



**Developing a Plan of Safe Care for
Infants with Prenatal Substance
Exposure, their Mothers and Caregivers:
Collaborative Approaches Learned in a
Six Site Initiative**

Linda Carpenter | Jill Gresham | Mollie Green | Dr. Mishka Terplan

**CWLA 2016 National Conference
Advancing Excellence in Practice & Policy: What
Works For Families Affected by Substance Use**

August 1, 2016 | Orange County, California



*Session
Goals:*

- 1) Overview of six sites and lessons learned
- 2) Discussion of CAPTA, hospital referrals and Plans of Safe Care
- 3) Discussion of the 5-points of intervention, including working with medical and substance use disorder treatment providers



National Center on
Substance Abuse and Child Welfare

Bringing Systems Together for
Family Recovery, Safety, and Stability

*Improving
Family
Outcomes*

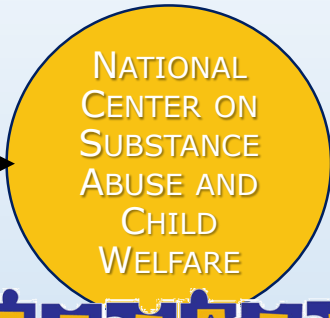
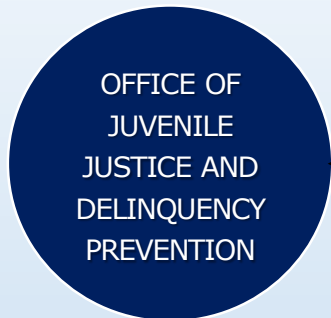
*Strengthening
Partnerships*

Acknowledgement

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Substance Abuse and Mental Health
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and Families
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Points of view or opinions expressed in this presentation are those of the presenter(s) and do not necessarily represent the official position or policies of the above stated federal agencies.



OJJDP



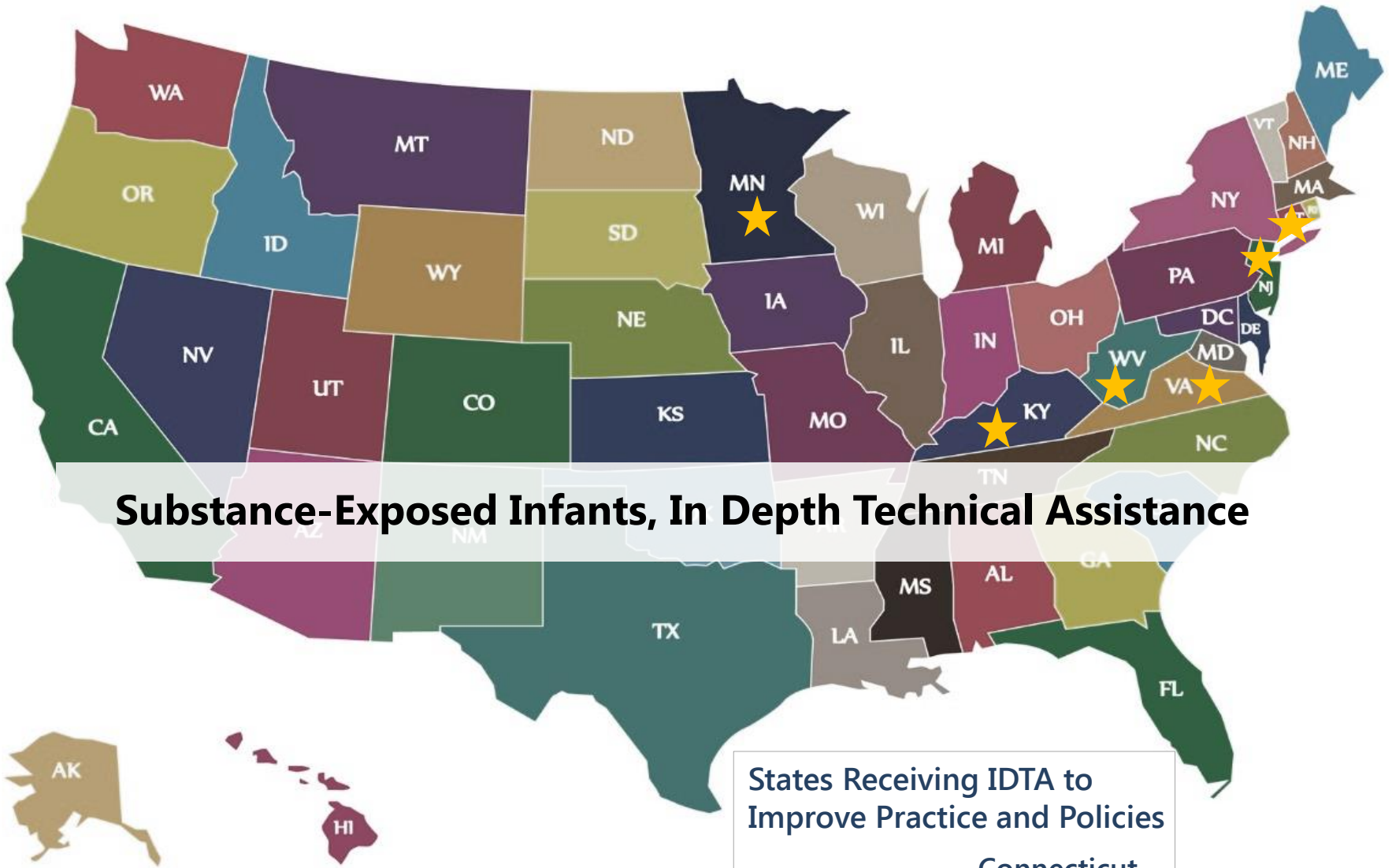
Children and
Family Futures



National Center on
Substance Abuse and Child Welfare




www.cffutures.org



Substance-Exposed Infants, In Depth Technical Assistance

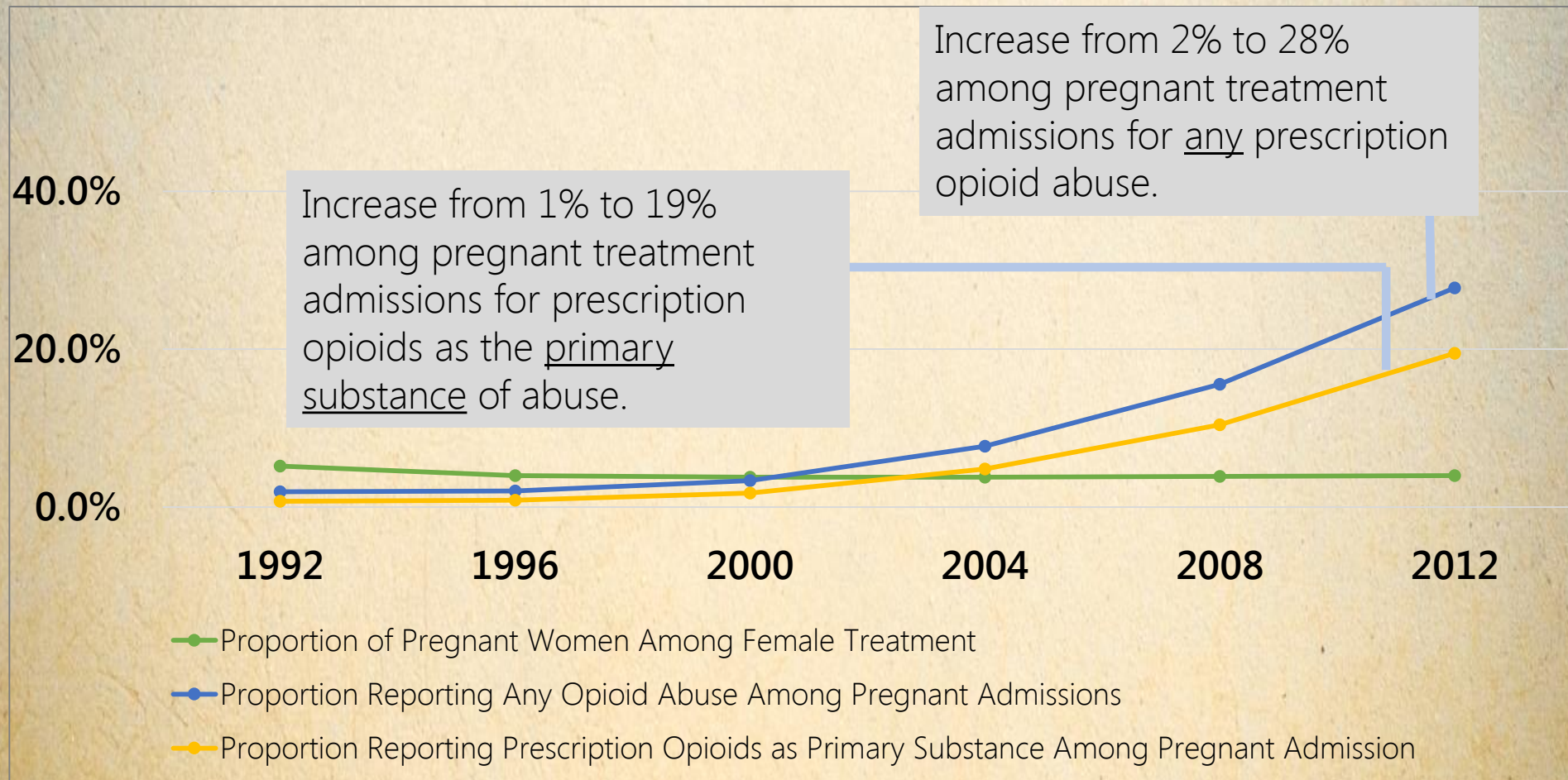
States Receiving IDTA to Improve Practice and Policies

- Connecticut
- Kentucky
- Minnesota
- New Jersey
- Virginia
- West Virginia

A landscape photograph showing a dirt path leading towards a horizon. The path is flanked by green grass and dark, rocky ground. The sky is bright blue with scattered white clouds. A semi-transparent dark green box is overlaid on the lower part of the image, containing white text.

The Scope of the Problem— National Data

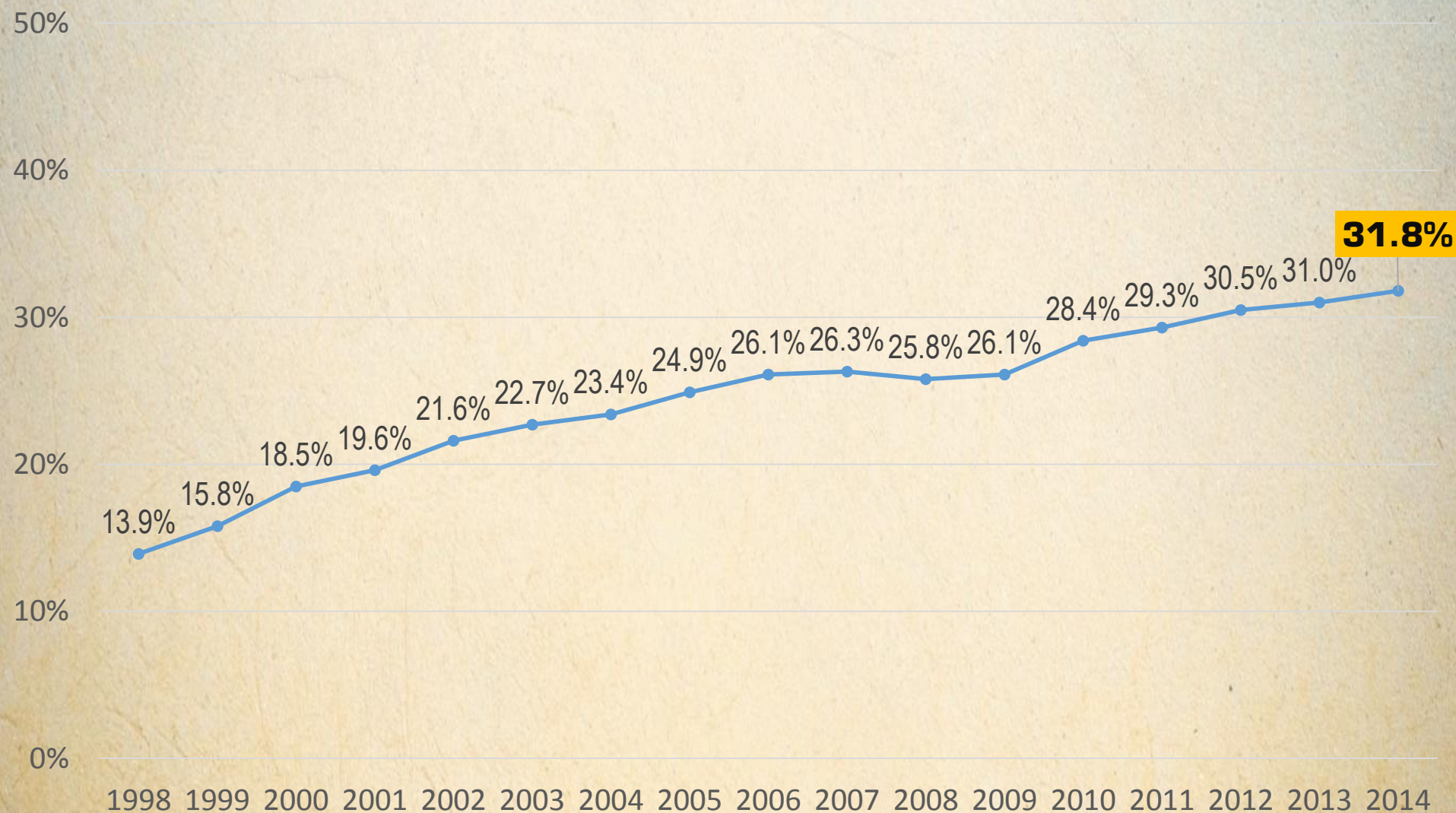
Pregnancy and Prescription Opioid Abuse Among Substance Use Disorder Treatment Admissions



Increase from 2% to 28% among pregnant treatment admissions for any prescription opioid abuse.

Increase from 1% to 19% among pregnant treatment admissions for prescription opioids as the primary substance of abuse.

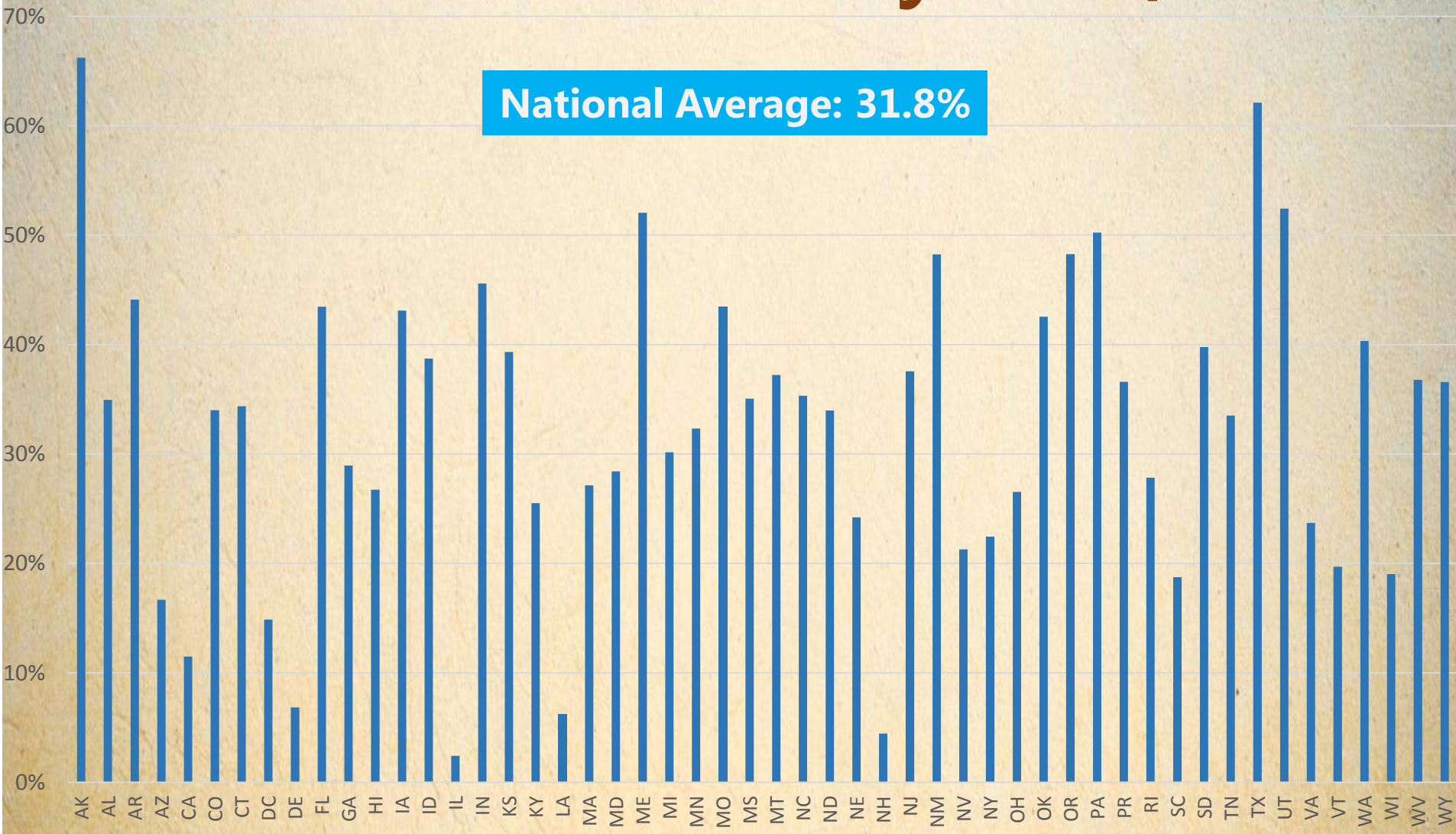
Parental AOD as Reason for Removal in the United States, 1999-2014



Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2014

Parental Alcohol or Drug Use as a Reason for Removal by State, 2014

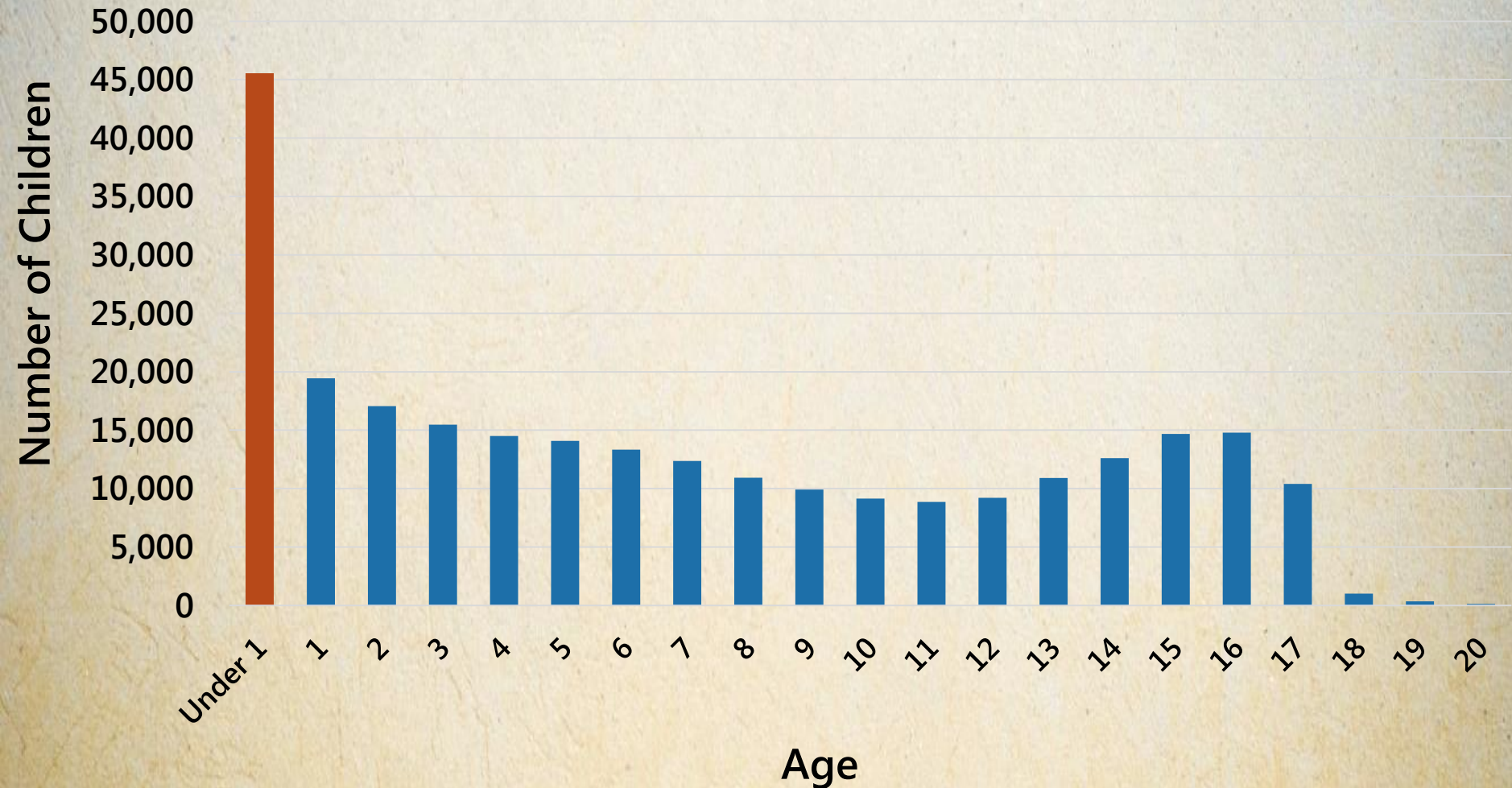


National Average: 31.8%

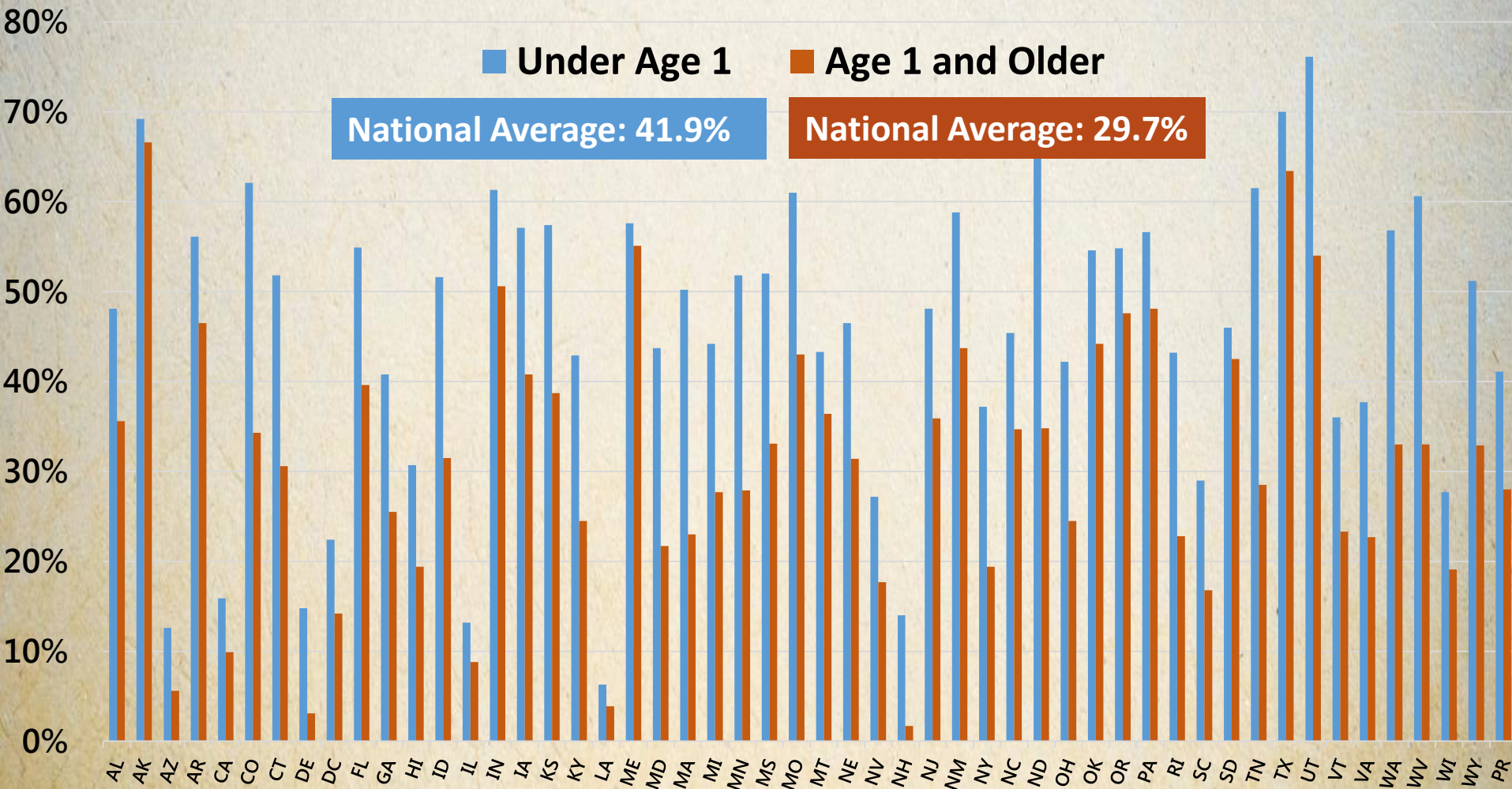
Note: Estimates based on all children who entered out of home care during Fiscal Year

Source: AFCARS Data, 2014

Age of Children who Entered Foster Care by Age, 2014 (N=264,746)



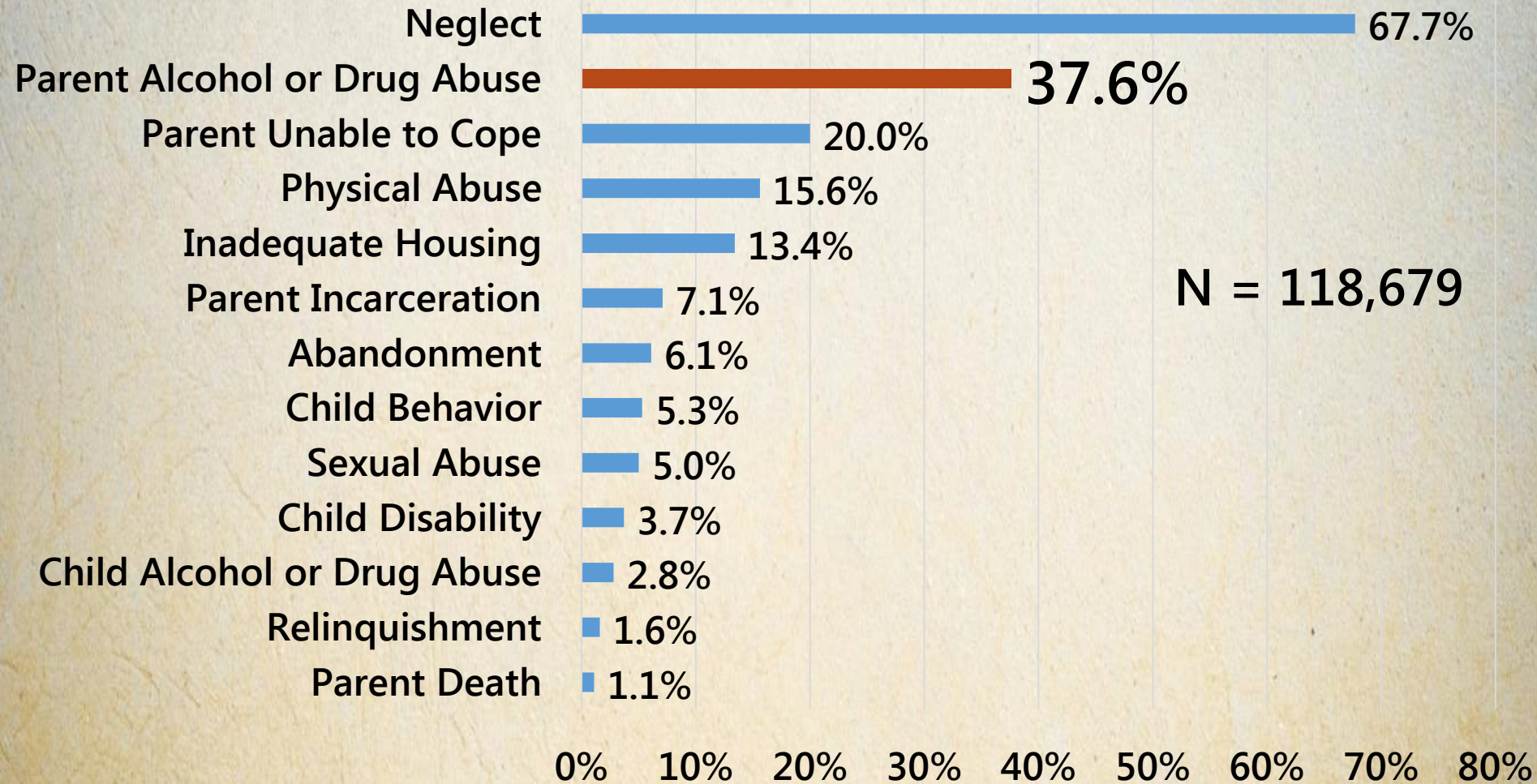
Percent of Children Removed with Parental AOD as a Reason for Removal by Age, 2014



Note: Estimates based on all children who entered out of home care during Fiscal Year

Source: AFCARS Data, 2014

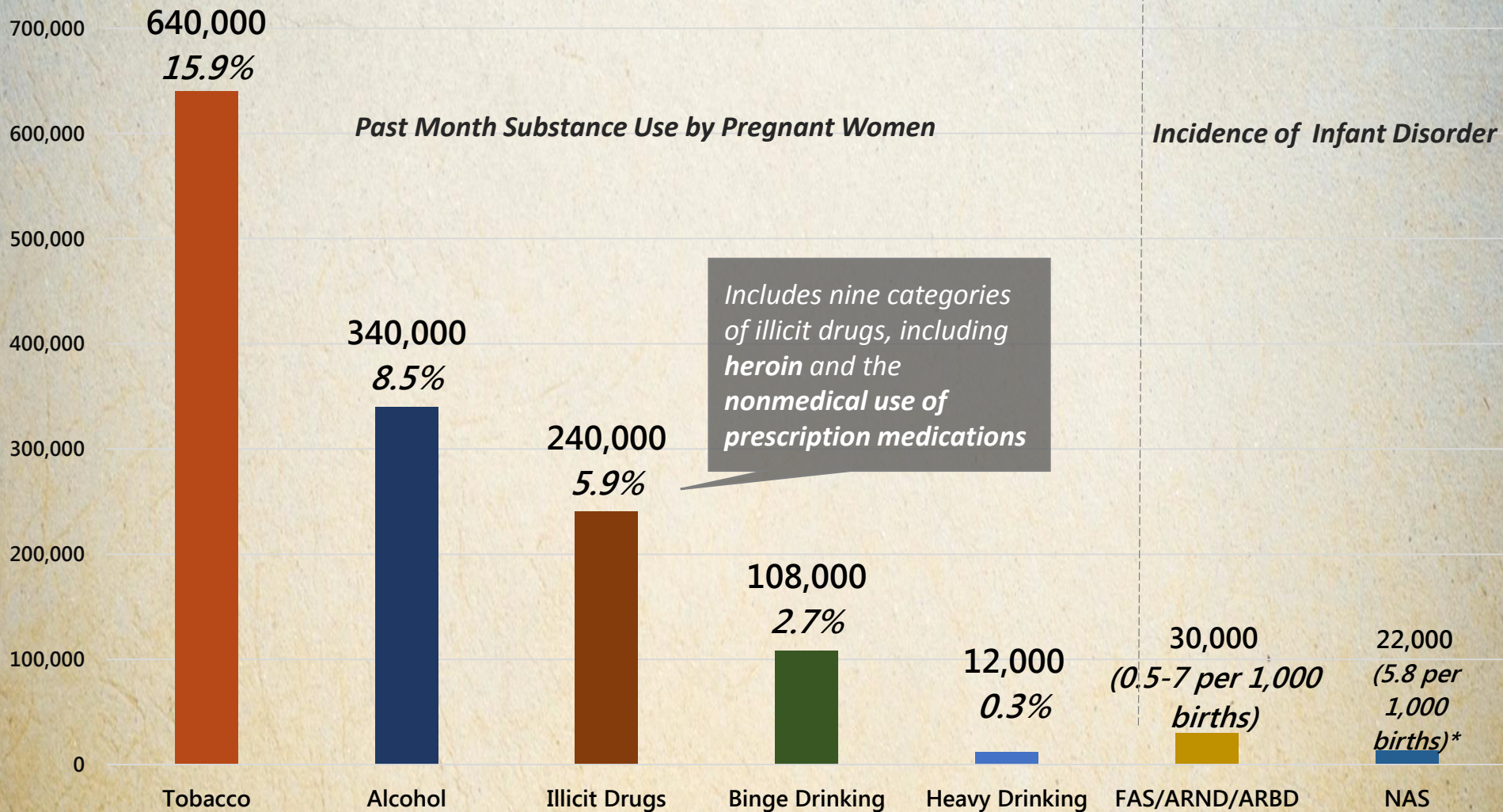
Percent of Children with Terminated Parental Rights by Reason for Removal in the United States, 2014



Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2014

Estimated Number of Infants* Affected by Prenatal Exposure, by Type of Substance and Infant Disorder

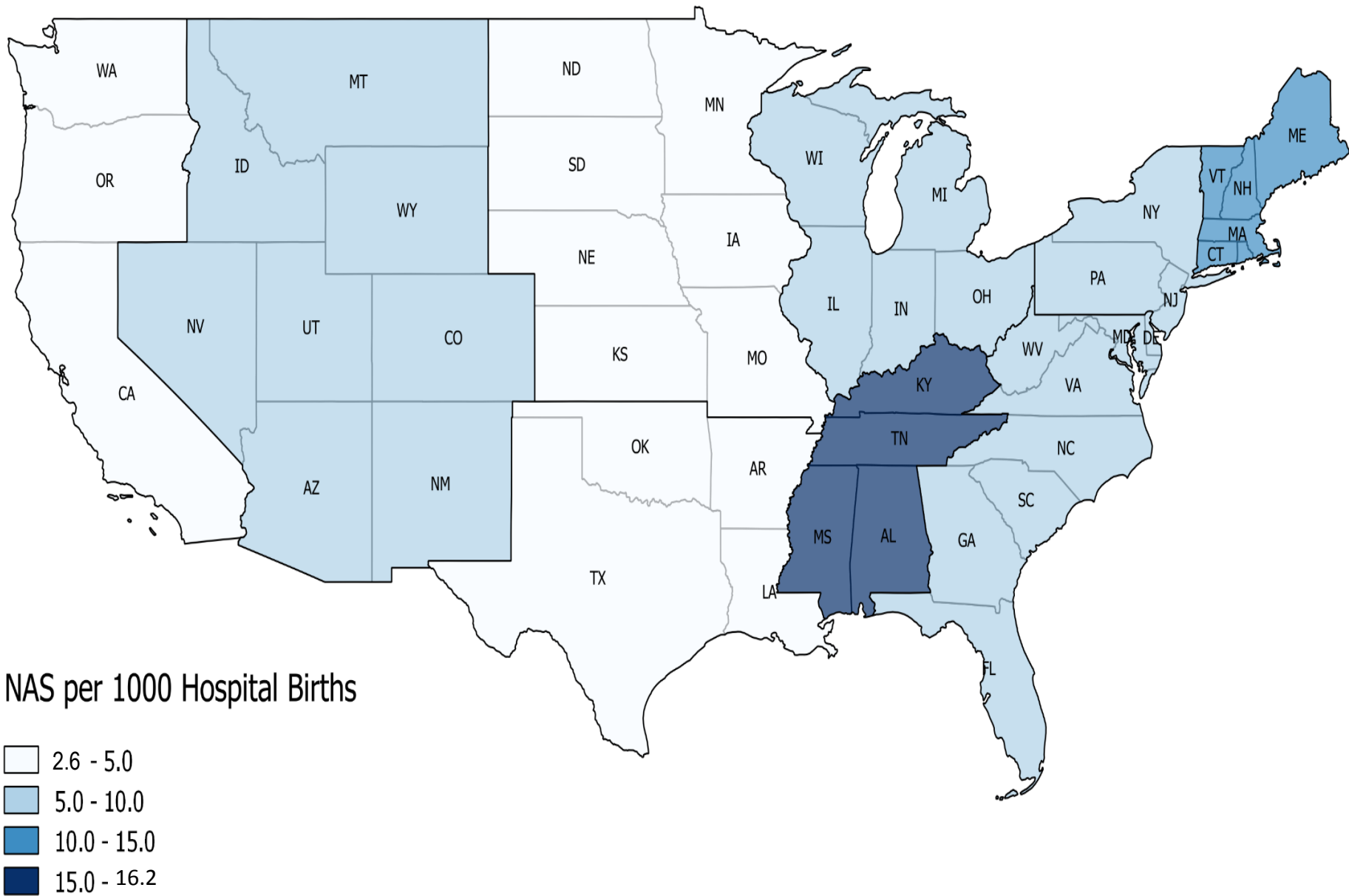


*Approximately 4 million (3,952,841) live births in 2012

Estimates based on: National Survey on Drug Use and Health, 2012; Martin, Hamilton, Osterman, Curtin & Mathews. Births: Final Data for 2012. National Vital Statistics Report, Volume 62, Number 9;

*Patrick, et al., (2015). Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. Journal of Perinatology 35, 650-655

JAMA.2012.3951; May, P.A., and Gossage, J.P.(2001).Estimating the prevalence of fetal alcohol syndrome: A summary.Alcohol Research & Health 25(3):159-167. Retrieved October 21, 2012 from <http://pubs.niaaa.nih.gov/publications/arh25-3/159-167.htm>



Patrick, S. W., Davis, M. M., Lehmann, C. U., & Cooper, W. O. (2015). Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. *Journal of Perinatology*, 35(8), 650-655.

Incidence of Neonatal Abstinence Syndrome

Nationally, the incidence of NAS increased from **1.20 per 1,000 hospital births** in 2000 to **3.39 per 1,000** in 2009.

38-state study found the rate of neonatal hospital stays involving substance use had a cumulative increase of **71%** between 2006 and 2012, from **5.1 to 8.7 per 1,000** neonatal stays.

In a study of 299 neonatal intensive care units (NICU) across the country, the rate of NICU admissions for infants with NAS increased from **7 cases per 1,000 admissions** in 2004 to **27 cases per 1,000 admissions** in 2013.

Patrick SW, et. al. Neonatal Abstinence Syndrome and Associated Healthcare Expenditures – United States, 2000–2009. JAMA. 2012 May 9;307(18):1934-40.

Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) from 38 States, 2006–2012

Toila, V.N, Patrick, S.W., Bennett, M.M., Murthy, K., Sousa, J., Smith, P.B., Clark, R.H., & Spitzer, A.R. (2010). Increasing incidence of neonatal abstinence syndrome in U.S. neonatal ICUs. New England Journal of Medicine, 372, 2118-2126

2006 and 2012 hospital costs for neonatal stays related to substance use had a cumulative increase of **135%**, from \$253.4 million in 2006 to **\$594.6 million** in 2012.

The mean length of stay for infants with NAS is **16.4 days** at an average cost of **\$53,000**.

Of the 30,653 neonatal hospital stays related to substance use in 2012, most involved neonatal drug withdrawal or unspecified narcotics

- **60.3%** NAS/withdrawal
 - Estimated **18,000 infants** = **\$356-\$950 million**
- 23.0 % unspecified narcotics
- 16.7 percent of neonatal stays involved specific substances:
 - 8.6 % cocaine
 - 4.5 % hallucinogens
 - 2.1 % multiple substances or conditions, or
 - 1.5 % fetal alcohol syndrome

Patrick SW, et. al. Neonatal Abstinence Syndrome and Associated Healthcare Expenditures – United States, 2000–2009. JAMA. 2012 May 9;307(18):1934-40.

Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) from 38 States, 2006–2012

Neonatal Costs

Fetal Alcohol Spectrum Disorders

- FASD is a group of conditions that can occur in individuals whose mother drank alcohol during pregnancy. FASD can result in birth defects, growth and development deficits, cognitive and learning issues, executive functioning problems, difficulty remaining attentive, and problems socializing, as well as other behavioral issues.
- FASD are the leading cause of cognitive disability in Western civilization, including the United States, and are 100 percent preventable...



Source:

Chasnoff, Ira, *Alcohol Use and Abuse During Pregnancy, Its Impact, and Related Policy Issues*, Child Advocacy Program Art of Social Change: Child Welfare, Education, & Juvenile Justice, February 5, 2015

Senate Resolution 259—112th Congress: A resolution designating September 9, 2011, as "National Fetal Alcohol Spectrum Disorders Awareness Day".

Fetal Alcohol Spectrum Disorders

- There are several types of FASD, including:
 - Fetal Alcohol Syndrome (FAS)
 - Partial FAS
 - Alcohol-Related Neurodevelopmental Disorders (ARND)
 - Alcohol-Related Birth Defects (ARBD)



Fetal Alcohol Spectrum Disorders

Estimates vary across studies:

- Full FAS estimated at 0.5-2.0 cases per 1000 births in U.S.
- Alcohol-affected births estimated to be 5 to 10 times higher, close to 1% of all newborns
- A more recent study reported the FAS prevalence in the U.S. to be at least

2 to 7 cases per 1000 births, with all levels of FASD estimated as high as 2-5% among younger school children

Sources:

Chasnoff, Ira, *Alcohol Use and Abuse During Pregnancy, Its Impact, and Related Policy Issues*, Child Advocacy Program Art of Social Change: Child Welfare, Education, & Juvenile Justice, February 5, 2015

NIH Fact sheet; P.A. May & J. P. Gossage, *Estimating the prevalence of Fetal Alcohol Syndrome: A Summary*, 25 ALCOHOL RESEARCH & HEALTH 159 (2001).

Diane V. Malbin, *Fetal Alcohol Spectrum Disorder (FASD) and the Role of Family Court Judges in Improving Outcomes for Children and Families*, JUVENILE & FAM. CT. J. 52 (2004).

Philip A. May, J. Phillip Gossage, Wendy O. Kalbert, Luther K. Robinson, David Buckley, Melanie Manning, and H. Eugene Hoyme, *Prevalence and epidemiologic characteristics of FASD from various research methods with an emphasis on recent in-school studies*. Dev Disabil Res Revs, 15: 176-192 doi: 10; 1002/ddrr.68 (2009).



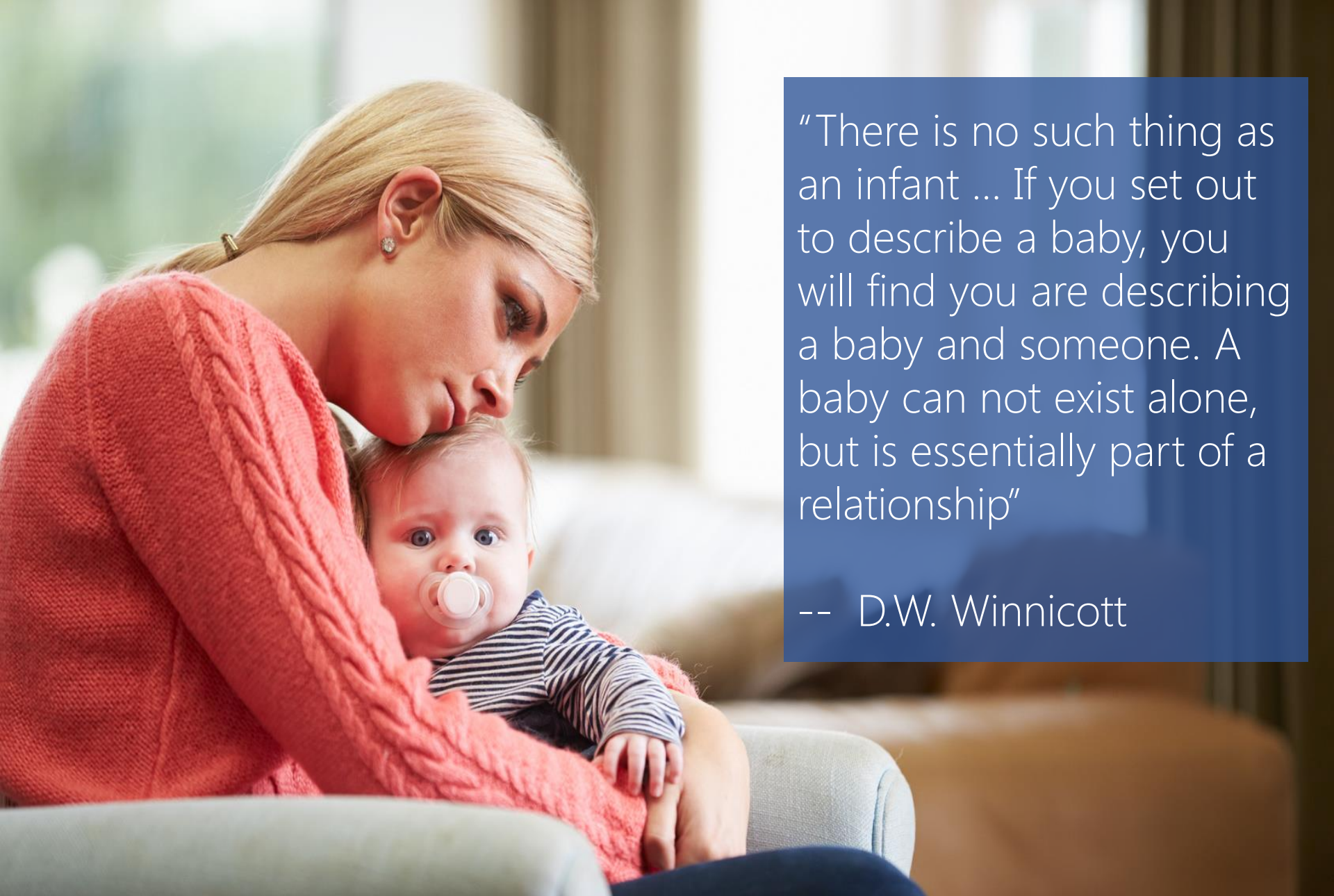
State Initiative Focus

Screening, Identification and Referral of pregnant women w/SUDs

Development of Guidelines for working with pregnant women and their infants

Hospital standards and discharge plans for infants and mothers

State strategies for CAPTA compliance and Plans of Safe Care

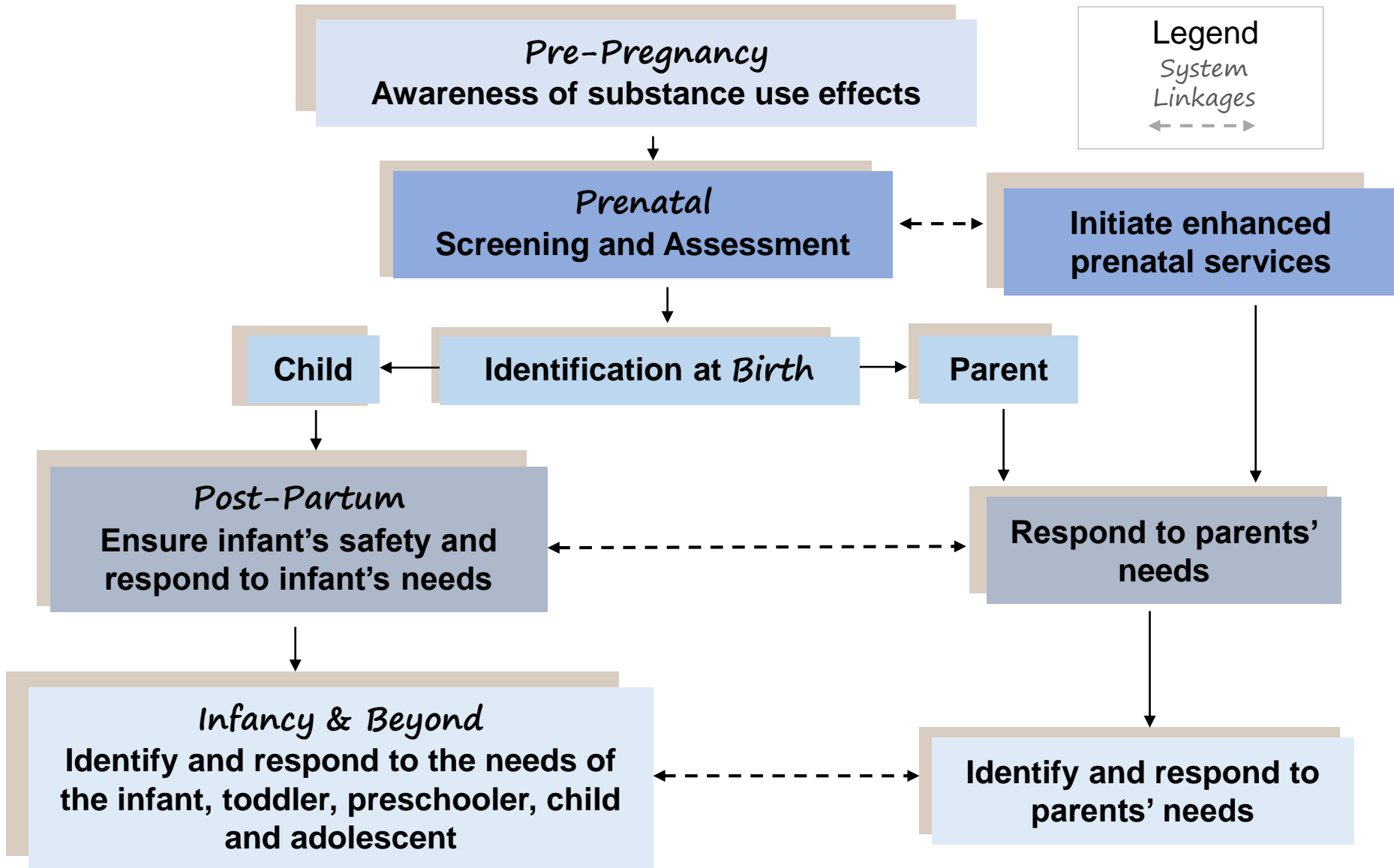


“There is no such thing as an infant ... If you set out to describe a baby, you will find you are describing a baby and someone. A baby can not exist alone, but is essentially part of a relationship”

-- D.W. Winnicott

Mother-Infant Dyad

Policy and Practice Framework: 5 Points of Intervention



A Collaborative Approach

A silhouette of a woman holding a baby up in the air, set against a background of a sunset over the ocean. The woman is standing on a beach, and the baby is being held high above her head. The sky is filled with soft, colorful clouds, and the ocean waves are visible in the foreground.

Women with substance use disorders are identified during pregnancy...

Engaged into prenatal care, medical care, substance use treatment, and other needed services...

A Plan of Safe Care for mother *and* baby is developed...

....Reducing the number of crises at birth for women, babies, and the systems!

Prenatal Screening & Assessment

A pregnant woman in a white lab coat is holding a white cup. A hand is holding a yellow pipette over the cup. The background is a soft-focus outdoor scene with greenery.

Are pregnant women universally screened for substance use at each trimester?

Do medical staff know where to refer women who screen positive for substance use?

Do Medication-Assisted Treatment/Substance Use Treatment providers share & receive information from prenatal care providers?

When substance use is identified, do providers begin to develop a plan of safe care?



Are mothers universally screened at the birth event? What dictates infant testing?

How is child welfare informed of infants with substance exposure? What is the definition of substance exposure?

How is the infant referred to Early Intervention/Part C services? Is there follow up?

How are pediatricians notified of infants' substance exposure?

Identification at Birth



What is included in discharge plans?
Who participates in development?

How are CSBs notified of the family
and the discharge plan?
How are the plans monitored?

How is the family referred to home
visiting services?

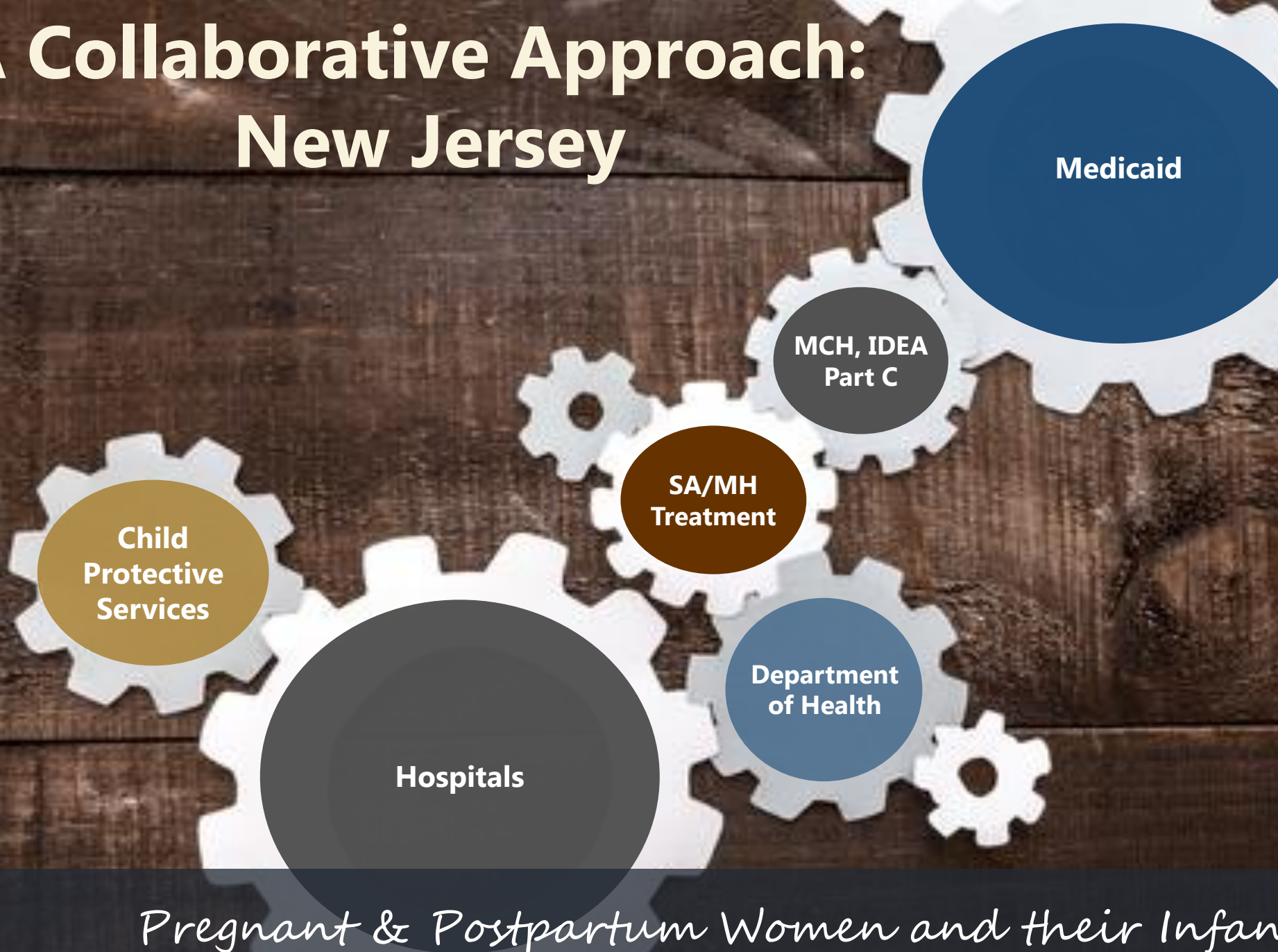
Post-Partum Period

Finding the Way to Collaboration

A top-down view of a desk with a spiral notebook, a smartphone, a watercolor palette, a pen, and a pair of headphones. The notebook is open and blank, with a silver spiral binding. To the left is a yellow folder with a black smartphone. To the right is a blue watercolor palette with various colors. A silver pen lies on the notebook. In the bottom left corner, a pair of white headphones is visible. The background is a light blue wall with a small potted plant.

No Single System can Solve this Problem

A Collaborative Approach: New Jersey



Pregnant & Postpartum Women and their Infants



***Developing a Plan of Safe Care for
Infants with Prenatal Substance
Exposure, their Mothers and
Caregivers: Collaborative Approaches
Learned in a Six-Site Initiative***

**Mollie Greene, Director of
Clinical Services**

August 1, 2016

2014 Prescription Drug Policy Academy

NJ selected for SAMHSA's 2014 Prescription Drug Abuse Policy Academy for Technical Assistance:

- Align & coordinate numerous well-planned initiatives & efforts to address prescription drug abuse currently underway
- Focus efforts on components proven to be essential aspects of an effective approach to combat opioid epidemic
- NJ Policy Academy Team – Representatives from Departments of Health, Human Services, Children and Families, Consumer who lost a child to opioid overdose and SUD Treatment Provider

NJ Opioid Workgroup

NJ expanded its Opioid Workgroup shortly after SAMHSA's Prescription Drug Abuse Policy Academy to include additional State representatives from:

- New Jersey State Police
- Juvenile Justice Commission
- Department of Human Services-Division of Medical Assistance and Health Services
- HIDTA NY/NJ Drug Policy Analyst based at NJ DOH

Mission:

- Implement the goals/objectives of NJ's comprehensive strategic approach to the opioid epidemic

Monthly meetings:

- Strategic planning for new initiatives and funding opportunities, updates on current initiatives, department/division information sharing, and data sharing updates.
-

Responding to New Jersey's Opioid Epidemic

NJ's comprehensive plan to address the opioid epidemic

- Expand & strengthen prevention strategies
- Improve monitoring & surveillance
- Expand & strengthen control & enforcement
- Improve access to & use of effective treatment & recovery support

NJ IDTA SEI

2014 NJ was awarded IDTA SEI through SAMHSA's National Center on Substance Abuse and Child Welfare (NCSACW):

- Strengthen collaboration and linkages across multiple systems for opioid dependent pregnant women and other SUDs - Addictions Treatment, Child Welfare, and Medical Communities
- Improve services for pregnant women with opioid and other SUDs and outcomes for their babies
- Develop uniform guidelines (across Departments DHS, DCF DOH)
- Improve collaboration along the entire spectrum (prenatal, labor and delivery, postpartum, continuing care) for women, infant, and their children

NJ IDTA SEI

Project Lead

DHS Division of Mental Health and Addiction Services, Office of Treatment and Recovery Supports, Special Initiatives, Women & Families

Partners

- New Jersey Department of Mental Health and Addiction Services
- New Jersey Department of Health
- New Jersey Department of Children and Families
- Treatment Providers, Maternal Health, Early Childhood, other Stakeholders
- New Jersey Hospitals (Obstetricians, Pediatricians, Neonatologists, Labor and Delivery Nurses)
- Medicaid

NJ IDTA SEI

IDTA mapped out current practices and barriers in the identification and treatment of SEIs and their mothers to assist NJ in implementing a best practice model with potential for statewide adoption.

Goal #1: Increasing perinatal SEI screening at multiple intervention points by changing practice to improve SEI perinatal screening rate

Goal #2: Leveraging existing programs and practices to collaboratively increase the rate at which women who screen positive on 4 Ps Plus get connected for a comprehensive SUD assessment

Goal #3: Leveraging existing programs and practices to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children receive early intervention and other support services for which they are eligible

Improving Systems for Screening, Intervention, and Engagement in Services

IDTA Workgroups Established:

Data Workgroup – Statewide data systems to capture prenatal screening, linkage to treatment & services following moms & children

- Linking data systems to understand the costs associated with NAS, treatment gaps and barriers across the state.
- Increase prenatal AOD screening rates for pregnant women on Medicaid and linkage to services (White Paper)

Prenatal Screening, Early Identification of Infants and Referral to Services

- Using Pregnancy Risk Assessment (PRA) Data, map out current screening and referral practices across the state
- Targeted response to low screening areas to improve utilization of the PRA and 4 Ps Plus
- Increase connections to appropriate treatment and supportive services; Central **Intake, Use of Perinatal Cooperatives**

Labor, Delivery and Engagement

- Develop guidelines for hospital practices for identifying SEIs and linking families to ongoing services (Hospital Birth Survey)
-



Impact on Women and Infants

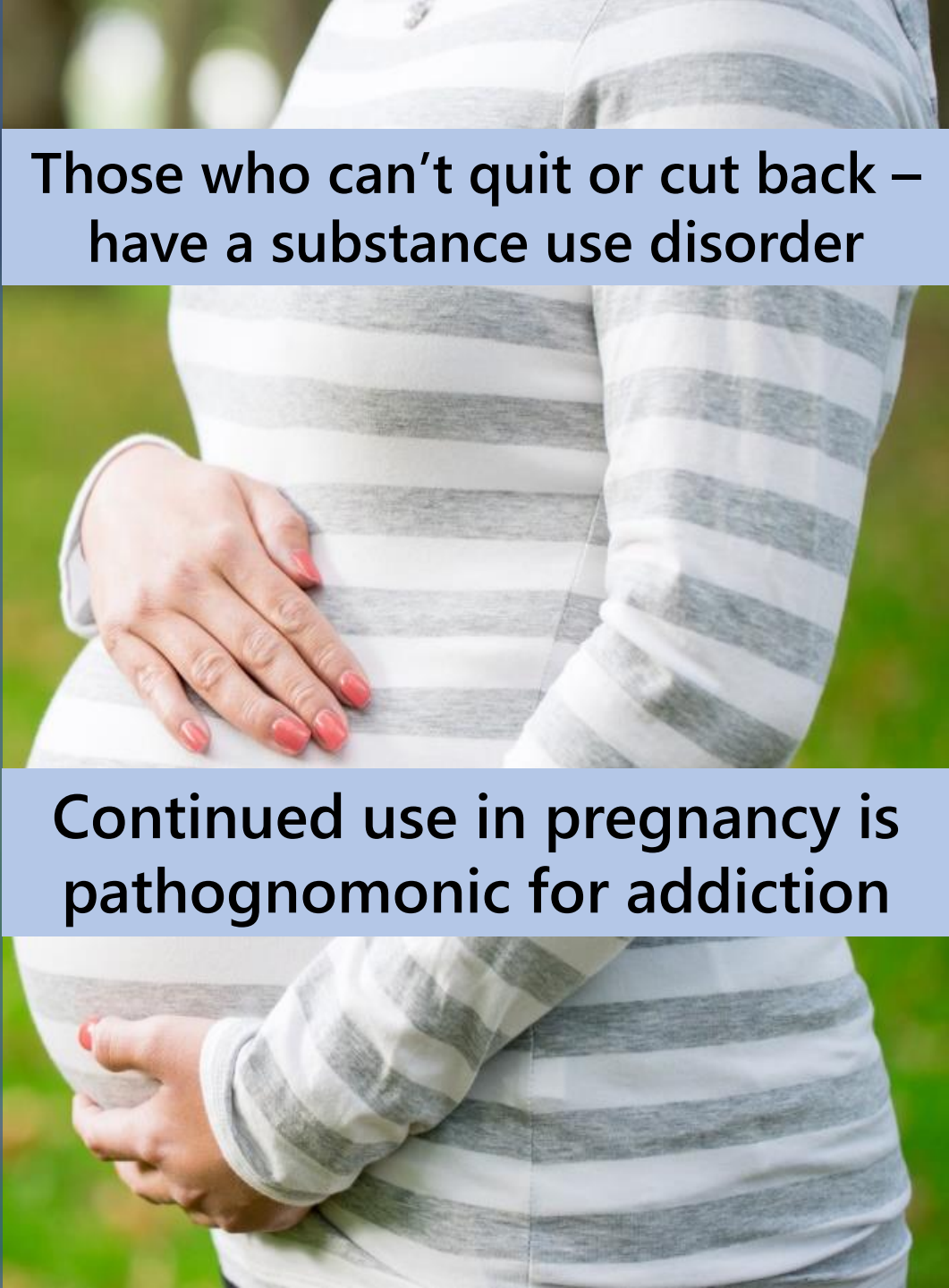
What happens when women who use substances get pregnant?

NSDUH 2012/13 Past Month

Substance use by trimester		Non-pregnant	Percent Change	Postpartum
Alcohol				
First	19.0	54.0	92%	45.4
Second	5.0			
Third	4.4			
Cigarettes				
First	19.9	24.0	47%	20.1
Second	13.4			
Third	12.8			
Illicit drugs				
First	9.0	11.4	79%	8.7
Second	4.8			
Third	2.4			

All pregnant women are motivated to maximize their health and that of their baby-to-be

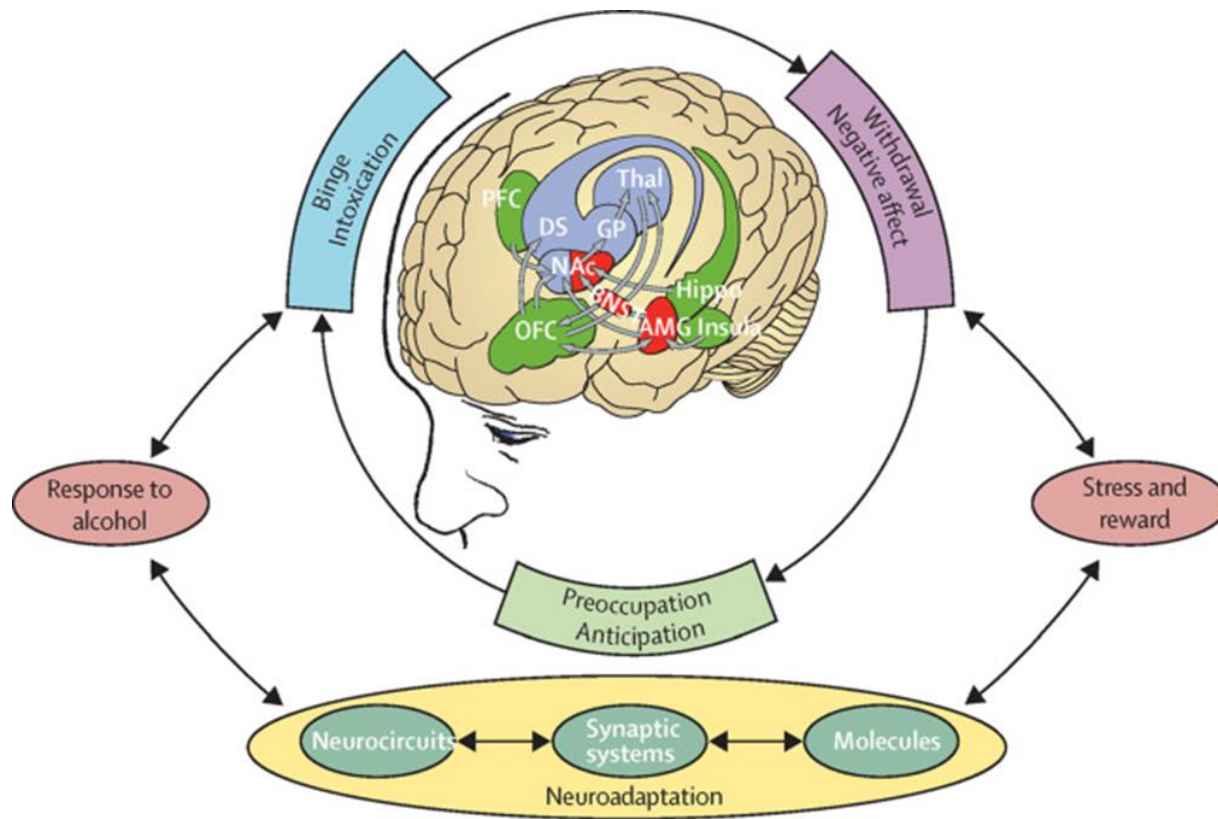


A pregnant woman wearing a grey and white horizontally striped long-sleeved shirt. She is standing outdoors with a green background. Her hands are resting on her pregnant belly. The image is split into two horizontal sections by a light blue banner.

Those who can't quit or cut back –
have a substance use disorder

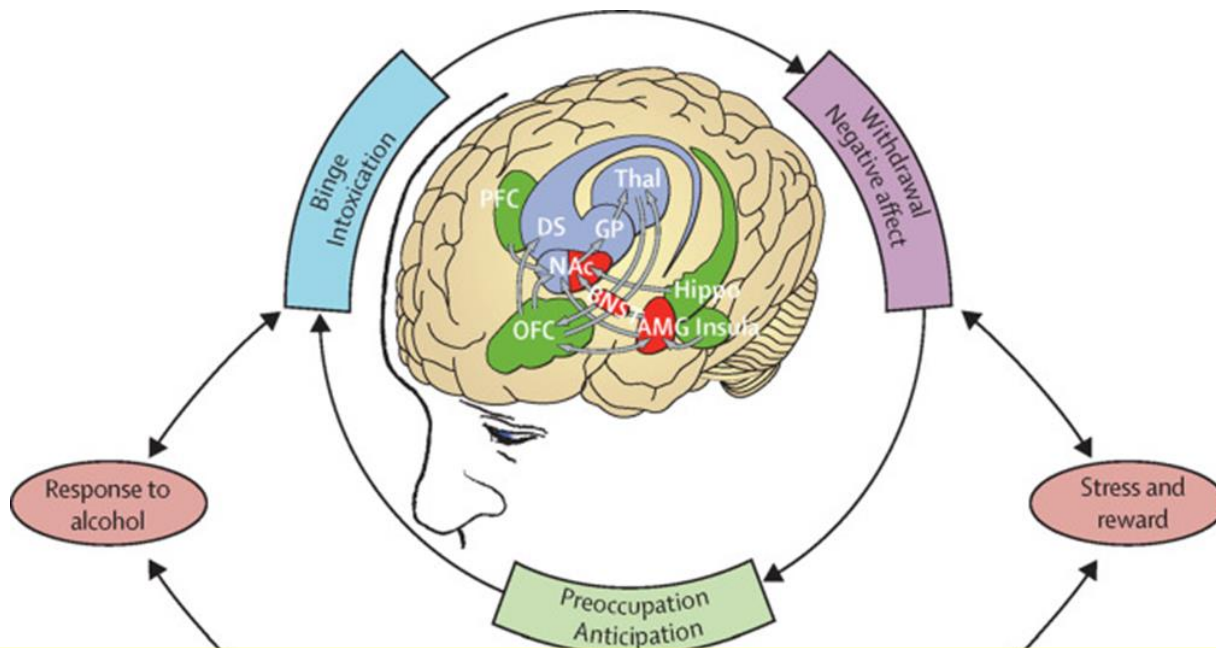
Continued use in pregnancy is
pathognomonic for addiction

**All pregnant
women are
motivated to
maximize their
health and that of
their baby-to-be**



A primary, chronic disease of brain **reward, motivation, memory** and **related circuitry**. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. (ASAM)

A chronic, relapsing disease characterized by **compulsive** drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain. (NIDA)



Addiction: A brain disease whose visible symptoms are behaviors

A primary, chronic disease of brain **reward, motivation, memory** and **related circuitry**. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. (ASAM)

A chronic, relapsing disease characterized by **compulsive** drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain. (NIDA)

Addiction is a Chronic Disease

- We know how to treat addiction
- We know something about how to prevent addiction
- **We don't know how to cure addiction**
- Disease severity may change over time – risk of symptom recurrence is always present
- Goal – lifelong management – support recovery

Women with SUD in Pregnancy



Reproductive Health Lifecourse

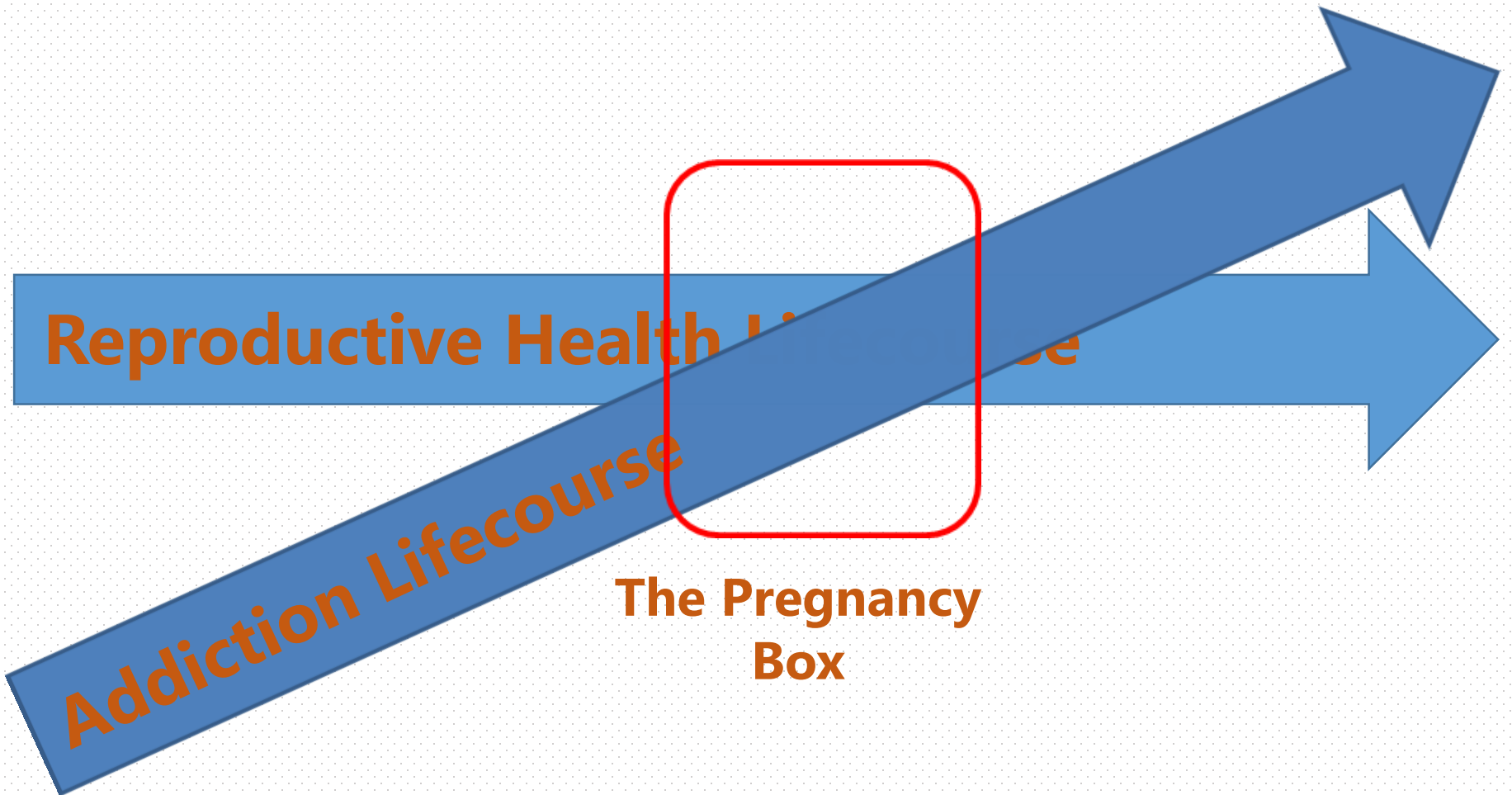
Women with SUD in Pregnancy



Reproductive Health Lifecourse

Addiction Lifecourse

Women with SUD in Pregnancy



Reproductive Health

Addiction Lifecourse

The Pregnancy Box

How do we identify pregnant women who use drugs?

Early identification is key

- Early identification of substance use allows for early intervention and treatment which minimizes potential harms to the mother and her pregnancy
- Maximize the motivation for change during pregnancy

Screening

- Screening pregnant women in prenatal care for substance use
- Screening reproductive aged women in SUD treatment for pregnancy – pregnancy intention

Screening

- **Universal Screening**
- **Instrument/Questionnaire – preferably validated**
 - Instruments can be either self-completed or done as part of the patient interview
 - Examples: 4 Ps Plus, CRAFFT, DAST
- **What about urine drug testing?**
 - Does not test for addiction
 - Short detection window (substance dependent)
 - Might not capture binge or intermittent use
 - Rarely detects alcohol
 - Doesn't capture prescription opioids (without confirmation testing)
 - Ethical issues – patient needs to give consent prior to specimen collection

Screening Barriers

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The New York Times U.S.

WORLD U.S. N.Y. / REGION BUSINESS TECHNOLOGY SCIENCE HEALTH SPORTS OPINION

POLITICS EDUCATION TEXAS

Case Explores Rights of Fetus Versus Mother



Darren Hauck for The New York Times

Alicia Beltran, 28, was sent to a drug-treatment center despite insisting she was not using drugs.

By ERIK ECKHOLM
Published: October 23, 2013 | 670 Comments

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A parent's heroin addiction, a newborn's death sentence



Nicole Beltrame with her 18-month-old daughter, Nevaeh, with whom she was recently reunited. Beltrame became addicted to painkillers after a bad car accident, but she's off the drugs now and pregnant again, with her baby due in a month.

By Crocker Stephenson of the Journal Sentinel Nov. 1, 2013

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Photo Gallery

No bystander could be more innocent. No damage so helplessly collateral.

Trysten Jacob Powell, delivered by C-section at Wheaton Franciscan-St. Joseph hospital on March 28, 2013, lived three months.

No bystander could be more innocent. No damage so helplessly collateral.



Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.

Women with SUD in Pregnancy

- Stigma or Discrimination
- Popular press messaging – shame and guilt
- Why - Substance use and pregnancy: Where Federal war on drugs collides with State “abortion” policy



STATE POLICIES ON SUBSTANCE ABUSE DURING PREGNANCY

STATE	SUBSTANCE ABUSE DURING PREGNANCY CONSIDERED:			WHEN ABUSE SUSPECTED, STATE REQUIRES:		DRUG TREATMENT FOR PREGNANT WOMEN		
	Criminal Act	Child Abuse	Grounds for Civil Commitment	Reporting	Testing	Targeted Program Created	Pregnant Women Given Priority Access in General Programs	Pregnant Women Protected from Discrimination in Publicly Funded Programs
Alabama		X [†]						
Alaska				X				
Arizona				X			X	
Arkansas		X				X		
California						X		
Colorado		X				X		
Connecticut						X		
Florida		X				X		
Georgia							X	
Illinois		X		X		X		
Indiana		X						
Iowa		X		X	X			X
Kansas							X	X
Kentucky					X	X	X	
Louisiana		X		X		X		
Maine				X				
Maryland				X		X	X	
Massachusetts				X				
Michigan				X				
Minnesota		X	X	X	X	X		
Missouri							X ^Q	X
Montana				X				
Nebraska						X [†]		
Nevada		X		X				
New York						X		
North Carolina						X		
North Dakota				X	X			
Ohio						X		
Oklahoma		X		X			X	X
Oregon						X [‡]		
Pennsylvania				X		X		
Rhode Island		X		X		X	X	
South Carolina		X [†]						
South Dakota		X	X					
Tennessee	X	X					X	
Texas		X					X	
Utah				X			X	
Virginia		X		X		X		
Washington						X		
Wisconsin		X	X				X	
TOTAL	1	18	3	18	4	19	12	4

Treatment: Opioid Use Disorder During Pregnancy

Drug treatment
– combined
with prenatal
care

Medication-Assisted
Treatment (Methadone or
Buprenorphine) combined
with behavioral counseling
is standard of care

Pregnant women who receive comprehensive care (both prenatal care and drug treatment) have birth outcomes almost identical to women who don't use drugs



Treatment: Opioid Use Disorder During Pregnancy

Methadone – 40+
years of experience,
Buprenorphine 15 yrs.

Women who receive MAT:

- Attend more PNC visit
- Better nutrition
- Less preterm birth
- Healthier babies

Newborns:

- Some (not all) will develop neonatal abstinence syndrome



Neonatal Abstinence Syndrome (NAS) is NOT Addiction



Newborns can't be "born addicted"

- NAS is withdrawal – due to dependence – dependence NOT addiction
- Addiction is brain disease whose visible symptoms are behaviors – newborn can't have the behaviors associated with addiction (compulsion, etc)
- Addiction is chronic disease – chronic illness can't be present at birth

Neonatal Abstinence Syndrome (NAS)

- Expected and treatable outcome of in-utero opioid exposure
- No long term ill effects
- Not all infants exposed to opioids develop NAS
 - Other substance exposure: cigarettes, benzodiazepines, SSRIs
 - Genetic factors
 - Screening and treatment protocols – and where we care for infants
 - NICU care – worse and longer NAS than rooming-in



Neonatal Abstinence Syndrome (NAS)

- Usually presents within days of birth – but can be delayed
- Parents, foster parents, all care givers and home visiting nursing should be aware of possible signs of NAS



Breastfeeding

- Should be encouraged
- Reduces duration and severity of NAS
- Promotes maternal/infant bonding
- Good for maternal and infant health
- Contraindications: active and untreated substance use, hepatitis C





Impact on Infants and Child Welfare

Prevention Services to Promote Healthy Outcomes for Children and Families

- We try to reach families early--during pregnancy, and with infants, toddlers and children up to age 8
- Services are offered to families in their homes (**home visiting**) or in their communities (health care, neighborhood centers, child care, schools)
- Prevention services are voluntary

Early Childhood Services Across 4 State Departments

TABLE 1: Current NJ State-Level Departments Providing Early Childhood Services & Supports

Education (DOE)	Human Services (DHS)	Children & Families (DCF)	Health (DOH)
Division of Early Childhood Education	Grow NJ KIDS (GNJK's)	Child Care Licensing	Title V MCH Block Grant
Office of Primary Education	Early Head Start and Child Care Partnerships	Family Childcare Registration	Perinatal Risk Assessment (PRA)–Addiction/Depression
State-Funded Preschool	Subsidized Child Care -	NJ Home Visiting Programs Central Intake	Improving Pregnancy Outcomes
Early Head Start	Child Care Development Block Grant (CCDBG)	Help Me Grow-NJ (NJ-ECCS)	Central Intake Expansion
Head Start Collaboration	Wraparound Care	Project LAUNCH	Community Health Workers
Teacher Credential & Licensing	NJ First Steps–Infant/Toddler	Infant/EC Mental Health	MIEC Home Visiting (admin lead)
Preschool Special Education (IDEA Part B)	Family Outreach Workers	Strengthening Families (SF) Protective Factors Framework	FQHCs / Primary Care
Project Child Find	Family Childcare Providers	NJ Local County Councils	WIC Services / Breastfeeding
School Support Services (for teen parents)	Child Care Resource & Referral Agencies (CCR&R)	Pregnant/Parenting Teens	Child Health / Immunizations
Federal Title I Services for low-income families	Childcare Workforce Registry	Parent-Linking/School-Based	Healthy Homes Initiative / Childhood Lead Poisoning
Other Federal Education Programs & Services	NJ School Age Child Care (SACC)	Project TEACH-Teen Parents	Adolescent Health / PREP Pregnancy Prevention Grant
Regional Achievement Centers (RAC)	NJ Inclusive Child Care (NJICC) (SPAN)	Family Success Centers	Shaping NJ / Let's Move Obesity Prevention Plan
Parent Training and Information Center (SPAN)	WorkFirst NJ-TANF/GA SNAP	DV & Women's Services	Early Intervention (IDEA Part C)
NJ Council Young Children	Emergency Services - Addiction and Mental Health	NJ Children's Trust Fund	EIS Statewide Phone Line
Race to the Top Early Learning Challenge (RTT-ELC)	Disability Services (parents)	Federal CBCAP Funds (Child Abuse Prevention)	Special Child Health Services
Preschool Expansion Grant	Medicaid / NJ FamilyCare	Children's System of Care - Child Behavioral Health & Developmental Disabilities	NJ ParentLink (web)
	Family-to-Family Health Information Center (SPAN)	Child Protection & Permanency	
	NJ Helps (web)		

NJ State-Level Early Childhood Structure



Evolution of Early Childhood System of Care

Central Intake Systems

- 7 counties (2011), 15 counties (2013), in ALL 21 counties (2015)

Home Visiting in NJ

- started with HFA (in 19 cities) -1995,
- as of 2011/12, 3 EBHV models PAT, NFP, and HFA (in ALL 21 counties)

Community Health Workers

- 13 counties (2013)

Local County Councils

- all 21 counties (2015)

Other MCH partners - health, education, family support, special child health etc; (eg. FSC's, FQHC's, WIC, EI, HS/EHS, SPAN, PLP, School based, DV services, etc.)

How do NJ families get linked to MCH Services?

Single Point of Entry (toll-free number) - *easy access* for

- Information, eligibility, assessment & referral to family support services

Reach Families Earlier – beginning in pregnancy (voluntary)

- Universal Perinatal Risk Assessment (PRA) – 4 P's Plus

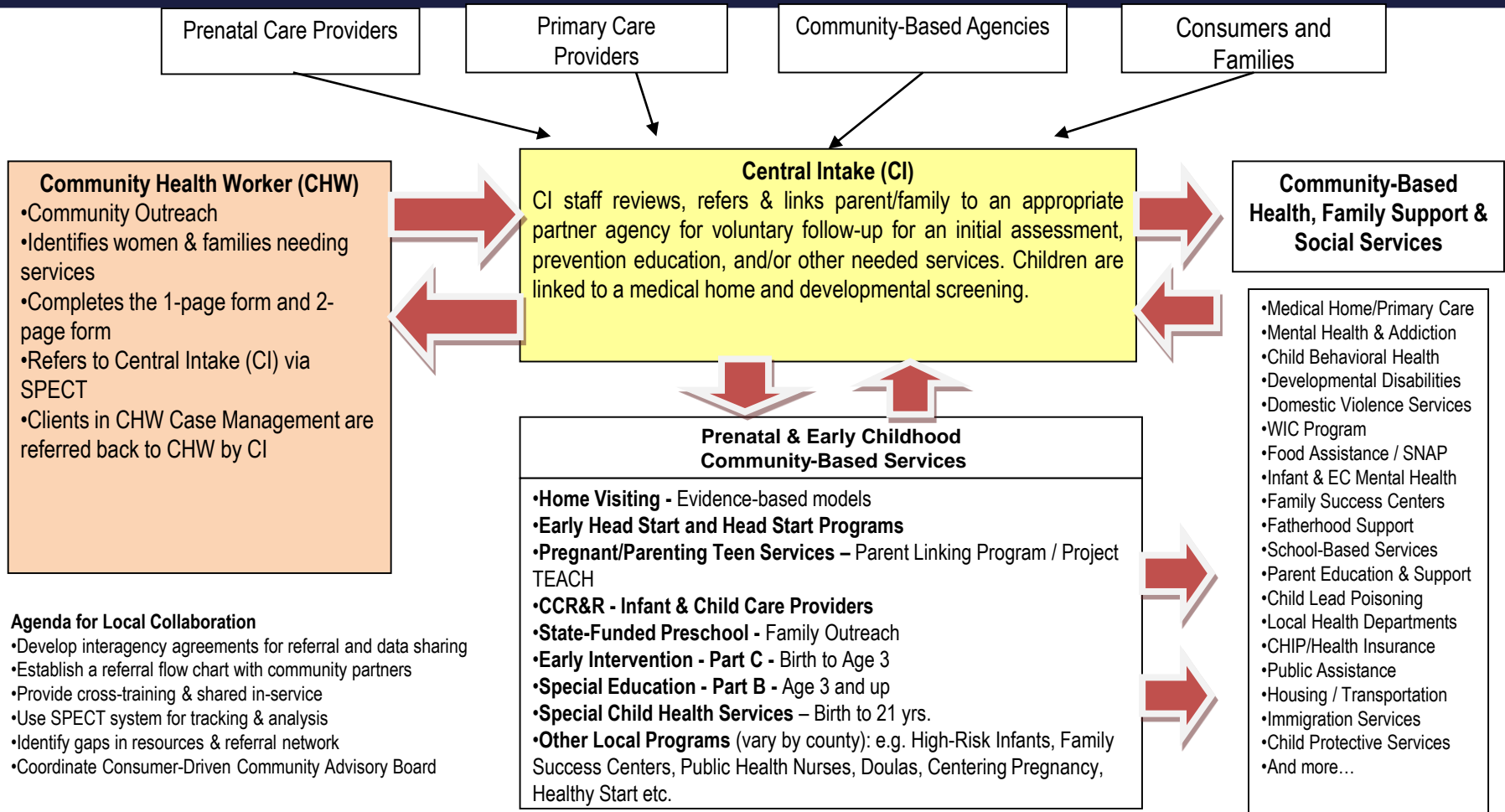
Effective Use of Limited Resources

- HV programs stay focused on service delivery--not outreach
- Reduces duplication of services / Identifies gaps in services

Locally Driven – Each county has a local lead coordinating agency

- Designated Central Intake Coordinator (1.5 FTE)
 - Partnering with local outreach / Community Health Workers
-

Early Childhood Comprehensive Systems Central Intake System



Why is Central Intake Important?

Integrate health care, child care, education and family support services... such as Home Visiting, Improving Pregnancy Outcomes, Help Me Grow, Project Launch and other community-based services...

Central tracking reduces duplication of services

Support families to... improve prenatal care, birth outcomes, early learning, medical home, preventative care and other supports

Strengthen communities to... prevent Infant Mortality and Child Abuse & Neglect

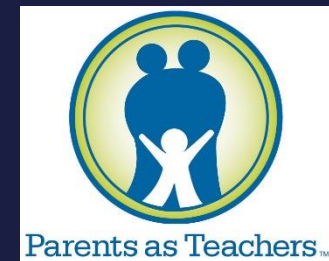
NJ's Evidence-Based HV Models

Common Model Elements:

- Research-driven models
- Strengths-based / family-centered approach
- Relationship-based / Multi-dimensional
- Visits begin early – prenatal/birth
- Voluntary participation of families
- Frequent, long-term home visits

Focus on:

- Prenatal & parent health
- Infant and child health & development
- Parent-child interaction / infant mental health
- Parent Education / Family Social Support
- Early Literacy / School Readiness
- Path to Parent/Family Self-Sufficiency



	NFP	HF	PAT	HIPPY
Target Population	Low income, 1 st time mother-to-be	Any at-risk pregnant woman/mother/family	Any at-risk pregnant woman/mother/family	Any family with a pre-school child
Enrollment Criteria	Pregnancy; no later than 28 weeks of gestation	During pregnancy or at birth; TANF families may enroll in infancy	Pregnancy, at birth, or anytime to age 3	Families with a child age 3 or 4 years old
Duration	Pregnancy up to age 2	Pregnancy and birth to age 3	Enrollment to ages 3 (to 5)	To age 5 or Kindergarten
Staffing	Registered Nurses	Family Support Workers	Parent Educators	HIPPY Grads (part-time)
Caseload	25 families (maximum)	15 to 25 families (maximum)	25 families (maximum)	10 to 12 families

Common Objectives Across HV Models

NJ State Process and Outcome Measures

- Level of Service (LOS) - enrollment / capacity
- Retention – are families staying connected? How long?
- Dosage – completed vs. expected home visits

MIECHV Six Target Areas

1. Improving Maternal and Newborn Health
 2. Reducing Child Injuries, Child Abuse & Neglect, Emergency Visits
 3. Improving School Readiness & Achievement
 4. Reducing Domestic Violence
 5. Strengthening Family Economic Self-Sufficiency
 6. Improving Coordination & Referral Linkages for Community Resources
-

HV Health Indicators FY 2015

WOMEN - PREGNANCY: On-schedule Prenatal Care Visits	76%
WOMEN - POSTPARTUM: Kept Postpartum Medical Visit	82%
LOW BIRTH WEIGHT (2010 NJ rate 8.2% for all --13.3% for Black women)	11.0%
MOTHERS: Initiated Breastfeeding (still breastfeeding at 4 weeks = 69%)	85%
WOMEN: Subsequent Pregnancy (>18 months birth to conception)	92%
INFANTS/CHILDREN: Health Insurance / Medical Home	97%
INFANTS/CHILDREN: Up-to-date for Developmental Screening	92%
INFANTS/CHILDREN: Up-to-date for Immunizations	78%
WOMEN: Mother Working or in School by the time child is age 2	66%

**NJHV data - NJ tracks many other performance indicators.*

Services for Children in Out of Home Placement

EBHV services

- Support health outcomes for children in out of home placement
- Help to sustain the infant/parent bond
- Promote positive parent engagement

Early Intervention Services

- CAPTA requires states to refer children under the age of 3 involved in a substantiated case of abuse or neglect for early intervention services under Part C of the IDEA
- IDEA Part C has complementary language requiring states to refer children under age 3 involved in a substantiated case of abuse or neglect *or identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure*, for early intervention services

Early Intervention Services

States have flexibility in implementing some IDEA requirements

- Single Point of Entry for Referral
- Parental Consent
- Screening and/or evaluation
- Eligibility determination
- Child and Family Assessment
- Individualized Family Service Plan

Individualized Family Service Plan

- Family strengths-based
- Identification of child's physical, cognitive, social/emotional, and developmental needs
- Family information
- Expected outcomes
- Specific services to be provided, including frequency and duration
- Natural environment where services will be delivered
- Service reimbursement plan
- Transition planning



Resources

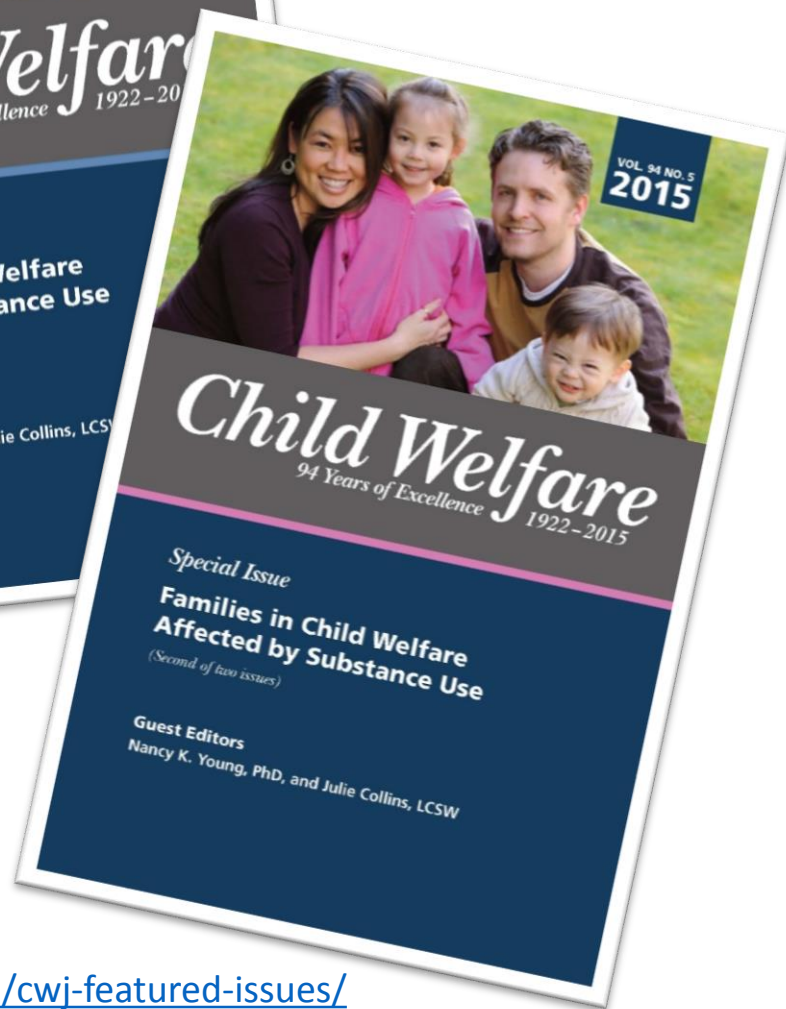
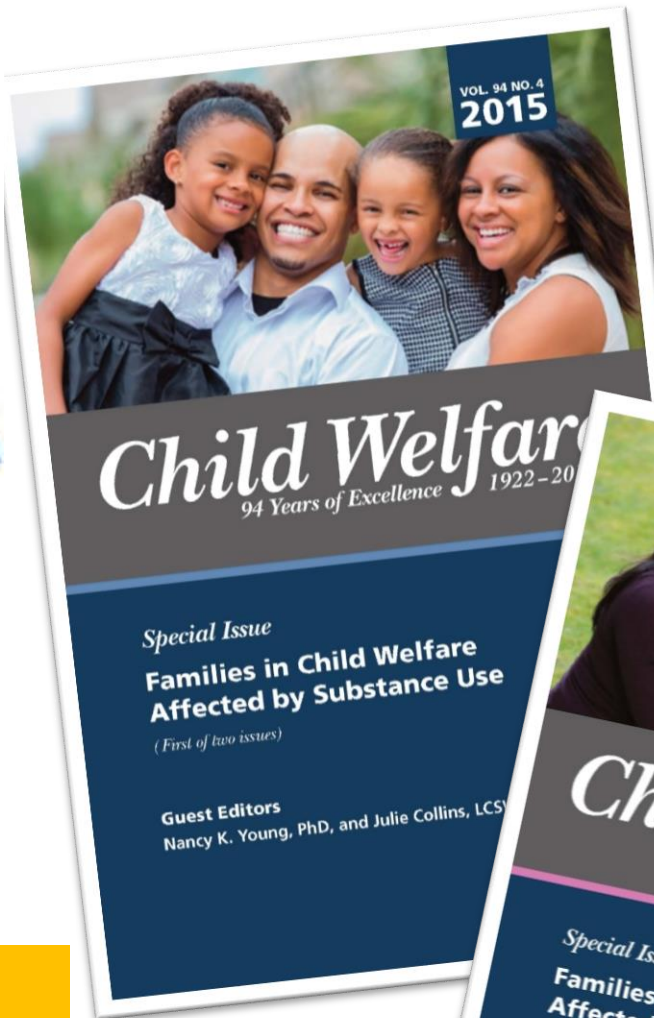


2015 Special Issue

CWLA

www.cwla.org

Families in Child Welfare Affected by Substance Use



<http://www.cwla.org/child-welfare-journal/cwj-featured-issues/>

Understanding Treatment of Opioid Use Disorders in Pregnancy

III) Treatment of Opioid Use Disorders in Pregnancy

These resources offer guidelines for the use of MAT to treatment opioid use disorders in pregnancy and the post-partum period. Included is information on dosing during pregnancy, breastfeeding while using MAT and the use of buprenorphine with pregnant women. Also included are resources on the treatment of other substance use disorders in pregnancy.

- *American Congress of Obstetricians and Gynecologists (ACOG), Committee on Health Care for Underserved Women and the American Society of Addiction Medicine (ASAM): Committee Opinion, Opioid Abuse, Dependence and Addiction in Pregnancy* www.acog.org
- Studies on the use of methadone and buprenorphine for the treatment of opioid use disorders during pregnancy:
 - *Maternal Opioid Treatment: Human Experimental Research (MOTHER) – approach, issues and lessons learned.* Jones, et al, 2010. A National Institute on Drug Abuse (NIDA)-supported clinical trial that examined the use of methadone and buprenorphine maintenance therapy during pregnancy. No significant difference was found with respect to any serious maternal or neonatal adverse events. <http://www.ncbi.nlm.nih.gov/pubmed/23106924>
 - *A Cohort Comparison of Buprenorphine versus Methadone Treatment for Neonatal Abstinence Syndrome.* Hall, et al, 2016. [http://www.ijepeds.com/article/S0022-3476\(15\)01451-1/abstract](http://www.ijepeds.com/article/S0022-3476(15)01451-1/abstract)
- *Medication Assisted Treatment During Pregnancy, Postnatal and Beyond:* Discusses the needs of pregnant women seeking medication assisted treatment. Karol Kaltenbach, PhD presents findings from the Maternal Opioid Treatment: Human Experimental Research (MOTHER) project. Facilitated as part of a webinar series – see the textbox, *National Center on Substance Abuse and Child Welfare:*

National Center on Substance Abuse and Child Welfare
Webinar Series
The following are selected webinars from the series. Contact NCSACW for additional information.

- 1) Medication Assisted Treatment for Families Affected by Substance Abuse Disorders
<http://www.cffutures.org/presentations/webinars/medication-assisted-treatment-families-affected-substance-abuse-disorders>
- 2) Medication Assisted Treatment During Pregnancy, Postnatal and Beyond
<http://www.cffutures.com/presentations/webinars/medication-assisted-treatment-during-pregnancy-postnatal-and-beyond>
- 3) Opioid Use in Pregnancy: A Community's Approach, The Children and Recovery Mothers (CHARM) Collaborative
<http://www.cffutures.com/presentations/webinars/opioid-use-pregnancy-community%E2%80%99s-approach-children-and-recovering-mothers-charm>
- 4) The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update
<https://cff-ncsacw.adobeconnect.com/p5okpdez3/>
- 5) Substance Use in Pregnancy, The OB/GYN Perspective
<http://www.cffutures.org/presentations/webinars/substance-use-pregnancy-obgyn-perspective>
- 6) Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome
<http://www.cffutures.org/presentations/webinars/opioid-use-disorders-and-treatment-pregnancy-webinar>
- 7) In-Depth Technical Assistance for Substance Exposed Infants (SEI) Conversations Across Six SEI-IDTA Sites

Medication Assisted Treatment During Pregnancy, Postnatal and Beyond
<http://www.cffutures.com/presentations/webinars/medication-assisted-treatment-during-pregnancy-postnatal-and-beyond>

The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update

<https://cff-ncsacw.adobeconnect.com/p5okpdez3/>

Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome
<http://www.cffutures.org/presentations/webinars/opioid-use-disorders-and-treatment-pregnancy-webinar>

NCSACW Online Resources

Please visit:

<https://ncsacw.samhsa.gov>

U.S. Department of Health and Human Services | Substance Abuse and Mental Health Services Administration | Administration for Children & Families

National Center on Substance Abuse and Child Welfare

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Tutorial 1

Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals

RESUME TUTORIAL

- View Description
- View Certificate - 9/15/2015

Tutorial 2

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals

RESUME TUTORIAL

- View Description
- Knowledge Assessment is in progress Continue

Tutorial 3

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Legal Professionals

RESUME TUTORIAL

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U.S. Department of Health and Human Services | Substance Abuse and Mental Health Services Administration | Administration for Children & Families

National Center on Substance Abuse and Child Welfare

Home > Trainings > Tutorials > Tutorial 2: Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals

Module 1: Primer on Substance Use Disorders for Child Welfare Professionals

OVERVIEW MODULES ASSESSMENT RESOURCES CERTIFICATE

MODULE 1 - Objectives

Module One: Primer on Substance Use Disorders for Child Welfare Professionals

Participant Objectives of Module One

After reviewing this module, child welfare professionals will:

- Understand substance use disorders as a disease that impacts the brain.
- Understand the impact of substance use disorders on family relationships.
- Understand how substance use disorders are diagnosed.
- Gain the critical context needed to understand parents with substance use disorders, and to effectively manage the challenges faced by the parents and their children.

Module 2: Engaging Families in Substance Abuse Treatment

Module 3: Substance Use

Page 1 of 2



NCSACW Online Tutorials

Free **CEUs!**

1. Understanding Substance Abuse and Facilitating Recovery:
A Guide for Child Welfare Workers
2. Understanding Child Welfare and the Dependency Court:
A Guide for Substance Abuse Treatment Professionals
3. Understanding Substance Use Disorders, Treatment and Family Recovery:
A Guide for Legal Professionals

**Updated *September 2015*: New content including updates on
opioids and Family Drug Courts!**

Additional Resources

NCSACW Technical Assistance Products

PUBLICATIONS ON IMPROVING COLLABORATION (CONTINUED)

Introduction to Cross-System Data Sources in Child Welfare, Alcohol and Other Drug Services, and Courts

An overview of the primary data reporting systems across the three agencies. It can be used to help identify the prevalence of substance abuse and child welfare issues and measure outcomes for families receiving substance abuse treatment and child welfare services.

Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare (TAP 27)

An overview of the challenges and opportunities that various State- and county-level jurisdictions experienced while building collaboration across the child welfare, substance abuse, and dependency court systems.

TRAINING AND STAFF DEVELOPMENT RESOURCES

Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers

An indispensable tool for anyone new to the child welfare system. It explains how to recognize substance abuse, motivate families to seek treatment, and facilitate cross-system collaboration.

Child Welfare Training Toolkit: Helping Child Welfare Workers Support Families with Substance Use, Mental, and Co-Occurring Disorders

A trainer's guide to educate child welfare professionals about substance use and mental health disorders. The kit contains six modules, each with a training plan, trainer scripts with PowerPoint slides, handouts, case vignettes, and training guidelines to facilitate discussions.

To download these publications, go to <http://www.ncsacw.samhsa.gov> and <http://www.childwelfare.gov/index.cfm>. Some publications are available in hard copy and can be ordered at <http://store.samhsa.gov/home> or by calling 1-877-726-4772.

NCSACW Technical Assistance Products

ONLINE TRAINING COURSES

All online courses are free and intended for anyone working with families involved with the child welfare, substance abuse, and court systems. The trainings take about 4 hours to complete and can be stopped and started as needed. A certificate is awarded upon completion, and FREE continuing education units (CEU) or continuing legal education (CLE) can be credited for each course.

Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals

An online course that provides information to treatment professionals so that they better understand how child welfare and family dependency court requirements affect parents in treatment. It offers strategies for effectively collaborating with child welfare agencies. This course is approved by the National Association of Addiction Professionals to provide four CEUs.

Understanding Substance Use Disorders, Treatment, and a for Child Welfare

An online course for professionals at disorders on page describes how a child abuse and when substance approved by the to provide four

Understanding Treatment, a for Legal Pro

A tutorial to help understanding of substance abuse with tips on how treatment. This Bar Association from State to State

OTHER RESOURCES

Substance-Exposed Infants: State Responses to the Problem

An overview of selected State policies and practices to address the needs of infants exposed to substances prenatally. A 5-point intervention framework is provided, which serves as a model for others and explains how to evaluate existing programs and identify gaps in services.

Drug Testing in Child Welfare: Practice and Policy Considerations

An excellent reference to help policymakers and program managers incorporate drug testing policies and procedures into their agency's comprehensive family and child welfare assessment protocol. This publication includes an

NCSACW Technical Assistance Products

OTHER RESOURCES (CONTINUED)

Funding Comprehensive Services for Families With Substance Use Disorders in Child Welfare and Dependency Courts

A look at existing resources for providing comprehensive services to families with substance use disorders.

Family-Centered Treatment for Women With Substance Use Disorders—History, Key Elements, and Challenges

An introduction to the concept of family-centered treatment for women and their families, including application of various treatment modalities and strategies to overcome commonly encountered barriers.

Funding Family-Centered Treatment for Women With Substance Use Disorders

A resource paper that helps treatment providers and State substance abuse agencies identify and access potential sources of funding for comprehensive family-centered treatment. It is a companion to *Family-Centered for Women With Substance Use Disorders—History, Key Elements, and Challenges*.

A Review of Alcohol and Drug Issues in the States' Child and Family Service Reviews (CFRS) and Program Improvement Plans (PIPs)

A summary and analysis of substance abuse issues from CFRS and PIPs in all 50 States, the District of Columbia, and Puerto Rico.

Annotated Bibliography on Cross-System Issues

A bibliography including major literature and research papers on cross-system issues involving child welfare, substance use disorders, and dependency courts.

Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers

The latest, up-to-date research on parental use of methamphetamine and its effects on children and families.

Methamphetamine Resource List

A comprehensive list of all the methamphetamine resources available through the various agencies and associated organizations.

Get a FREE copy of these tools and protocols today!

To download these publications, go to <http://www.ncsacw.samhsa.gov> and <http://www.childwelfare.gov/index.cfm>.

Some publications are available in hard copy and can be ordered at <http://store.samhsa.gov/home> or by calling 1-877-726-4772.

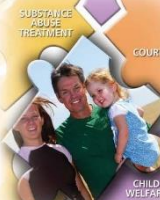


National Center on Substance Abuse and Child Welfare
Visit our Web site at <http://www.ncsacw.samhsa.gov>.
For assistance, call 866-493-2758.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families

National Center on Substance Abuse and Child Welfare Technical Assistance Products



PUBLICATIONS ON IMPROVING COLLABORATION

Screening and Assessment for Family Engagement, Retention and Recovery (SAFER)

This step-by-step guide provides a framework to strengthen screening and assessment practices while building a collaborative team among the child welfare, substance abuse, and dependency court systems. Appendices include examples of screening and assessment tools, factsheets, and information about confidentiality.

Facilitating Cross-System Collaboration: A Primer on Child Welfare, Alcohol and Other Drug Services, and Courts

An essential reference providing an introduction to each of the child welfare, substance abuse, and court systems. It helps professionals become familiar with the operations of the other organizations that also serve their clients.

NCSACW demonstrates the importance of cross-system collaboration among the child welfare, substance abuse treatment, and court systems by providing materials that document current best practices and policies from across the country. The following products are all available FREE online or via the U.S. mail.



National Center on Substance Abuse and Child Welfare
Visit our Web site at <http://www.ncsacw.samhsa.gov>.
For assistance, call 866-493-2758.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families

Taking these Lessons to Your Community

Explore if there are current initiatives, a Task Force, or workgroups already meeting or discussing this within your community or state



Ask local hospitals how they are responding to prenatally exposed infants

Ask your local birthing hospitals about screening and testing practices

Think about missing partners and reach out to build relationships

Work with partners to develop plans for how you can engage foster parents for care of infants with NAS who are not going home. How can you ensure they are receiving support and training to manage these infants?



Think about the use of language and its impact on the families (i.e.: addicted babies vs. infants with prenatal substance exposure)



Discussion



*What's
Next*

Session #2: Developing
Plans of Safe Care

2:00pm – 3:30pm

*Improving outcomes for children
and families affected by
substance use disorders*



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Linda Carpenter

**Program Director
In Depth Technical Assistance Program
National Center on Substance Abuse
and Child Welfare
(714) 505-3525
lcarpenter@cffutures.org**

Mollie Greene, MA, CADC

**Director of Clinical Services
Office of Child and Family Health
Department of Children
mollie.greene@dcf.state.nj.us**

Jill Gresham

**Senior Program Associate
In-Depth Technical Assistance Program
National Center on Substance Abuse
and Child Welfare
(714) 505-3525
jgresham@cffutures.org**

Mishka Terplan, MD, MPH, FACOG, FASAM

**Medical Director
Behavioral Health System
Baltimore, MD
mishka.terplan@bhsbaltimore.org**



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Thank You