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
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
Acknowledgement

This presentation is supported by:

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
and the
Administration on Children, Youth and Families
Children’s Bureau
Office on Child Abuse and Neglect

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.
Substance-Exposed Infants, In Depth Technical Assistance

States Receiving IDTA to Improve Practice and Policies
- Connecticut
- Kentucky
- Minnesota
- New Jersey
- Virginia
- West Virginia
The Scope of the Problem—National Data
Pregnancy and Prescription Opioid Abuse Among Substance Use Disorder Treatment Admissions

- Increase from 1% to 19% among pregnant treatment admissions for prescription opioids as the primary substance of abuse.
- Increase from 2% to 28% among pregnant treatment admissions for any prescription opioid 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
Percent of Children Removed with Parental AOD as a Reason for Removal by Age, 2014

National Average: 41.9%
National Average: 29.7%

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

<table>
<thead>
<tr>
<th>Reason for Removal</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Neglect</td>
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<tr>
<td>Parent Alcohol or Drug Abuse</td>
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<tr>
<td>Parent Unable to Cope</td>
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<td>Physical Abuse</td>
<td>15.6%</td>
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<tr>
<td>Inadequate Housing</td>
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<td>Parent Incarceration</td>
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<td>Child Disability</td>
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<td>Relinquishment</td>
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<tr>
<td>Parent Death</td>
<td>1.1%</td>
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</table>

N = 118,679

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

Source: AFCARS Data, 2014
*Approximately 4 million (3,952,841) live births in 2012.


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

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<thead>
<tr>
<th>Substance</th>
<th>Affected Infants</th>
<th>Percentage</th>
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<tr>
<td>Tobacco</td>
<td>640,000</td>
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<tr>
<td>Alcohol</td>
<td>340,000</td>
<td>8.5%</td>
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<tr>
<td>Illicit Drugs</td>
<td>240,000</td>
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<tr>
<td>Binge Drinking</td>
<td>108,000</td>
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<tr>
<td>Heavy Drinking</td>
<td>12,000</td>
<td>0.3%</td>
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<tr>
<td>FAS/ARND/ARBD</td>
<td>30,000 (0.5-7 per 1,000 births)</td>
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</tr>
<tr>
<td>NAS</td>
<td>22,000 (5.8 per 1,000 births)*</td>
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</tbody>
</table>

*Includes nine categories of illicit drugs, including heroin and the nonmedical use of prescription medications.
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.


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%** of neonatal stays involved specific substances:
  - **8.6%** cocaine
  - **4.5%** hallucinogens
  - **2.1%** multiple substances or conditions, or
  - **1.5%** fetal alcohol syndrome


*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*
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:

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)

Source: National Institute on Alcohol Abuse and Alcoholism, Alcohol Alert, Fetal Alcohol Spectrum Disorders: Understanding the Effects of Prenatal Alcohol Exposure, No. 82.
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:
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
Policy and Practice Framework: 5 Points of Intervention

Pre-Pregnancy
Awareness of substance use effects

Prenatal Screening and Assessment

Initiate enhanced prenatal services

Identification at Birth

Respond to parents’ needs

Child

Post-Partum
Ensure infant’s safety and respond to infant’s needs

Infancy & Beyond
Identify and respond to the needs of the infant, toddler, preschooler, child and adolescent

Legend
System Linkages

Parent

Identify and respond to parents’ needs
A Collaborative Approach

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

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

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

....Reducing the number of crises at birth for women, babies, and the systems!
Prenatal Screening & Assessment

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?
Identification at Birth

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?
Post-Partum Period

How are CSBs notified of the family and the discharge plan?
How are the plans monitored?
What is included in discharge plans?
Who participates in development?
How is the family referred to home visiting services?
Finding the Way to Collaboration

No Single System can Solve this Problem
A Collaborative Approach: New Jersey

Pregnant & Postpartum Women and their Infants

Child Protective Services

Hospitals

SA/MH Treatment

MCH, IDEA Part C

Department of Health

Medicaid
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
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
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

<table>
<thead>
<tr>
<th>Substance use by trimester</th>
<th>Non-pregnant</th>
<th>Percent Change</th>
<th>Postpartum</th>
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<tbody>
<tr>
<td>Alcohol</td>
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</tr>
<tr>
<td>First</td>
<td>19.0</td>
<td>54.0</td>
<td>92%</td>
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<tr>
<td>Second</td>
<td>5.0</td>
<td>4.4</td>
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<tr>
<td>Third</td>
<td>4.4</td>
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<tr>
<td>Cigarettes</td>
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<tr>
<td>First</td>
<td>19.9</td>
<td>24.0</td>
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<tr>
<td>Second</td>
<td>13.4</td>
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<tr>
<td>Third</td>
<td>12.8</td>
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<tr>
<td>Illicit drugs</td>
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<td></td>
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</tr>
<tr>
<td>First</td>
<td>9.0</td>
<td>11.4</td>
<td>79%</td>
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<tr>
<td>Second</td>
<td>4.8</td>
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<tr>
<td>Third</td>
<td>2.4</td>
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</tbody>
</table>
All pregnant women are motivated to maximize their health and that of their baby-to-be.
All pregnant women are motivated to maximize their health and that of their baby-to-be.

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

Continued use in pregnancy is pathognomonic for addiction.
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)
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 Lifecourse

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
• **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

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

<table>
<thead>
<tr>
<th>State</th>
<th>Substance Abuse During Pregnancy Considered:</th>
<th>When Abuse Suspected, State Requires:</th>
<th>Drug Treatment for Pregnant Women</th>
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<td></td>
<td>Criminal Act</td>
<td>Child Abuse</td>
<td>Grounds for Civil Commitment</td>
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<td><strong>Total</strong></td>
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<td>18</td>
<td>3</td>
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Source: Guttmacher Institute, March 1, 2016
Treatment: Opioid Use Disorder During Pregnancy

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

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

**Early Learning Commission**
Commissioners of Education, Health, Children & Families and Human Services
*Considers proposed plans and approves policy and funding decisions*

**Interdepartmental Planning Group**
State Administrators
*Considers feasibility of each recommendation, makes plans for implementation*

**New Jersey Council for Young Children**
Stakeholders
*Makes recommendations (Strategic Plan)*

**Local County Councils for Young Children**
Parents and Community Stakeholders
*Parent driven county level advisory boards to make recommendations, develop and implement action plans for county level needs.*
Evolution of Early Childhood System of Care

Central Intake Systems

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

Community Health Worker (CHW)
• Community Outreach
• Identifies women & families needing services
• Completes the 1-page form and 2-page form
• Refers to Central Intake (CI) via SPECT
• Clients in CHW Case Management are referred back to CHW by CI

Central Intake (CI)
CI staff reviews, refers & links parent/family to an appropriate partner agency for voluntary follow-up for an initial assessment, prevention education, and/or other needed services. Children are linked to a medical home and developmental screening.

Prenatal & Early Childhood Community-Based Services
• Home Visiting - Evidence-based models
• Early Head Start and Head Start Programs
• Pregnant/Parenting Teen Services – Parent Linking Program / Project TEACH
• CCR&R - Infant & Child Care Providers
• State-Funded Preschool - Family Outreach
• Early Intervention - Part C - Birth to Age 3
• Special Education - Part B - Age 3 and up
• Special Child Health Services – Birth to 21 yrs.
• Other Local Programs (vary by county): e.g. High-Risk Infants, Family Success Centers, Public Health Nurses, Doulas, Centering Pregnancy, Healthy Start etc.

Agenda for Local Collaboration
• Develop interagency agreements for referral and data sharing
• Establish a referral flow chart with community partners
• Provide cross-training & shared in-service
• Use SPECT system for tracking & analysis
• Identify gaps in resources & referral network
• Coordinate Consumer-Driven Community Advisory Board

Community-Based Health, Family Support & Social Services
• Medical Home/Primary Care
• Mental Health & Addiction
• Child Behavioral Health
• Developmental Disabilities
• Domestic Violence Services
• WIC Program
• Food Assistance / SNAP
• Infant & EC Mental Health
• Family Success Centers
• Fatherhood Support
• School-Based Services
• Parent Education & Support
• Child Lead Poisoning
• Local Health Departments
• CHIP/Health Insurance
• Public Assistance
• Housing / Transportation
• Immigration Services
• Child Protective Services
• And more…
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
<table>
<thead>
<tr>
<th></th>
<th>NFP</th>
<th>HF</th>
<th>PAT</th>
<th>HIPPY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Low income, 1(^{st}) time mother-to-be</td>
<td>Any at-risk pregnant woman/mother/family</td>
<td>Any at-risk pregnant woman/mother/ family</td>
<td>Any family with a pre-school child</td>
</tr>
<tr>
<td><strong>Enrollment Criteria</strong></td>
<td>Pregnancy; no later than 28 weeks of gestation</td>
<td>During pregnancy or at birth; TANF families may enroll in infancy</td>
<td>Pregnancy, at birth, or anytime to age 3</td>
<td>Families with a child age 3 or 4 years old</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Pregnancy up to age 2</td>
<td>Pregnancy and birth to age 3</td>
<td>Enrollment to ages 3 (to 5)</td>
<td>To age 5 or Kindergarten</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>Registered Nurses</td>
<td>Family Support Workers</td>
<td>Parent Educators</td>
<td>HIPPY Grads (part-time)</td>
</tr>
<tr>
<td><strong>Caseload</strong></td>
<td>25 families (maximum)</td>
<td>15 to 25 families (maximum)</td>
<td>25 families (maximum)</td>
<td>10 to 12 families</td>
</tr>
</tbody>
</table>
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

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

*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.
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

Early Intervention Services
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

Source: Center for Parent Information and Resources
Families in Child Welfare Affected by Substance Use

http://www.cwla.org/child-welfare-journal/cwj-featured-issues/
Medication Assisted Treatment During Pregnancy, Postnatal and Beyond

The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update
https://cff-ncsacw.adobeconnect.com/p5okpdezt3l/

Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome

Understanding Treatment of Opioid Use Disorders in Pregnancy

Medication Assisted Treatment During Pregnancy, Postnatal and Beyond

The following use selected websites from all of the above. Contact NCSACW for additional information.

3) Medication Assisted Treatment During Pregnancy

5) Substance Use in Pregnancy: The OB/GYN Perspective

7) In-Depth Technical Assistance for Substance Use and Maternity Care

The following are selected websites from the series. Contact NCSACW for additional information.

1) Medication Assisted Treatment During Pregnancy

2) Medication Assisted Treatment During Pregnancy, Postnatal and Beyond

4) The Use of Medication-Assisted Treatment During Pregnancy: Clinical Research Update
   - https://cff-ncsacw.adobeconnect.com/p5okpdezt3l/

6) Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome

The following are selected websites from the series. Contact NCSACW for additional information.

1) Medication Assisted Treatment During Pregnancy, Postnatal and Beyond: Discusses the needs of pregnant women seeking medication assisted treatment. Karol Kaltnebak, 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 websites from the series. Contact NCSACW for additional information.

III) Treatment of Opioid Use Disorders in Pregnancy
These resources offer guidelines for the use of MAT to treat opioid use disorders in pregnancy and the postpartum 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.

- 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, 2016. A National Institute on Drug Abuse (NIDA) supported clinical trial that examined the use of methadone and buprenorphine maintenance therapy during pregnancy. No significant differences were found with respect to any serious maternal or neonatal adverse events. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3106924
- Medication Assisted Treatment During Pregnancy, Postnatal and Beyond: Discusses the needs of pregnant women seeking medication assisted treatment. Karol Kaltnebak, 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:

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NCSACW Online Resources

Please visit: https://ncsacw.samhsa.gov


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

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.

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 funding for comprehensive family-centered treatment. It is a companion to the Family-Centered Treatment 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 (CFSRs) and Program Improvement Plans (PIPs)

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

Annotated Bibliography on Cross-System Issues

A bibliography of major literature and reports 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 the potential 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!


Some publications are available in hard copy and can be ordered at http://store.samhsa.gov/home or by calling 1-877-726-4727.
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).
WE WANT TO KNOW....

Discussion
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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Thank You