice. The Substance Abuse and Mental Health Services Administration (SAMHSA) and others have developed a multitude of guidance documents highlighting the benefits and need for a coordinated and collaborative system of care for pregnant women with substance use issues and their infants.¹⁰⁻¹³ However, multiple barriers exist that may inhibit or prevent a fully functioning coordinated, collaborative system of care. Prior studies have found that pregnant and postpartum women with SUDs report poor and conflictual relationships with their healthcare providers, perceive judgment and stigma

by health care providers for having used substances while pregnant, fear of child welfare and criminal justice involvement, lack of information regarding their SUD in pregnancy, and challenges getting treatment and care.¹⁴⁻¹⁹

To gain a better understanding of the existing system of care for pregnant and postpartum women with SUDs in Houston, Texas, we established and supported a multisector collaborative and conducted needs and readiness assessments in 2018. Findings from the assessment were presented to the collaborative, and together, recommendations were developed to facilitate improved cross-sector coordination and support for pregnant and postpartum women. These recommendations were developed to help improve each sector's response and to create a system of care where fewer women would fall through the cracks.

Since the conclusion and dissemination of the needs assessment results, much progress has been made in Houston towards many of the recommendations. However, the impacts of the Covid-19 pandemic on these initiatives are unknown. Initial findings from an assessment by the Houston High Intensity Drug Trafficking Area (HIDTA) indicate changes in multiple areas of drug use (e.g., overdose death rates, the types of drugs available, treatment facility policies, and treatment seeking populations), suggesting that potential changes in the Houston substance use response landscape are needed.²⁰ The first purpose of this paper was to briefly describe the results of the needs and readiness assessments, highlighting the areas where improvements were needed and Houston organizations indicated readiness for change. The second purpose was to discuss both the progress that has been made as well as the impact the pandemic has had on this progress. Results from the assessments may be used by other cities to design a coordinated cross-sector approach to best care for pregnant and postpartum women with SUDs. Additionally, sharing our experiences of the effect of the Covid-19 pandemic on our progress may help other cities consider this population as they respond to and plan for Covid-19 and similar events.

Brief Description of the Houston Area's Rates, Sectors, Programs, and Services for Pregnant Women with SUDs

Houston, the fourth largest city in the US, is one of the country's most ethnically diverse cities. Its metro area is home to nearly 7 million people. Over the past decade, Houston's toxic overdose fatalities have risen. In 2018, Houston had more drug-involved overdose fatalities than many other states.²¹⁻²³ However, rates of prenatal substance exposure and opioid withdrawal were some of the lowest in the state (5.5 and 1.14 per 1,000 births, respectively).²¹ As a large, populous city, Houston has programs and services across multiple sectors that serve pregnant and postpartum women and their infants. Below is a brief description of these sectors and services (as of the 2018 assessment):

Treatment. Houston has a large number of treatment facilities, including ones that provide inpatient, outpatient, and medically assisted treatment (MAT). However, it has been noted that many require insurance or cash payments, which limit access to treatment, and waitlists for services can be long.²⁴ Pregnant women are considered a priority population; however, spots remain limited.⁸ The city has one residential treatment facility that allows children to accompany the mother to treatment. In 2017 the Texas Health and Human Services Commission funded 2 (of the state's 18) Pregnant and Postpartum Intervention (PPI) programs in Houston. These programs are designed to support pregnant and postpartum women with or at risk for SUDs to engage in prenatal care, seek treatment if needed, and address parenting, mental health, and other needs in order to provide a healthy home for themselves and their children.

Healthcare. Over 30 hospitals deliver the nearly 100,000 births across the metro region each year.²⁵ Approximately 46.7% of the births in the city are covered by Medicaid, and an estimated 25% of adult females in Houston did not have health insurance in 2017.^{26,27} Despite having the largest medical center in the world and multiple medical schools, Houston is known as a mental health professional shortage area with limited services for mental health conditions.

Criminal Justice. Houston has 2 primary law enforcement agencies (the Houston Police Department and the Harris County Sheriff's Office) with additional smaller departments servicing the metro area. Harris County has multiple specialty court programs for substance use related cases including the Positive Pathways Family Reunification Court, which provides intensive programming for families in the child welfare system with a history of substance use. The Harris County Jail also has a specialty reunification program for incarcerated pregnant and parenting women.

Child Welfare. For children under the age of 1, there were over 3700 completed child maltreatment investigations with 1297 confirmed victims in Harris County in fiscal year 2018.²⁸ Per the Texas Family Code, the Texas Department of Family and Protective Services (DFPS) cannot investigate or intervene with a family unless a child is in the home (i.e., until after they are born), and per federal legislation, physicians are required to notify DFPS if a child is born with substance exposure.²⁹ In 2018, DFPS did not have specialized investigators for substance-exposed births or parental substance use in the Houston region. For families involved with DFPS with substance use issues, DFPS caseworkers commonly include treatment and recovery services as part of their service plan. However, numerous issues have been documented that limit access and participation in substance use treatment.⁸

Methods and Approach

Needs Assessment

A mixed-methods approach was used to develop the needs assessment that guided the development of recommendations that would improve cross-sector coordination and

response to pregnant women with substance use disorders. This assessment focused on (1) analysis of administrative hospital data to investigate the burden of prenatal drug exposure in the community and (2) stakeholder interviews. For the purpose of brevity, this report focuses only on the results from the stakeholder interviews.

Throughout 2018, the project team met with stakeholders to gain an understanding of 4 key questions: (1) How do sectors and agencies respond to perinatal opioid use? (2) Are sectors intentionally interacting with one another to address perinatal opioid use? (3) What resources and programs are available, and which are needed? (4) What barriers and challenges exist that prevent sectors and agencies working with one another to address perinatal substance use specifically?

Interviews were informal and information-gathering in nature to both understand the unique challenges of the sector and gain trust between the interviewee and sector. Interviews were conducted with multiple organizations and roles within each sector to help provide a comprehensive answer to each question. Notes were taken by the interviewer, and interviews were recorded at the discretion of the interviewee. These interviews were conducted through several formats including face-to-face discussion, video conference, and phone calls. When possible, other project staff members were included and listened to the interview. After each interview, the interviewer and any staff present discussed the interview, listened to recordings when available, and consolidated notes. If something was not clear or the two heard a point differently, the interviewer sought clarification from the interviewee.

Stakeholder and collaborative meetings were also held. All of those interviewed were invited to participate and were encouraged to invite others from their organization and sector. During these meetings anonymous insight and major themes from the interviews were presented and the members discussed their sector's perspective. These meetings had the goal of increasing trust among the sectors and disambiguating each sector's role. Further, these meetings served as a forum to develop recommendations that would facilitate and support cross-sector collaboration.

Readiness to Implement Recommendations

A survey was conducted with participants and stakeholders in order to assess acceptability and feasibility for the recommendations that were developed from the needs assessment, stakeholder feedback, and collaborative meetings. This survey was designed to assess feasibility by asking them to: (1) rate each recommendation, (2) identify the likelihood that the recommendation would have an immediate short-term impact, and (3) identify likelihood that the impact would be felt long-term. Each of these areas of feasibility were rated on at 5-point scale.

If respondents felt that their organization or sector would be implementing or directly impacted by the recommendation, they were further asked questions about organizational readiness. Questions that were focused on readiness were developed using the Organization Readiness for Change Assessment (ORCA) framework. The questions focused on assessing context and facilitation within the sector. The questions asked about the following: (1) the level of leadership support for implementing the recommendation, (2) whether there was organizational infrastructure to implement it, and (3) whether multisector cooperation existed to implement the recommendation. These were also rated on a 5-point scale.

The goal of this survey was to determine which of these recommendations were perceived as important and would result in improvements within a year of being implemented. The second goal of this survey was to gain additional information about organizational barriers that existed for the recommendations. The recommendations varied in their alignment with statewide priorities and other opportunities that were becoming available. Therefore, this assessment also provided insight into what additional work would be needed to implement the recommendations that were aligned with state and funding priorities.

Progress Towards Recommendations and the Impact of COVID-19

To identify progress made on the recommendations and discuss the impacts of Covid-19 on this progress, we interviewed 9 program leaders representing 5 organizations and 3 sectors. All interviews were conducted virtually on the phone or via teleconference in June and July 2020. Because Houston was still very much in an emergency response mode during the interview period, interviewees were selected using convenience sampling. Those interviewed were invited to participate because members of the study team were aware of initiatives that had been started. Interviewees were asked to describe the progress made in the last 2 years specific to the recommendation(s) they were working on and to discuss what happened to this work during the pandemic, including policy/procedure changes. The interviewer took notes during each interview. All of the notes were compiled and reviewed, and overarching themes were identified. Each theme identified was discussed by at least 2 participants and impacted multiple sectors. Direct quotes that were emblematic of a specific theme and represented experiences of the participants were selected for inclusion.

Results

Sample Description

Three groups of participants were represented in the results of this project. The first group was interviewed for the needs assessment and consisted of 59 individuals who

represented 5 sectors (Table 1). The second group comprised 25 individuals who represented 4 sectors and completed the readiness survey. The third group provided information on the impact of COVID-19 and consisted of 9 individuals working on initiatives and projects related to our recommendations. These groups were not mutually exclusive, with overlap between the samples.

Table 1: Sample Description

	Needs Assessment	Readiness Survey	Follow-Up COVID Interview
Community	4	0*	2 (public health)
Healthcare	28	8	2
Law enforcement/Justice	14	4	0
Treatment	6	10	5
Child Welfare	7	3	0
Total	59	25	9

**In the readiness survey, community was not an option provided. The respondent had to choose the sector (healthcare, law enforcement/justice, treatment, or child welfare) in which they would be implementing the recommendations.*

Needs Assessment

A total of 59 individuals across 5 sectors (Table 1) were interviewed to help determine the care landscape for pregnant women with SUDs, where sectors were misaligned, and what was needed to better support pregnant and postpartum women with SUDs. The results of the interviews were aggregated to the level of the sector. The results of these interviews are presented in terms of the 4 key questions that framed all the interviews.

How do sectors and agencies respond to perinatal opioid use?

Many of the sectors we interviewed did not have documented policies or procedures guiding their response to perinatal substance use. In the case of child welfare, this was intentional as to encourage responses that addressed each family's unique circumstances. For the healthcare sector, however, the lack of written policy was described more often as a result of this issue not being prioritized.

Whether intentional or not, the lack of clear policies and procedures resulted in sectors viewing each other's response as inconsistent. The inconsistency in response, within and across sectors, made it difficult for members of one sector to understand, describe, and ultimately prepare their clients for their future interactions with the other sectors. No matter the sector, other sectors often repeated the same refrain of "it depends on who you get." This inconsistent response resulted in mistrust within and across sectors.

It was also clear through our interviews that sectors that did have policies were not routinely reviewing and updating them to follow current research and recommended best practices. Many sectors had practices that were out of date with the current evidence base on effective SUD treatment. These out-of-date policies were particularly found in the use of MAT with pregnant women and created conflict with sectors that had more up-to-date policies. This conflict was particularly clear with respect to whether or not women who recently delivered would be kept on MAT.

Are sectors intentionally interacting with one another to address perinatal opioid use?

A dominant takeaway from these interviews was that a robust or high-functioning system of care to support women with SUDs and their children did not exist in Houston. There were pockets of cross-sector trust and collaboration between 2 or 3 agencies, mostly occurring through the diligent work of individuals and small groups. However, there was no institutionally codified interaction or cooperation between sectors that supported pregnant women.

The interviews showed that sectors did not interact with enough consistency and intention to have a good understanding of one another's roles, responsibilities, and limitations. Assumptions and judgments were often expressed about what specific sectors are able to do and may or may not be doing. For example, law enforcement expressed frustration that many people thought that typical street officers can take substance-using individuals to treatment when this type of service is not within their scope of work. Similarly, child welfare workers noted that they are not viewed as an agency that provides resources and support to families, but instead are viewed as an adversary. Further, many sectors also thought that child welfare services had the power to intervene in situations that were outside its legal bounds (i.e., with pregnant women with no other children at home).

What resources and programs are available, and which are needed?

Interviewees in all sectors identified additional resources needed to effectively respond to SUD during pregnancy. Increases in staffing, resources, and substance use treatment beds were often cited as needs. However, with few exceptions, these resources would not necessarily lead to more cross-sector collaboration.

A common resource that was cited as a need across sectors, but that no single sector could address, was housing for families. Treatment, courts, law enforcement, and child welfare services all identified a lack of affordable housing and transitional housing as a major barrier to helping families. Housing for a family could be the tipping point between compliance and noncompliance with court orders and between a family remaining

together or having their infant removed. Every sector that discussed housing as a need talked about the extraordinary lengths they would go through to get families into housing, but all also said there simply were not enough housing vouchers or housing availability to cover the need.

A need that was discussed that could directly impact cross-sector collaborations was training and education. Training and education on SUDs, best practices for treatment, and local programming options would help decrease stigma as well as promote and improve cross-sector collaboration. However, most sectors are not required to receive ongoing education on topics specific to SUD despite the prevalence of SUDs within the populations they serve.

What barriers and challenges exist that prevent sectors and agencies working with one another to address perinatal substance use specifically?

Policies that are meant to guide interagency collaboration are often misunderstood. As one interviewee stated, "The only thing worse than HIPAA is what people think HIPAA is." This sentiment was expressed by many and reflected an inconsistent application of laws meant to protect an individual's privacy. The misinterpretation and lack of understanding of the Health Insurance Portability and Accountability Act (HIPAA) has caused child welfare workers not to share a child's information with their pediatrician and agencies not to share data or collaborate to support individuals for fear of violating HIPAA. Title 42 CFR part 2, which provides additional privacy protection to those in SUD treatment, has also caused confusion and missed opportunities for intervention. Several hospital social workers we interviewed were fearful of providing SUD treatment information or referring a patient to treatment because of their (mis)understanding of these privacy regulations.

Readiness to Implement Recommendations and Progress Made

From these interviews and the stakeholder meetings, 25 recommendations were developed. These recommendations focused on changes that could increase cross-sector collaboration; changes that would reduce a barrier in one sector, making another sector's response easier; and changes that impacted all sectors. All recommendations were included in the readiness assessment. The skip patterns of the readiness assessment insured that only those sectors that would be involved in implementing the recommendation were contributing to the readiness score. Therefore, the score represents a cross-sector readiness assessment.

Since the assessment, progress has been made on 8 recommendations. Reported here is the mean level of readiness for these 8 recommendations as well as a brief description of the progress made subsequent to the assessment.

Recommendations Focused on Healthcare

Several recommendations focused on healthcare's response to pregnant women with SUD. These recommendations included:

Strengthen partnerships and linkages between obstetricians and treatment facilities with community resources to address underlying drivers of health such as food insecurity, housing, and employment.

Establish healthcare clinics that specialize in the treatment and care of women with substance use disorders and drug-exposed infants.

Obstetric practices should universally screen all patients for drugs and alcohol using the Screening Brief Intervention and Referral to Treatment (SBIRT) model at the first prenatal visits and at the beginning of each trimester.

Of these recommendations, "establishment of specialized healthcare clinics for women with SUD" was ranked as having the most immediate impact if implemented, but it was viewed that the sector was not ready to implement (6.2 out of 12) and had the second lowest readiness score of all 25 recommendations. Complimentary to this low readiness, the other 2 recommendations, which would also support better cross-sector collaboration between healthcare and treatment facilities, also had low readiness scores (both below 8 out of 12).

Progress. In 2019, one of Harris County's safety-net hospitals became one of two pilot sites for the Alliance for Innovation on Maternal Health (AIM) bundle on Obstetric Care for Women with Opioid Use Disorder in Houston and established a specialty outpatient obstetrics clinic for pregnant women with substance abuse issues. The multidisciplinary clinic team includes: maternal and fetal medicine specialists, obstetric anesthesiology, neonatology, addiction medicine psychiatry, social workers, case managers, a psychologist, fellows from psychiatry and obstetrics, and peer support and community services provided by a local treatment facility. This multidisciplinary approach allows for coordination of care for physical and mental health, substance use disorders, and assistance with other needs (food, housing, transportation, etc) as well as creates a collaborative and welcoming environment for patients. Prior to and at the end of each clinic day, the team of providers "huddle" and review the patients being seen that day, discuss any challenges and successes, and strategize to ensure they are providing the best care possible to the women in their care. Within several months of being open, the clinic recognized the demand for the service and started planning to expand from 1 full day to 2 per week. In early 2020, the Texas Health and Human Services Commission in partnership with the clinic was awarded an innovation grant from the Center for Medicare and Medicaid to help support improvement efforts.

Also beginning in 2019, the Southeast Texas Regional Advisory Council's Maternal Mortality and Morbidity Workgroup unanimously approved a quality improvement project that would have each hospital in the region develop a process for screening for substance use disorder for their pregnant and postpartum women with appropriate treatment and referral processes.³⁰

Medically Assisted Treatment in Jails

Jails and prisons should expand the use of MAT to all inmates with opioid addiction, including the continuation of MAT post-childbirth.

This recommendation was one of the few recommendations that would directly impact more than just pregnant women with SUD and was specific to a single sector. However, the collateral impact of increased overdose deaths that all sectors saw as a result of current policy made this recommendation a priority. This recommendation had an above-average ranking in importance but was seen as having generally low readiness (6.7 out of 12).

Progress. During the needs assessment, the Harris County Jail was piloting the use of vivitrol for opioid-dependent inmates. The medication for the pilot was donated by the pharmaceutical company and was intended for 30 inmates just prior to release to decrease the likelihood of overdose post-incarceration. Through funding and partnership with the Harris County Public Health Innovation Lab accelerator program, the Harris County Sheriff's Office has been able to expand the use of vivitrol within the jail. The partnership also provided an additional counselor to work with inmates with substance use disorders, support to develop a structured linkage to the care system and process, and assistance establishing new community partnerships to identify patient populations and increase access to MAT and continuity of recovery support services post-release.

Recommendations Focused on Awareness, Prevention, and Training

A common theme that emerged throughout the year of this work was that there needed to be baseline education for both women with SUD and the workforce that interacted with them. Three recommendations were developed that focus on this theme:

Increase awareness of available treatment services for perinatal substance use through a public awareness campaign that targets this population specifically and is delivered in locations that pregnant substance users and opioid users frequent.

More initiatives are needed to prevent substance use disorders by engaging with community sectors that provide community-based primary prevention services.

Each sector encountering clients/patients with substance use disorders should develop a policy for training their staff, including mandates for annual/routine training requirements.

All 3 of these recommendations had high readiness scores, with training for staff having the highest (9.3 out of 12). It must be noted that education and training for the workforce that interacted with women with SUD were being developed and implemented in parallel with this readiness assessment. Therefore, these high scores on readiness reflected this work.

Progress. For over 15 years, the Texas Health and Human Service Commission has supported local PPI programs across the state, with 2 located in Houston focusing on high-risk populations in 2018. Over the last 2 years, both programs utilized philanthropic funds to increase their outreach efforts and add partnerships with medical and social service agencies to expand their reach, including providing co-located or integrated services in a number of these locations.

As indicated in the needs assessment results, training and education were needed in all sectors. Subsequently, education and training were included as part of all of the initiatives described above. For the 2 Houston hospitals participating in the AIM bundle on Obstetric Care for Women with Opioid Use Disorder pilot, increasing the education and training within their facility has been a focus. For the hospital with the new specialty clinic, this has included: education to leadership about importance and needs for this population; education sessions with inpatient and outpatient nursing to decrease stigma and bias; trainings with nurses on how to give medications like buprenorphine films; and community presentations focused on increasing awareness within other obstetric clinics and birthing hospitals. On the prevention side, both PPI recipients are active participants in the Harris County Neonatal Abstinence Syndrome (NAS) collaborative, which has been working on increasing the availability of training for all levels of providers (including medical assistants, social workers, and physicians) and awareness of treatment and support resources across greater Houston. Additionally, Harris County Public Health received a 3-year grant from the Centers for Disease Control and Prevention. This grant not only is assisting with the expansion of MAT services within the jail, but also includes creating awareness and a toolkit for the prescription drug monitoring program usage for prescribers and buprenorphine waiver trainings with follow-up support for participants to help tackle barriers and ensure providers are comfortable and able to prescribe once waived.

Plans of Safe Care Recommendation

Texas should refine their plan for how the state is going to comply with the 2016 Child Abuse Prevention and Treatment Act (CAPTA) and Comprehensive

Addiction and Recovery Act (CARA) requirements, including the new provision for plans of safe care.

Several recommendations focused on making the child welfare response more transparent and coordinated; however, the recommendation surrounding plans of safe care was the only one driven by statewide and federal policy. The child welfare-focused recommendations all had low readiness scores. The recommendation for plans of safe care had the lowest among these (6.8 out of 12). This recommendation was also rated as low importance and in the bottom 10 of the recommendations. We attributed this low ranking to participants not understanding the purpose of plans of safe care and the value for families. At the time of this assessment, even partners within child welfare did not understand how this requirement was different from what they were already doing with families.

Progress. Despite being federally mandated to provide a plan of safe care for substance-affected infants since 2003, the concept of plans of safe care was relatively unknown during the 2018 needs assessment.³¹ However, as both federal guidance and pressure to develop plans of safe care have increased, so too has interest. The DFPS 2015-2019 Title IV-B 5-year report outlined the directives of the new “Substance Abuse Project”, which included strengthening collaborations to support and improve plans of safe care and communication between support services and child welfare but did not include the development of tools that could be used in the field.³² In late 2019, public health researchers at a Houston-based medical school received grant funding to develop and pilot the plans of safe care within the greater Houston area. A cross-sector steering committee, including representatives from child welfare, treatment, healthcare (obstetrics and pediatrics), and justice (jail and court), was formed and has been meeting to develop the tools and pilot them with women in their care. Many of the participants in this steering committee previously participated in the needs and readiness assessment conducted in 2018. In 2020, the state’s Prevention and Early Intervention provided additional funding to expand this pilot and develop additional training.

Impact of the Covid-19 Pandemic

Across the 9 interview respondents, themes emerged regarding the impact of the coronavirus pandemic and how the subsequent changes to business practices influenced their programs’ and organization’s ability to continue to make progress. While some of these impacts may be true for many services, others could be unique to the cross-sector interactions and needs of pregnant and postpartum women with substance use issues.

Integrated Care Was Greatly Challenged and in Some Circumstances Stopped

One of the major ways Houston organizations provide integrated care is through partnerships with outside organizations to provide that care onsite and in coordination with their providers. For example, the specialty outpatient obstetrics clinic for pregnant women with substance abuse issues works in partnership with a local treatment facility to provide access to treatment and recovery support during patient visits. Not only does the treatment staff attend clinic and emergency visits with the pregnant woman, but they also help liaise between hospital staff and the woman while teaching her how to navigate the system and advocate for herself. The partnership also includes bidirectional referrals to assist with engagement in both prenatal and treatment services, and treatment staff participate in before and after visit huddles to assist providers with patient care and in understanding patient needs. In response to safety concerns during the Covid-19 pandemic, all hospital visitation was stopped. This included staff from outside partner organizations, which greatly impacted the treatment and recovery support that could be provided during patient clinic visits. Similarly, recovery coaches hired by Harris County Public Health as part of the MAT expansion in the jail were also prohibited from coming into the jail facilities.

Limitations on Visitors and Additional Supports

Not only did the new policies around limitations on visitors and supports allowed into facilities impact integration of care, they also affected a number of other initiatives. For the Plan of Safe Care initiative, document development was able to continue through virtual meetings, but piloting the use of the tools by mothers with their providers and obtaining feedback were placed on hold for several months. Within the Harris County Jail, family visitation has been suspended, but phone privileges have been expanded and the cost of phone calls reduced. Within clinical care, pregnant women were not allowed to have their partners or a support person with them during medical visits or at delivery. Clinics attempted to use video calls to help pregnant women feel less alone, but this did not always work due to barriers in technology. During the beginning of the pandemic, at least one clinic experienced an increase in their pregnant and postpartum patients leaving against medical advice. Additionally, visitation restrictions also applied to mothers and babies post-delivery when the infant needed to stay for observation but the mother was released. “It was nearly impossible to get them back in to see their baby,” stated one healthcare clinician. This was in part due to limitations on testing and strict requirements on who, other than essential staff, could be in the hospital.

Administrative Changes and Delays

Administrative changes manifested in multiple ways, from how consents and power of attorney documents were handled to staffing changes, and delays in contracts being signed. As one clinician said, “*Pretty much everything we did had to change.*” This

seemed particularly true for clinical services providing care to pregnant and postpartum women. For both AIM pilot hospitals, major changes were made to ensure the safety of staff and patients as well as prepare for increasing capacity to accommodate Covid-19 positive patients. This included new processes for checking patients in while maintaining social distancing, obtaining consent forms, and receiving information through screeners and questionnaires electronically instead of on paper; unit and staff reassignments to make accommodations for new Covid-19 units; staffing shortages; limitations on staff movement across services (no sharing of staff across inpatient to outpatient services); and prioritization of staff provided full personal protective equipment, which limited some providers to no contact visits. Nearly all programs interviewed experienced delays in new contracts and agreements being executed as well as staffing shortages and hiring challenges, all of which impacted their ability to maintain their current level of services much less expand as planned.

Teleservices are Working for Some but Not for All

Utilization and rapid expansion of teleservices allowed many organizations to continue providing care and services to patients/clients during the Covid-19 pandemic. For the prevention programs, which typically provide services in the community and already had flexibility to “meet clients where they are”, the transition with current clients was reported to be relatively easy. One prevention program staff noted that “through tele-services we are seeing a higher completion rate. We are able to accommodate more people, and childcare and transportation are less of an issue.” The same program staff also noted that they have noticed an increase in child welfare’s ability to follow-up and support clients completing the program. Additionally, training and educational sessions have been able to move to remote delivery, though perhaps not reaching the same or all of the intended audiences. It was also reported that the expansion of teleservices has helped prepare programs and organizations for future work enabling continuity of care through transitions (e.g., keeping the same recovery coach when leaving the jail or inpatient treatment) and allowing for coverage of larger geographic areas.

For other programs, however, teleservices have not been working as well. Telehealth was not available in the county jail due to both lack of technology and approved processes and protocols. For the specialty outpatient obstetrics clinic, telehealth was attempted but ultimately “took longer and was substantially less helpful than in-person visits,” per a clinic provider. One unique challenge in this clinic was the fact that many of the patients were residents at an inpatient treatment facility that does not permit residents to have cellphones. Coordinating video and phone visits was extremely challenging due to providers running late, added time to locate the woman for her visit, and connection issues. While in-person visits were preferred by the physicians, it was also noted that because providers were wearing full personal protective equipment, it

was challenging to interact and build rapport with patients. This was particularly evident during visits with patients with trust issues and histories of trauma.

Conclusions

Pregnant and postpartum women with substance use disorders are a unique and vulnerable population that engage with many sectors. While Houston did not have a comprehensive and high-functioning system of care to support women with SUDs and their children in 2018, many efforts are currently underway to better support these families and improve the system of care. Unfortunately, much of this progress has been slowed or disrupted due to the Covid-19 pandemic and the resulting policy and procedure changes that ensued to help limit infection exposure. While some of the consequences have likely impacted many sectors and populations (e.g., staffing shortages, delays in hiring and contract execution), others may be unique to pregnant and postpartum women with SUDs and the organizations working with this population (e.g., telehealth challenges during obstetrics care for women in treatment, hospital/clinic visitation policies). The goal of this paper was to illustrate the progress that is possible when cross-sector collaborations and community efforts focus on best serving pregnant women with substance use disorders, as well as share the unique challenges and opportunities for growth due to the pandemic. As we reflect on all we have learned during this time to strengthen our current response and plan for future events, policymakers and organizations should be thoughtful in understanding the needs of this specific population and evaluate the potential policy implications for this population and their providers. Similarly, practitioners, researchers, and services providers working with this special population (and others) need to be documenting what we have learned-- what was tried, what worked, what did not work, what policies should and should not remain after the pandemic--and what we still do not know to better inform our leaders and policymakers.

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