Children and Family Futures

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

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CWLA 2016 National Conference

Advancing Excellence in Practice & Policy: What Works For Families Affected by Substance Use

August 1, 2016 | Orange County, California

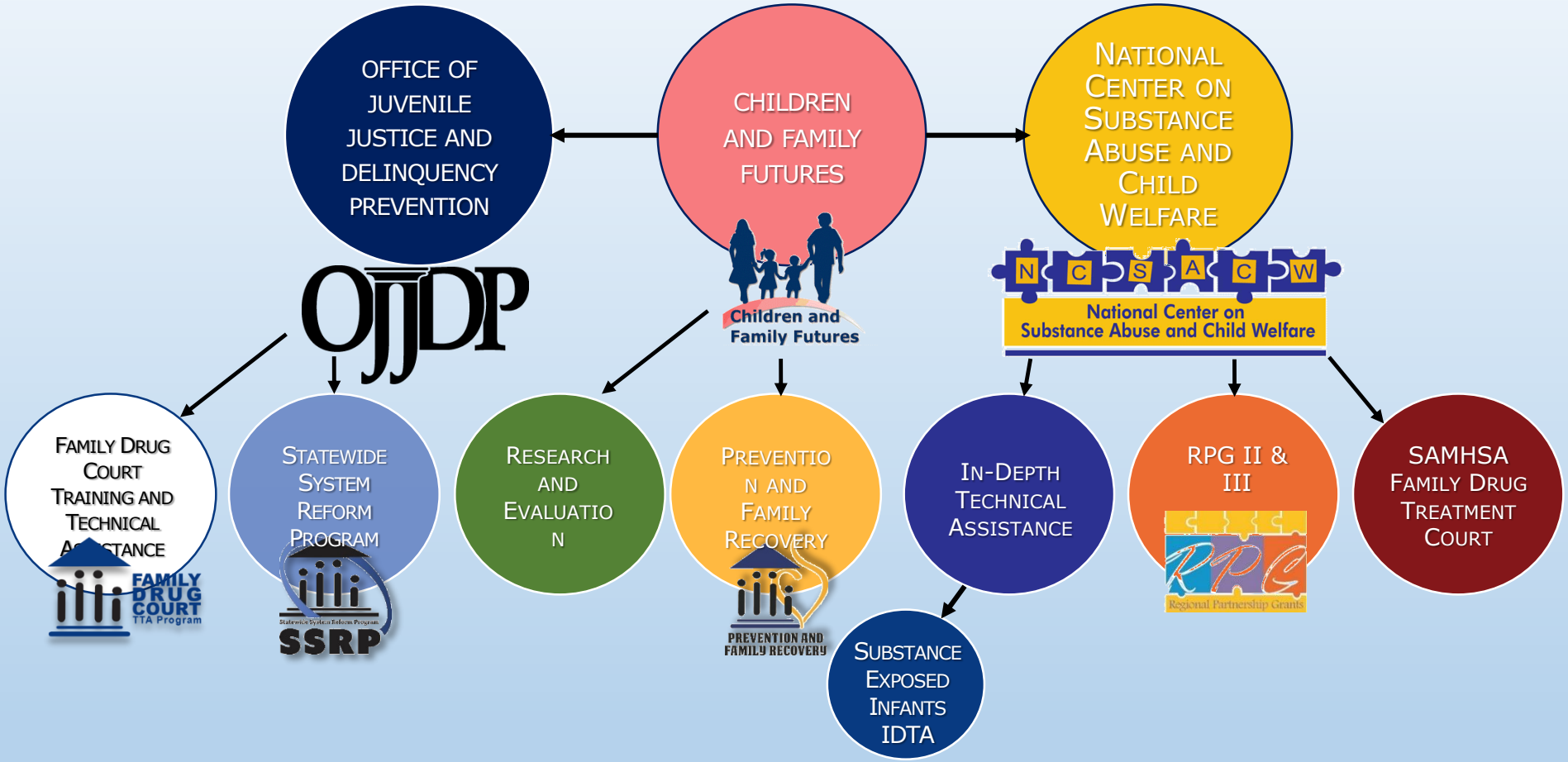
1) Overview of six sites and lessons learned
2) Discussion of CAPTA, hospital referrals and Plans of Safe Care
3) Discussion of the 5-points of intervention, including working with medical and substance use disorder treatment providers

Acknowledgement

This presentation is supported by:

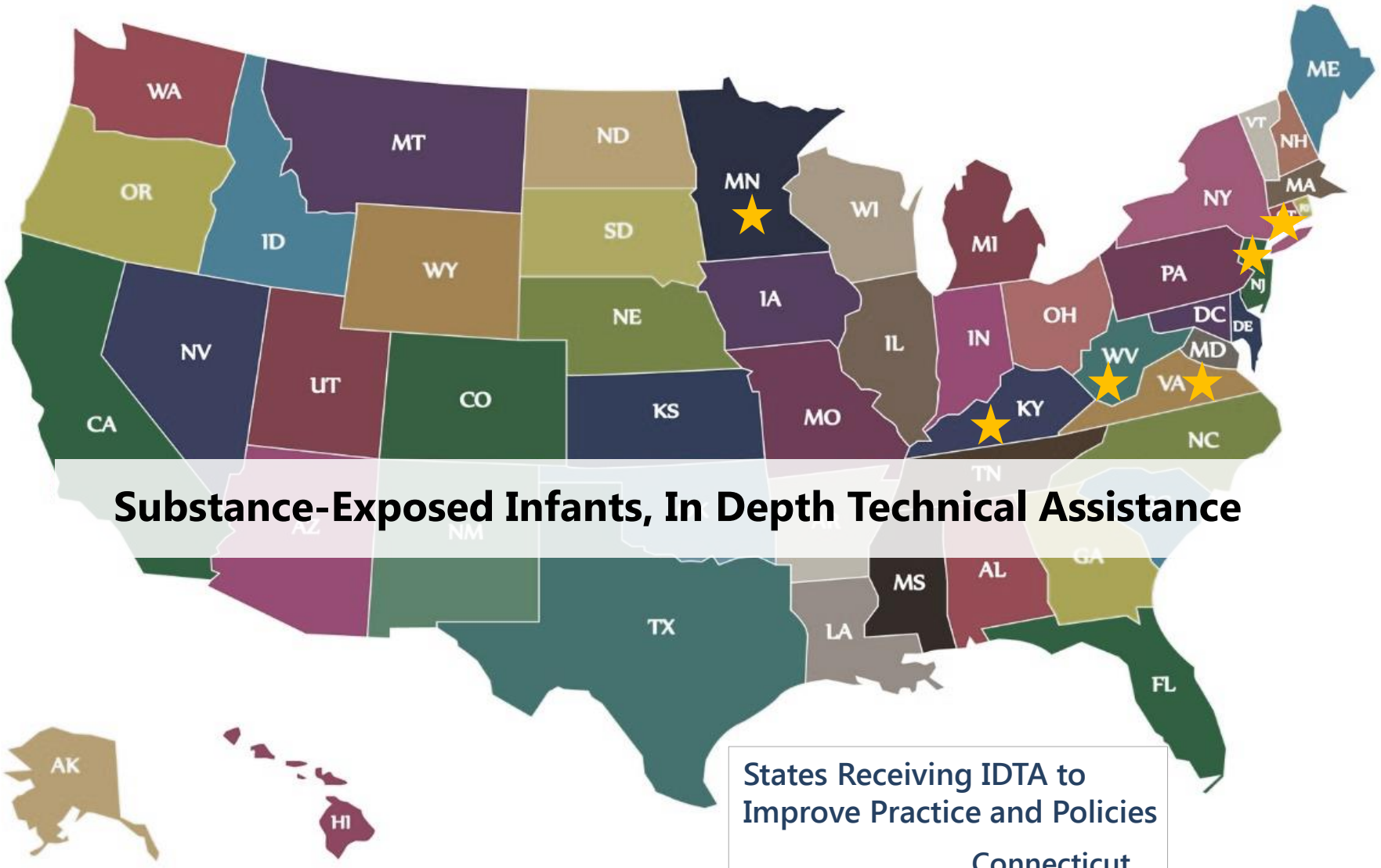
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
and the
Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

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.



www.cffutures.org

Substance-Exposed Infants, In Depth Technical Assistance

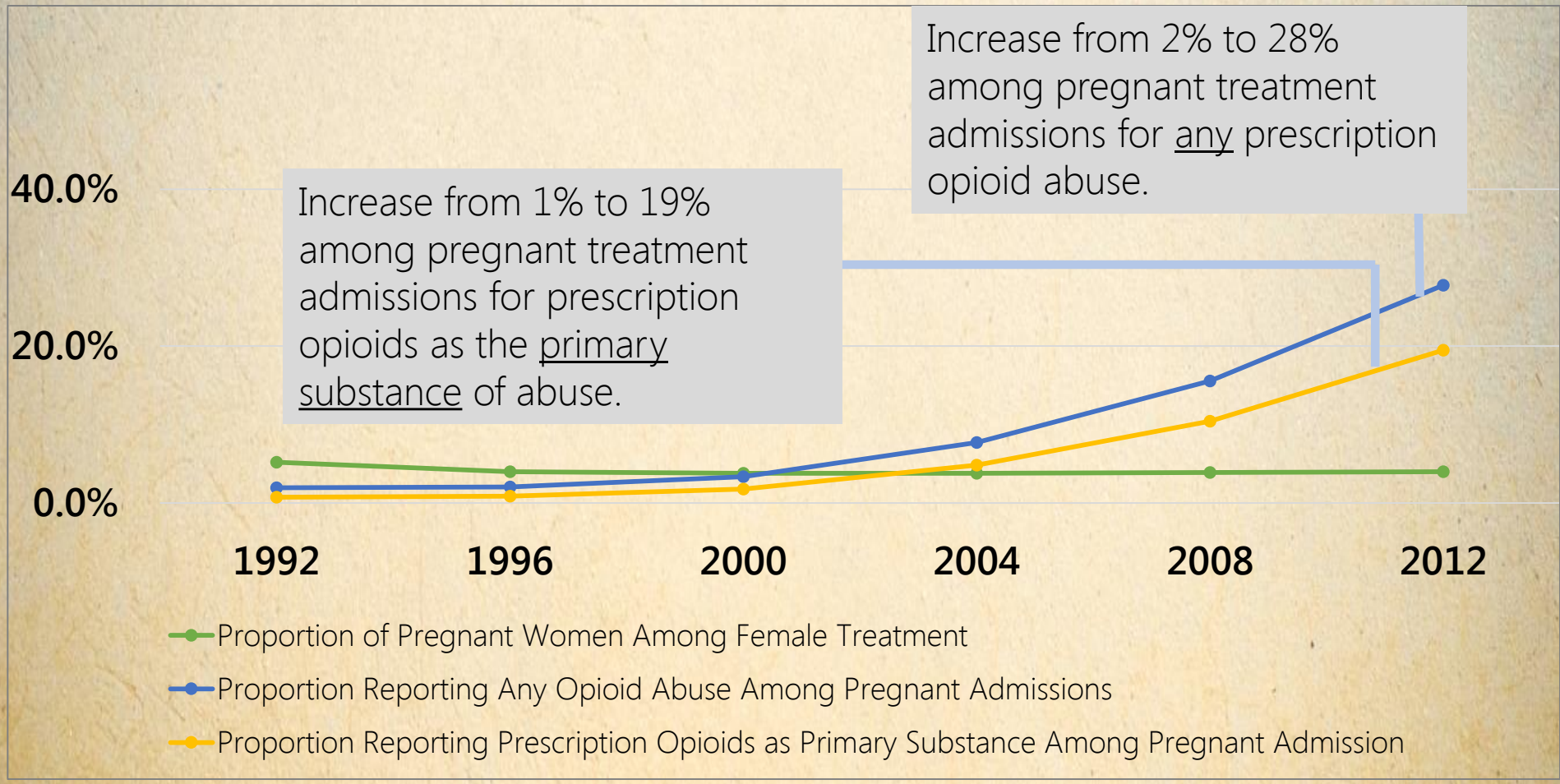


States Receiving IDTA to Improve Practice and Policies

★ Connecticut
★ Kentucky
★ Minnesota
★ New Jersey
★ Virginia
★ West Virginia

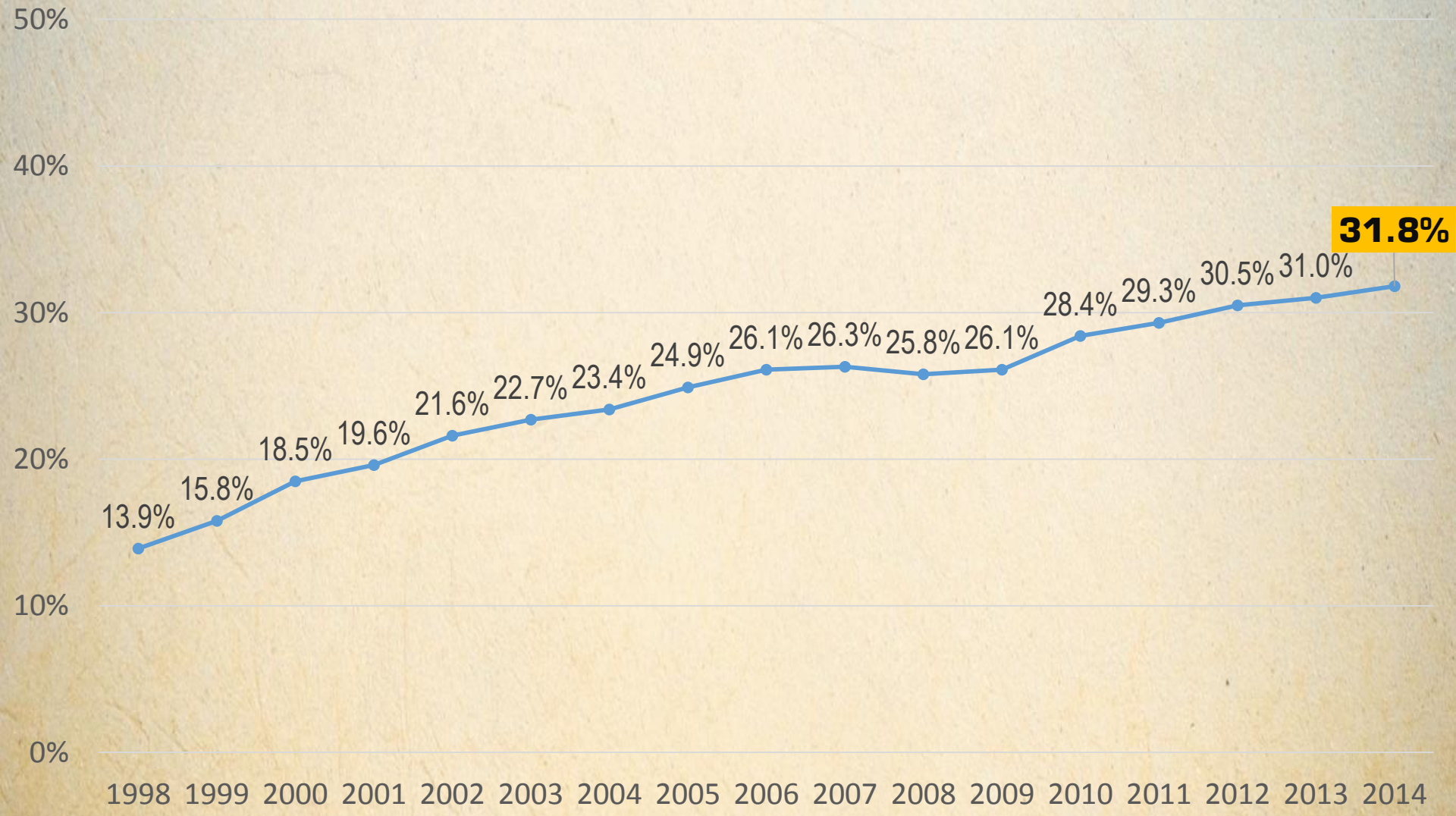

The Scope of the Problem—
National Data

Pregnancy and Prescription Opioid Abuse Among Substance Use Disorder Treatment Admissions



Martin, C.E., et al., Recent trends in treatment admissions for prescription opioid abuse during pregnancy. Journal of Substance Abuse Treatment (2014), http://dx.doi.org/10.1016/j.sat.2014.07.007

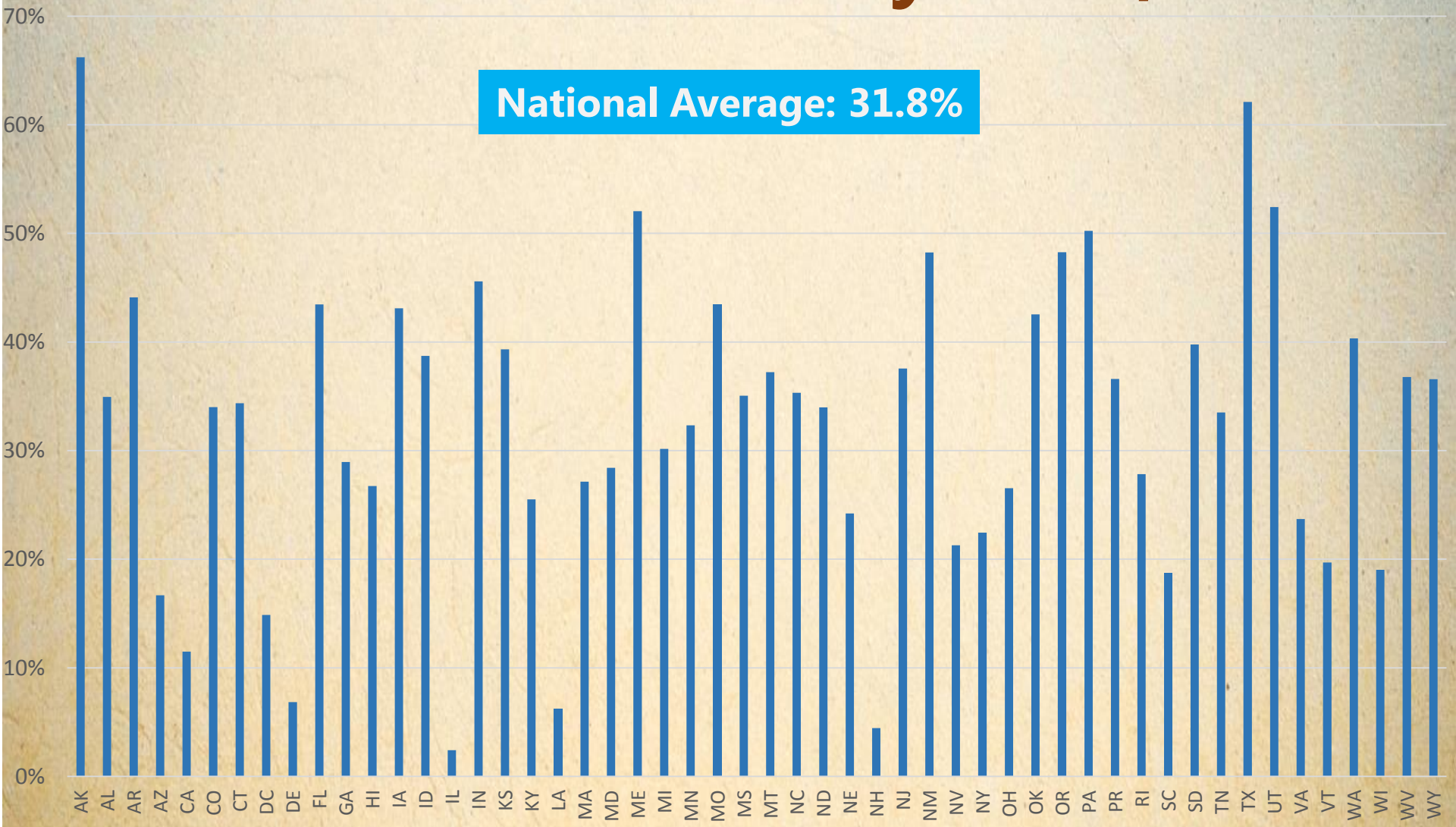
Parental AOD as Reason for Removal in the United States, 1999-2014



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

Source: AFCARS Data, 2014

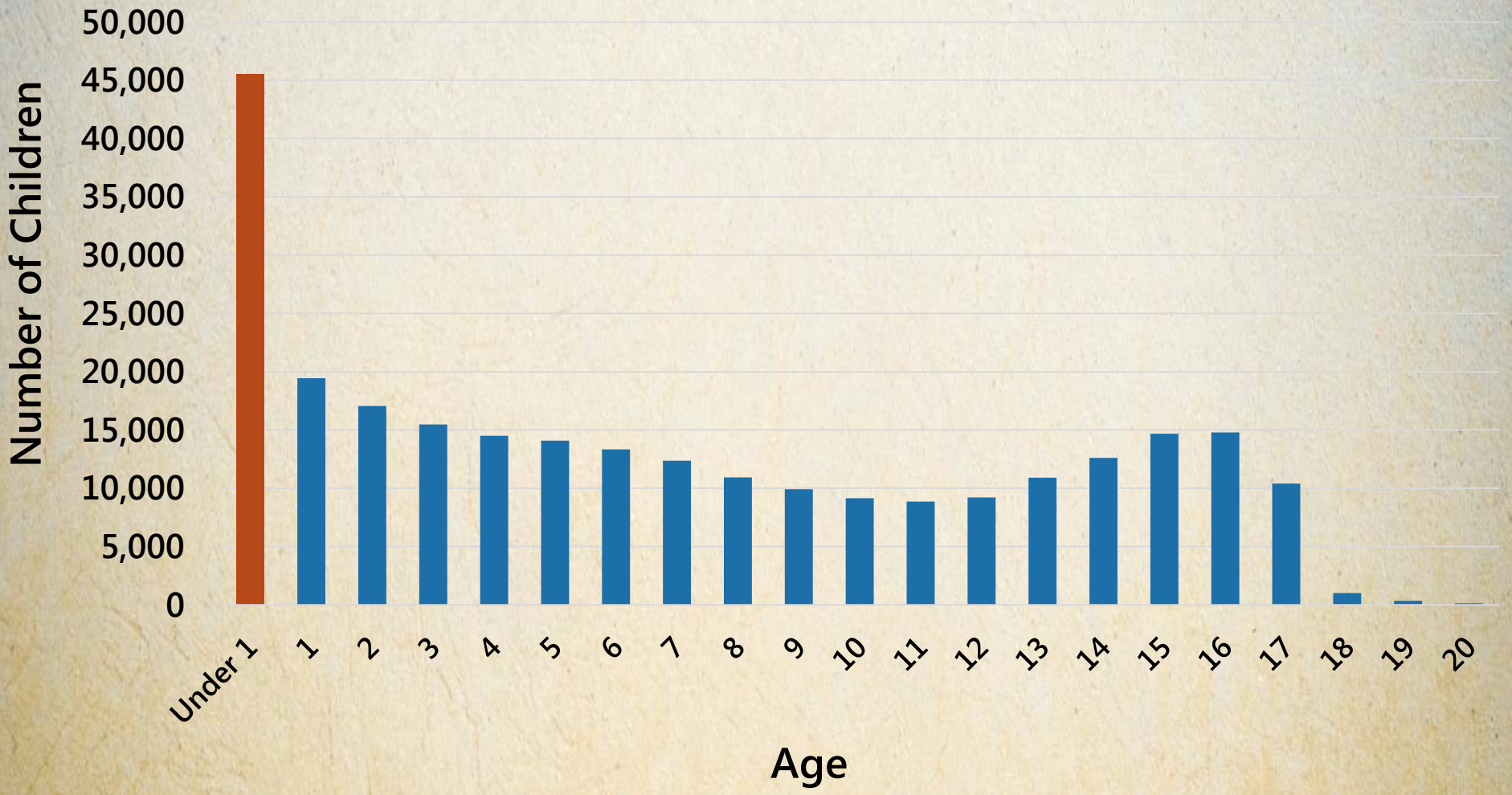
Parental Alcohol or Drug Use as a Reason for Removal by State, 2014



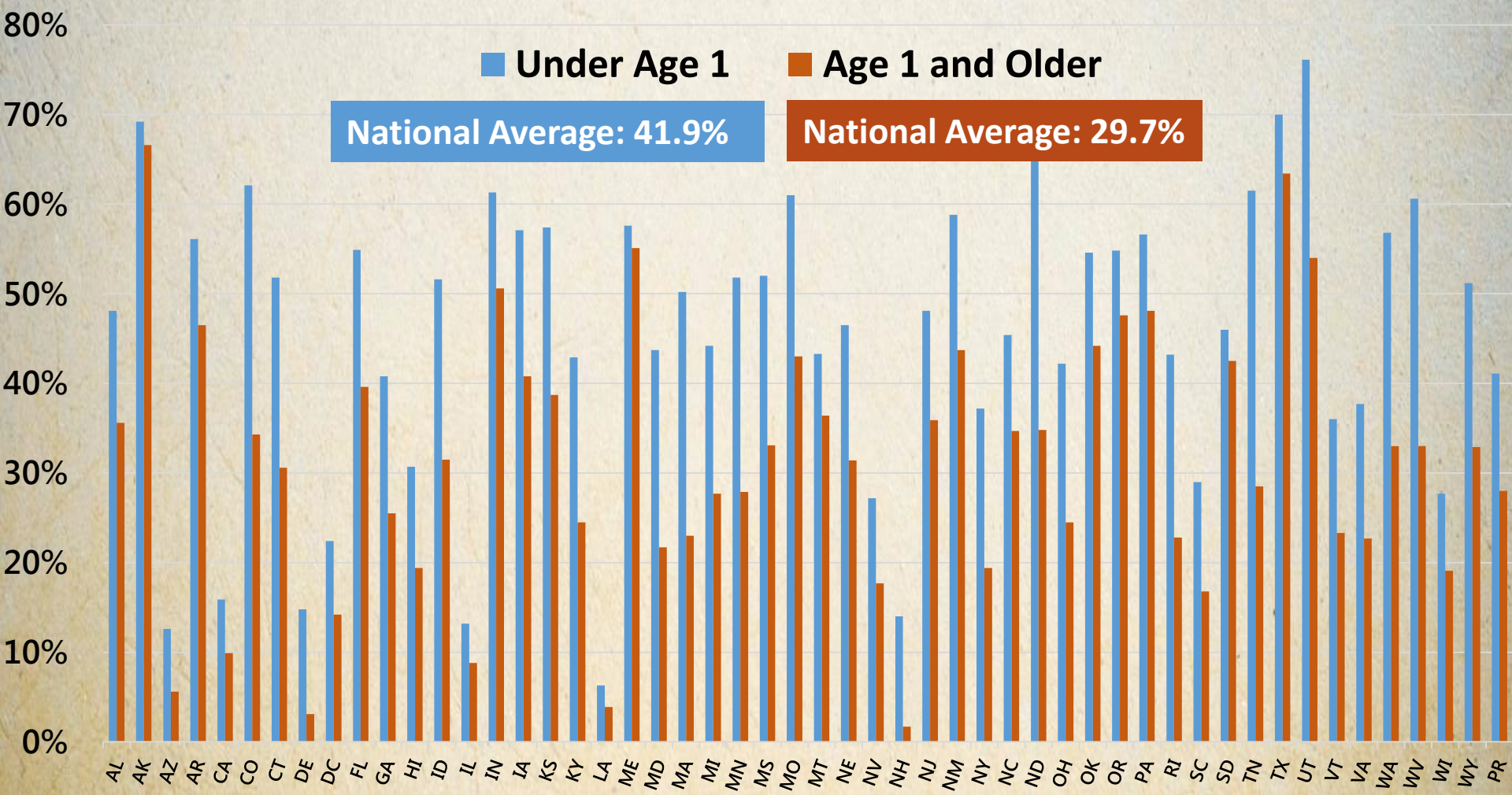
Note: Estimates based on all children who entered out of home care during Fiscal Year

Source: AFCARS Data, 2014

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



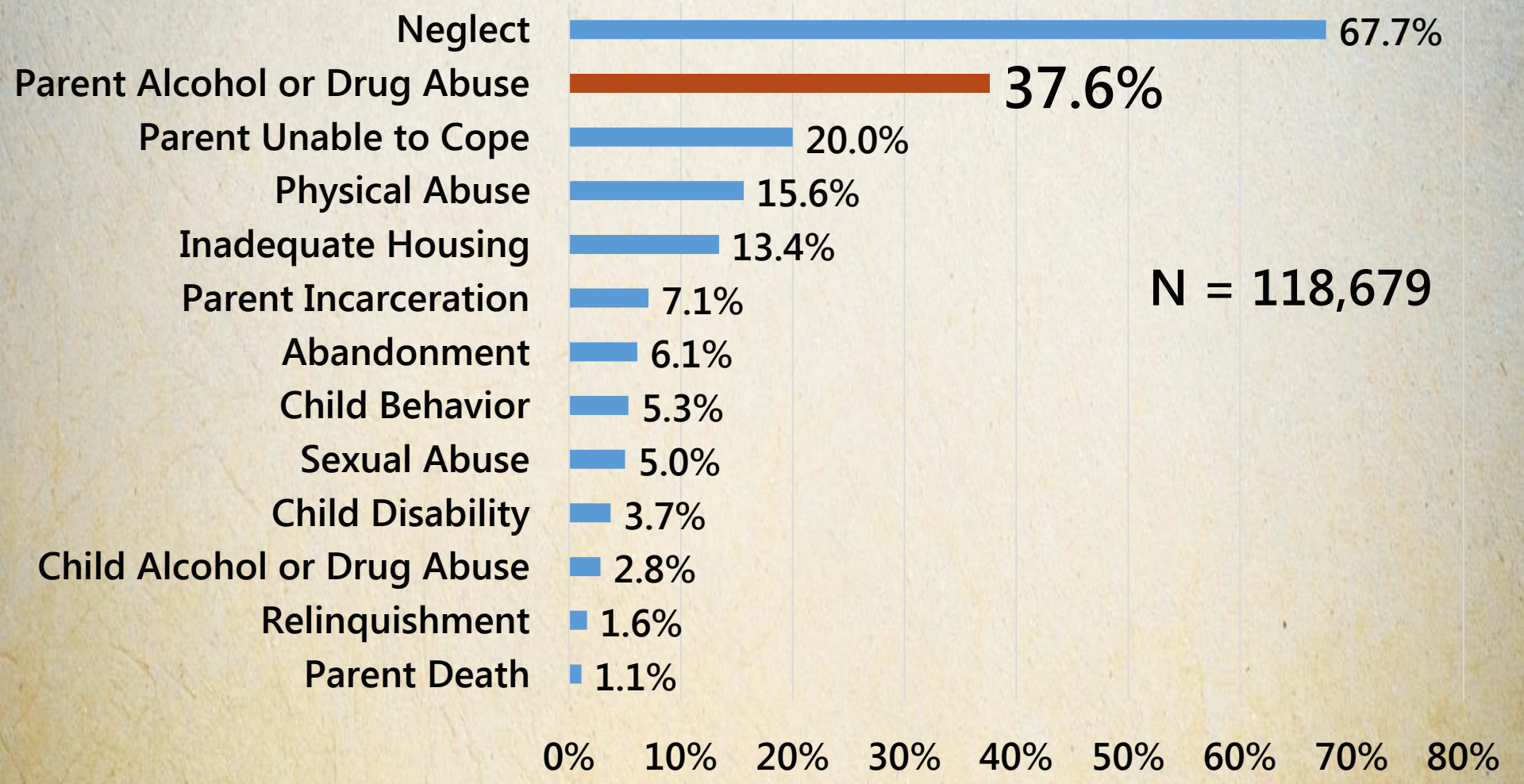
Percent of Children Removed with Parental AOD as a Reason for Removal by Age, 2014



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

Source: AFCARS Data, 2014

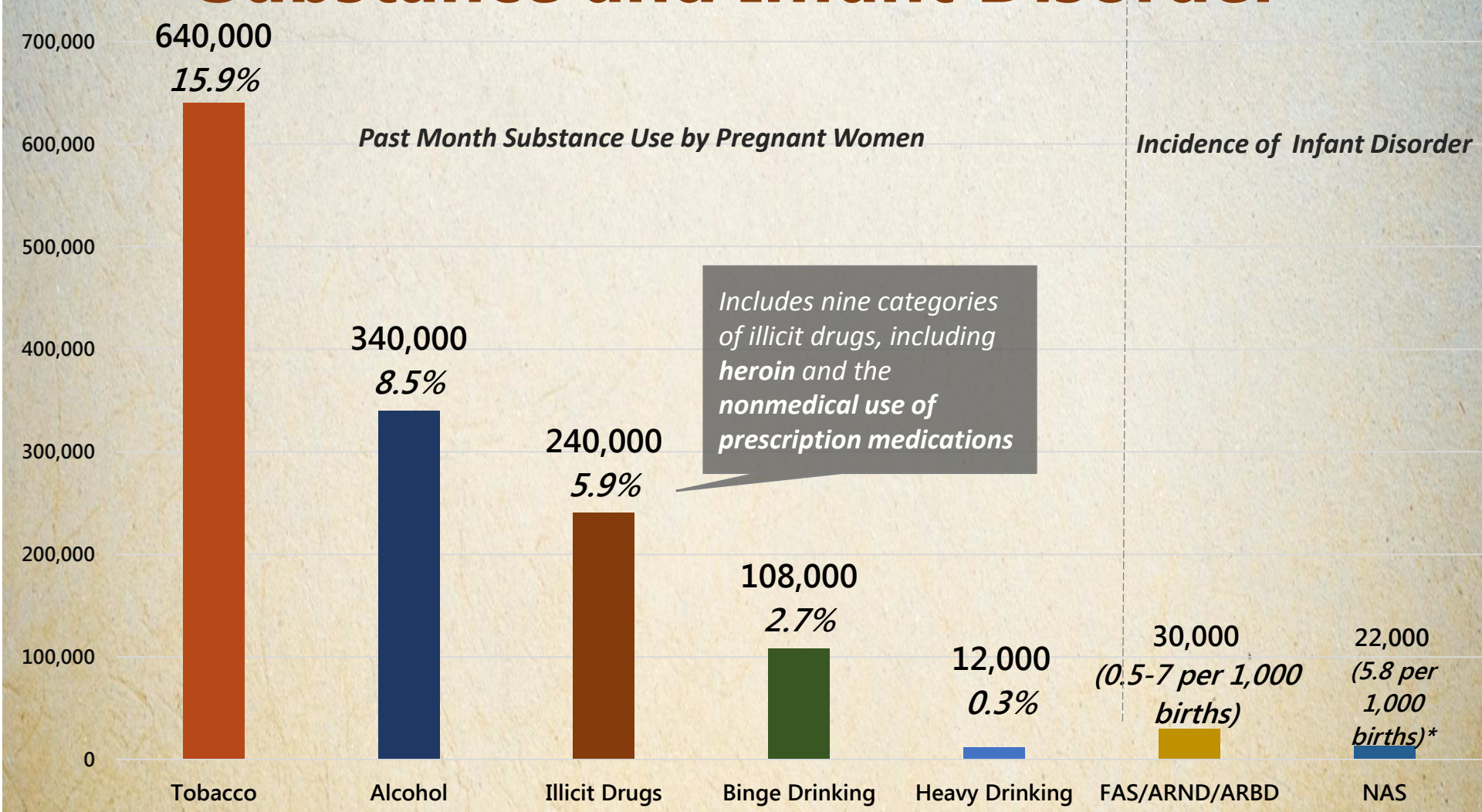
Percent of Children with Terminated Parental Rights by Reason for Removal in the United States, 2014



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

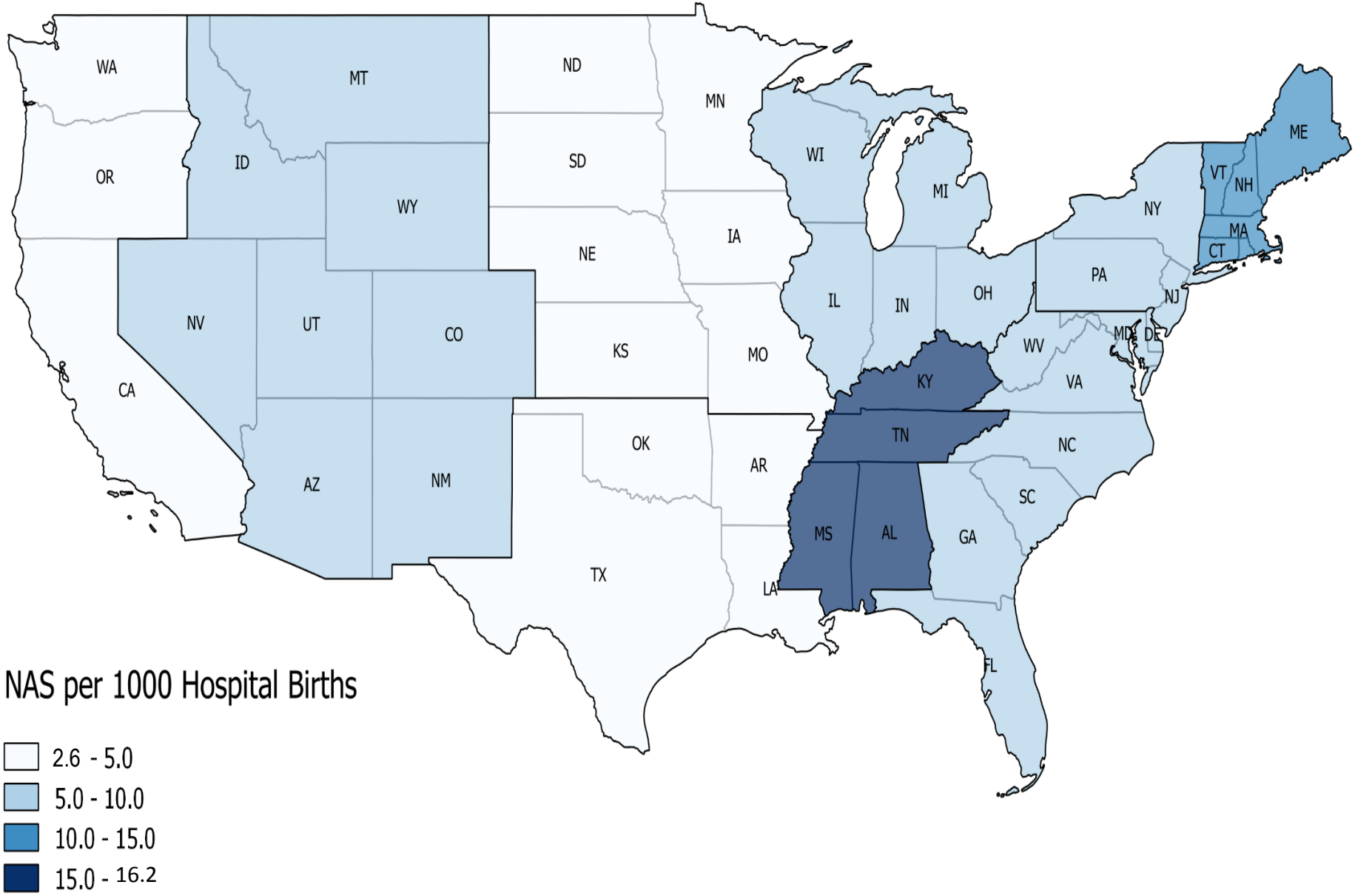


*Approximately 4 million (3,952,841) live births in 2012

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

Neonatal Costs

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

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…

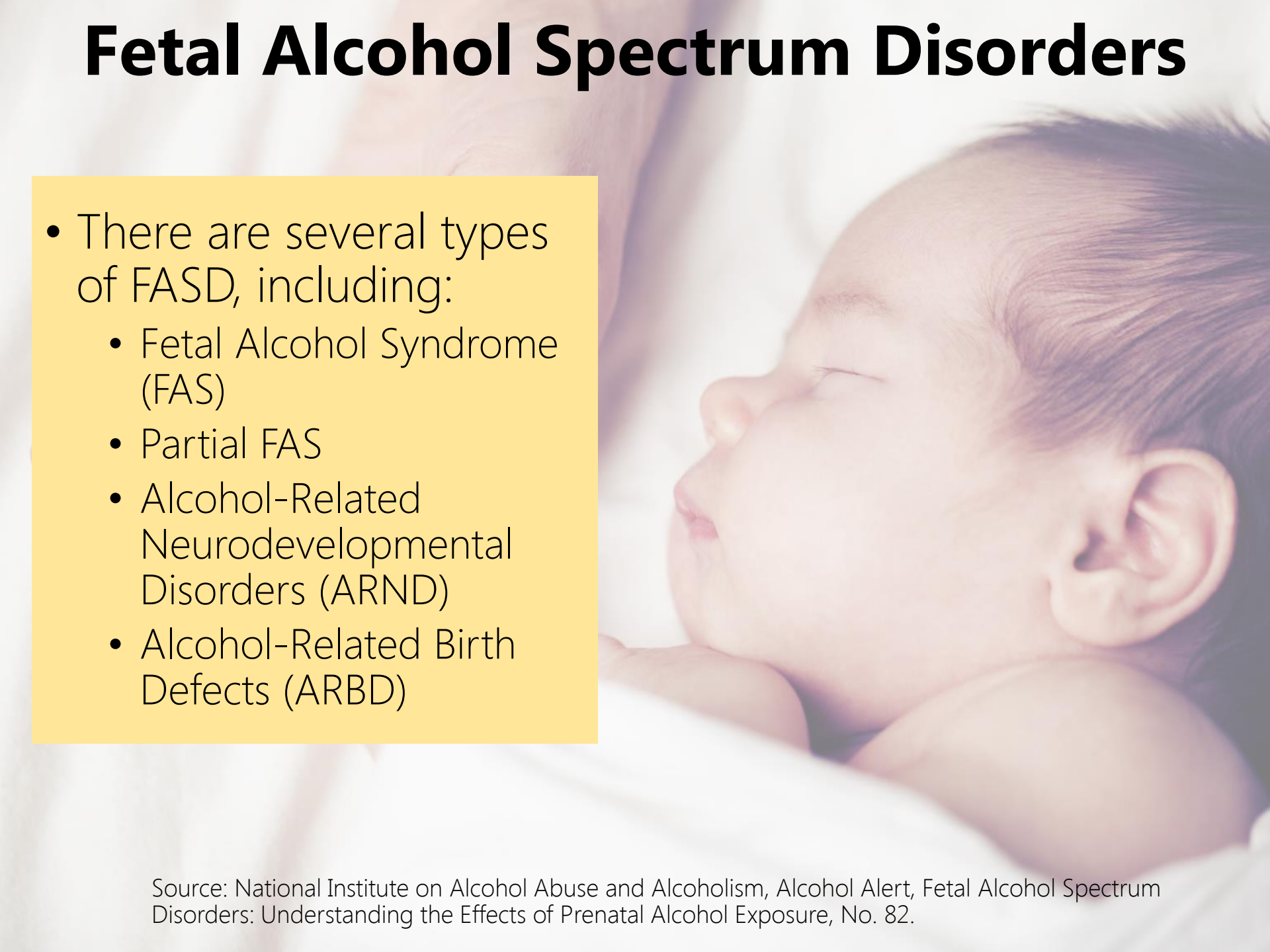
Source:

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)



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:
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).

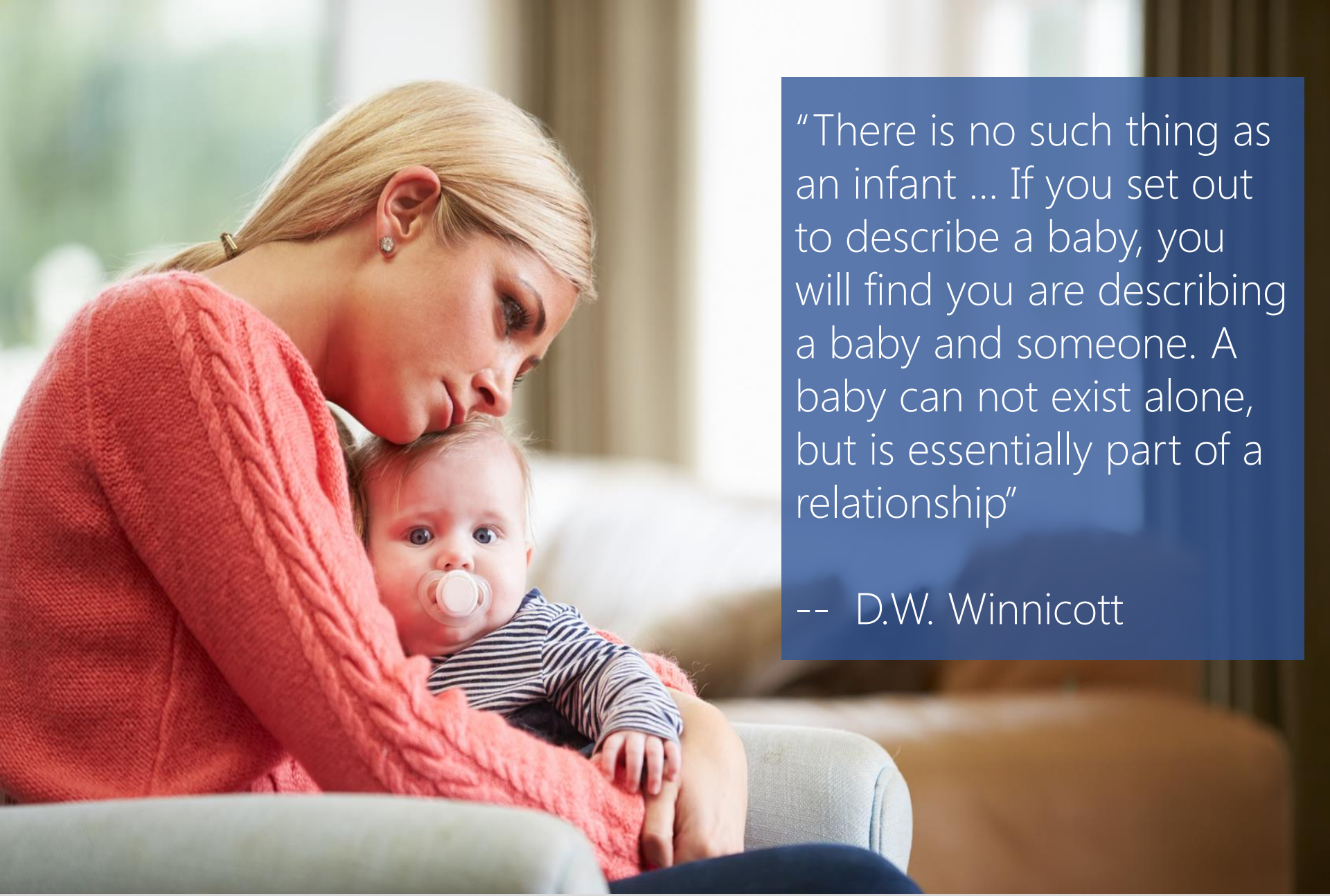
State Initiative Focus

Screening, Identification and Referral of pregnant women w/SUDs

Development of Guidelines for working with pregnant women and their infants

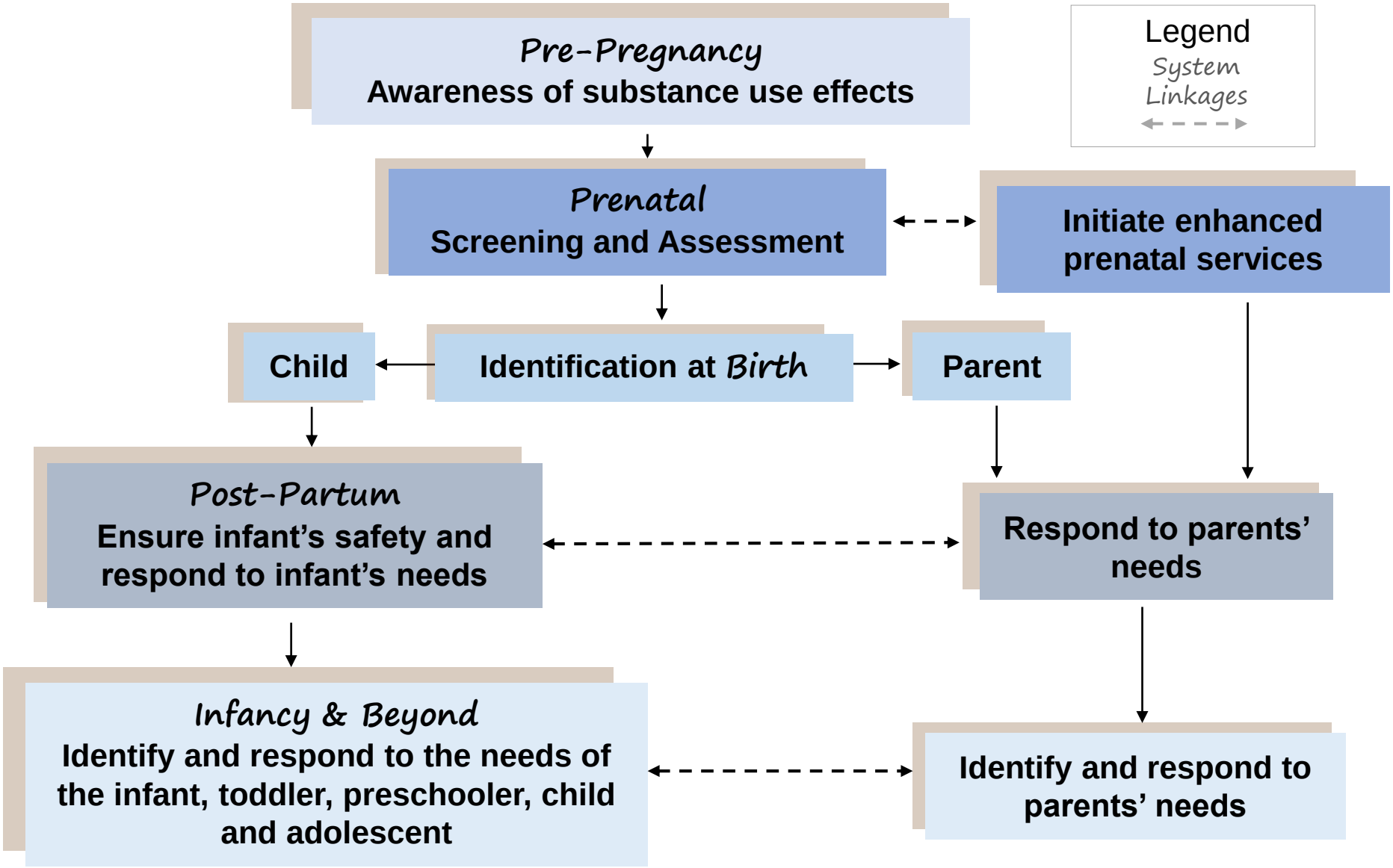
Hospital standards and discharge plans for infants and mothers

State strategies for CAPTA compliance and Plans of Safe Care

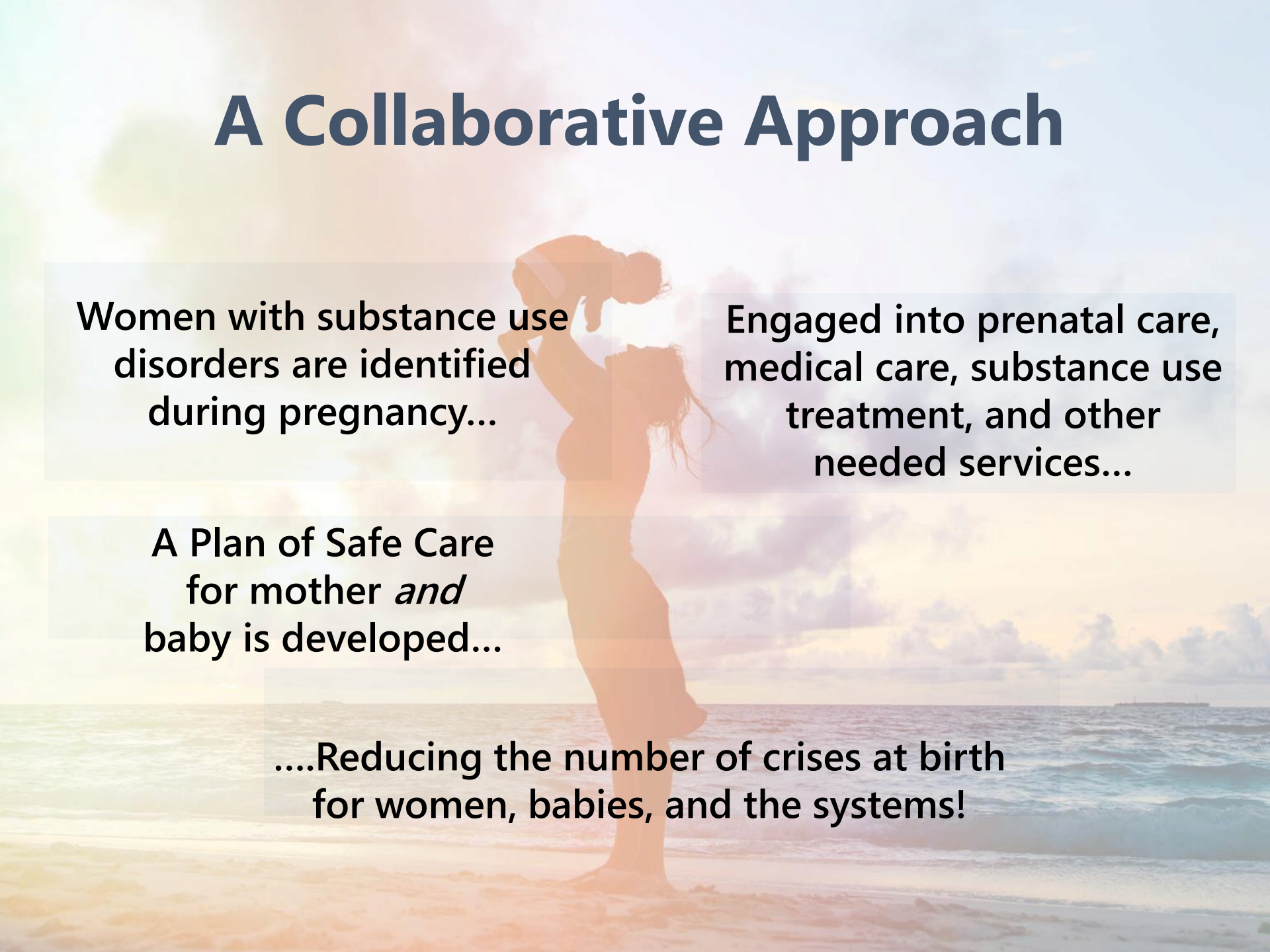


Mother-Infant Dyad

Policy and Practice Framework: 5 Points of Intervention



A Collaborative Approach



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!

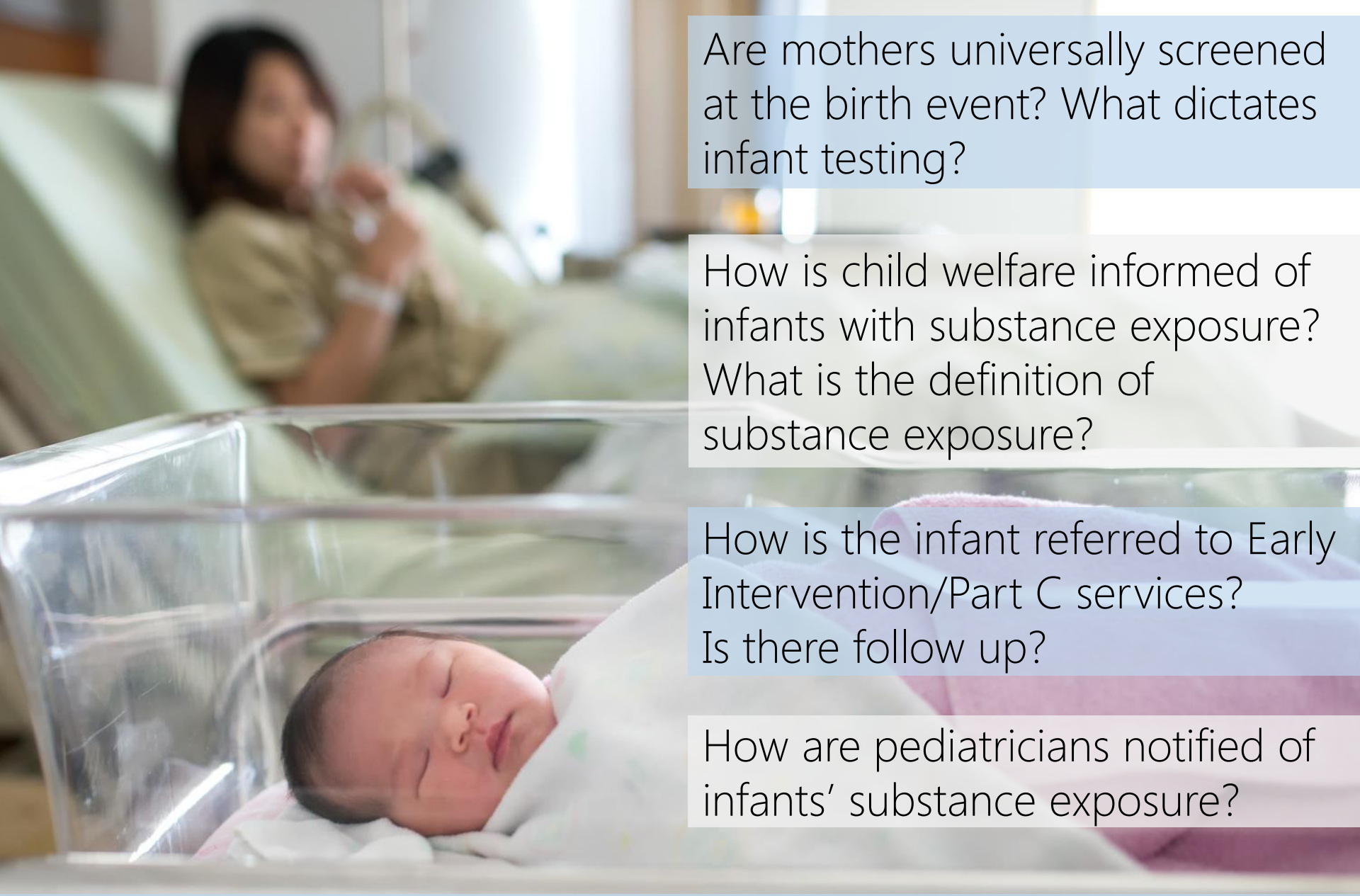
Prenatal Screening & Assessment

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?



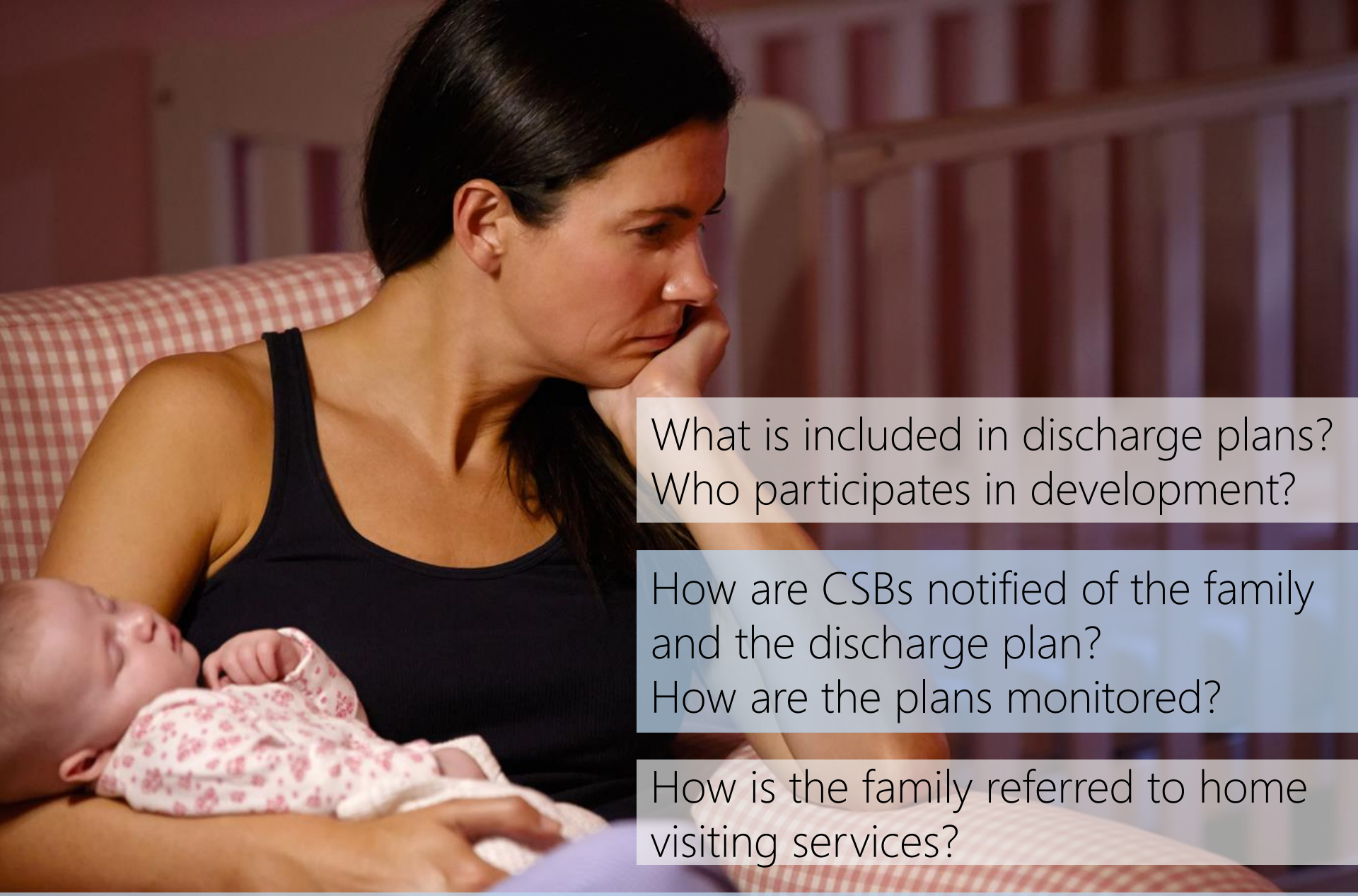
Are mothers universally screened at the birth event? What dictates infant testing?

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



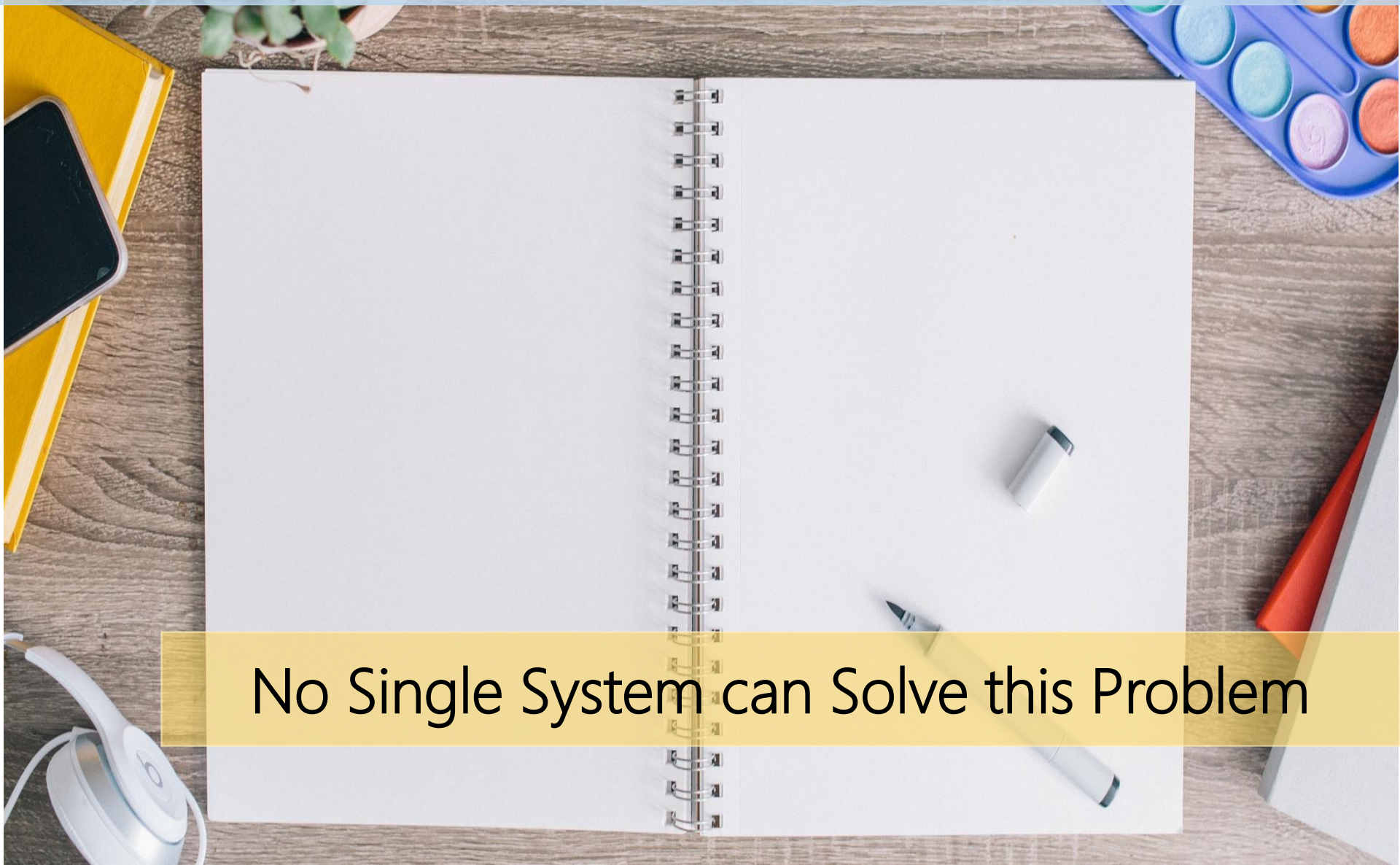
What is included in discharge plans?
Who participates in development?

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

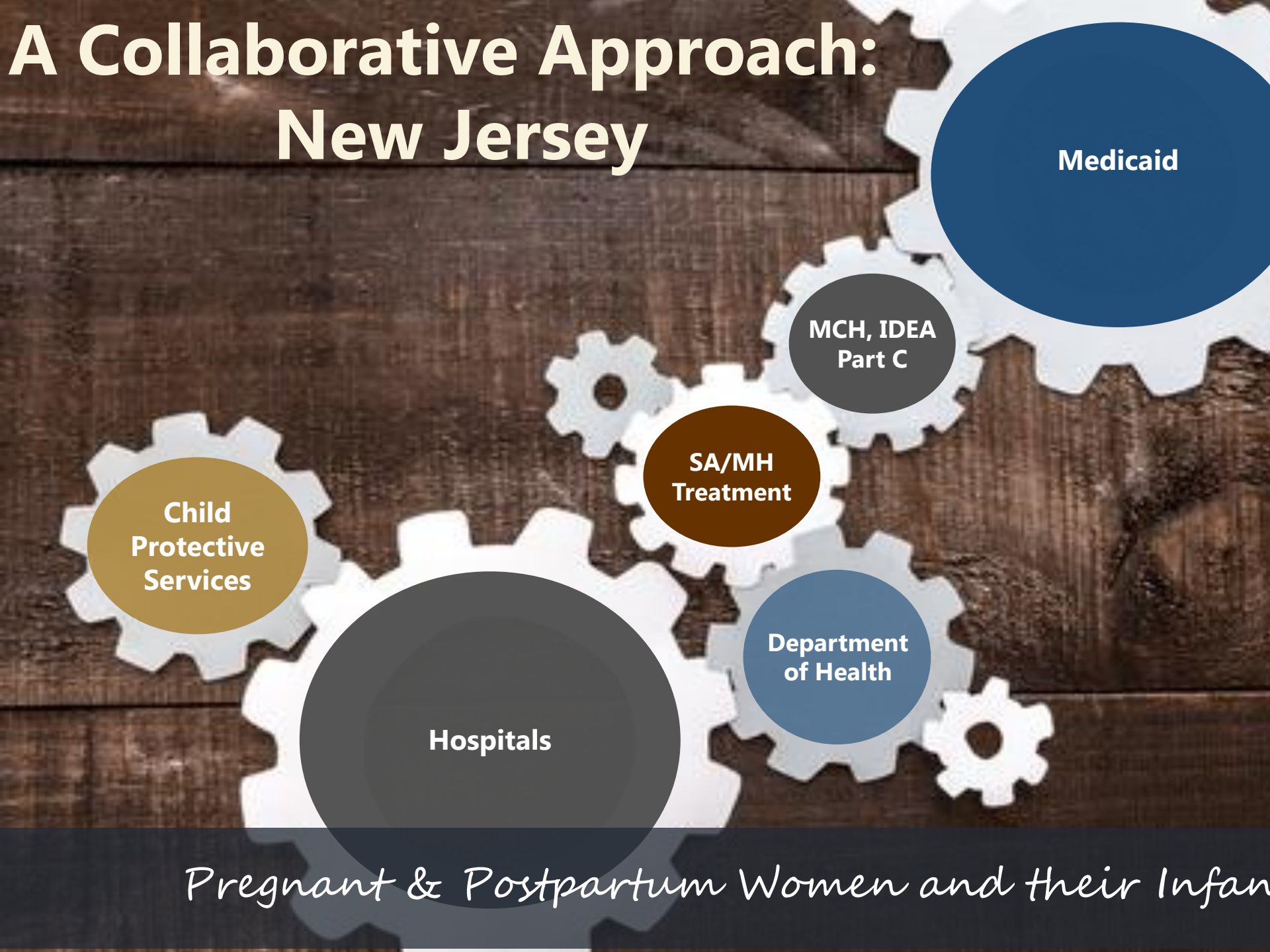
How is the family referred to home visiting services?

Post-Partum Period

Finding the Way to Collaboration



A Collaborative Approach: New Jersey



Pregnant & Postpartum Women and their Infan

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

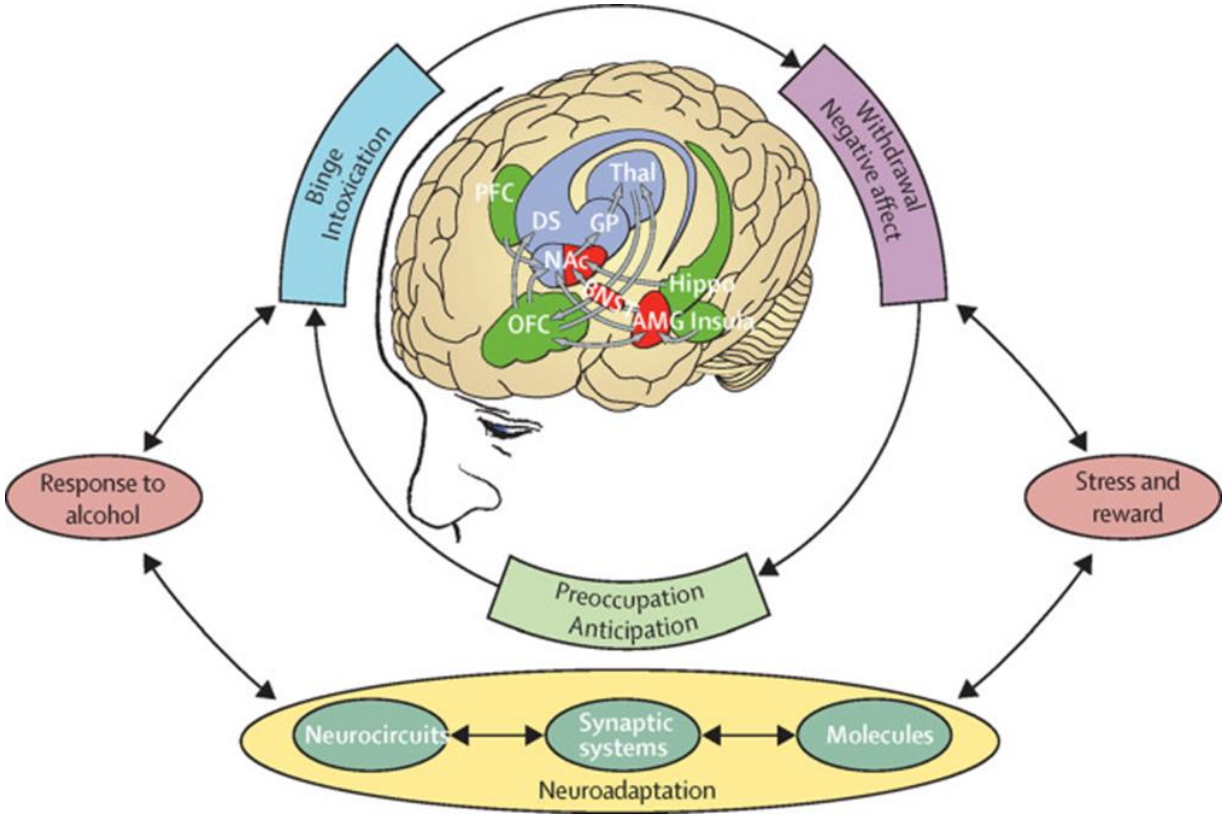
Substance use by trimester		Non-pregnant	Percent Change	Postpartum
Alcohol				
First	19.0	54.0	92%	45.4
Second	5.0			
Third	4.4			
Cigarettes				
First	19.9	24.0	47%	20.1
Second	13.4			
Third	12.8			
Illicit drugs				
First	9.0	11.4	79%	8.7
Second	4.8			
Third	2.4			

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

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

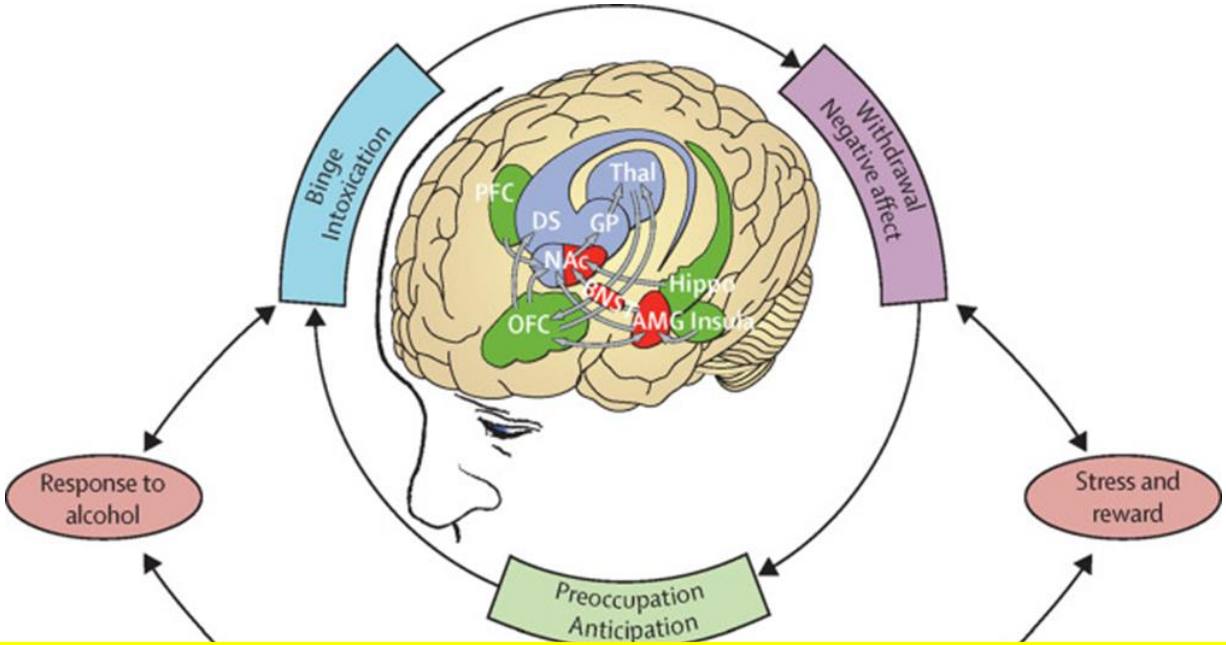
Those who can't quit or cut back – have a substance use disorder

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)

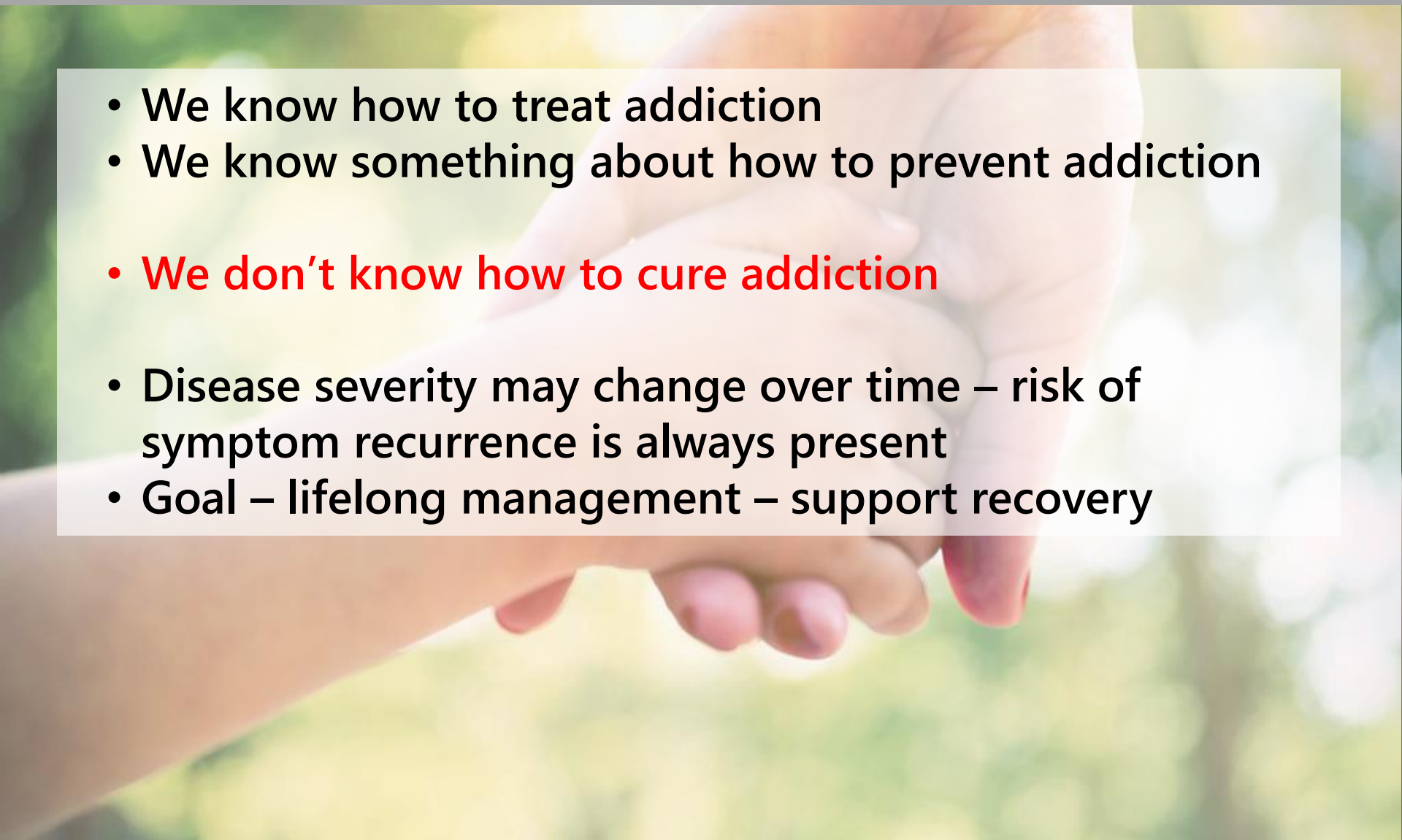


Addiction: A brain disease whose visible symptoms are behaviors

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

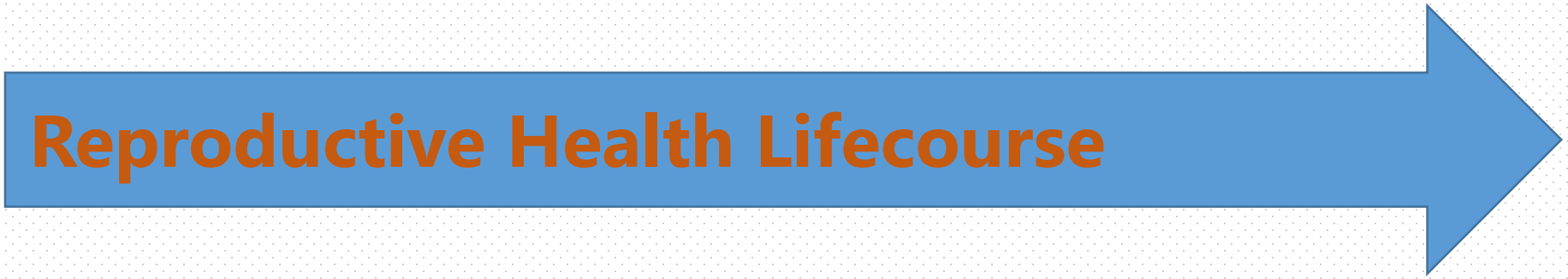


- We know how to treat addiction
- We know something about how to prevent addiction

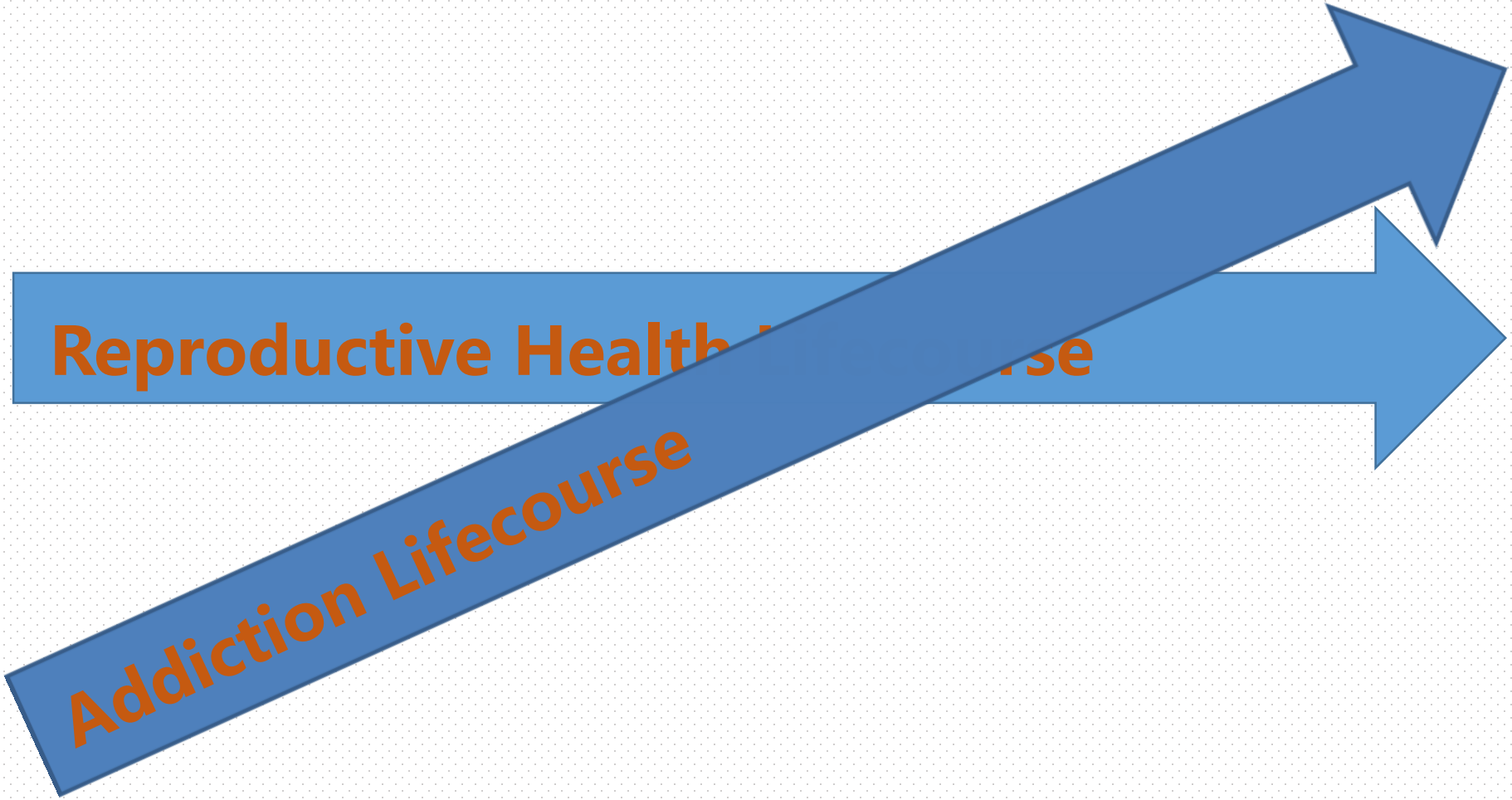
- We don't know how to cure addiction

- Disease severity may change over time – risk of symptom recurrence is always present
- Goal – lifelong management – support recovery

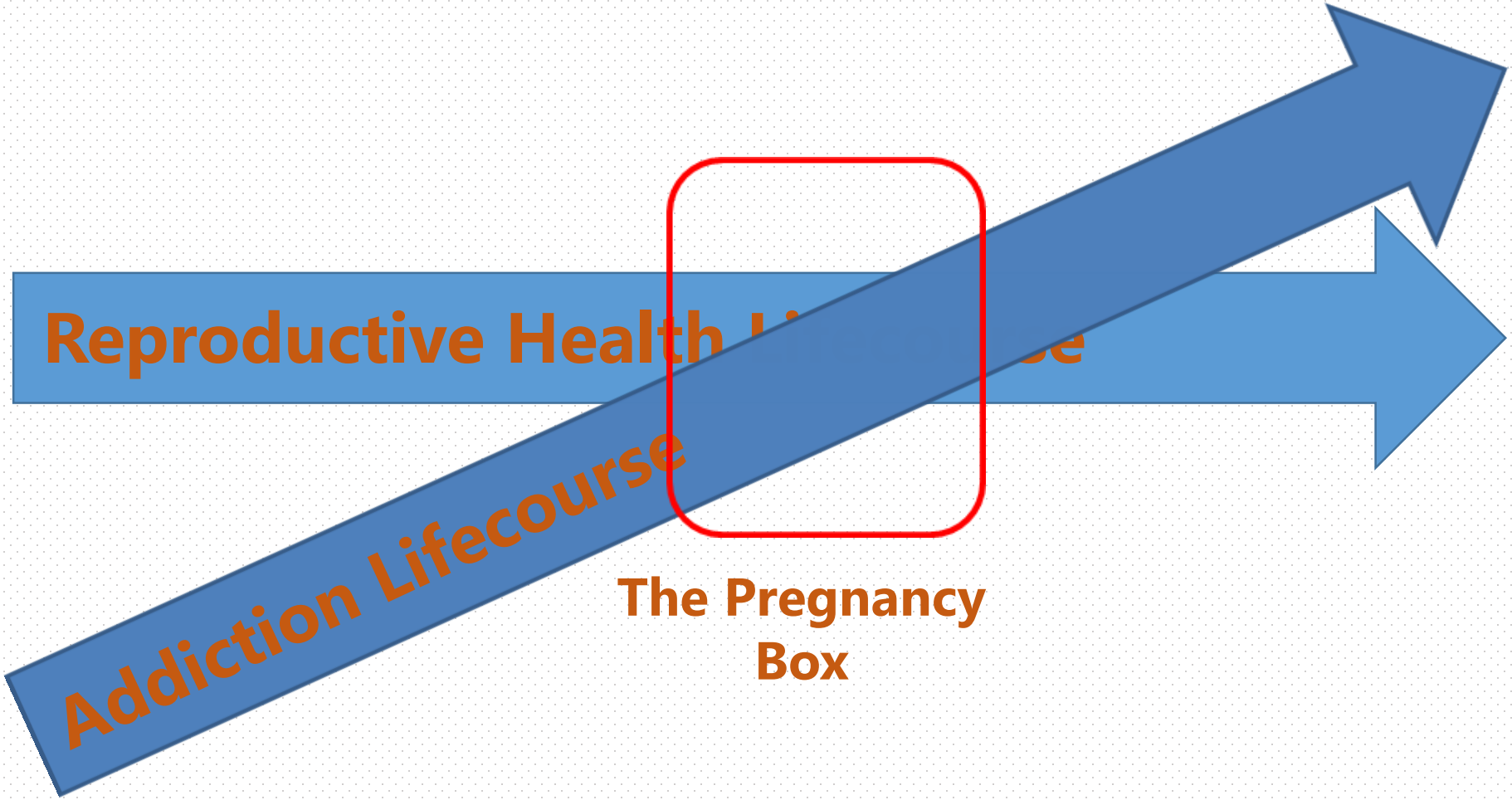
Women with SUD in Pregnancy



Women with SUD in Pregnancy



Women with SUD in Pregnancy



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

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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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Wisconsin

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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 beca addicted to painkillers after a bad car accident, but she's off the drugs now and pregnant again, with her baby d month.

By *Crocker Stephenson of the Journal Sentinel* Nov. 1

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.

Photo Gallery

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.

WaPo 1989

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[Ω]	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**

Source: Guttmacher Institute, March 1, 2016

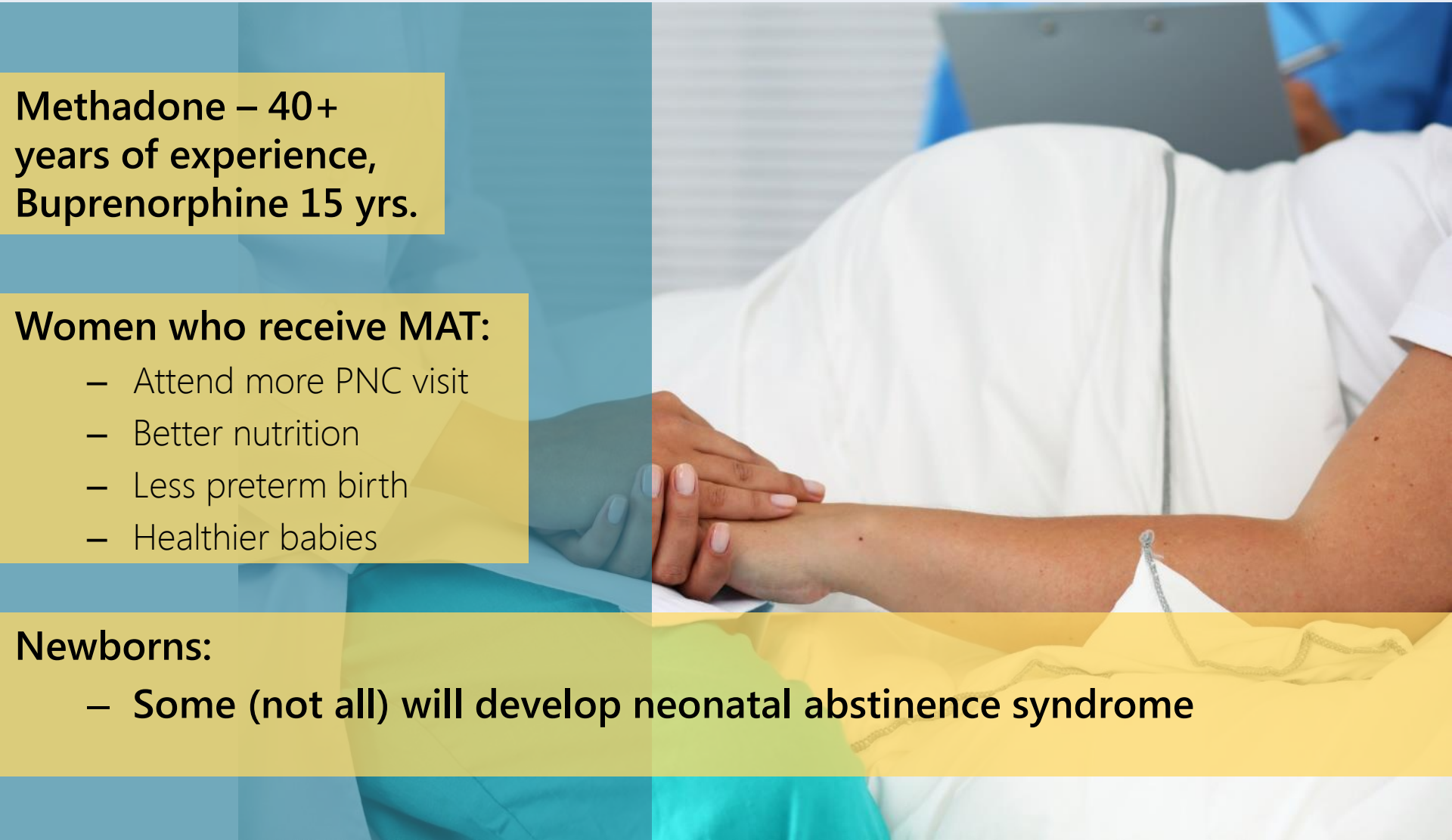
Treatment: Opioid Use Disorder During Pregnancy

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 terms 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 <u>voluntary</u>

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

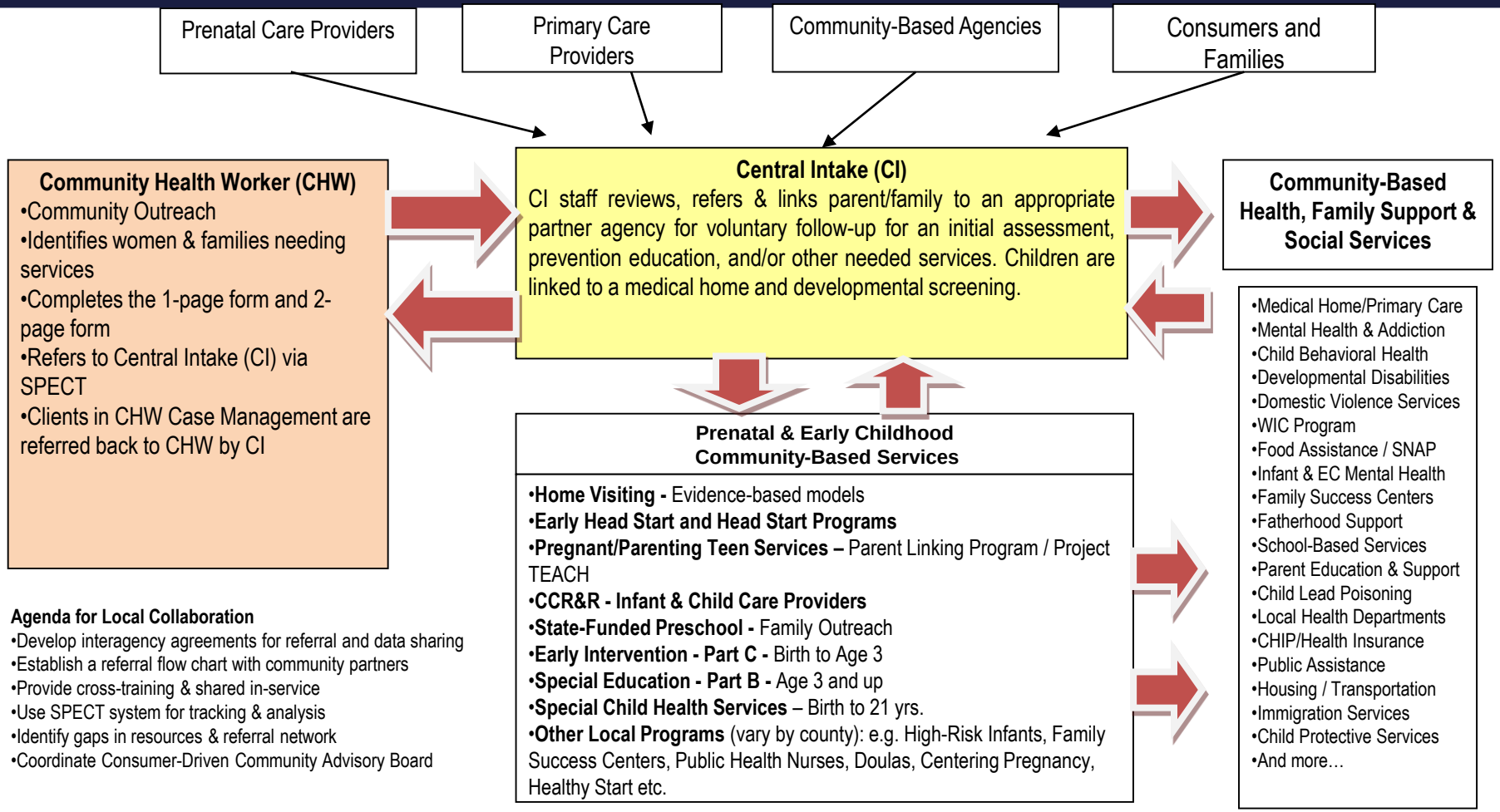
Effective Use of Limited Resources

- 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

healthy families america®

Nurse-Family Partnership
Helping First-Time Parents Succeed

Parents as Teachers™

New Jersey Department of Children and Families

HIPPYUSA
Home Instruction for Parents of Preschool Youngsters

New Jersey Department of Children and Families

	NFP	HF	PAT	HIPPY
Target Population	Low income, 1st 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.*

New Jersey Department of Children and Families

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

Source: Center for Parent Information and Resources

Resources

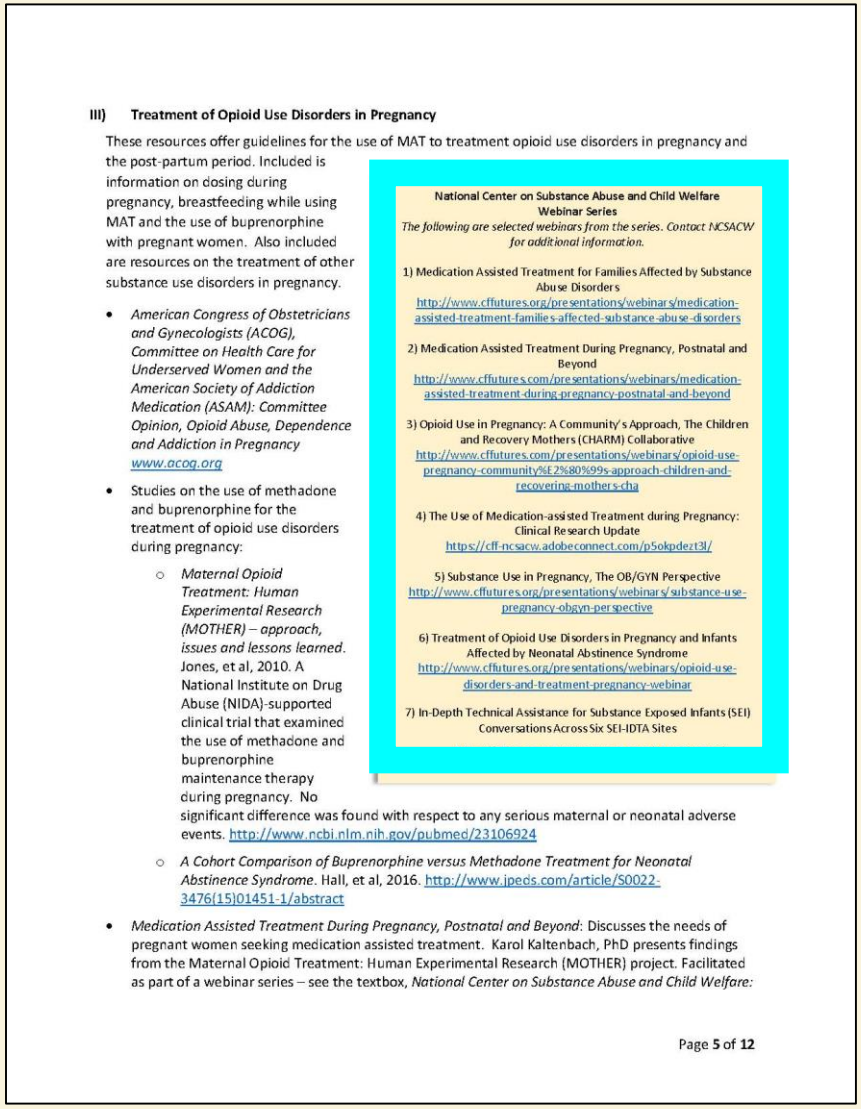
2015 Special Issue

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 Medication (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.jpeds.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-cha

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

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

Page **5** of **12**

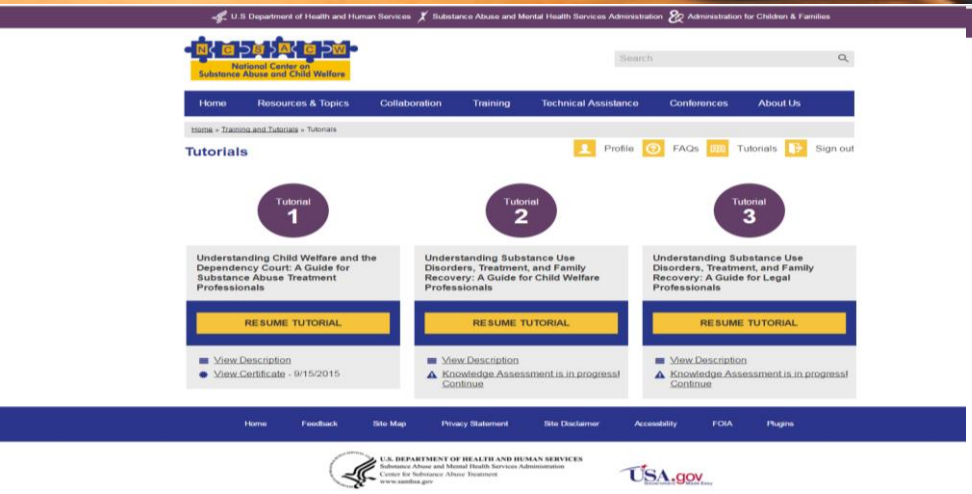
Medication Assisted Treatment During Pregnancy, Postnatal and Beyond
http://www.cffutures.com/presentations/webinars/medication-assisted-treatment-during-pregnancy-postnatal-and-beyond

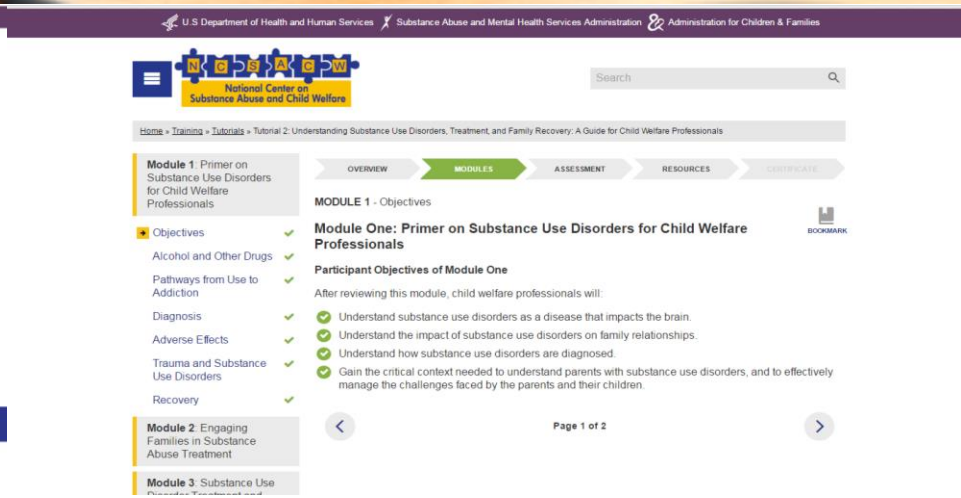
The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update
https://cff-ncsacw.adobeconnect.com/p5okpdezt3l/

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





NCSACW Online Tutorials

Free CEUs!

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

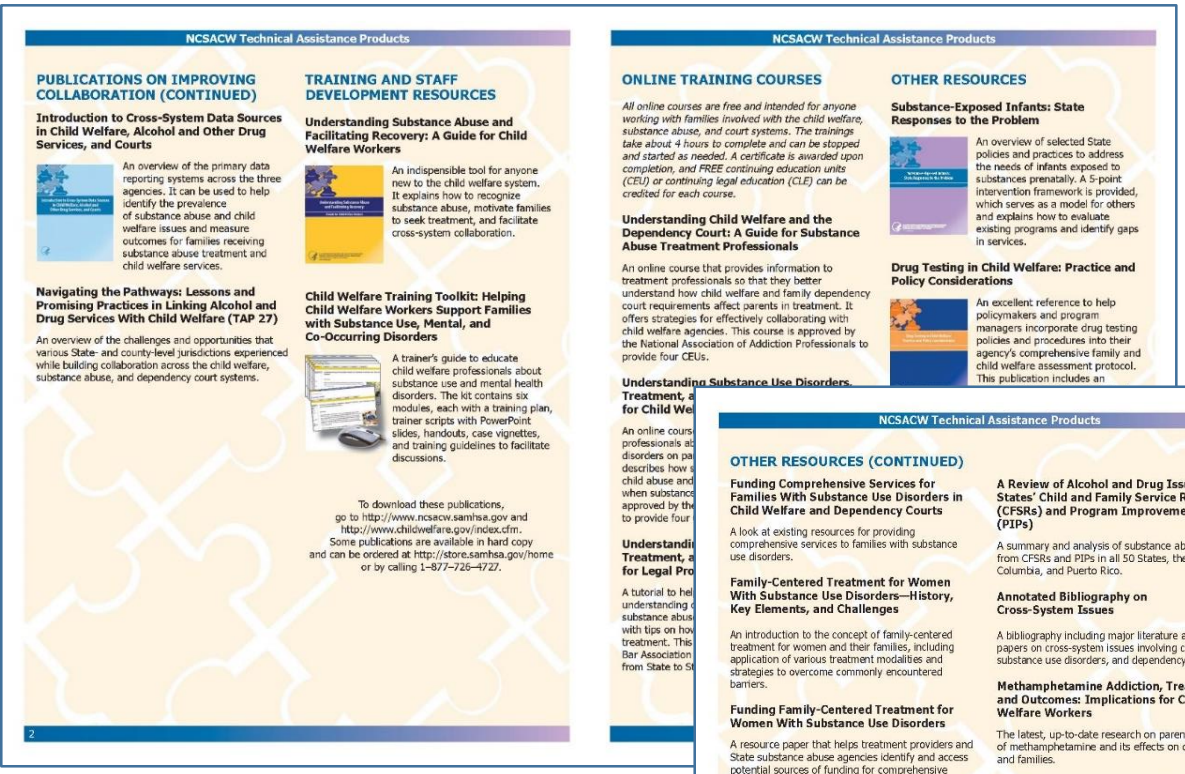
2. Understanding Child Welfare and the Dependency Court:
   A Guide for Substance Abuse Treatment Professionals

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!

https://ncsacw.samhsa.gov/training/default.aspx

Additional Resources



https://www.ncsacw.samhsa.gov/

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

Session #2: Developing Plans of Safe Care

2:00pm – 3:30pm

Linda Carpenter

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Works For Families Affected by Substance Use
Thank You