Maternal Health
Learning & Innovation Center™

Substance Use and Pregnancy:

Understanding Plans of Safe Care for Maternal Health Professionals

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Acknowledgement Statement

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Welcome

- You are muted upon entry
- Submit all questions via the chat Q&A
- 10-15 minutes of Q&A
- Please complete an evaluation survey at the end
- www.maternalhealthlearning.org

Who We Are

UNC

AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

R.A.C.E. for EQUITY
RESULTS ACHIEVED THROUGH COMMUNITY ENGAGEMENT

Ph
Solutions

Georgia Health Policy Center

ACOG
The American College of Obstetricians and Gynecologists

Objectives & Overview

1. Describe appropriate universal screening, referral, and treatment for substance use disorder in pregnancy.
2. Understand what a Plan of Safe Care includes, where to locate resources, and how to identify equitable considerations.
3. Recognize how to collaborate with partner organizations and community resource providers to optimize care and services for families.

I. Introduction

I. Screening, Referral, Treatment
Stigma & Equity Considerations

III. Plan of Safe Care Overview and Resources

IV. Q&A, Wrap-up, & Evaluation Survey

Speaker Introduction

Mishka Terplan MD, MPH, FACOG, DFASAM

Jill Gresham, MA

Substance Use and Pregnancy: Understanding Plans of Safe Care for Maternal Health Professionals

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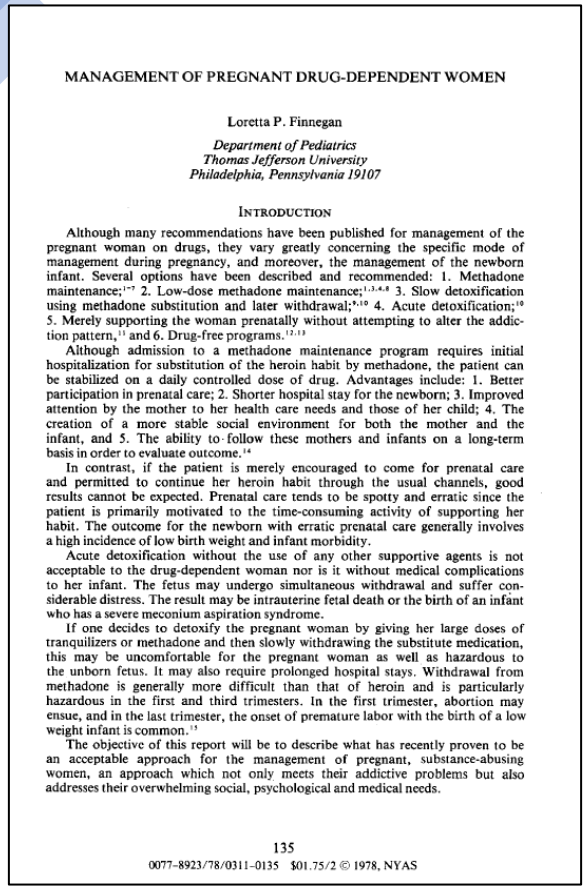

MANAGEMENT OF PREGNANT DRUG-DEPENDENT WOMEN

Loretta P. Finnegan

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Thomas Jefferson University
Philadelphia, Pennsylvania 19107

INTRODUCTION

Although many recommendations have been published for management of the pregnant woman on drugs, they vary greatly concerning the specific mode of management during pregnancy, and moreover, the management of the newborn infant. Several options have been described and recommended: 1. Methadone maintenance;[1-7] 2. Low-dose methadone maintenance;[1,3,4,8] 3. Slow detoxification using methadone substitution and later withdrawal;[9,10] 4. Acute detoxification;[10] 5. Merely supporting the woman prenatally without attempting to alter the addiction pattern,[11] and 6. Drug-free programs.[12,13]

Although admission to a methadone maintenance program requires initial hospitalization for substitution of the heroin habit by methadone, the patient can be stabilized on a daily controlled dose of drug. Advantages include: 1. Better participation in prenatal care; 2. Shorter hospital stay for the newborn; 3. Improved attention by the mother to her health care needs and those of her child; 4. The creation of a more stable social environment for both the mother and the infant, and 5. The ability to follow these mothers and infants on a long-term basis in order to evaluate outcome.[14]

In contrast, if the patient is merely encouraged to come for prenatal care and permitted to continue her heroin habit through the usual channels, good results cannot be expected. Prenatal care tends to be spotty and erratic since the patient is primarily motivated to the time-consuming activity of supporting her habit. The outcome for the newborn with erratic prenatal care generally involves a high incidence of low birth weight and infant morbidity.

Acute detoxification without the use of any other supportive agents is not acceptable to the drug-dependent woman nor is it without medical complications to her infant. The fetus may undergo simultaneous withdrawal and suffer considerable distress. The result may be intrauterine fetal death or the birth of an infant who has a severe meconium aspiration syndrome.

If one decides to detoxify the pregnant woman by giving her large doses of tranquilizers or methadone and then slowly withdrawing the substitute medication, this may be uncomfortable for the pregnant woman as well as hazardous to the unborn fetus. It may also require prolonged hospital stays. Withdrawal from methadone is generally more difficult than that of heroin and is particularly hazardous in the first and third trimesters. In the first trimester, abortion may ensue, and in the last trimester, the onset of premature labor with the birth of a low weight infant is common.[15]

The objective of this report will be to describe what has recently proven to be an acceptable approach for the management of pregnant, substance-abusing women, an approach which not only meets their addictive problems but also addresses their overwhelming social, psychological and medical needs.

0077-8923/78/0311-0135 $01.75/2

	Obstetrical Complications	LBW
Untreated OUD – No PNC	36.9%	47.7%
Methadone – No PNC	32.1%	35.5%
Methadone - + PNC	33.7%	19.7%
No SUD – No PNC	32.3%	19.4%
No SUD - + PNC	32.0%	13.9%

Matern Child Health J (2017) 21:893–902
DOI 10.1007/s10995-016-2190-y

The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotelchuck[1] · Erika R. Cheng[2] · Candice Belanoff[3] · Howard J. Cabral[3] · Hermik Babakhanlou-Chase[4] · Taletha M. Derrington[5] · Hafsatou Diop[6] · Stephen R. Evans[3] · Judith Bernstein[3]

Core Principle of PNC:

Optimize maternal health via chronic disease management

	No Addiction	Treated Addiction	Untreated Addiction
Preterm Birth	8.7%	10.1%	19.0%
Low Birthweight	5.5%	7.8%	18.0
Fetal Death	0.4%	0.5%	0.8%
Neonatal Mortality	0.4%	0.4%	1.2%
Post Neonatal Mortality	0.05%	0.03%	0.1%

Recovery: The Goal of Treatment

- More than abstinence
- Life of integrity
- Connection to others
- Purpose
- Serenity
- Fully compatible with medication

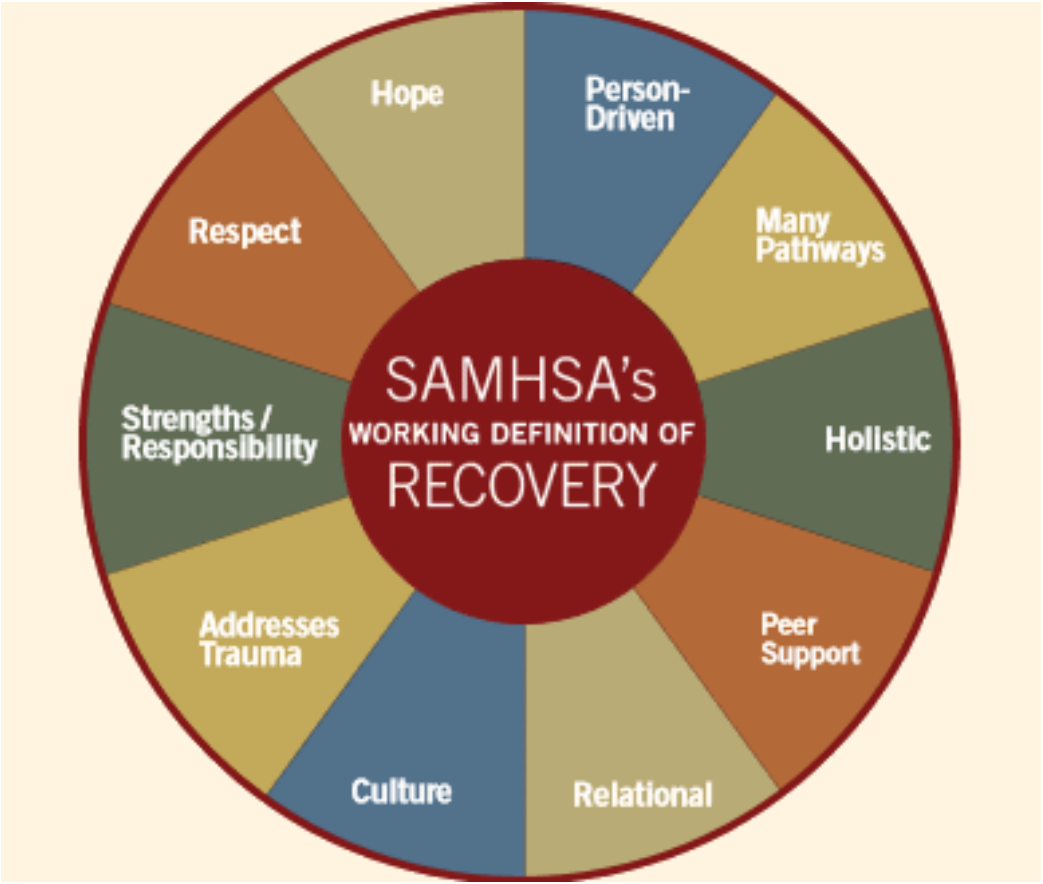
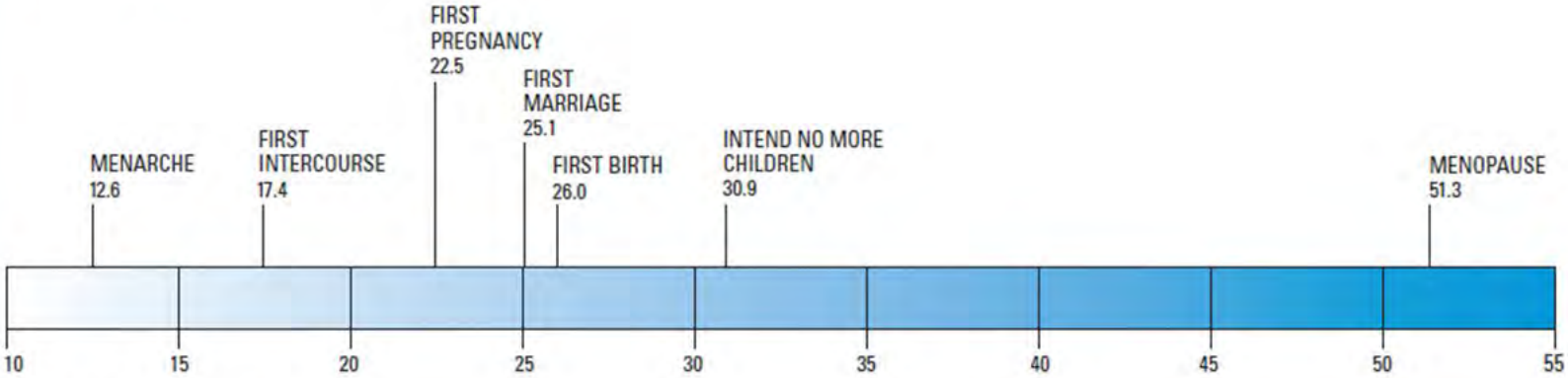


FIGURE 1.1

The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.



Median age at which event occurs*

Note *Age by which half of women have experienced event.
Source Reference 6.

Opioids: *Original Research*

Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

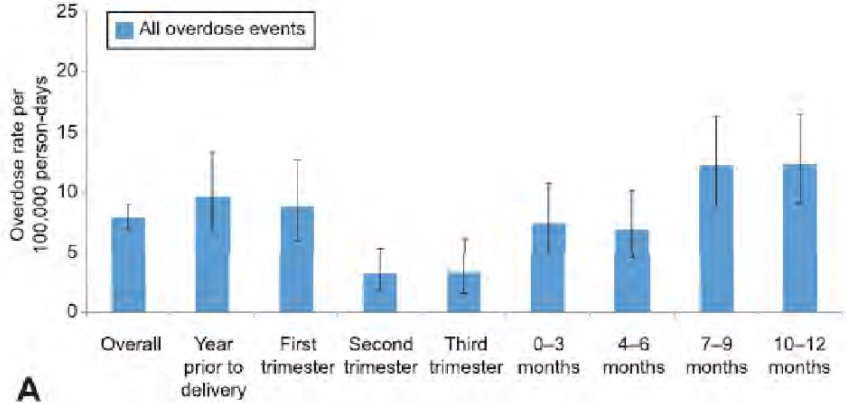
OBSTETRICS & GYNECOLOGY

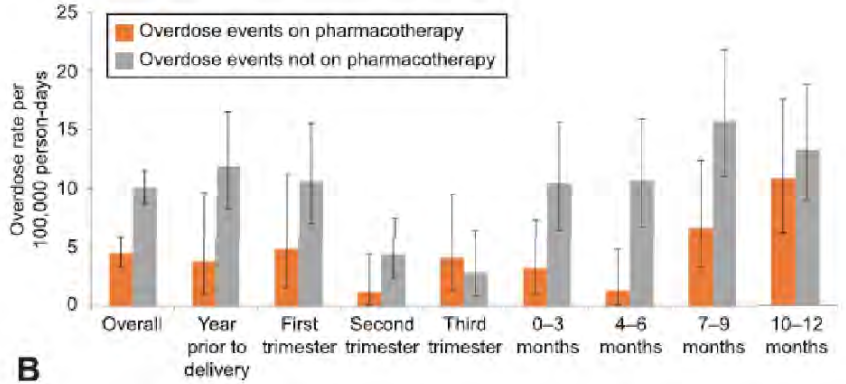
Davida M. Schiff, MD, MSc, Timothy Nielsen, MPH, Mishka Terplan, MD, MPH, Malena Hood, MPH, Dana Bernson, MPH, Hafsatou Diop, MD, MPH, Monica Bharel, MD, MPH, Timothy E. Wilens, MD, Marc LaRochelle, MD, MPH, Alexander Y. Walley, MD, MSc, and Thomas Land, PhD

Table 2. Opioid Overdose Rates Among Pregnant and Parenting Women With Evidence of Opioid Use Disorder in the Year Before Delivery (n=4,154)

Period Relative to Delivery	All OD Events	OD Events While Receiving Pharmacotherapy	OD Events Not Receiving Pharmacotherapy
Overall	7.99 (7.01–9.06)	4.43 (3.28–5.86)*	10.04 (8.67–11.56)*
Year before delivery–conception	9.72 (6.91–13.29)	3.74 (1.02–9.57)	11.89 (8.28–16.54)
Trimester (weeks of gestation)			
1st (0–12)	8.88 (6.04–12.61)	4.79 (1.56–11.18)	10.63 (6.94–15.58)
2nd (13–28)	3.23 (1.81–5.32)	1.20 (0.15–4.35)	4.35 (2.32–7.44)
3rd (29 or greater)	3.32 (1.59–6.10)†	4.08 (1.32–9.51)	2.80 (0.91–6.53)
Postpartum (mo)			
0–3	7.41 (4.92–10.71)	3.17 (1.03–7.41)	10.44 (6.62–15.67)
4–6	6.89 (4.50–10.10)	1.31 (0.16–4.74)*	10.67 (6.84–15.88)*
7–9	12.2 (8.93–16.28)†	6.74 (3.23–12.40)	15.75 (11.03–21.80)
10–12	12.35 (9.07–16.42)†	10.84 (6.20–17.60)	13.3 (9.04–18.88)

OD, opioid overdose.
Data are rate/100,000 person-days (95% CI).
* Denotes statistically significant difference between overdose rates among women receiving pharmacotherapy vs women not receiving pharmacotherapy.
† Denotes statistically significant difference between overall overdose rates during third trimester and 7–12 months postpartum.





Assessment: Screening and Testing

What is a Drug Test?

Presumptive

- Point-of-care
- Elisa
- Rapid and Cheap
- Results Binary

Definitive

- Gas Chromatography / Mass Spectrometry
- Costly and Timely
- Results specific and quantified

Definitive testing required “when the results inform decisions with major clinical or non-clinical implications for the patient” (ASAM)

Drug Tests: Overused and Misinterpreted

"Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with healthcare services."

ASAM Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022

Drug Testing NOT required in CAPTA and NOT criteria for reporting

Professional Society Recommendations are Clear:

- Drug Test NOT an Assessment of Addiction
- Positive Drug Test NOT sign of health or ill health
- Positive Drug Test NOT evidence of harm
- Positive Drug Test NOT criteria for discharge

Consent Required for Testing

"Test or Talk: Empiric Bias and Epistemic Injustice" Terplan M, AJOG, 2022

Screening vs. Testing Professional Society Recommendations

Universal Screening:

Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)

- Voluntary (ACOG, SAMHSA, CDC)

Testing:

Not Recommended - Not an appropriate measurement of addiction (ACOG, ASAM, SAMHSA)

Substance Use Disorder: *Original Research*

OPEN

Accuracy of Three Screening Tools for Prenatal Substance Use

Victoria H. Coleman-Cowger, PhD, Emmanuel A. Oga, MD, MPH, Erica N. Peters, PhD, Kathleen E. Trocin, MPH, Bartosz Koszowski, PharmD, PhD, and Katrina Mark, MD

OBJECTIVE: To compare and evaluate the accuracy of three screening tools in identifying illicit drug use and prescription drug misuse among a diverse sample of pregnant women.

METHODS: This prospective cross-sectional study enrolled a consecutive sample of 500 pregnant women, stratified by trimester, receiving care in two prenatal clinical settings in Baltimore, Maryland, from January 2017 to January 2018. All participants were administered three index tests: 4P's Plus, NIDA Quick Screen-ASSIST (Modified Alcohol, Smoking and Substance Involvement Screening Test), and the SURP-P (Substance Use Risk Profile-Pregnancy scale, and administered reference tests (urine and line visit. To ass screening tool later by teleph specificity, pos value and test- were stratified

RESULTS: Of completed the reference testing, and 453 underwent test-retest analysis. For the 4P's Plus, sensitivity=90.2% (84.5, 93.8), and specificity=29.6% (24.4, 35.2). For the NIDA Quick Screen-ASSIST, sensitivity=79.7% (71.2, 84.2), and specificity=82.8% (78.1, 87.1). For the SURP-P, sensitivity=92.4% (87.6, 95.8) and specificity=21.8% (17.4, 27.2). Test-retest reliability (phi correlation coefficients) was 0.84, 0.77, and 0.79 for the 4P's Plus, NIDA Quick Screen-ASSIST and the SURP-P, respectively. For all screening tools, there were differences in validity indices by age and race, but no differences by trimester.

From the Battelle Memorial Institute and the University of Maryland Medical School, Baltimore, Maryland.

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Each author has confirmed compliance with the journal's requirements for authorship.

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lic health issue in the United States, with increasing illicit drug use observed among pregnant women from 2015 to 2017.[1] According to the 2016 National Survey on Drug Use and Health, self-reported past-month illicit drug use (inclusive of nonmedical use of prescription drugs) is 14.3% among pregnant adolescents ages 15–17 years, 10.1% among pregnant young adults (18–25 years), and 5.6% among pregnant adults (26–44 years).[2] These rates vary by trimester, with substance use typically decreasing over the course of pregnancy.[3] Substance use during pregnancy may lead to multiple health and social problems for both mother and child, including miscarriage, stillbirth, low birth weight, prematurity, physical malformations, and neurologic damage.[4]

The American College of Obstetricians and Gynecologists strongly recommends substance use screening for pregnant women,[5] and a 2012 expert panel convened by the Centers for Disease Control

ORIGINAL RESEARCH

Prenatal Practice Staff Perceptions of Three Substance Use Screening Tools for Pregnant Women

Kathleen E. Trocin, MPH, Nicole I. Weinstein, MSW, Emmanuel A. Oga, MD, MPH, Katrina S. Mark, MD, and Victoria H. Coleman-Cowger, PhD

Objective: There is a need to identify an acceptable and comprehensive substance use screening tool for pregnant women in the United States. This qualitative study sought to better understand prenatal practice staff perceptions of three existing substance use screening tools for use among pregnant women in an outpatient practice setting.

Methods: Eight focus groups with 40 total participants were conducted with clinical and administrative staff of 2 diverse Maryland prenatal practices to determine the acceptability and usability of 3 substance use screening tools (4P's Plus, NIDA-Modified Alcohol, Smoking and substance use screening and provides evidence that the 4P's Plus may be a preferred screening tool for standardized use in prenatal care.

Key Words: pregnancy, prenatal substance use, qualitative research, screening

(*J Addict Med* 2019;xx: xxx–xxx)

From the Battelle Memorial Institute (KET, NIW, EAG, VHC-C); Bureau of Primary Health Care/Office of Quality Improvement, Health Resources and Services Administration, Rockville, MD (KET); Center for Applied Public Health Research, RTI International, Rockville, MD (EAO); Department of Obstetrics, Gynecology and Reproductive Sciences, University of Maryland School of Medicine, Baltimore, MD (KSM, VHC-C); The Emmes Company, LLC, Rockville, MD (VHC-C).

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The authors report no conflicts of interest.

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Substance use during pregnancy is linked to negative health outcomes for both the mother and baby (Chang et al., 2017; NIDA, 2017). Despite these effects, many pregnant women in the United States use substances (Center for Behavioral Health Statistics and Quality et al., 2016). According to data from the 2016 National Survey on Drug Use and Health, 20% of pregnant women aged 15 to 44 years self-reported use of illicit drugs, tobacco products, or alcohol in the past month.

Screening is necessary to identify substance use during care. and their pre- en do ndard rican ingly preg- ening ntive

Services Task Force (USPSTF), there is no screening tool for illicit drug use or prescription drug misuse that has been recommended for use with pregnant women (USPSTF, 2008; World Health Organization (WHO), 2014; ACOG, 2017).

There is a need to compare existing substance use screening tools to determine which is more accurate in identifying substance use among pregnant women in the United States, considered acceptable among their providers, and is easily integrated into prenatal care to increase substance use screening among this population. The quantitative portion of this study that compares and validates the accuracy of the 3 screening tools when compared with biologic testing is detailed elsewhere (Coleman-Cowger et al., 2018). The 3 screening tools utilized in this study—4P's Plus, NIDA Quick Screen/NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), and Substance Use Risk Profile-Pregnancy scale (SURP-P) (Table 1)—were chosen because they are brief and are the only ones listed by the WHO to have been validated (though the ASSIST had not been validated with a pregnant population; our quantitative study did this with results reported in Oga et al., in press elsewhere) and allow screening of multiple substances (Chasnoff et al., 2005; Humeniuk et al., 2008; Yonkers et al., 2010; World Health Organization [WHO], 2014). This study is intended to be a qualitative companion to the

Ask permission

"Is it OK if I ask you some questions about smoking, alcohol and other drugs?"

“Test and Report” -- Provider Culpability

- Most child welfare reports (<1yr) are from medical professionals during birthing hospitalization
- Health Professional Reporting increased 400% in past decade
- Driven by (misuse of) urine drug testing
- Compounds racial inequities

Rate of Screened-in Reports from Medical Professionals

Manuscript in preparation by Edwards F, Terplan M, Roberts S, Raz M Data from the NCANDS

HHS 2020 https://www.childwelfare.gov/pubs/factsheets/cpswork/

AAP 2015 https://pediatrics.aappublications.org/content/135/5/948

“Better Safe Than Sorry”? Child Welfare Report and Consequence for Drug Exposure

20% children experience abuse or neglect in out-of-home placement

Mental health and somatic conditions greater among children in foster care compared to general population

Toxic stress: The physiologic result of dangerous, recurrent, or prolonged experience of trauma caused by the initiation of the stress response without the protective existence of a compassionate adult

Non-death Loss and Grief in Foster Care

Dorsey S, *Journal of Child & Family Studies*, 2012; Jonkowski MK, *Child Maltreatment*, 2019
Forkey HC, *J of Child & Family Studies*, 2016; Mitchell MB, *Child Adolesc Soc Work J*, 2018

Mandatory Reporting Does Not Improve Population Health Outcomes

FAHERTY, ET AL., *ASSOCIATION BETWEEN PUNITIVE POLICIES AND NEONATAL ABSTINENCE SYNDROME AMONG MEDICAID-INSURED INFANTS IN COMPLEX POLICY ENVIRONMENTS.* ADDICTION, 2022

THOMAS, ET AL., *DRUG USE DURING PREGNANCY POLICIES IN THE UNITED STATES FROM 1970 TO 2016.* CONTEMPORARY DRUG PROBLEMS, 2018

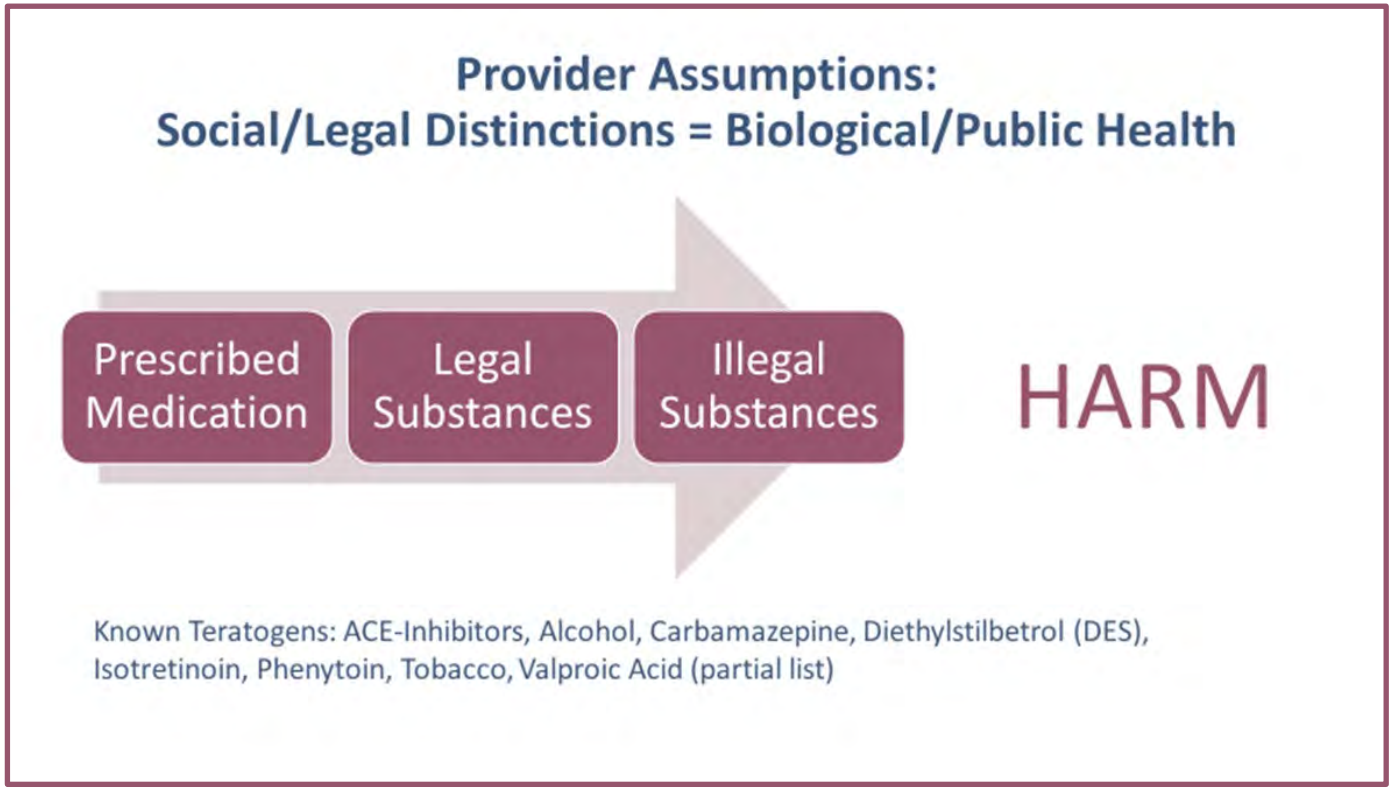
CARROLL, *THE HARMS OF PUNISHING SUBSTANCE USE DURING PREGNANCY.* IJDP, 2021

ROBERTS, ET AL., *FORTY YEARS OF STATE ALCOHOL AND PREGNANCY POLICIES IN THE USA: BEST PRACTICES FOR PUBLIC HEALTH OR EFFORTS TO RESTRICT WOMEN'S REPRODUCTIVE RIGHTS?* ALCOHOL AND ALCOHOLISM, 2017

Punitive Policies Associated with:

- No Improvement in Birth Outcomes
- Increased Odds of Neonatal Abstinence Syndrome
- Increased Odds of Low Birth Weight
- Increased Odds of Preterm Delivery
- Decreased Odds of any Prenatal Care and APGAR 7+

The fetus does not know if the exposure is prescribed, used as directed or misused, legal or illegal, natural or synthetic



Alcohol use during pregnancy can lead to lifelong effects.

Up to 1 in 20 US school children may have FASDs.

People with FASDs can experience a mix of the following problems:

Physical issues

- low birth weight and growth
- problems with heart, kidneys, and other organs
- damage to parts of the brain

Which leads to...

Behavioral and intellectual disabilities

- learning disabilities and low IQ
- hyperactivity
- difficulty with attention
- poor ability to communicate in social situations
- poor reasoning and judgment skills

These can lead to...

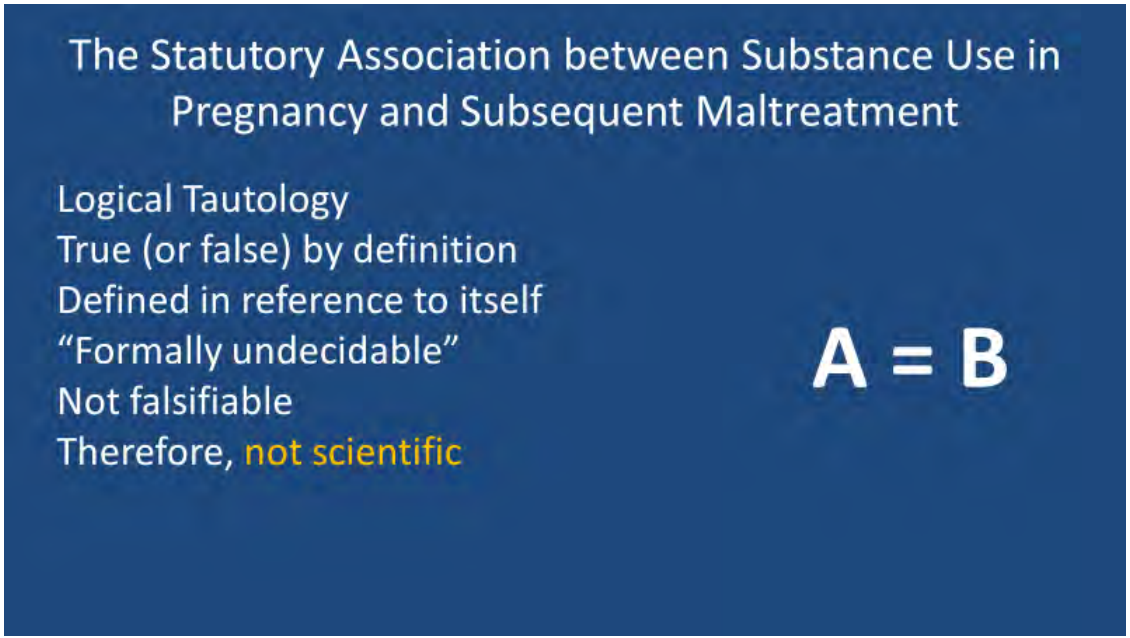
Lifelong issues with

- school and social skills
- living independently
- mental health
- substance use
- keeping a job
- trouble with the law

FASD United, the National Voice on FASD

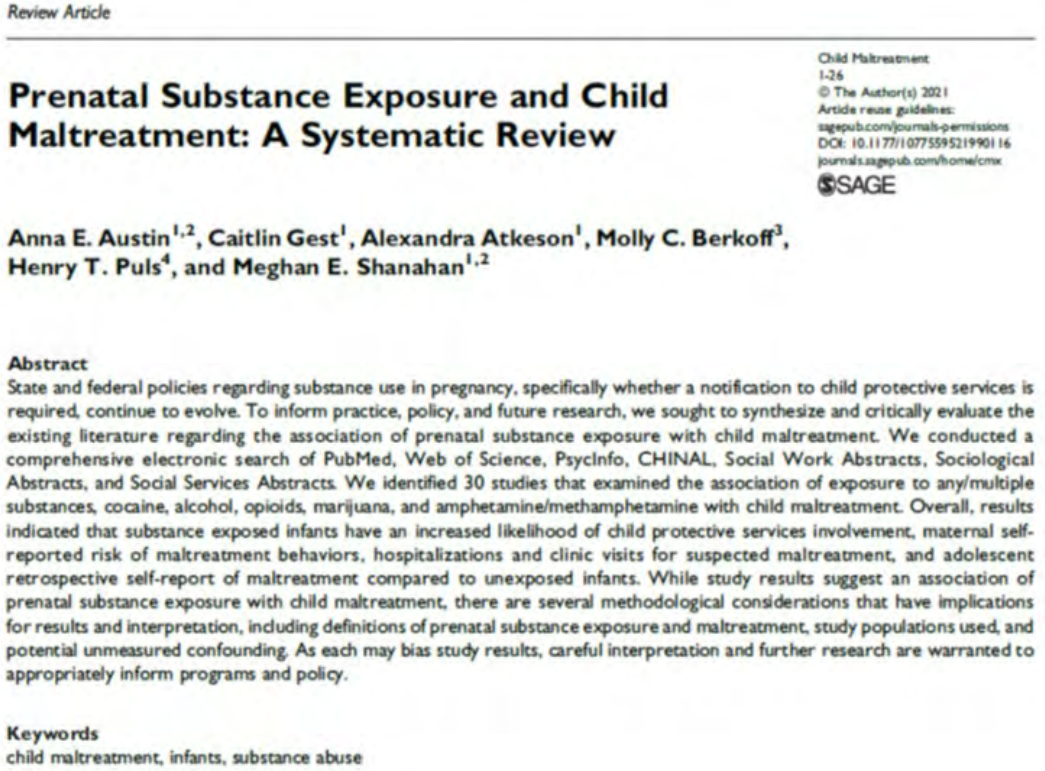
fasdunited.org

Logical Tautologies and Misinformation



Substance Use in Pregnancy and Subsequent Child Maltreatment: Where is the Evidence?

- Substance-exposed infants have increased likelihood of child welfare involvement
- No strong evidence of substantiated maltreatment
- Overall literature is of poor methodological quality



Review Article

Child Maltreatment
1-26

DOI: 10.1177/1077559521990116
journals.sagepub.com/home/cmx
SAGE

Prenatal Substance Exposure and Child Maltreatment: A Systematic Review

Anna E. Austin[1,2], Caitlin Gest[1], Alexandra Atkeson[1], Molly C. Berkoff[3], Henry T. Puls[4], and Meghan E. Shanahan[1,2]

Abstract

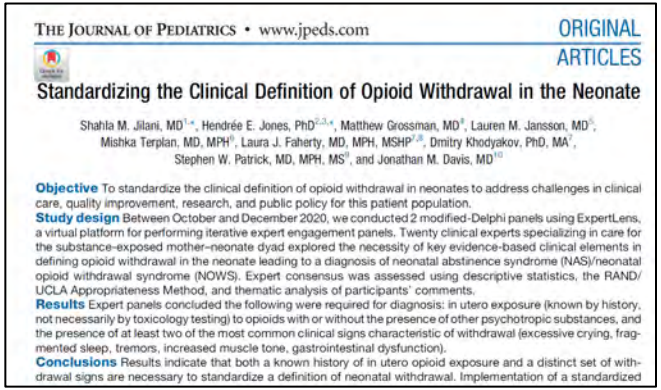
State and federal policies regarding substance use in pregnancy, specifically whether a notification to child protective services is required, continue to evolve. To inform practice, policy, and future research, we sought to synthesize and critically evaluate the existing literature regarding the association of prenatal substance exposure with child maltreatment. We conducted a comprehensive electronic search of PubMed, Web of Science, PsycInfo, CHINAL, Social Work Abstracts, Sociological Abstracts, and Social Services Abstracts. We identified 30 studies that examined the association of exposure to any/multiple substances, cocaine, alcohol, opioids, marijuana, and amphetamine/methamphetamine with child maltreatment. Overall, results indicated that substance exposed infants have an increased likelihood of child protective services involvement, maternal self-reported risk of maltreatment behaviors, hospitalizations and clinic visits for suspected maltreatment, and adolescent retrospective self-report of maltreatment compared to unexposed infants. While study results suggest an association of prenatal substance exposure with child maltreatment, there are several methodological considerations that have implications for results and interpretation, including definitions of prenatal substance exposure and maltreatment, study populations used, and potential unmeasured confounding. As each may bias study results, careful interpretation and further research are warranted to appropriately inform programs and policy.

Keywords

child maltreatment, infants, substance abuse

Table III. Foundational principles for the clinical definition of opioid withdrawal in the neonate

1. Substance use disorder is a disease requiring compassionate, ethical, equitable, and evidence-based care.
2. The maternal–neonate dyad is the appropriate subject of care; this definition is intended to identify clinical and supportive care needs of the dyad; shared interests should be prioritized.
3. A diagnosis of NAS or NOWS does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.
4. Environmental factors, family influences, and social structures strongly influence neonatal outcome and should be recognized.



THE JOURNAL OF PEDIATRICS • www.jpeds.com ORIGINAL ARTICLES

Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate

Shahla M. Jilani, MD[1,*], Hendrée E. Jones, PhD[2,3,*], Matthew Grossman, MD[3], Lauren M. Jansson, MD[5], Mishka Terplan, MD, MPH[6], Laura J. Faherty, MD, MPH, MSHP[7,8], Dmitry Khodyakov, PhD, MA[7], Stephen W. Patrick, MD, MPH, MS[9], and Jonathan M. Davis, MD[10]

Objective To standardize the clinical definition of opioid withdrawal in neonates to address challenges in clinical care, quality improvement, research, and public policy for this patient population.
Study design Between October and December 2020, we conducted 2 modified-Delphi panels using ExpertLens, a virtual platform for performing iterative expert engagement panels. Twenty clinical experts specializing in care for the substance-exposed mother–neonate dyad explored the necessity of key evidence-based clinical elements in defining opioid withdrawal in the neonate leading to a diagnosis of neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS). Expert consensus was assessed using descriptive statistics, the RAND/UCLA Appropriateness Method, and thematic analysis of participants' comments.
Results Expert panels concluded the following were required for diagnosis: in utero exposure (known by history, not necessarily by toxicology testing) to opioids with or without the presence of other psychotropic substances, and the presence of at least two of the most common clinical signs characteristic of withdrawal (excessive crying, fragmented sleep, tremors, increased muscle tone, gastrointestinal dysfunction).
Conclusions Results indicate that both a known history of in utero opioid exposure and a distinct set of withdrawal signs are necessary to standardize a definition of neonatal withdrawal. Implementation of a standardized

Pregnancy and Addiction: Mutual Mistrust

Provider

- Mistrust (often) misplaced
- Rooted in discrimination and prejudice
- Consequences of misplaced trust are minor

Patient

- Mistrust warranted by people who experience oppression
- Legitimate: historic memory and everyday discrimination
- Consequences of misplaced trust are severe

Power Differential
Risk/Vulnerability Different
Responsibility for Overcoming Mistrust Rests with Providers

Resisting Stigma and Discrimination By Speaking

Trust-Building through clinical discussion

- What is the most important thing to you about treatment or recovery?
- What do you know about methadone?
- Do you have any fears or concerns from previous treatment experiences?
- What do you need to feel safe?
- What are you looking for in a provider?
- How do you feel your care is going so far?

Focus on Medicine and Public Health as Practice

Evidence-Based

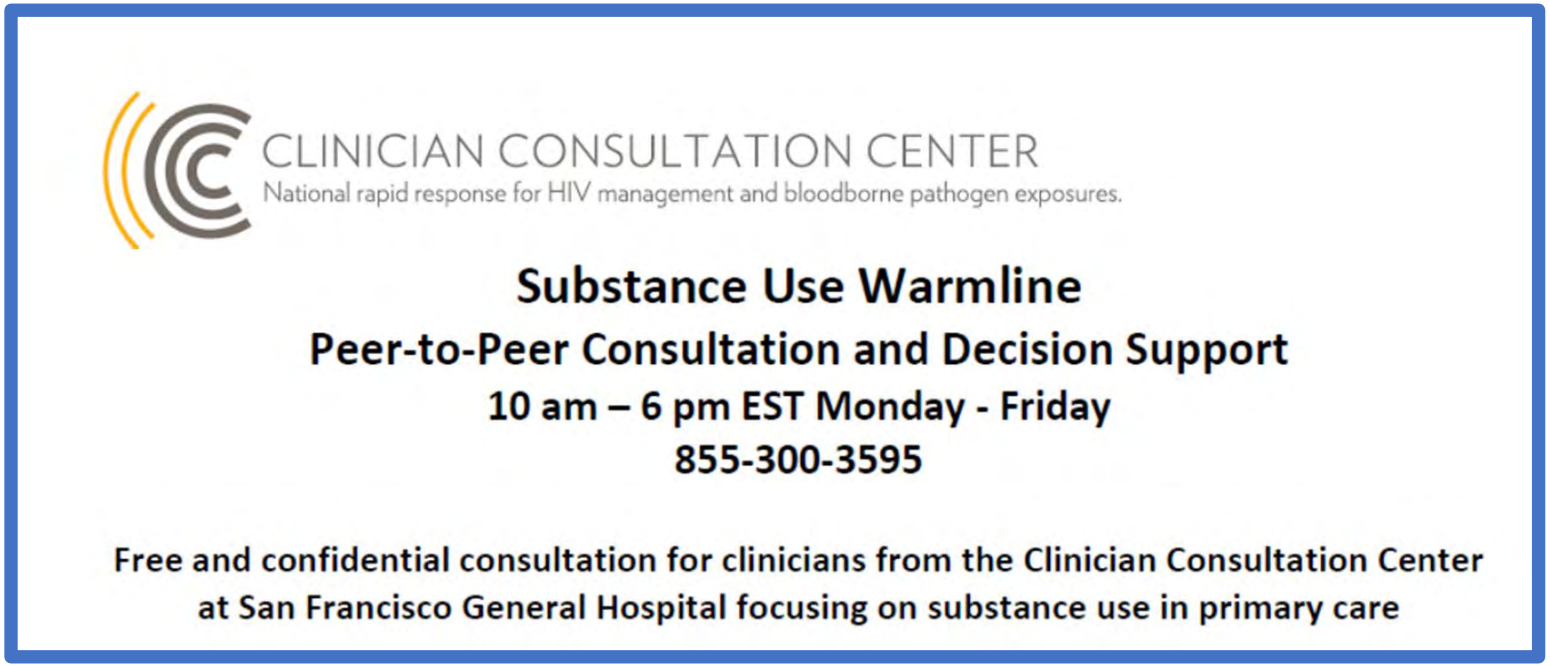
AND

Person-Centered

Conclusion: Do Less Harm

- Evidence-Based: Grounded in Science
  - Harms of illicit substances exaggerated; Effects of licit substances minimized
  - Overstate the importance of intrauterine exposure; Neglect the role of the care-giving environment
- Person-Centered: Ethical and Grounded in Human Rights
  - Reproductive Health as a Human Right - Right to determine whether and when to become pregnant, and right to raise children in safe and sustainable environments
  - Support autonomy and maternal subjectivity in decision making surrounding pregnancy
  - Remain attuned to the unique demands we place on pregnant and parenting people, their bodies and their minds

Thank You mterplan@friendsresearch.org
@Do_Less_Harm



National Center on Substance Abuse and Child Welfare

SUPPORTING FAMILIES WITH THE PLAN OF SAFE CARE (POSC)

May 1, 2023

12:00 – 1:00 PM ET

Acknowledgement

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Children's Bureau

& ACF

SAMHSA
Substance Abuse and Mental Health Services Administration

National Center on Substance Abuse and Child Welfare

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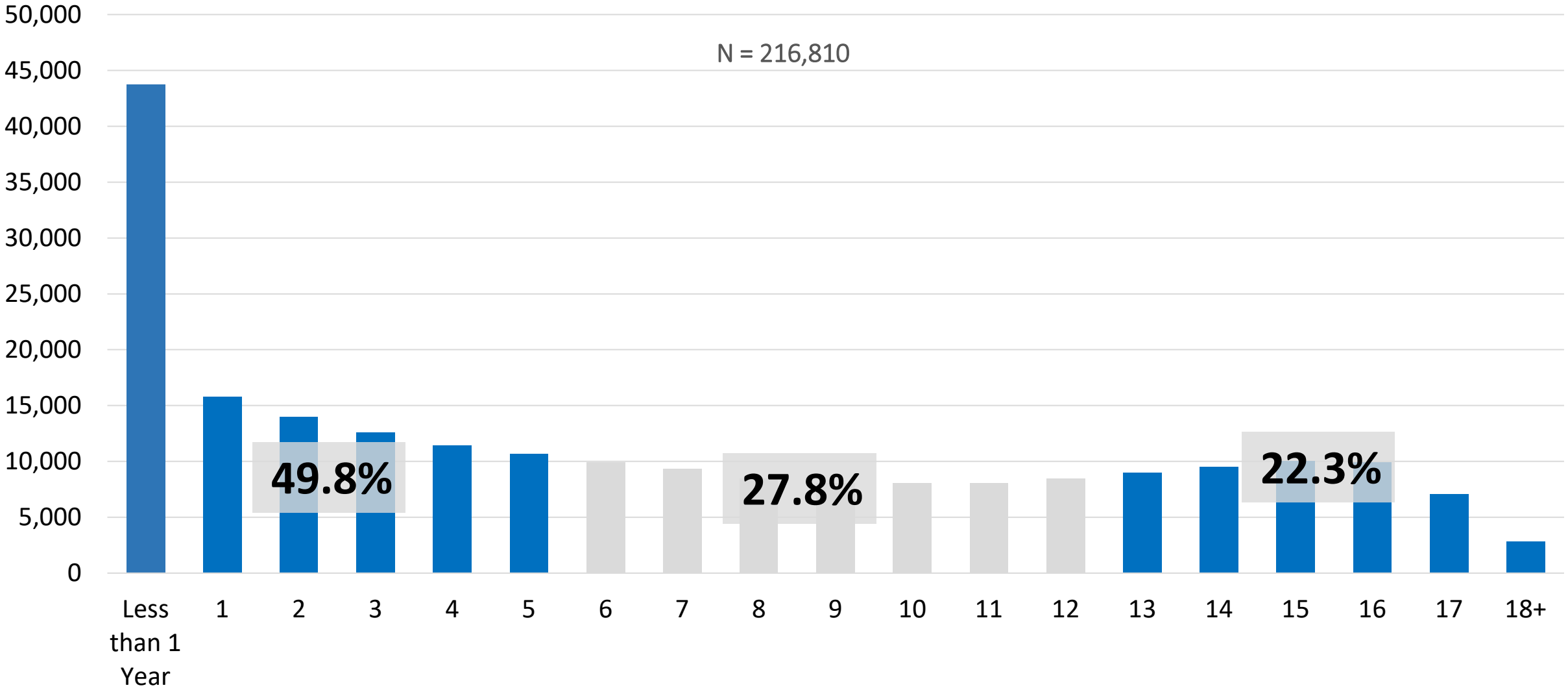
NUMBER OF CHILDREN WHO ENTERED OUT OF HOME CARE, BY AGE AT REMOVAL IN THE UNITED STATES, 2020*



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

**2020 Estimates may be influenced by the COVID-19 pandemic*

(AFCARS Data, 2020 v1)

OVERVIEW

COMPREHENSIVE ADDICTION AND RECOVERY ACT (CARA) AMENDMENTS TO THE CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

Primary Changes in **CAPTA** Related to Infants with Prenatal Substance Exposure

1974	CAPTA
2003	The Keeping Children and Families Safe Act
2010	The CAPTA Reauthorization Act
2016	CARA

CARA PRIMARY CHANGES TO CAPTA IN 2016

- Further clarified population to infants “born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” **specifically removing “illegal”**
- Specified **data to be reported** by States to the maximum extent practicable
- Required **POSC** to address “the health and substance use disorder treatment needs of the infant and affected family or caregiver.”
- Required “the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.”

What Healthcare Providers Need to Know

- Who Needs a POSC in your state
- Are there different pathways for different populations of infants?
- Who oversees the POSC when CPS is not needed/required?
- Is there a POSC template to use?

HOW IS POSC DIFFERENT?

Child Welfare Services Safety Plan

SUD Treatment Plan

Hospital Discharge Plan

Who Needs a POSC

1. Based on healthcare provider interpretation of “affected by substance abuse”, “withdrawal” and “FASD”

2. Based on toxicology test results of mother and/or infant at birth event

3. Based on toxicology test reports of mother during pregnancy and birth event and of infant at birth

WHY CONSIDER CREATING A CAPTA NOTIFICATION PATHWAY?

- Currently many infants with prenatal substance exposure are receiving an investigation or assessment from child welfare.
- However, some are closed after initial investigation with services recommended, but the family does not engage, and no provider is charged with monitoring.

What if:

- A CAPTA notification option for families with a lower risk profile were created, AND
- Family engagement, POSC development, and ongoing tracking were provided by a community partner

Then:

- All infants with prenatal substance exposure and their families receive supports and services. Higher risk families receive a POSC from child welfare. Lower risk families receive a POSC from a community partner.

HOW DO NOTIFICATION PATHWAYS FUNCTION?

Hospital healthcare providers determine if infants are exposed to substances in utero. All infants are called in to child welfare.

Child welfare screens the calls to determine if the family meets criteria for a report or a notification.

Child Welfare provides the POSC for all families through their different program areas, including alternative response.

HOW DO NOTIFICATION PATHWAYS FUNCTION?

Hospital healthcare providers determine if infants are exposed to substances in utero. All infants are called in to child welfare.

Child welfare screens the calls to determine if the family meets criteria for a report or a notification.

Child Welfare provides the POSC for those families who require a report.

Child welfare refers family who require a notification to outside providers who oversee the POSC.

HOW DO NOTIFICATION PATHWAYS FUNCTION?

Hospital healthcare providers determine if infants require a report, or a notification based on state definitions or policies.

Reports are sent to Child Welfare who completes Safety Screening and develops the POSC.

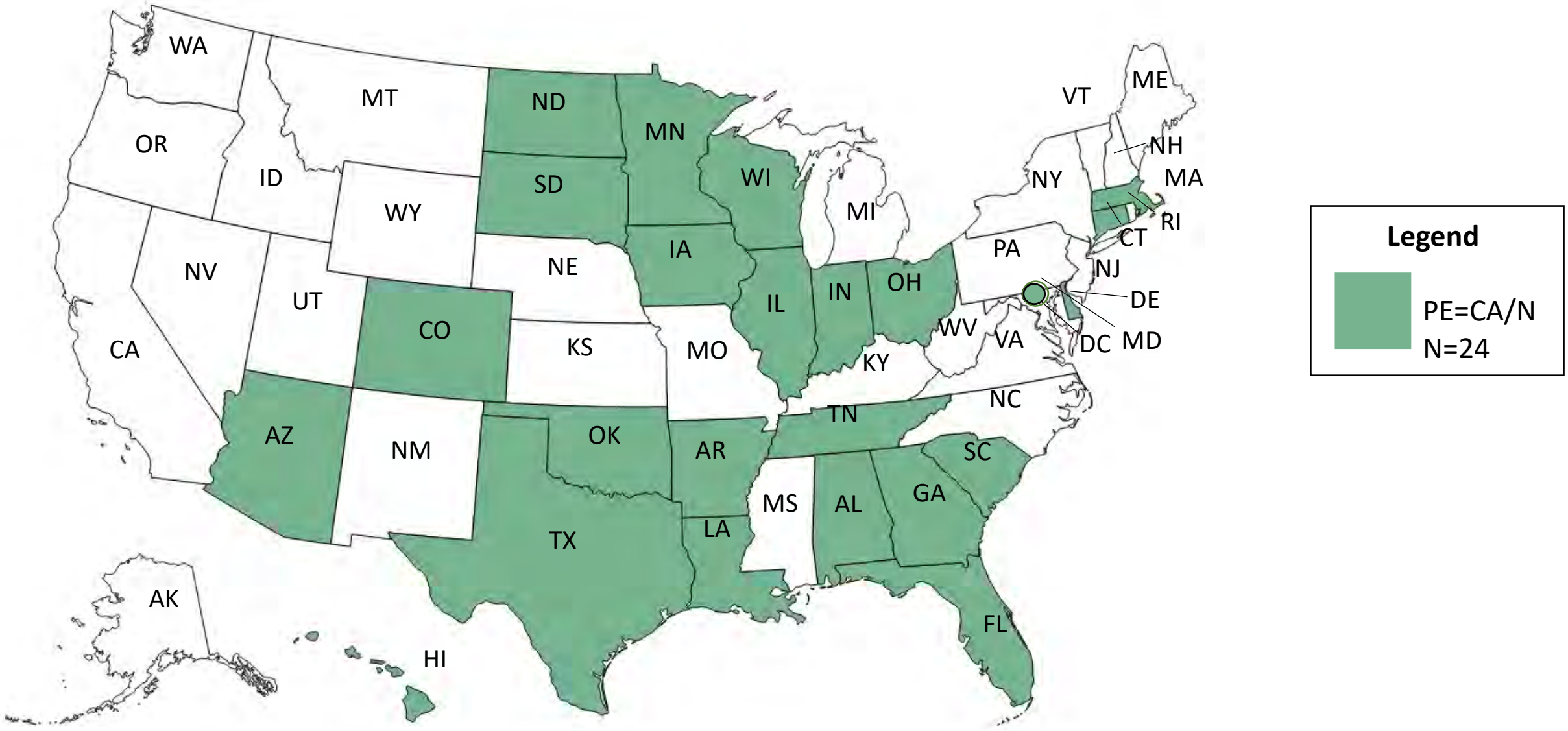
For notifications, the hospital develops the POSC & completes the notification form and sends it to Child Welfare (de-identified).

Hospital Sends POSC to an outside provider for oversight and service connection.

DETERMINING WHEN REPORTING IS REQUIRED

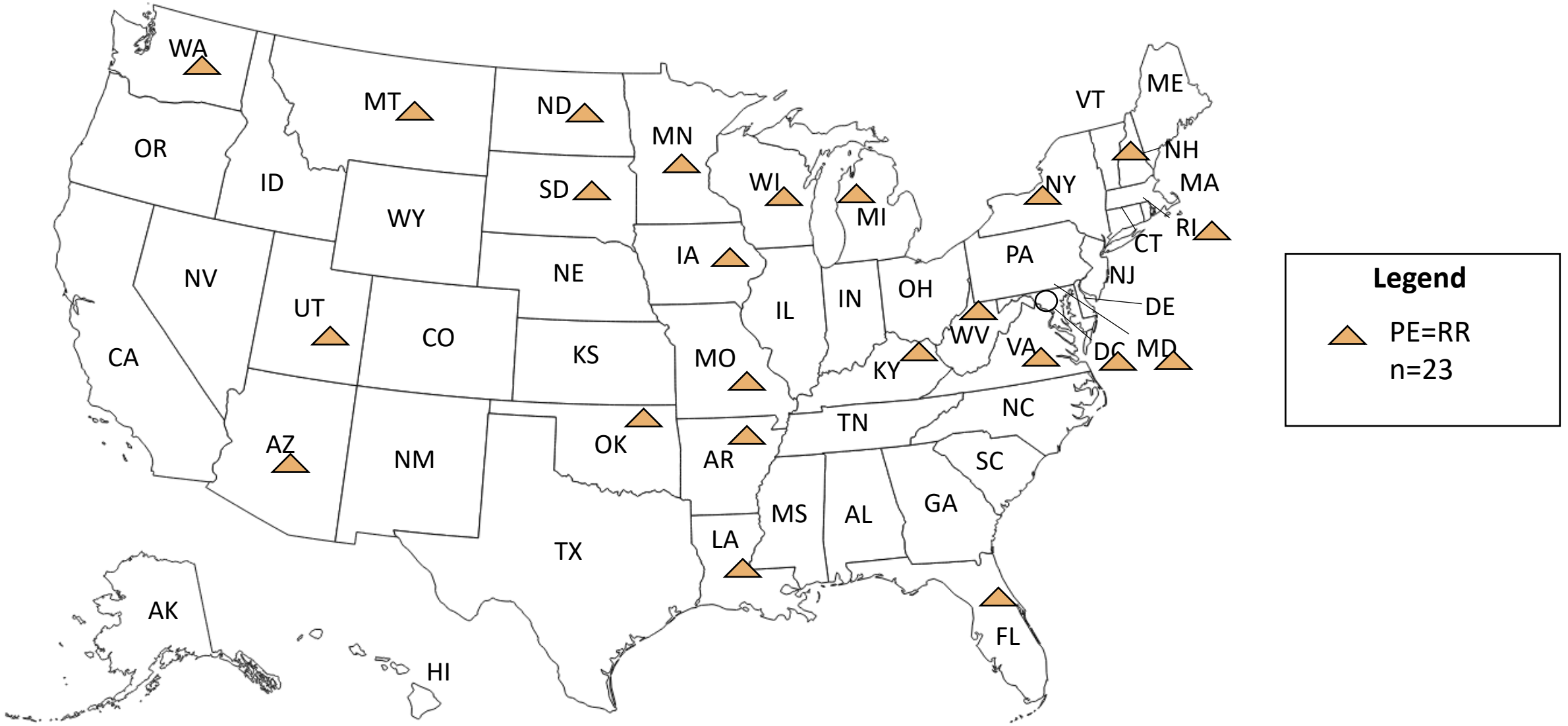
State Law	State Guidance	Tools
Reporting Requirements	Notifications Or Reports?	Decision Trees & Assessments

MAP 2: PRENATAL EXPOSURE DEFINED AS CHILD ABUSE OR NEGLECT (PE=CA/N) N=24



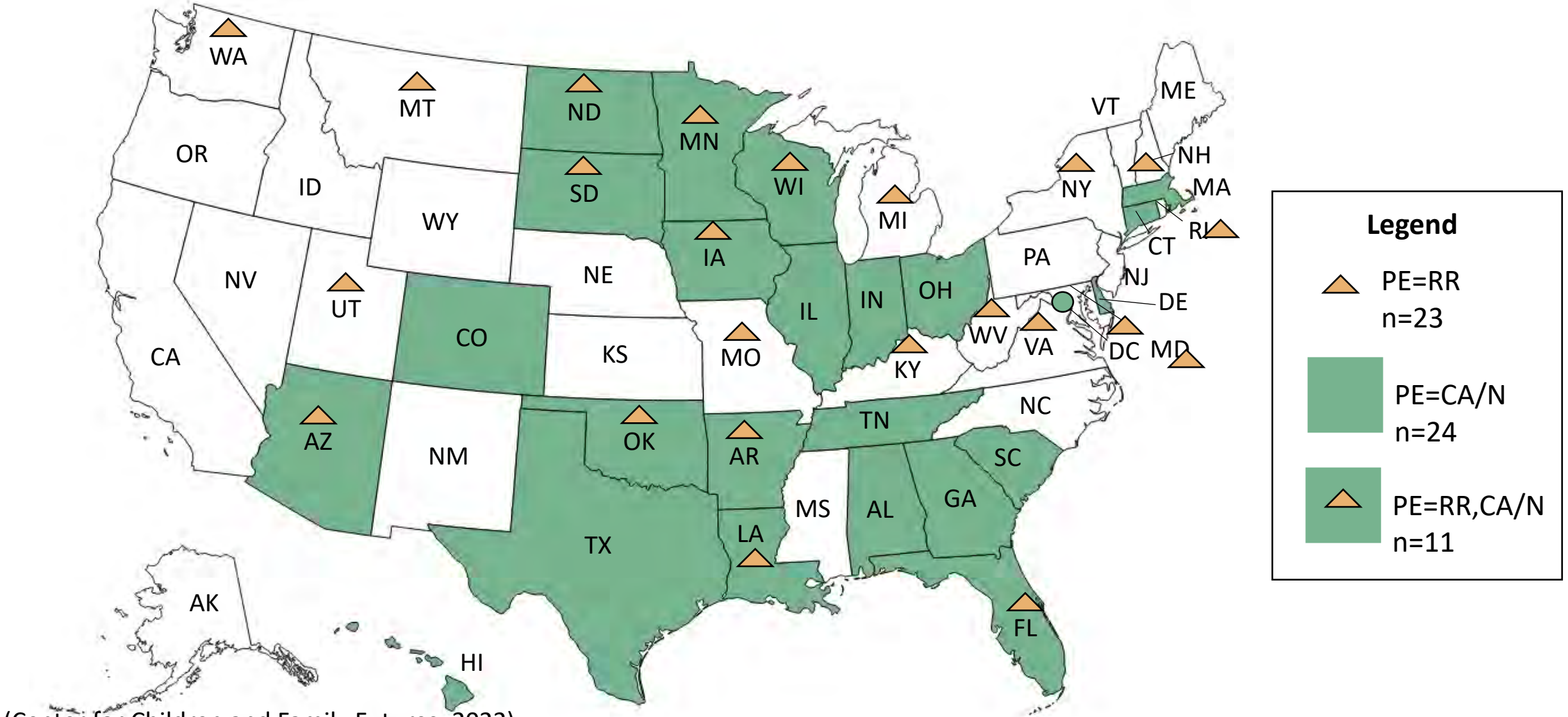
(Center for Children and Family Futures, 2022)

MAP 1: PRENATAL EXPOSURE REQUIRES A REPORT TO CHILD WELFARE (PE= RR) N=23



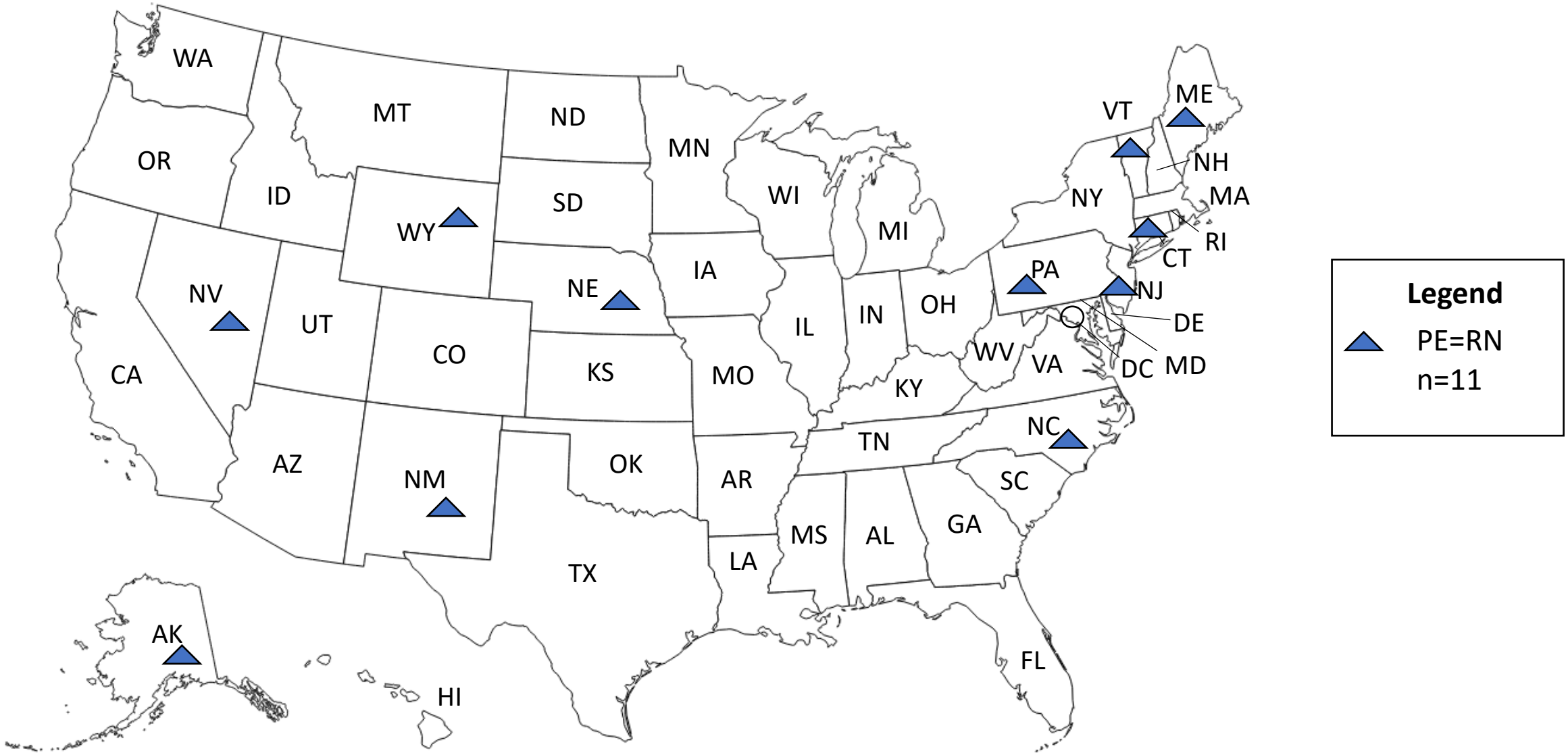
(Center for Children and Family Futures, 2022)

MAP 3: PRENATAL EXPOSURE REQUIRES A REPORT TO CHILD WELFARE *AND* DEFINED AS CHILD ABUSE OR NEGLECT (PE=RR,CA/N) N=11



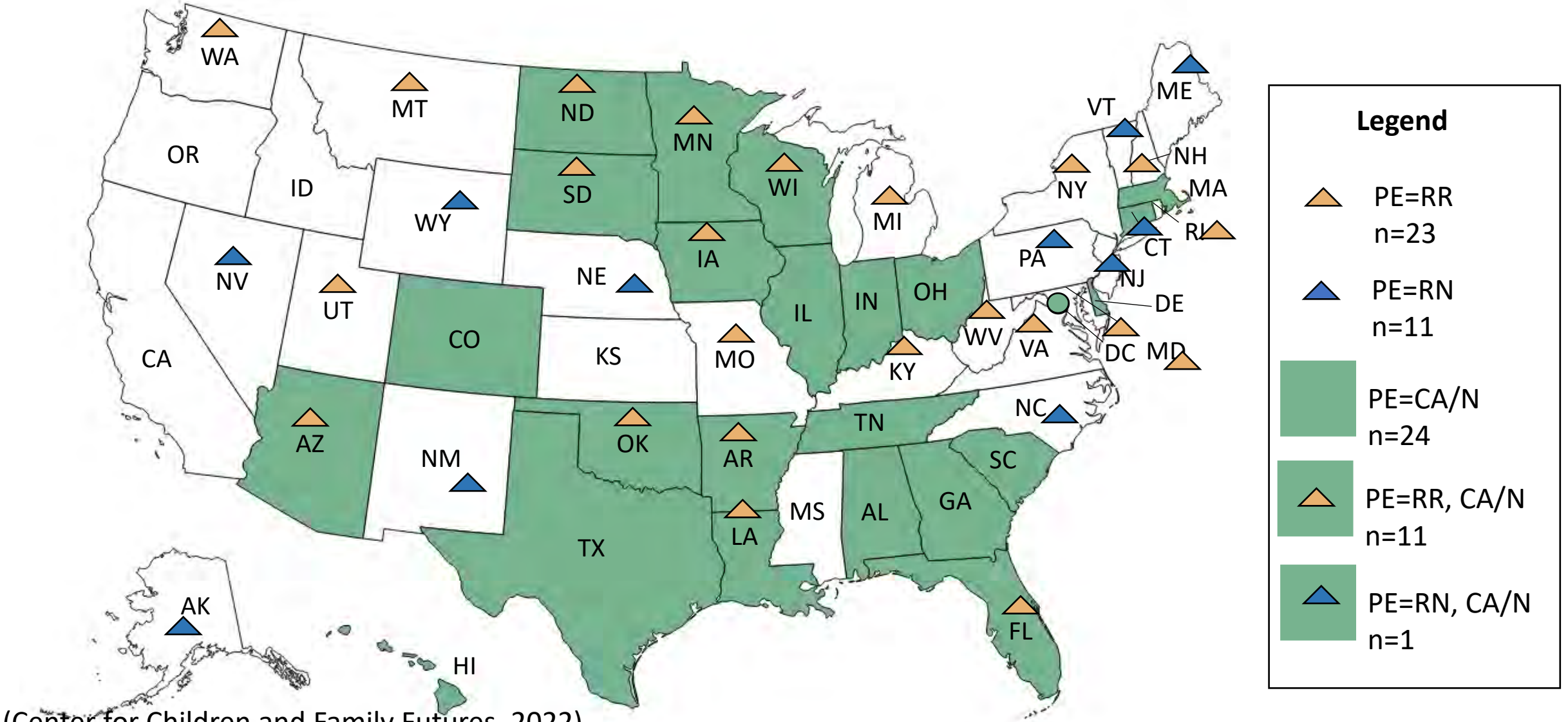
(Center for Children and Family Futures, 2022)

MAP 4: PRENATAL EXPOSURE REQUIRES A NOTIFICATION TO CHILD WELFARE (PE= RN) N=11



(Center for Children and Family Futures, 2022)

PRENATAL SUBSTANCE EXPOSURE (PE)
REQUIRES A REPORT TO CHILD WELFARE (PE=RR); DEFINED AS CHILD ABUSE/NEGLECT (PE=CA/N);
REQUIRES A NOTIFICATION TO CHILD WELFARE (PE=RN)



(Center for Children and Family Futures, 2022)

POSC: BUILDING A SUPPORTIVE RESPONSE

SUPPORTIVE RESPONSES

For women with SUDs and their infants and families

Prenatal

Universal Screening
& Referral
Use of Peers & Mentors

Birth

Family-Centered
Responses

Beyond

Home Visiting
& Early Intervention

WHY CONSIDER POSCS DURING THE PRENATAL PERIOD?

- Can be developed with women and families by SUD or MAT programs, maternal health care providers, home visitor, or other public health supports (e.g., Early Head Start, Healthy Start, etc.) during pregnancy
- Supports stronger partnerships across providers
- Can inform child welfare response to infants affected by prenatal substance exposure
- Can mitigate impact of exposure & minimize a crisis at the birth event
- *Not required by federal CAPTA changes*, but a supportive, **preventive** practice

TWO COMMUNITIES…

- No prenatal screening or assessment
- Isolation, discrimination
- No engagement specialist
- Late, inadequate, or non-existent treatment
- No postnatal POSC
- Outcomes?

- Early prenatal screening and assessment
- Supported engagement into treatment
- Quality treatment: MAT, Family-Centered, Trauma-informed, Recovery Support
- Prenatal POSC
- Focus on Equity

WHERE DO YOU LIVE?


HOW CAN YOU
GET INVOLVED?

PRACTICE CHANGE

- Investigate verbal screening tools and how to implement equitable screening practices
- Reach out to local child welfare offices to understand their practices
- Investigate POSC templates and find one that works for you team

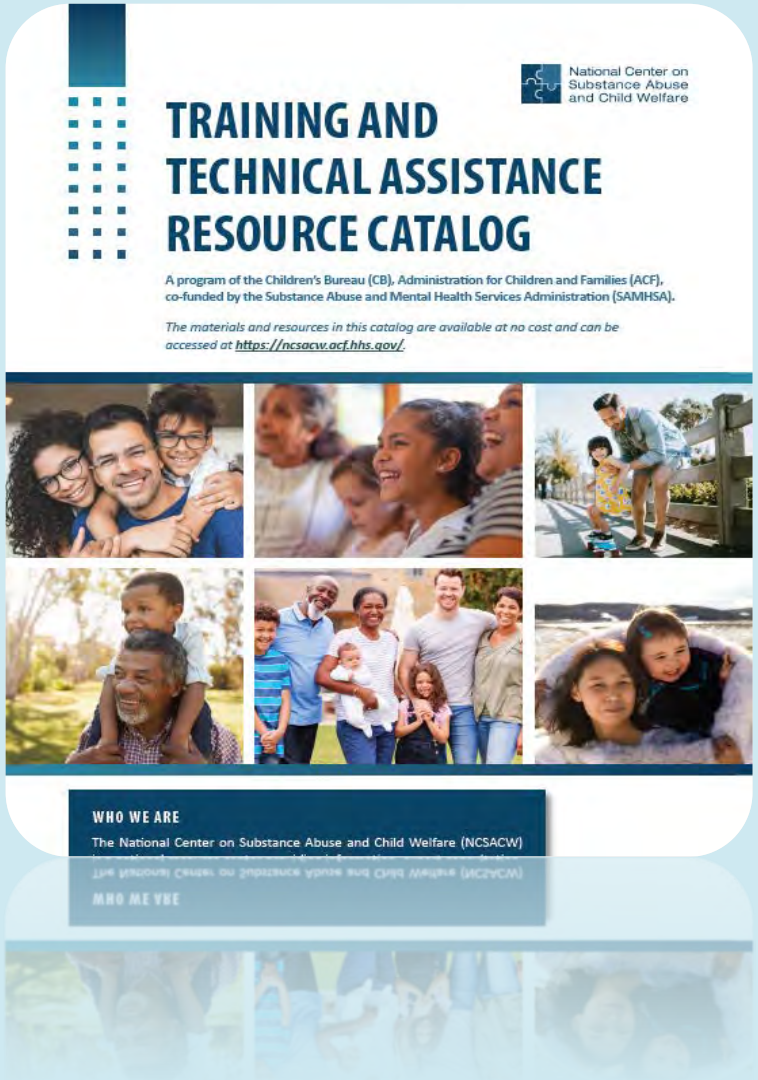
POLICY CHANGE

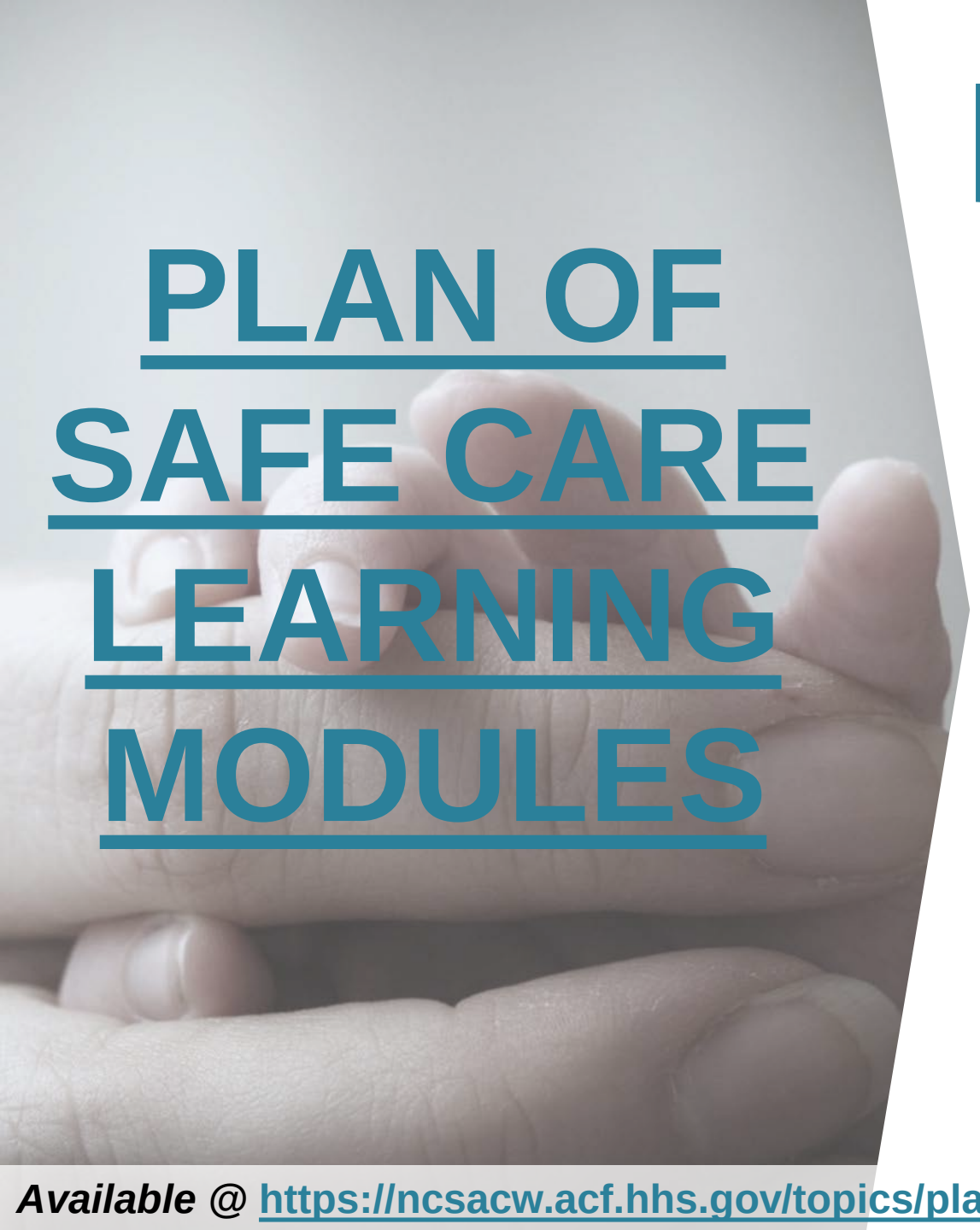
- Research what the current status is of POSCs in your jurisdiction
- Join state teams working on POSC pathways and policies
- Advocate for greater integration of people with lived experience across healthcare settings

RESOURCES

LEARN MORE ABOUT RESOURCES FROM NCSACW!

Use this QR code to access ***The Training and Technical Resource Catalog*** which includes all the most recent materials from NCSACW to help professionals best serve families.





PLAN OF SAFE CARE LEARNING MODULES

Five Learning Modules

- ***Brief 1:*** *Preparing for Plan of Safe Care Implementation*
- ***Brief 2:*** *Collaborative Partnerships for Plans of Safe Care*
- ***Brief 3*****:** *Determining Who Needs a Plan of Safe Care*
- ***Brief 4:*** *Implementing and Monitoring Plans of Safe Care*
- ***Brief 5:*** *Overseeing State Plans of Safe Care Systems and Reporting Data*

Available @ https://ncsacw.acf.hhs.gov/topics/plans-of-safe-care-learning-modules.aspx

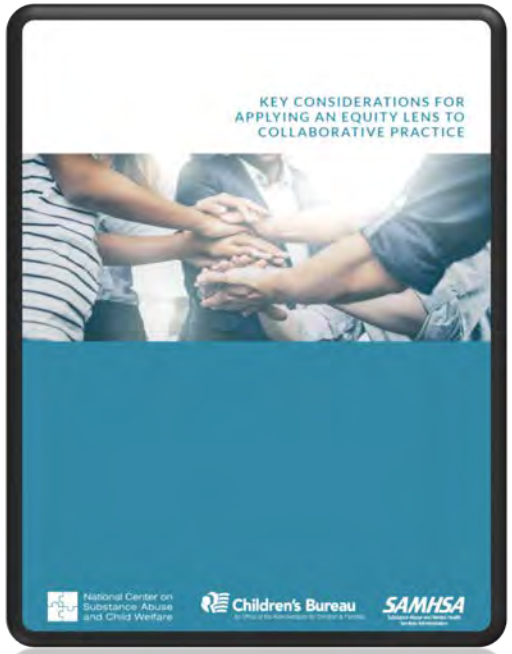
National Center on Substance Abuse and Child Welfare

How States Serve Infants and Their Families Affected by Prenatal Substance Exposure

- Brief 1: Identification and Notification
- Brief 2: Plan of Safe Care Data and Monitoring
- Brief 3: Lesson from Implementation of Plans of Safe Care

Available @ https://ncsacw.acf.hhs.gov/topics/plans-of-safe-care.aspx

Key Considerations for Applying an Equity Lens to Collaborative Practice



This brief helps collaborative teams formally ***assess existing policies*** to determine if and how they ***contribute to disproportionate and disparate outcomes for families*** being served.

By working through the "Questions to Consider", teams begin applying an ***equity lens*** to collaborative policies and practices.

Available @ https://ncsacw.acf.hhs.gov/files/equity-lens-brief.pdf

Safety & Risk Video Series

National Center on Substance Abuse and Child Welfare

This video series provides child welfare professionals with details on child safety and risk factors related to parental substance use disorders (SUDs). The series highlights strategies to promote parent engagement and support a coordinated approach—across systems—that helps families mitigate child safety and improve family well-being. It includes considerations when planning for safety with families.

- ***Engagement and Safety Decision-Making in Substance Use Disorder Cases***
- ***Planning for Safety in Cases When Parental Substance Use Disorder is Present***

@ **https://ncsacw.acf.hhs.gov/training/videos-and-webinars/webinars.aspx**

Free Online Tutorials for Cross-Systems Learning

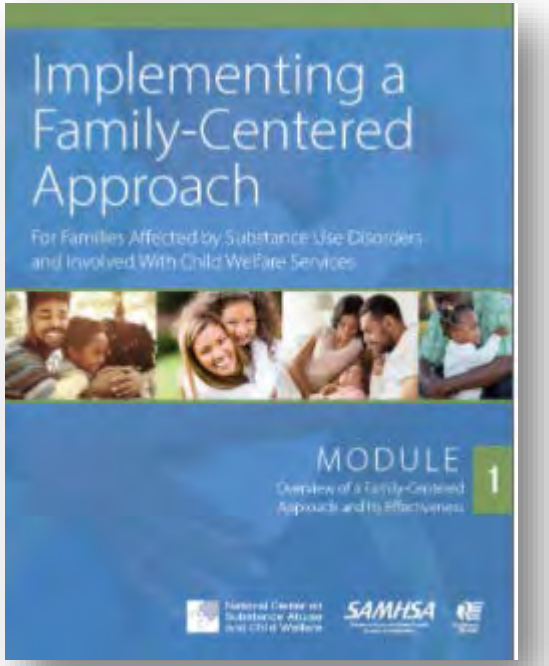
Understanding Substance Use Disorders and Facilitating Recovery: A Guide for Child Welfare Workers

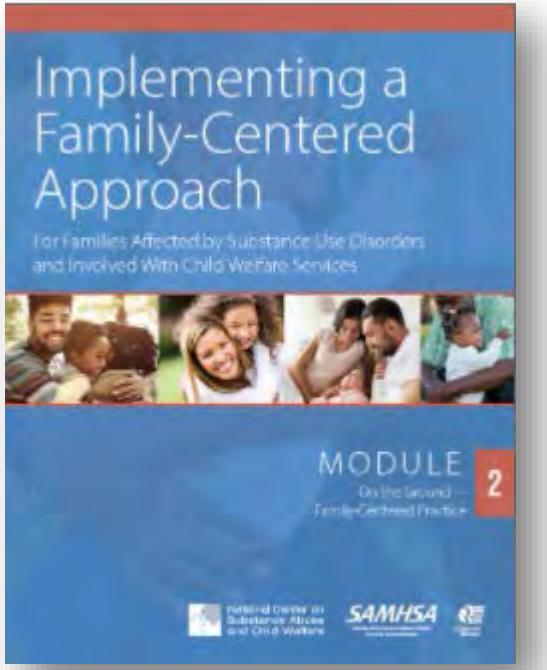
Understanding Child Welfare and the Dependency Court: A Guide for Substance Use Treatment Professionals

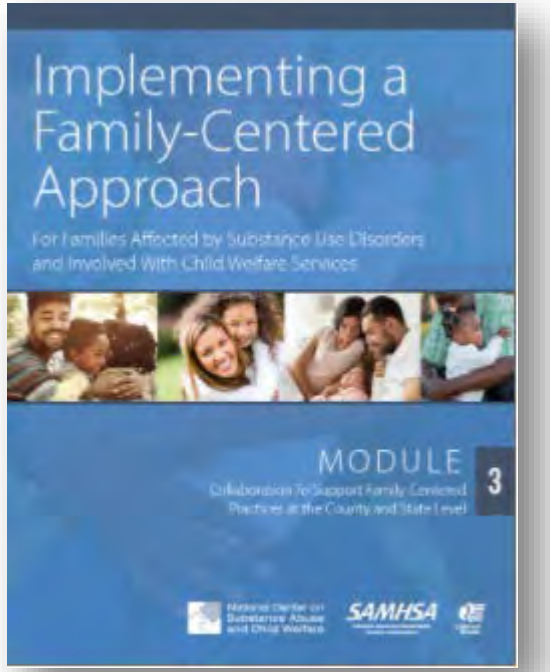
Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

@ https://ncsacw.acf.hhs.gov/training/default.aspx

Family Centered Approach Modules







https://ncsacw.acf.hhs.gov/topics/family-centered-approach/fca-modules.aspx

QUESTIONS?

Reminder: 2nd Webinar in Plan of Safe Care Series

May 16th 1-2pm EST: State & Local Implementation of Plans of Safe Care

- Learn different state and local approaches to implementing plans of safe care and connecting families to appropriate services
- Discuss interdisciplinary approaches to optimize plan of safe care implementation
- Highlight tools for implementing plans of safe care

REGISTRATION IS OPEN at www.mhlic.org

Speakers will share implementation examples from Houston, San Francisco, and the state of Washington

Evaluation Survey

Please complete a brief evaluation survey for this webinar

Use the link or scan the QR code

https://unc.az1.qualtrics.com/jfe/form/SV_9uxuBisEHHVpzvg