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

MaternalHealthLearning.org
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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
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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University of California, San Francisco
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%
### The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotchuck¹ · Erika R. Cheng² · Candice Belanoff³ · Howard J. Cabral³ · Hermik Babakhani-Chase⁴ · Taletha M. Derrington⁵ · Hafsata Diop⁶ · Stephen R. Evans³ · Judith Bernstein³

<table>
<thead>
<tr>
<th></th>
<th>No Addiction</th>
<th>Treated Addiction</th>
<th>Untreated Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm Birth</td>
<td>8.7%</td>
<td>10.1%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Low Birthweight</td>
<td>5.5%</td>
<td>7.8%</td>
<td>18.0</td>
</tr>
<tr>
<td>Fetal Death</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>0.4%</td>
<td>0.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Post Neonatal Mortality</td>
<td>0.05%</td>
<td>0.03%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

**Core Principle of PNC:**
Optimize maternal health via chronic disease management.
Recovery: The Goal of Treatment

- More than abstinence
- Life of integrity
- Connection to others
- Purpose
- Serenity
- Fully compatible with medication
The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.

- Menarche: 12.6
- First intercourse: 17.4
- First pregnancy: 22.5
- First marriage: 25.1
- First birth: 26.0
- Intend no more children: 30.9
- Menopause: 51.3

Median age at which event occurs*

Note: *Age by which half of women have experienced event.
Source: Reference 6.
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Davida M. Schiff, MD, MS, Timothy Nielsen, MPH, Mishka Terplan, MD, MPH, Malena Hood, MPH, Dana Berson, MPH, Hafsatou Diop, MD, MPH, Monica Bharel, MD, MPH, Timothy E. Wilens, MD, Marc LaRochelle, MD, MPH, Alexander Y. Walley, MD, MS, 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)

<table>
<thead>
<tr>
<th>Period Relative to Delivery</th>
<th>All OD Events</th>
<th>OD Events While Receiving Pharmacotherapy</th>
<th>OD Events Not Receiving Pharmacotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>7.99 (7.01-9.06)</td>
<td>4.43 (3.28-5.86)*</td>
<td>10.04 (8.67-11.56)*</td>
</tr>
<tr>
<td>Year before delivery–conception</td>
<td>9.72 (6.91-13.29)</td>
<td>3.74 (1.02-9.57)</td>
<td>11.89 (8.28-16.54)</td>
</tr>
<tr>
<td>Trimester (weeks of gestation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st (9-12)</td>
<td>8.88 (6.04-12.61)</td>
<td>4.79 (1.56-11.18)</td>
<td>10.63 (6.94-15.58)</td>
</tr>
<tr>
<td>2nd (13-20)</td>
<td>3.23 (1.61-5.32)</td>
<td>1.20 (0.15-4.35)</td>
<td>4.35 (2.32-7.44)</td>
</tr>
<tr>
<td>3rd (29 or greater)</td>
<td>3.32 (1.93-6.08)</td>
<td>4.06 (1.32-9.51)</td>
<td>2.80 (0.89-6.53)</td>
</tr>
<tr>
<td>Postpartum (mo)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>7.41 (4.92-10.71)</td>
<td>3.17 (1.03-7.41)</td>
<td>10.44 (6.62-15.67)</td>
</tr>
<tr>
<td>4-6</td>
<td>6.89 (4.50-10.10)</td>
<td>1.31 (0.16-4.74)*</td>
<td>10.67 (6.84-15.38)*</td>
</tr>
<tr>
<td>7-9</td>
<td>12.2 (8.93-16.28)*</td>
<td>6.74 (2.32-12.40)</td>
<td>15.75 (11.03-21.80)</td>
</tr>
<tr>
<td>10-12</td>
<td>12.35 (9.07-16.42)*</td>
<td>10.84 (6.20-17.60)</td>
<td>13.3 (9.04-18.88)</td>
</tr>
</tbody>
</table>

OD, opioid overdose.
Data are rates/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?

<table>
<thead>
<tr>
<th>Presumptive</th>
<th>Definitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point-of-care</td>
<td>Gas Chromatography / Mass Spectrometry</td>
</tr>
<tr>
<td>Elisa</td>
<td>Costly and Timely</td>
</tr>
<tr>
<td>Rapid and Cheap</td>
<td>Results specific and quantified</td>
</tr>
<tr>
<td>Results Binary</td>
<td></td>
</tr>
</tbody>
</table>

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)
“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

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

- 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

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 HARM 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.

Provider Assumptions: Social/Legal Distinctions = Biological/Public Health

- Prescribed Medication
- Legal Substances
- Illegal Substances

HARM

Known Teratogens: ACE-Inhibitors, Alcohol, Carbamazepine, Diethylstilbestrol (DES), Isotretinoin, Phenytoin, Tobacco, Valproic Acid (partial list)
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

The Statutory Association between Substance Use in Pregnancy and Subsequent Maltreatment

Logical Tautology
True (or false) by definition
Defined in reference to itself
“Formally undecidable”
Not falsifiable
Therefore, not scientific

A = B
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
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.

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**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 2008, we conducted 2 modified Delphi panels using ExpertLabs, 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 dysmotility).

**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
SUPPORTING FAMILIES WITH THE PLAN OF SAFE CARE (POSC)

May 1, 2023
12:00 – 1:00 PM ET
Acknowledgement

This content is supported by contract number 75S20422C00001 from the Children’s Bureau (CB), Administration for Children and Families (ACF), co-funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The views, opinions, and content of this presentation are those of the presenters and do not necessarily reflect the views, opinions, or policies of ACF, SAMHSA or the U.S. Department of Health and Human Services (HHS).

https://ncsacw.acf.hhs.gov | ncsacw@cffutures.org
Note: Estimates based on children who entered out of home care during Fiscal Year 2020. Estimates may be influenced by the COVID-19 pandemic.
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
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.
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.
Hospital healthcare providers determine if infants require a report, or a notification based on state definitions or policies.

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

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

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

Legend
- 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

Legend
- PE=RR n=23

(Center for Children and Family Futures, 2022)
MAP 3: PRENATAL EXPOSURE REQUIRE A REPORT TO CHILD WELFARE AND DEFINED AS CHILD ABUSE OR NEGLECT (PE=RR,CA/N) N=11

Legend
- PE=RR n=23
- PE=CA/N n=24
- PE=RR,CA/N 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)

Legend
- PE=RR
  - n=23
- PE=RN
  - n=11
- PE=CA/N
  - n=24
- PE=RR, CA/N
  - n=11
- PE=RN, CA/N
  - n=1

(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 POCS 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?

WHERE DO YOU LIVE?

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

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
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
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**

Free Online Tutorials for Cross-Systems Learning

- 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