Planning for Safe Care– What Your Family Treatment Court Needs to Know about Opioid Use Disorders and Serving Mothers and Their Infants

California Association of Collaborative Courts Conference

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LEARNING OBJECTIVES

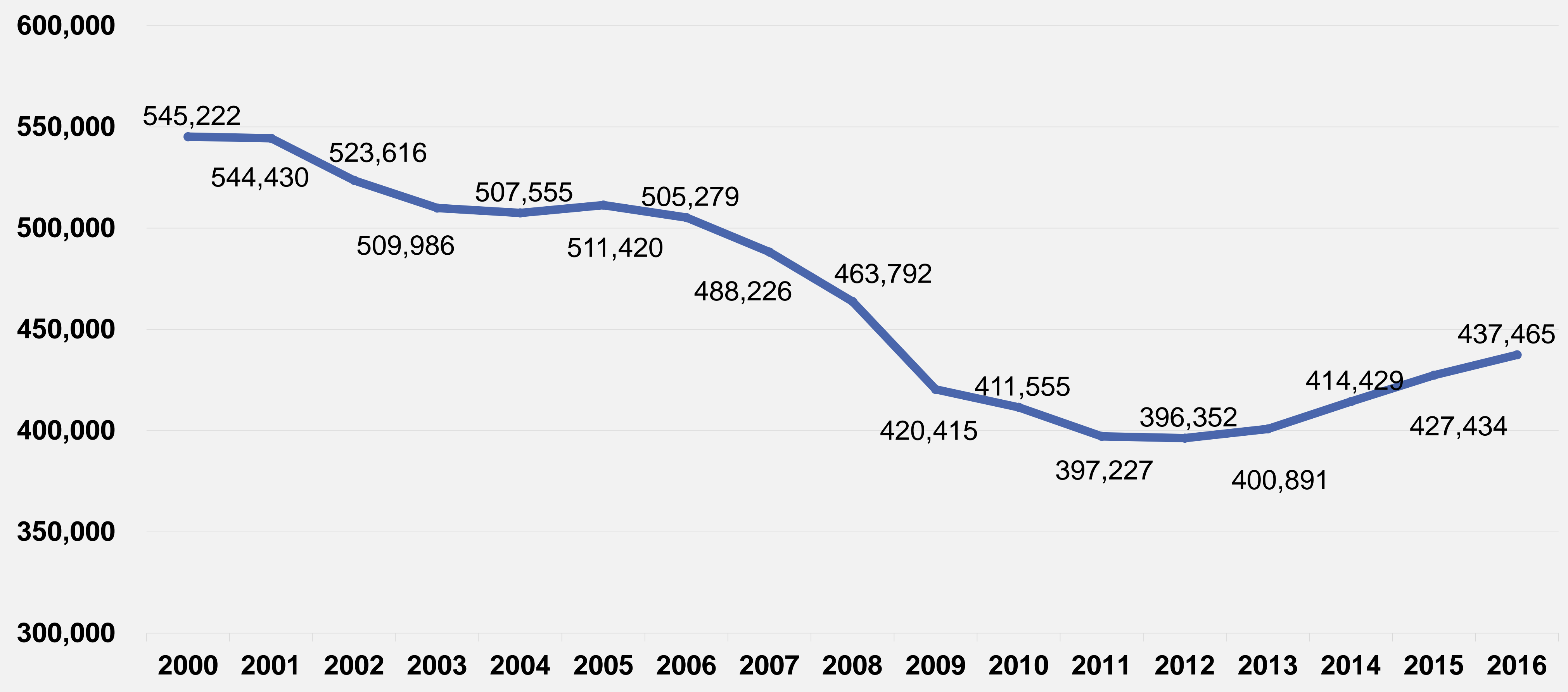
Understand the data on the effects of parental substance use on children and families, child welfare services, and courts

Understand family-centered, mediation-assisted treatment for families affected by opioid use disorders

Identify strategies to expand the family treatment court collaborative approach to effectively work with families affected by opioid use disorders

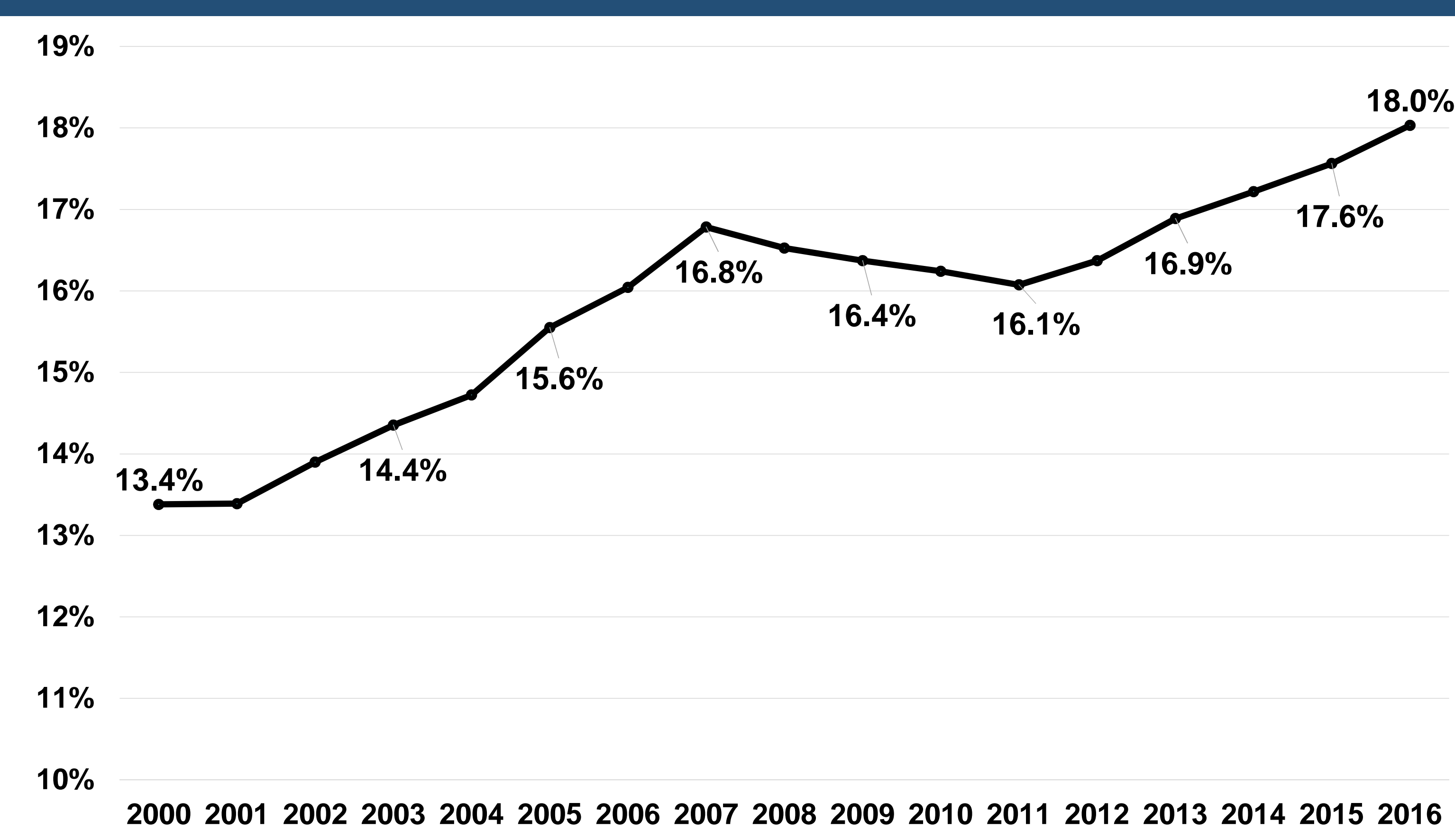
Learn how collaborative teams can develop an approach to implement comprehensive and effective CAPTA Plans of Safe Care

THE CHALLENGE
Effects of Parental Substance Use on Children and
Families, Child Welfare Services, and Courts


Number of Children in Out of Home Care at
End of Fiscal Year in the United States, 2000 to 2016
600,000
550,000
500,000
450,000
400,000
350,000
300,000
545,222
544,430
523,616
509,986
507,555
511,420
505,279
488,226
463,792
420,415
411,555
397,227
396,352
400,891
414,429
427,434
437,465
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Note: Estimates based on children in foster care as of September 30
Source: AFCARS Data, 2000-2016

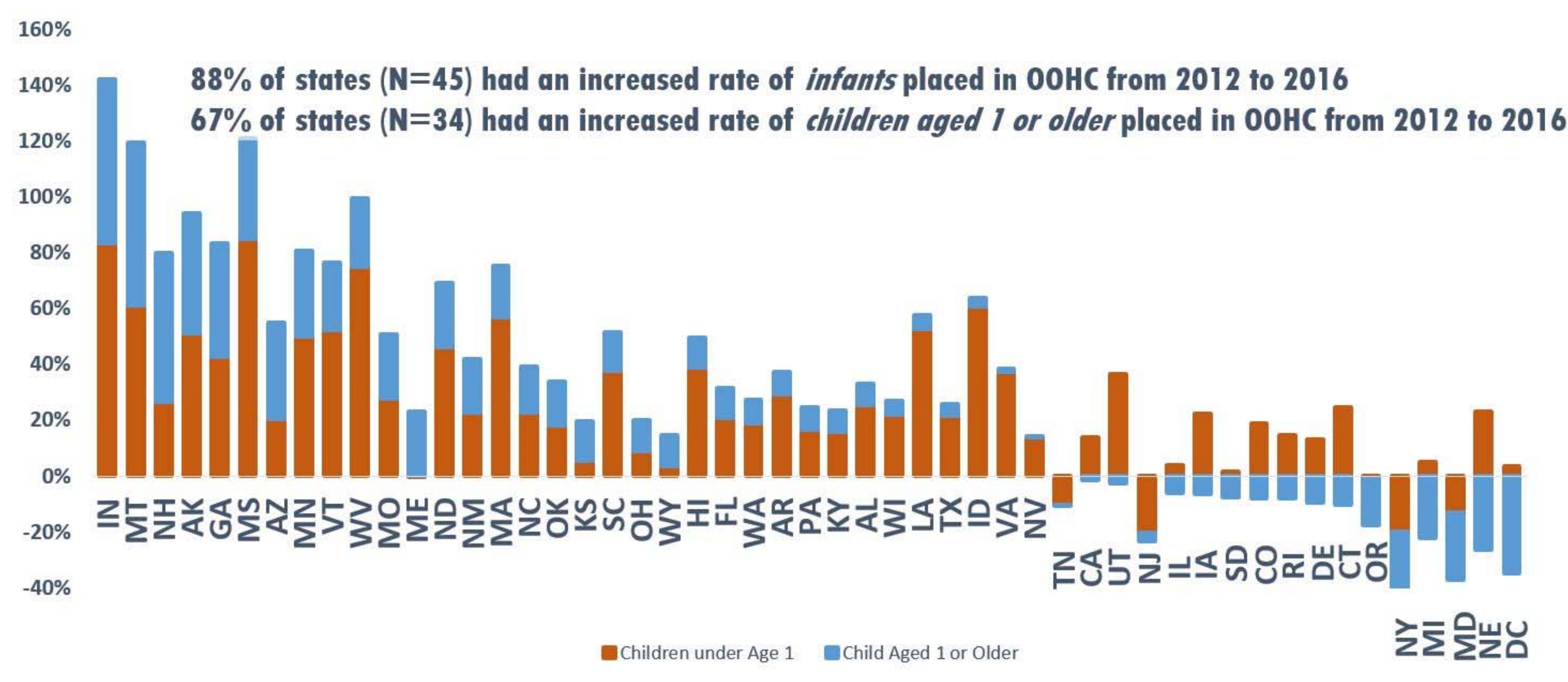
Children under age one are a growing percentage of children who enter out of home care each year.

Of all Children who Entered Out of Home Care, Percent who were Under Age One, 2000 to 2016



Source: AFCARS Data, 2000-2016

Percent Change of Children Under Age 1 or Older Placed in Out of Home Care by State, 2012-2016



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

(AFCARS, 2012-2016)

Prevalence of Parental Alcohol or Other Drug Use Reported as a Contributing Factor for Reason for Removal in the United States, 2000 to 2016

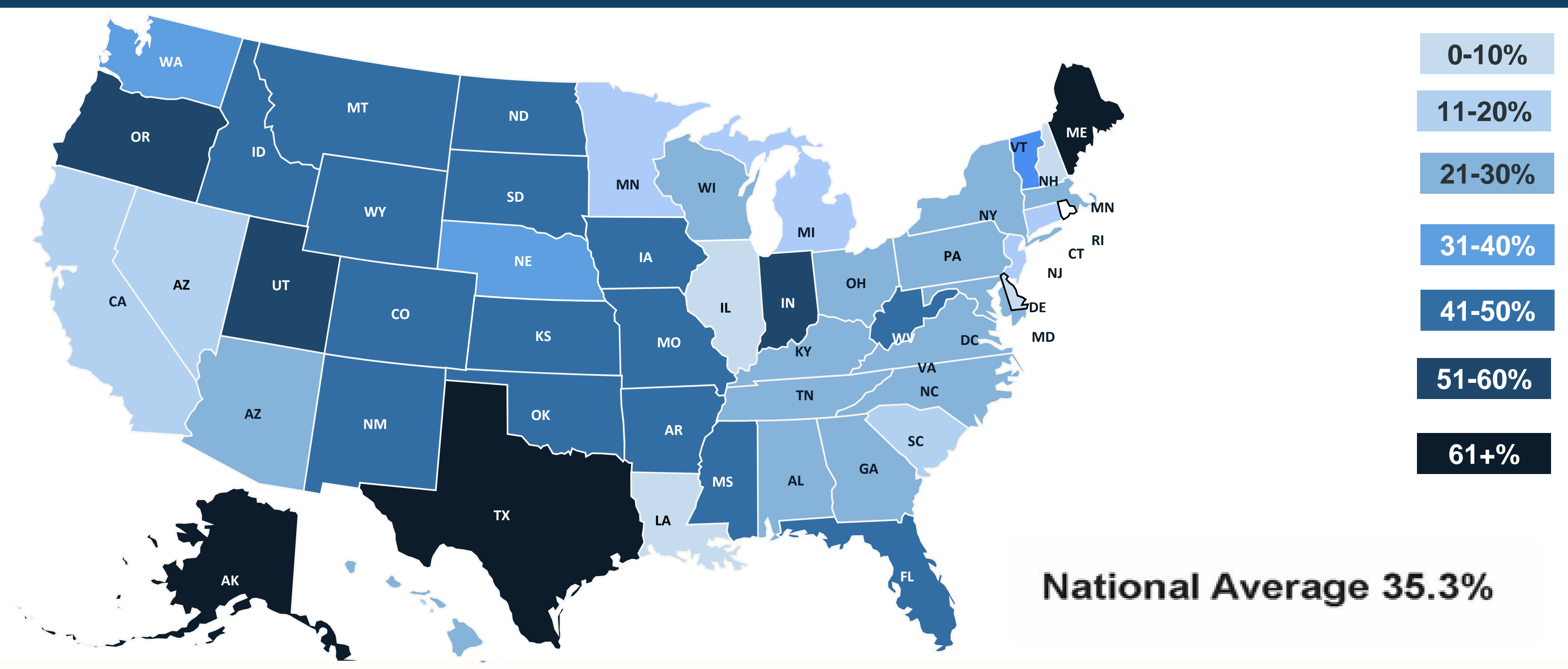
Year	Percentage
2000	18.5%
2001	19.6%
2002	21.9%
2003	23.0%
2004	23.9%
2005	24.7%
2006	25.9%
2007	26.5%
2008	26.0%
2009	26.2%
2010	28.5%
2011	29.5%
2012	30.7%
2013	31.3%
2014	32.2%
2015	34.4%
2016	35.3%

40% 35% 30% 25% 20% 15% 10% 5% 0%

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

Source: AFCARS Data, 2000-2016

Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal by State, 2016

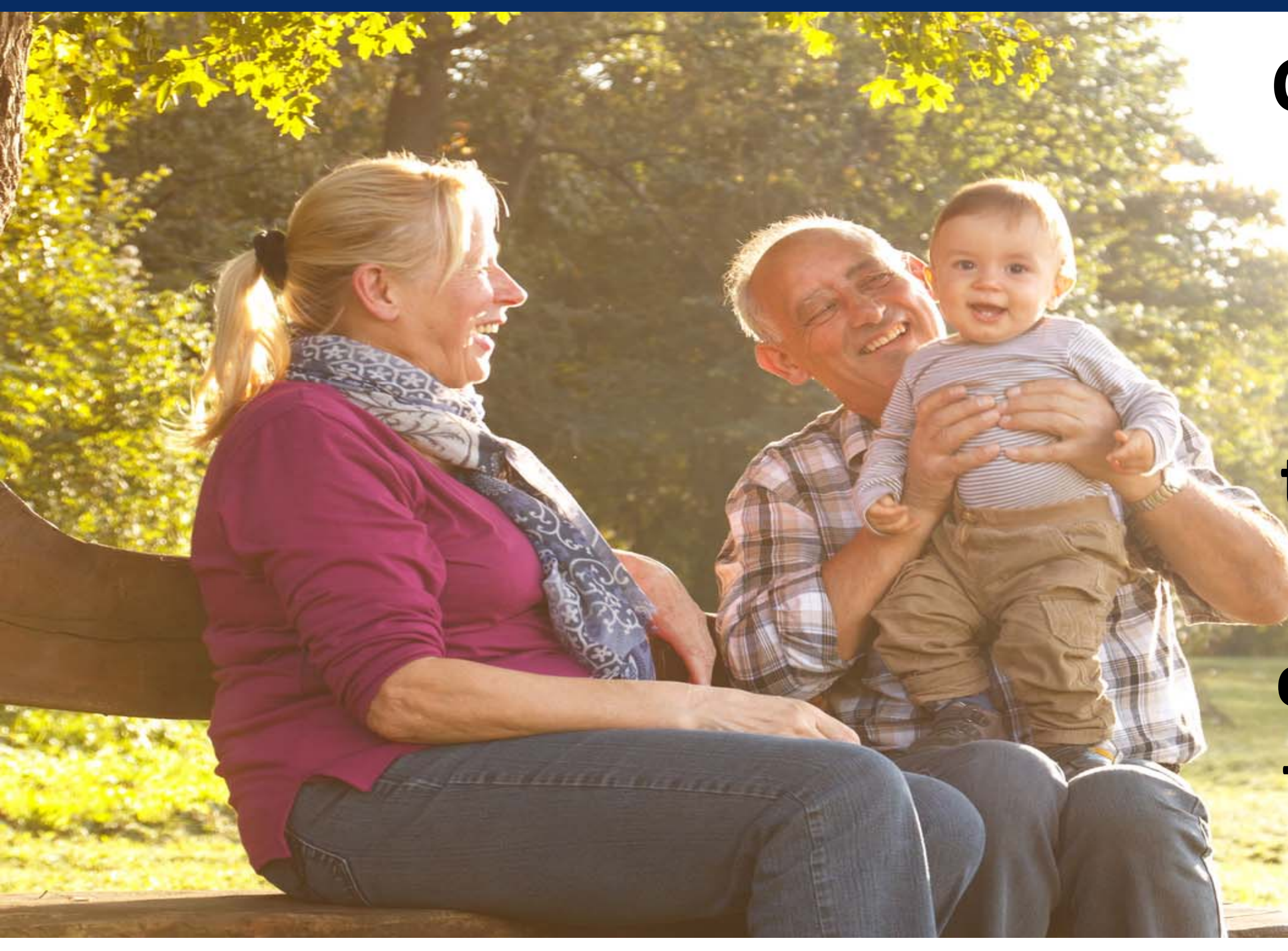


Efforts in data collection have improved in recent years, but significant undercount remains in some states.

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

Source: AFCARS Data, 2016

Extended families are particularly affected by the opioid epidemic



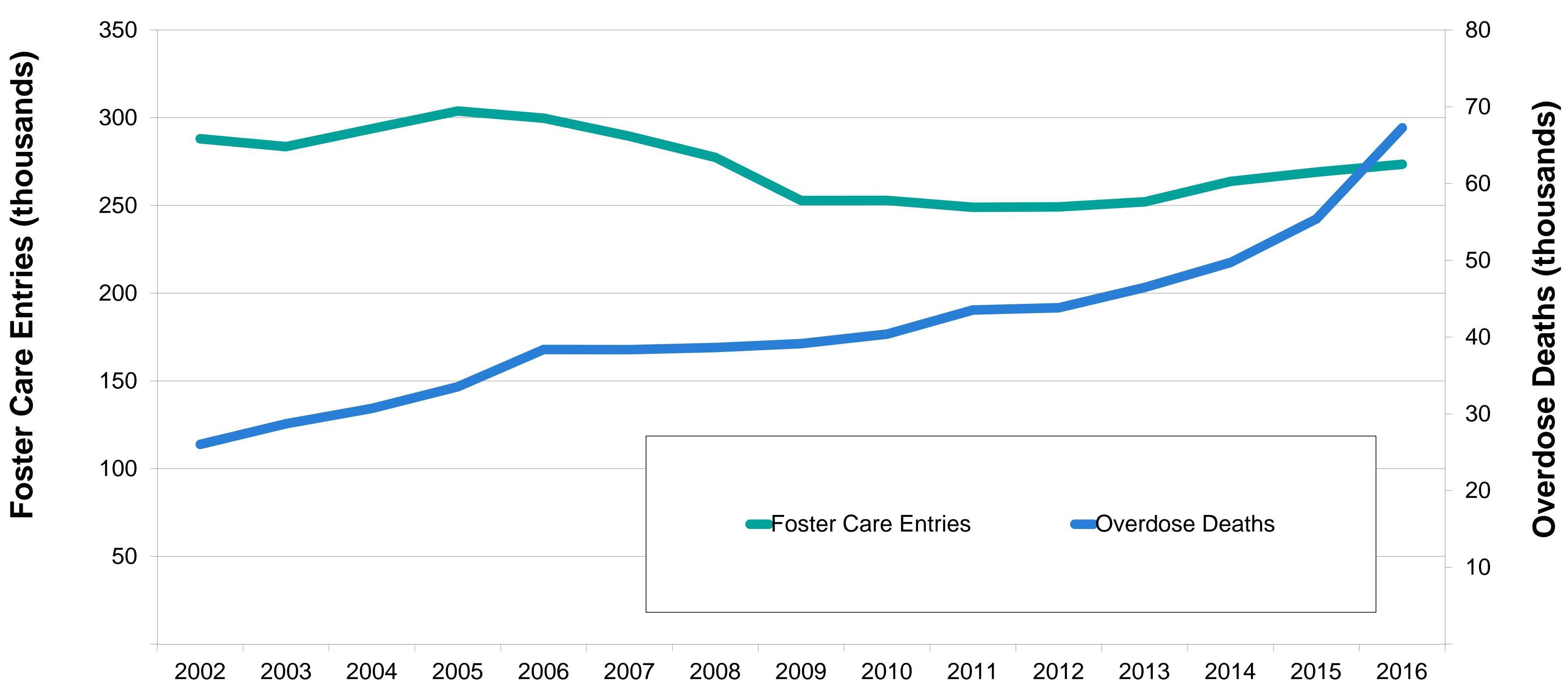
Children removed because of parental AOD were more likely to be placed with relatives than children removed for other reasons

(Vanderploeg et al., 2007)

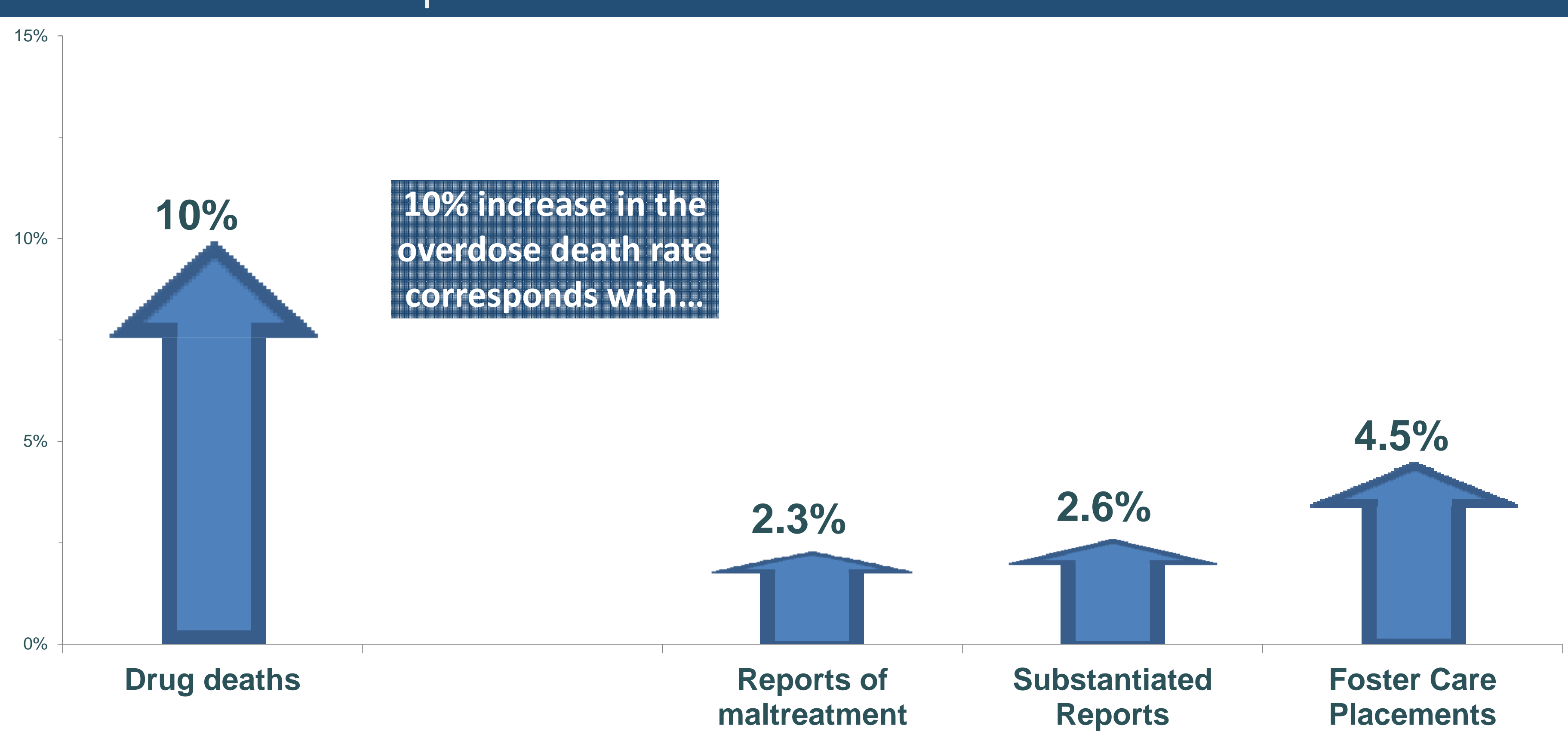
Assistant **Secretary** on Planning and Evaluation (ASPE) Study on Substance Misuse and Child Welfare

- Quantitative
  - Identify the effect of substance use prevalence and drug death rates on child welfare caseloads, including:
    - Total reports of child maltreatment
    - Substantiated reports of child maltreatment
    - Foster care entries
- Qualitative
  - Interviews with over 170 professionals to understand barriers and practice challenges

Quantitative Study Findings

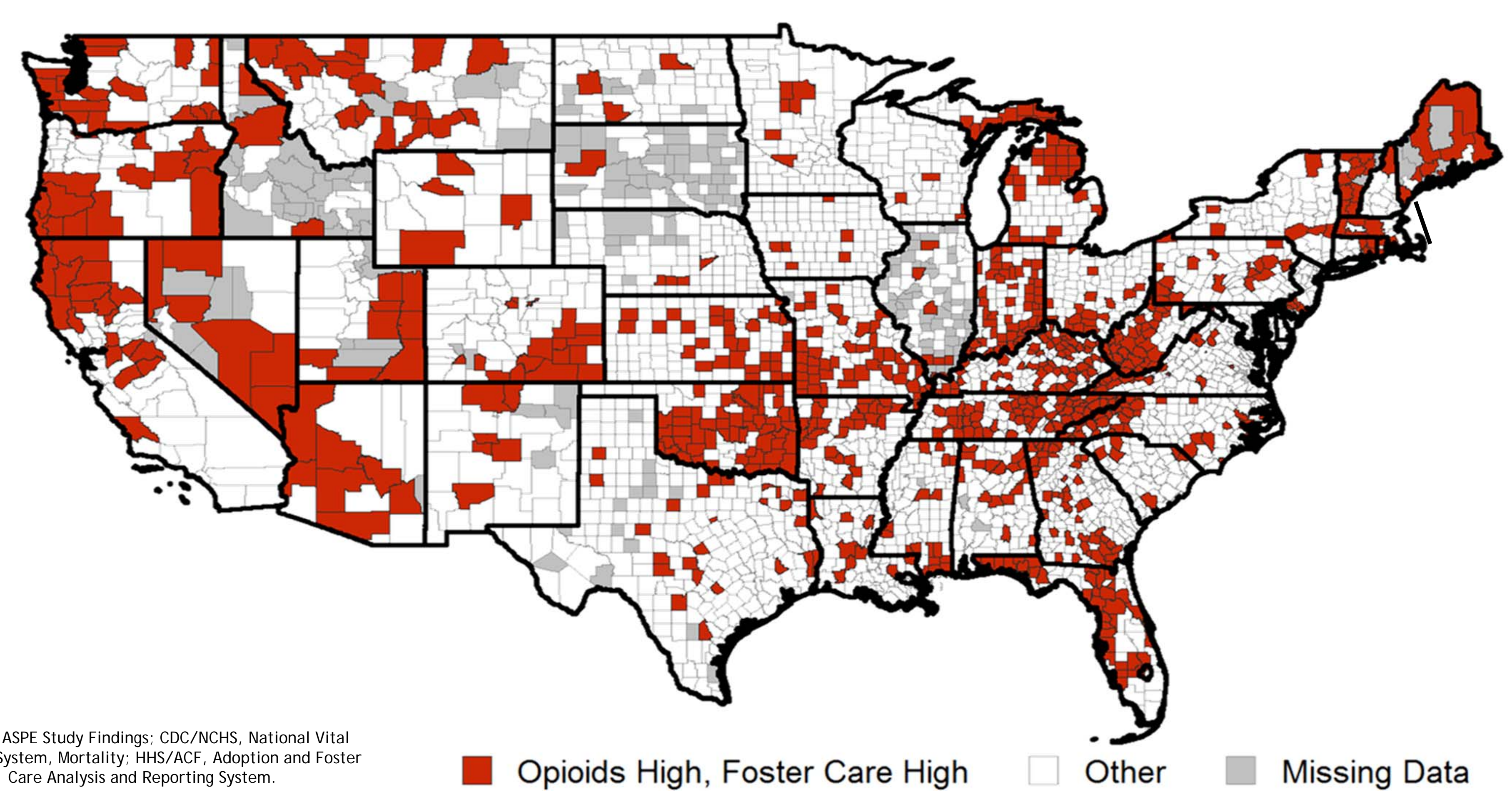


Sources: ASPE (2018) CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.



Sources: ASPE (2018) CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.

Counties where Rates of Drug Overdose Deaths and Foster Care Entries were both above the National Median in 2015



Sources: ASPE Study Findings; CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.

Findings from the ASPE Study: Services for New Mothers

- Lack of treatment specific to pregnant women
- Clients received repeated detoxification
- Mistrust of MAT
- Family-friendly treatment options were limited
- Haphazard substance use assessment practices, barriers to collaboration and shortages of trained staff undermine the effectiveness of agencies' responses to families

(Radel et al., 2018)

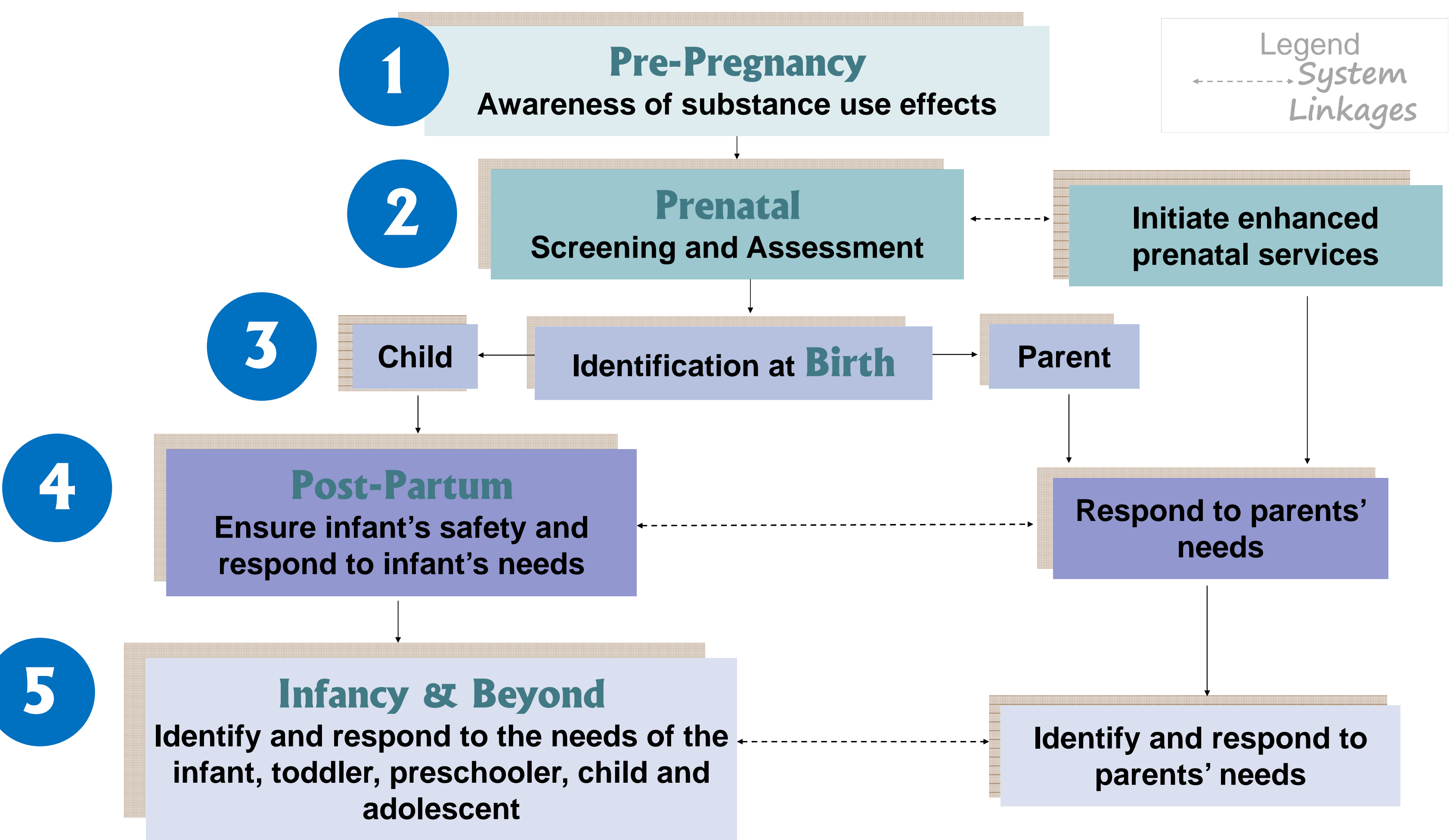
Assistant Secretary on Planning and Evaluation (ASPE) Study on Substance Misuse and Child Welfare

- Identify the effect of substance use prevalence and drug death rates on child welfare caseloads, including:
  - Total reports of child maltreatment
  - Substantiated reports of child maltreatment
  - Foster care entries

(Radel et al., 2018)

THE CHALLENGE
Effects of Prenatal Substance Exposure on
Infants, Parents, and Families

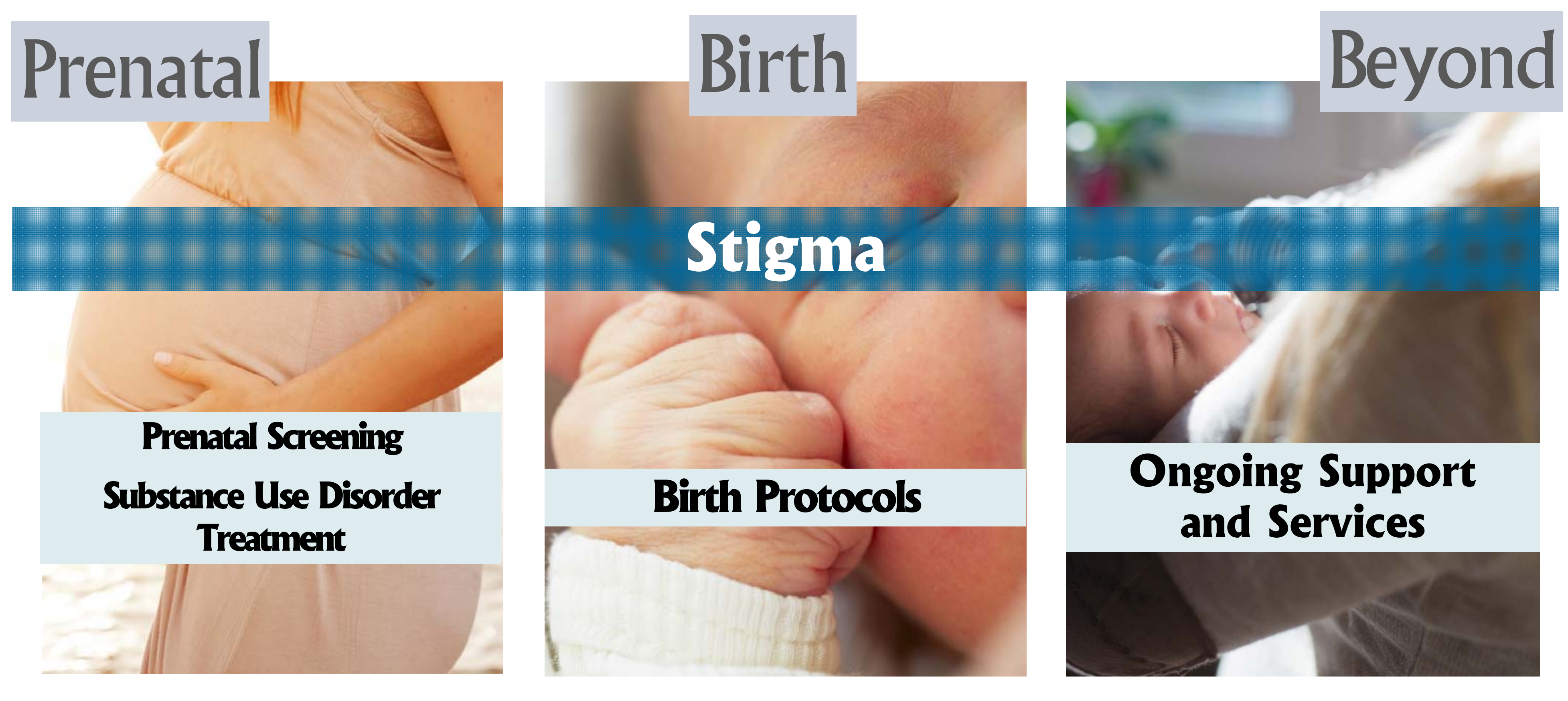
Policy and Practice Framework: 5 Points of Intervention



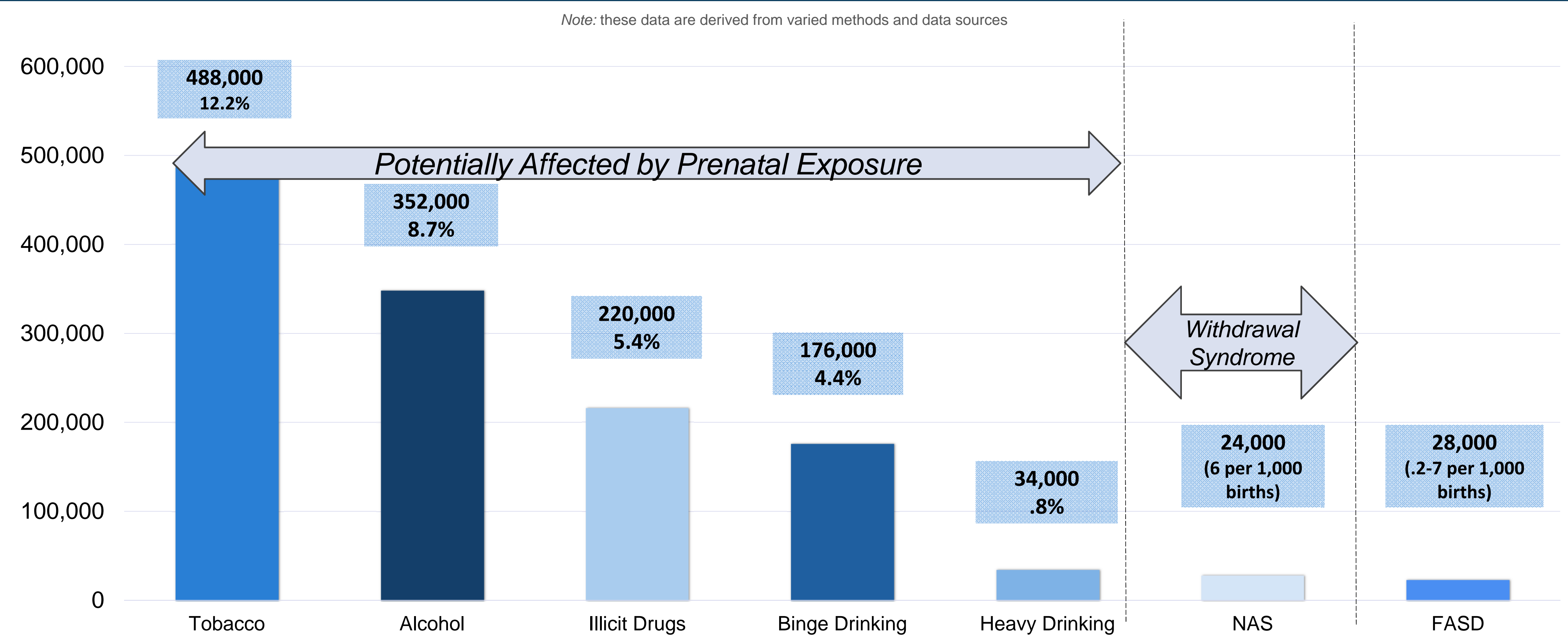
Young, 2009

Opportunities and Challenges

For women with substance use disorders and their infants and families



Estimated Number of Infants Affected by Prenatal Exposure by Type of Substance and Diagnosis



(National Vital Statistics Report, 2017; NSDUH, 2017; Patrick et al., 2015; May & Gossage, 2001)

The reporting of NAS has increased over the past 15 years

There are a number of data sources that have looked at the incidence of NAS. While it appears that the incidence is rising due to the opioid epidemic it is difficult to determine how much attention to NAS and improvements in identification are driving this increase as opposed to real growth in infants being born with NAS.

In 2000, 1.2 per 1000 hospital births were diagnosed as having Neonatal Abstinence Syndrome (NAS).

(Patrick et al., 2012)

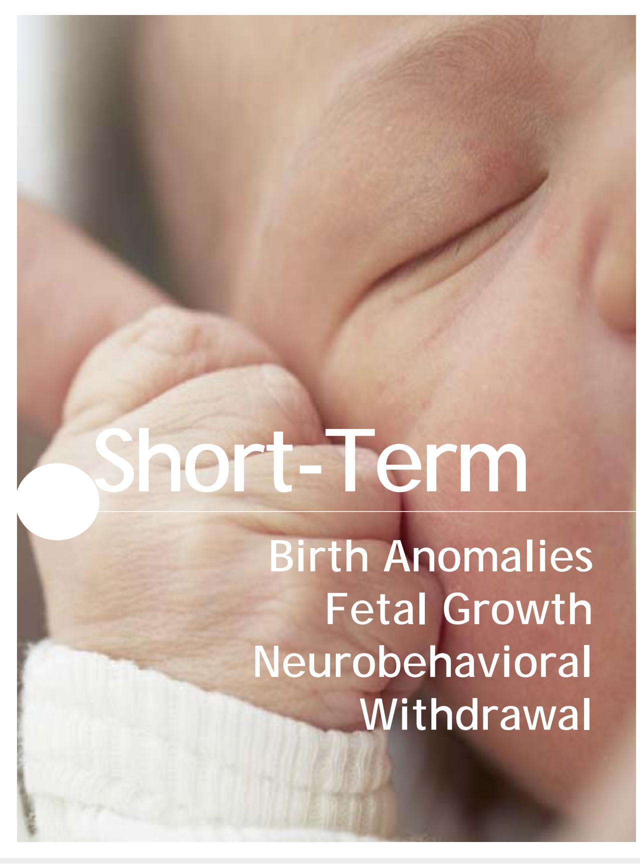
In, 2016 data from 23 hospitals in the US Pediatric system indicate 20 per 1000 live births were diagnosed as having Neonatal Abstinence Syndrome (NAS).

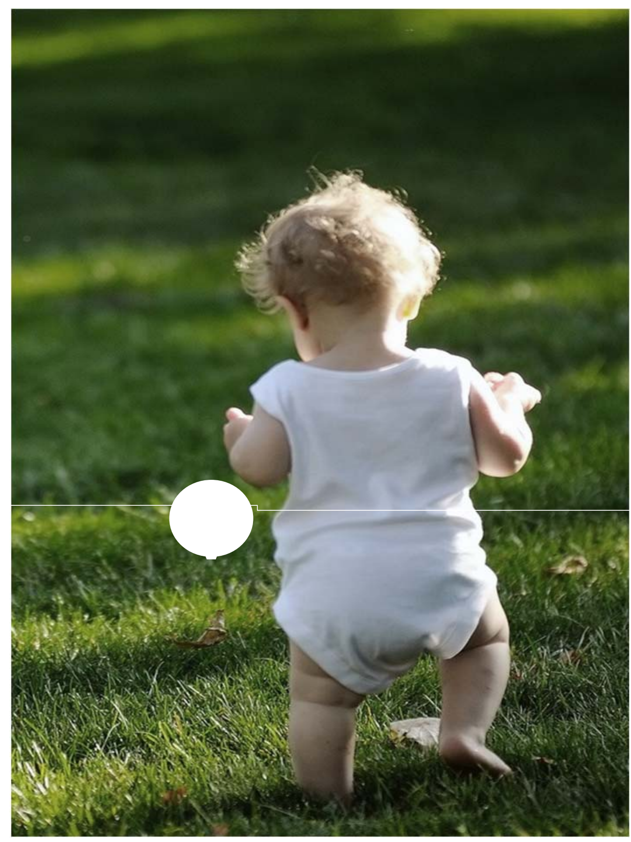
(Milliren et al., 2017)

Effects of Substance Exposure:

American Academy of Pediatrics Technical Report

Comprehensive review of ~275 peer reviewed articles over 40 years (1968-2006)





(Behnke & Smith, 2013)

SHORT-TERM EFFECTS OF PRENATAL EXPOSURE

	Growth	Anomalies	Withdrawal	Neurobehavioral
Alcohol	**Strong Effect**	**Strong Effect**	No Effect	Effect
Nicotine	Effect	No consensus	No Effect	Effect
Marijuana	No Effect	No Effect	No Effect	Effect
Opiates	Effect	No Effect	**Strong Effect**	Effect
Cocaine	Effect	No Effect	No Effect	Effect
Methamphetamine	Effect	No Effect	**Lack of Data**	Effect

(Behnke & Smith, 2013)

LONG-TERM EFFECTS OF PRENATAL EXPOSURE

	Growth	Behavior	Cognition	Language	Achievement
Alcohol	**Strong Effect**	**Strong Effect**	**Strong Effect**	Effect	**Strong Effect**
Nicotine	**No consensus**	Effect	Effect	Effect	Effect
Marijuana	No Effect	Effect	Effect	No Effect	Effect
Opiates	No Effect	Effect	**No consensus**	**Lack of Data**	**Lack of Data**
Cocaine	**No consensus**	Effect	Effect	Effect	**No consensus**
Methamphetamine	**Lack of Data**	**Lack of Data**	**Lack of Data**	**Lack of Data**	**Lack of Data**

(Behnke & Smith, 2013)

American Academy of Pediatrics (AAP) 2013 Technical Report
Prenatal substance abuse: Short- and long-term effects on the exposed fetus

Key Takeaways:

- While opioids have a strong effect on short-term withdrawal symptoms, other substances such as alcohol, cocaine, marijuana and nicotine show more areas of effect on long-term outcomes.
- Prenatal exposure to alcohol has effects in 9 of 10 domains studied including short-term/birth outcomes and long-term outcomes.
- There are some substances and outcomes for which there is not consensus or not enough data to determine consensus.

(American Academy of Pediatrics, Behnke & Smith, 2013)

COMPLEX INTERPLAY
OF FACTORS

Interaction of various prenatal and environmental factors:

- Family characteristics
- Prenatal care
- Exposure to multiple substances (alcohol and tobacco)
- Early childhood experiences in bonding with parent(s) and caregiver(s)
- Other health and psychosocial factors have a significant impact

(The American College of Obstetricians and Gynecologists, 2012; Bandstra et al., 2010; Baldacchino et al., 2014; Nygaard et al., 2015)

NEONATAL ABSTINENCE SYNDROME (NAS) & NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

These terms are often used inter-changeably and without clear definition in many studies:

- **NAS refers to withdrawal symptoms resulting from exposure to a variety of substances**
- **NOWS is withdrawal from opioid exposure specifically**

The American College of Obstetricians and Gynecologists 2012; U.S. National Library of Medicine 2014; Hudak & Tan, 2012; Jansson et al., 2009; SAMHSA 2018; Jones et al., 2012)

Neonatal Abstinence Syndrome (NAS) & Neonatal Opioid Withdrawal Syndrome (NOWS)

NAS occurs with notable variability, with *50-80%* of exposed infants developing symptoms and ~50% receiving treatment

NOWS is an expected and treatable condition that follows prenatal exposure to opioids

Symptoms generally begin within 1-3 days after birth may take 5-10 days to appear

The American College of Obstetricians and Gynecologists 2012; U.S. National Library of Medici
2014; Hudak & Tan, 2012; Jansson et al., 2009; SAMHSA 2018; Jones et al., 2012)

Neonatal Abstinence Syndrome (NAS) & Neonatal Opioid Withdrawal Syndrome (NOWS)

NAS is a complex disorder, with many factors contributing to its incidence & severity

Significant uncertainty – who to treat, when to treat, how to treat, how to wean, and the optimal agent(s)

Concerns of safety and efficacy of NAS treatments – longer term follow up is essential

Variability in NAS expression in need for treatment, response to treatment, and longer-term outcome

Clinical and genetic factors appear to be important, but larger studies are needed to establish definitive genetic links

(Davis, 2018)

NAS presents unique risks to an infants safety due to…

Poorly interpretable cues

- Escalation of NAS display
- Use of medication
- Prolonged hospital stay

Inappropriate interpretation of cues

- Decreases in parenting confidence
- Inappropriate response

Lack of training and/or protocols for responding to opioid affected dyads

- Over/under medication
- Premature hospitalization
- Rehospitalization

(Velez & Jansson, 2018; Velez & Jansson, 2014)

A constellation of factors affect the likelihood that an infant will develop NAS and the intensity of NAS symptoms including:

- Mothers opioid dose and medication type
- Prenatal stage at exposure(s)
- Genetics
- Environment
- Polysubstance use, including tobacco
- Gestational age at delivery
- Gender

(Graham, 2018; Vorhees, 1989)

Consensus is emerging suggesting that, When **safe** and **feasible**, infants with NAS should be **cared for outside of the NICU,** should **room-in with parents** and should be **breastfeed if there are no contraindications**

But areas of uncertainty and needed research exist about:

- how to assess when medication therapy is needed
- the best location to wean infants from medications, and
- how these decisions affect long-term neurodevelopment or family outcomes.

(Wachman et al., 2018)

Promising Practice:
A Revised Approach to NAS Treatment from a Multi-Year Improvement Effort at Yale New Haven Children's Hospital
(Grossman et al., 2017)

Interventions for infant treatment focused **on simplified approach to assessment, nonpharmacological therapies, care outside of the NICU** and **empowering messages to parents** led to…

…substantial and sustained decreases in average length of stay, proportion of infants treated with morphine, and hospital costs. (Grossman et al., 2017)

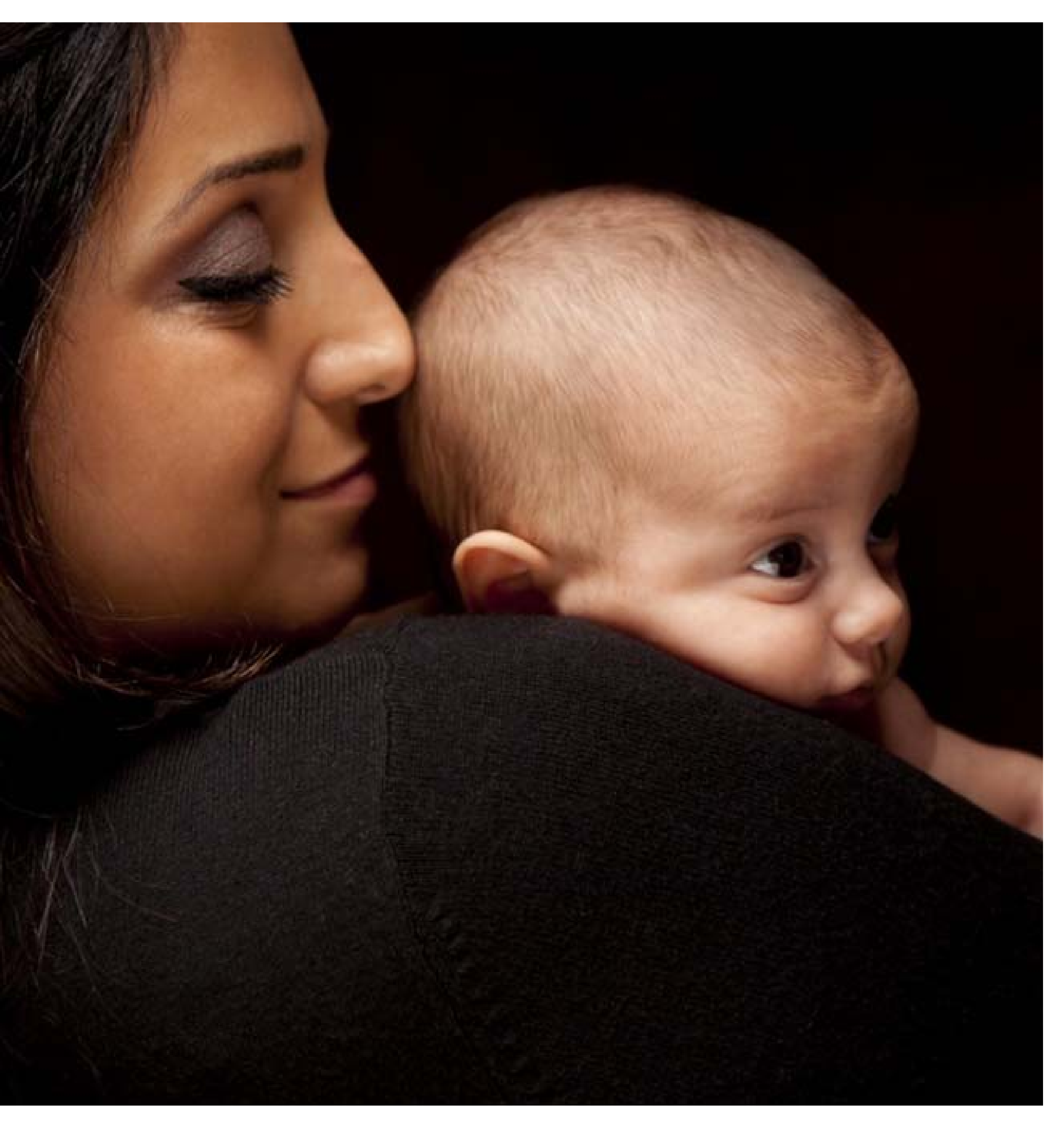
What was different?

- Used **eat**, **sleep** and **console** assessment

- No automatic transfer to NICU
- No automatic prescribing
- Moms and babies were transferred and stayed together on the general hospital floor

(Grossman et al., 2017)

"Treat babies like babies
and moms like moms"
– Dr. Matt Grossman



Changes from this program affected hospital culture including…

- additional bonding time
- increased breastfeeding
- more time for observation of parenting capacity
- opportunities for real-time parenting support

(Grossman et al., 2017)

Benefits of the Approach in this Study Site

Length of hospital stay for infants

22.4 to 5.9 days

Infants receiving pharmacological treatment

98% to 14%

Hospital costs per family

$44,824 to $10,289

(Grossman et al., 2017)

Promising Practice:

Many hospitals across the country are implementing these practice changes for non-pharmacological approaches

There remains a critical need for additional research to understand:

- Implementation challenges and lessons
- Operational definitions of assessment of eat, sleep, console
- Criteria for the use of medications
- Longer-term outcomes for infants and families beyond length of stays in hospitals

(Graham, D.L., 2015)

THE OPPORTUNITY
Family Centered Treatment and Recovery

Practice Strategies to Support Infants with Substance Exposure and their Families

- Use the convening power of the court to meet with hospitals and health providers to create change
- Clarify how substance abuse is identified during pregnancy
- Ensure effective treatment solutions for infant and family are available
- Understand the recovery process – some parents can safely remain/reunify with children when they are in treatment and recovery

Practice Strategies to Support Infants with Substance Exposure and their Families

- Hospitals universally screen pregnant women and mothers at delivery. Infants are tested based on identified criteria and policies
- Hospitals understand and follow notification criteria
- Pediatricians and/or health homes are identified *before* hospital discharge and participate in the POSC
- Non-pharmacological treatments for NAS are used, including breastfeeding and rooming in where not contraindicated.

Barriers to Screening

Patient

Fear of discrimination, judgment, or CPS

Previous bad experience with health care provider

Don’t consider use problematic

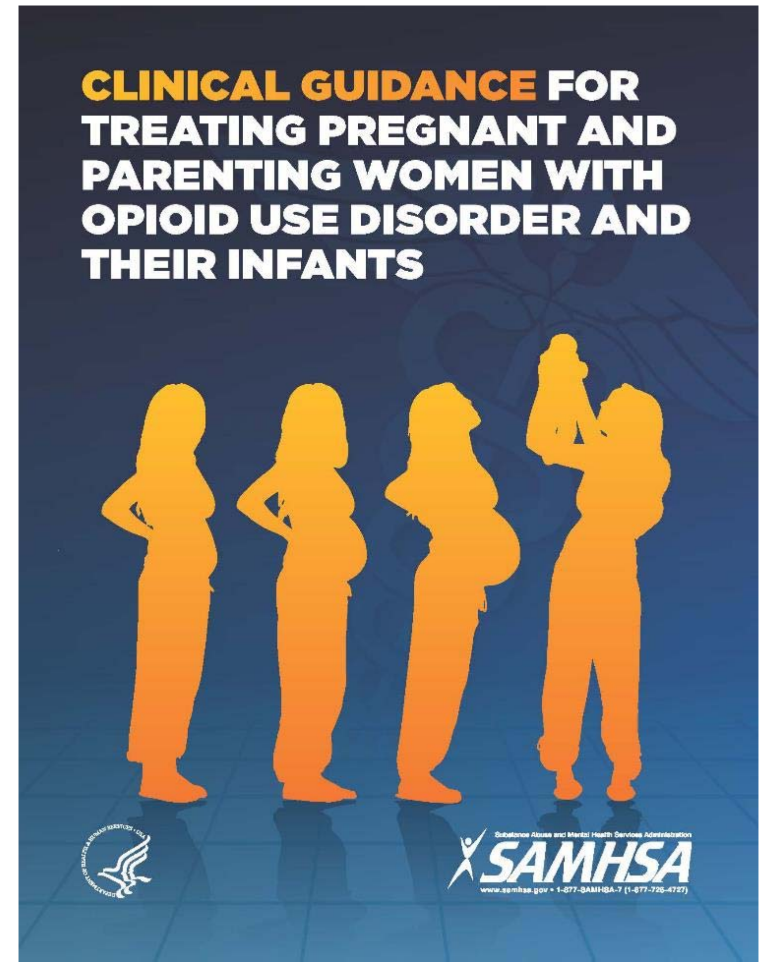
Provider

“My patients don’t use drugs”

“I don’t have time”

“I won’t get paid”

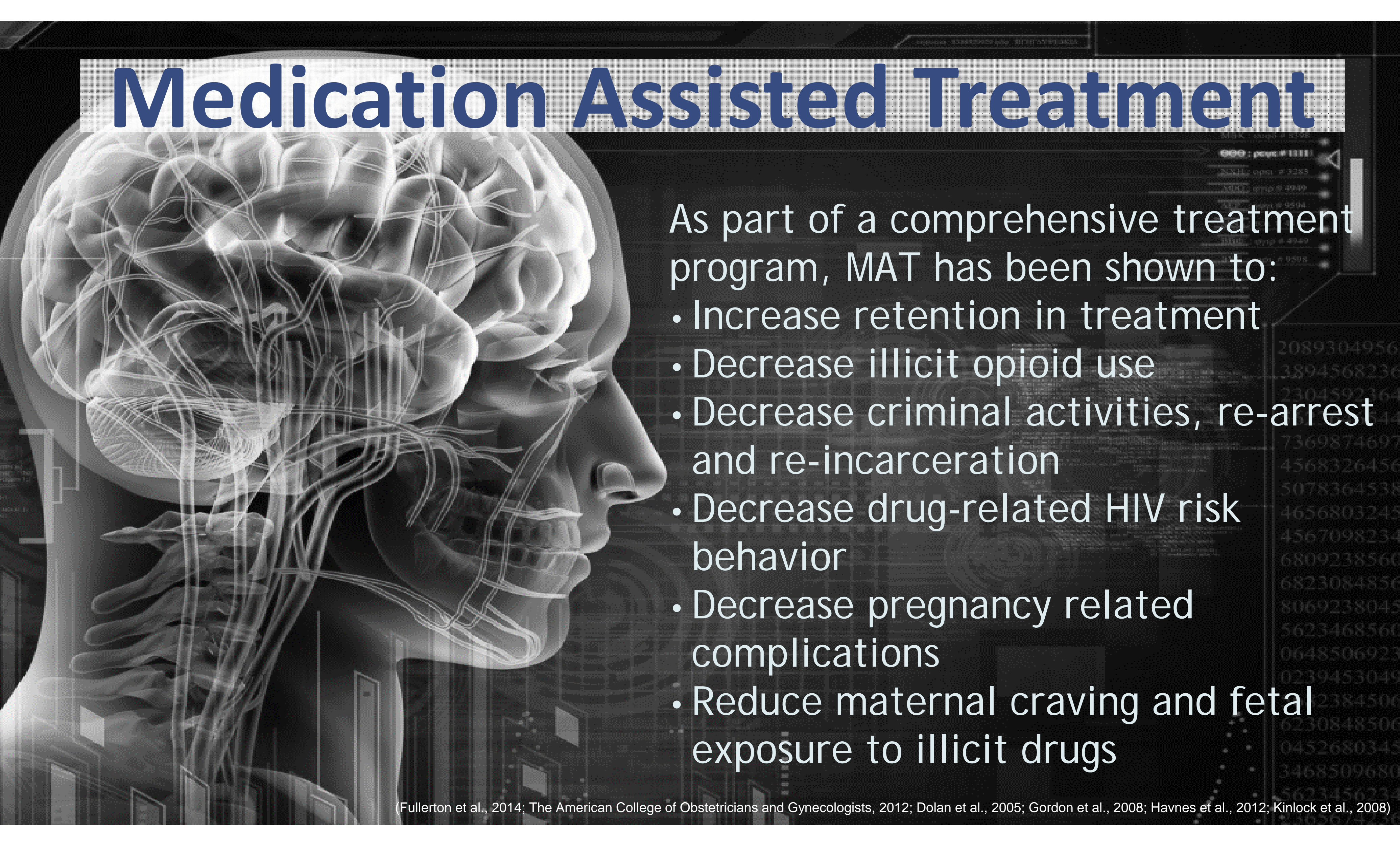
“I don’t know what to do if they screen positive”

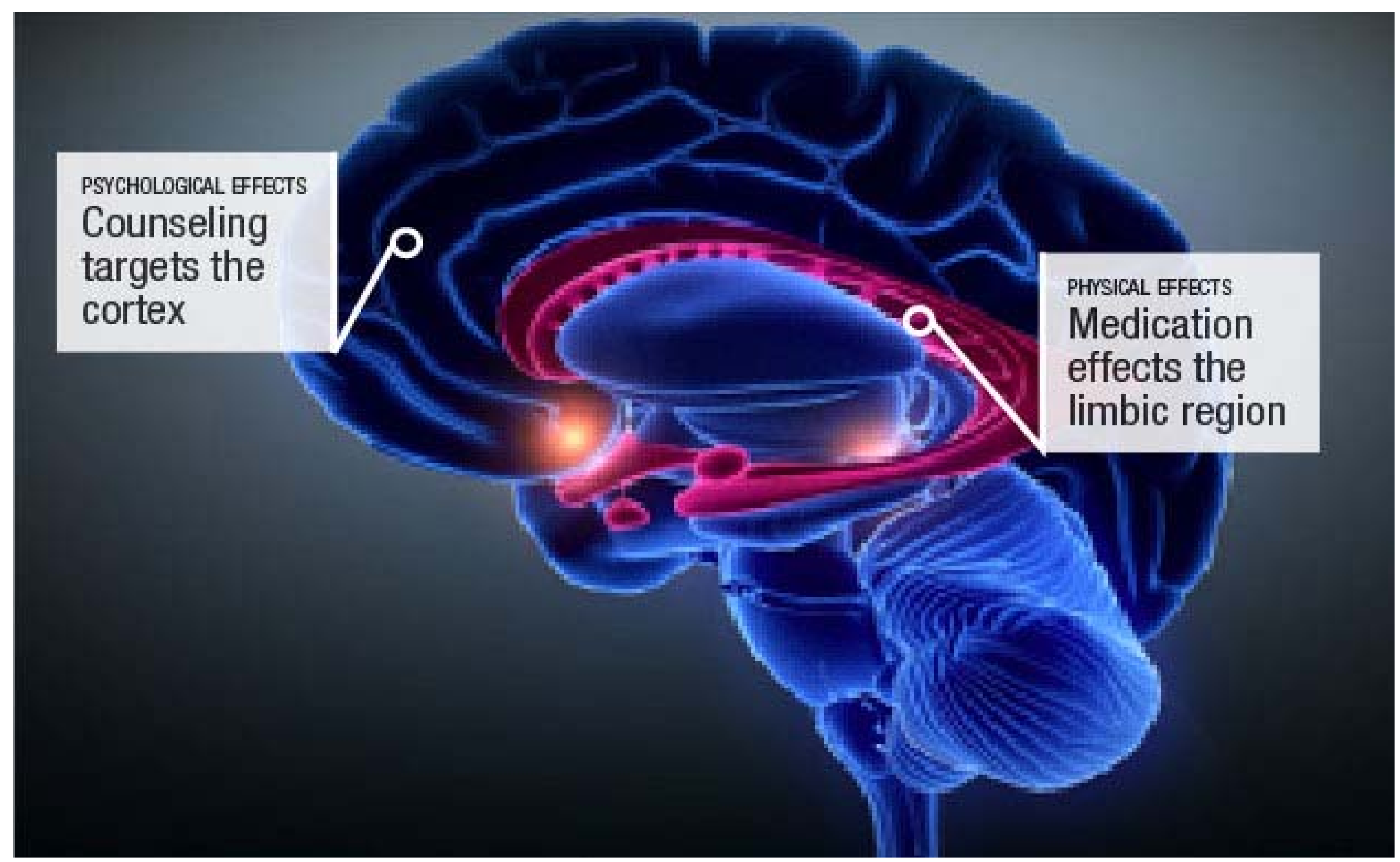


Comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorders and their infants.

The Clinical Guide helps healthcare professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

Available for download here: https://store.samhsa.gov/shin/content//SMA18-5054/SMA18-5054.pdf


Medication Assisted Treatment
As part of a comprehensive treatment program, MAT has been shown to:
• Increase retention in treatment
• Decrease illicit opioid use
• Decrease criminal activities, re-arrest and re-incarceration
• Decrease drug-related HIV risk behavior
• Decrease pregnancy related complications
• Reduce maternal craving and fetal exposure to illicit drugs
(Fullerton et al., 2014; The American College of Obstetricians and Gynecologists, 2012; Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008)



(Alkermes, Inc., 2017)

Stability for pregnant woman and fetus, prevent relapse
Substance Abuse and Mental Health Services Administration. Clinical Guidance, 2018

Medications used to Treat Opioid Use Disorders

- Methadone (50 year research base)
- Buprenorphine (Subutex; 2010- MOTHER Study)
- Buprenorphine-Naloxone Combination (Suboxone®; Zubsolv)
- Naltrexone Extended-Release (Vivitrol®) – Once per Month injection
- Naloxone (Narcan®) – Reverses overdose

Used During Pregnancy (Methadone; Buprenorphine)

"…opiate dependence is a medical disorder and … pharmacologic agents are effective in its treatment."

(NIH, 2017; Jones et al., 2012)

POSTPARTUM
AND BEYOND

Treatment that Supports Families

- Encourages retention in treatment
- Increases parenting skills and capacity
- Enhances child well-being

(Werner et al., 2007)

Supporting the Mother-Infant Dyad

- **The neonatal period is an optimal time to begin interventions to optimize dyadic interaction**
- **Improving clinician attitudes positively impact dyadic interactions**
- **Nurses who demonstrated caring behaviors towards mothers were better able to help them recognize and interpret infant cues, thus enhancing mother-infant interactions**

(Velez & Jansson, 2008; Velez & Jansson, 2014))

Family Centered Treatment is not Only in Residential Treatment

INDIVIDUAL

Parent - Substance use, employment, health or mental health status
Child - developmental progress, educational performance, improved resiliency
Other family members - substance use, employment, health or mental health status

RELATIONAL

Whole families - family stability, reduced violence, healthy communication and parenting improvement
Between family members- parent-child relationship, attachment, relationship satisfaction, reunification

SYSTEM - SOCIETAL

Community- cost savings and increased tax base from improved employment, cost savings from reduced criminal recidivism, improved prenatal and birth outcomes, reduced school problems, future health costs.

(Werner et al., 2007)

SAMHSA's Working Definition

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Recovery is not treatment

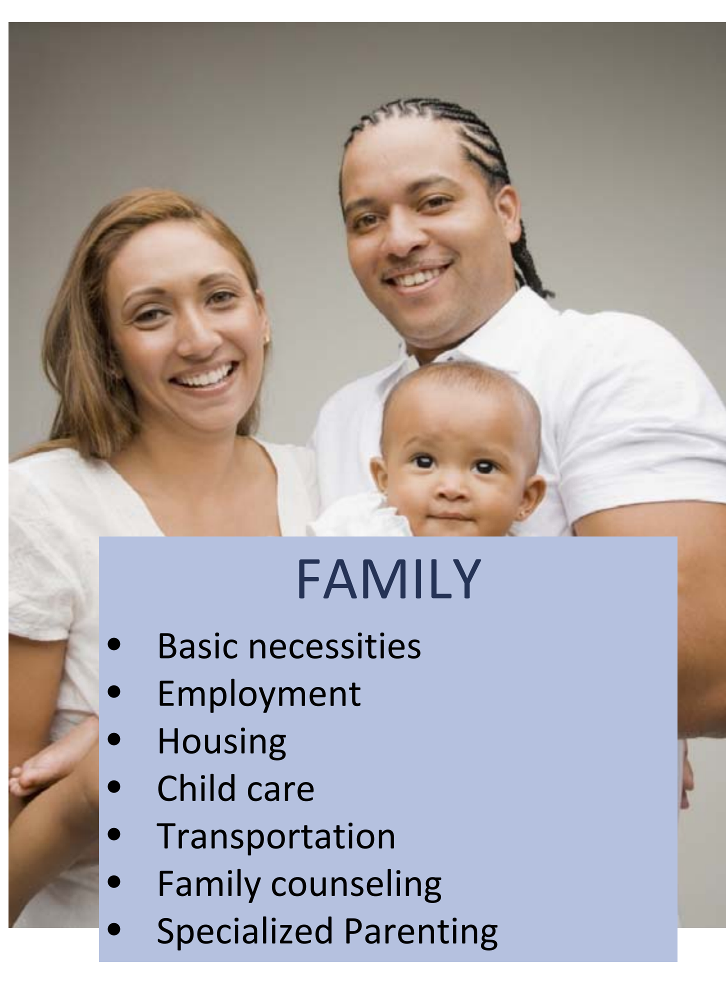
Access to evidence-based substance use disorder treatment and recovery support services are important building blocks to recovery.

(SAMHSA, 2011)

Family Recovery is not Only Treatment Completion

PARENTS

- Parenting skills and competencies
- Family connections and resources
- Parental mental health
- Medication management
- Parental substance use
- Domestic violence



FAMILY

- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling
- Specialized Parenting

CHILD

- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance abuse
- At-risk youth prevention

(Werner et al., 2007)

Recovery Support Matters

A Randomized Control Trial of Recovery Coaches in Child Welfare
Cook County, IL (n=3440)

Comprehensive Screening & Assessment

Early Access to Treatment

Consistently High Reunification Rate

(Ryan et al., 2017)

Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment

Early Access to Treatment

31% increase in reunification

(Ryan et al., 2017)

Legislative Overview
1. Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Prevention and Treatment Act (CAPTA)
2. Omnibus Budget 2018 Funding for CAPTA
3. Families First Prevention Services Act (FFPSA)

THE OPPORTUNITY
Comprehensive Addiction and Recovery Act (CARA) changes to the Child Abuse Prevention and Treatment Act (CAPTA) including Plans of Safe Care (PoSC)

Primary Changes in CAPTA Related to Infants with Prenatal Substance Exposure

1974
Child Abuse Prevention and Treatment Act (CAPTA)

2003
The Keeping Children and Families Safe Act

2010
The CAPTA Reauthorization Act

2016
Comprehensive Addiction and Recovery Act (CARA)

1974 Child Abuse Prevention and Treatment Act (CAPTA)

- Federal funding to support prevention, assessment, investigation, prosecution, and treatment activities related to child abuse and neglect
- Current funding provides several grant programs:
  - **State Grants**: a formula grant to improve CPS
  - **Discretionary grants**: competitively awarded funds to support research, technical assistance, and demonstration projects
  - **Community-based Grants** (CBCAP): funding to all states for support of community-based activities to prevent child abuse and neglect
  - **Children's Justice Act Grants**: to States and territories to improve the assessment, investigation, and/or prosecution of child abuse and neglect cases with particular focus on sexual abuse and exploitation of children, child fatalities, and children who are disabled or with serious health disorders

2003 The Keeping Children and Families Safe Act of 2003

- Amended CAPTA and creates new conditions for States to receive their State grant
  - Congressional report states: **"To identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child"** and...
  - "**the development of a safe plan of care**...to protect a child who may be at increased risk of maltreatment, regardless of whether the State had determined that the child had been abused or neglected as a result of prenatal exposure"
- To receive State grant, Governor must assure they have policies and procedures for:
  - Appropriate referrals to address needs of infants **"born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure"**
  - **"health care providers involved in the delivery or care of such infants notify the child protective services system…"**
  - **"the development of a plan of safe care…"**

2010 The CAPTA Reauthorization Act of 2010

- Conditions for receipt of State grant were updated to clarify definition of substance exposed infant and added Fetal Alcohol Spectrum Disorder:

  "Born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure **or a Fetal Alcohol Spectrum Disorder**"

- Added reporting requirements to Annual State Data Reports to include:
  - Number of children referred to child welfare services identified as prenatally drug exposed or FASD
  - Number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral to Part C of the Individuals with Disabilities Education Act (children under age 3)
  - Number of children referred to agencies providing early intervention services under Part C

2016 Comprehensive Addiction and Recovery Act (CARA)

- Further clarified population requiring a Plan of Safe Care:

  "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"**

- Required the Plan of Safe Care to include needs of both the infant and family/caregiver:

"the **development of a Plan of Safe Care** for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –

(I) **addressing the health and substance use disorder treatment needs of the infant and affected family/caregiver**'"

2016 Comprehensive Addiction and Recovery Act (CARA)

- **Specified data reported by States**, to the extent practicable, through National Child Abuse and Neglect Data System (NCANDS)
  - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
  - The number of infants for whom a Plan of Safe Care was developed
  - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver

- Specified **increased monitoring and oversight**
  - Children's Bureau through the annual CAPTA report in the State plan
  - States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services

CARA's Primary
Changes to CAPTA
1. Further clarified population to infants "born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder," specifically removing "illegal"
2. Specified data to be reported by States
3. Required Plan of Safe Care to include needs of both infant and family/caregiver
4. Specified increased monitoring and oversight by States to ensure that Plans of Safe Care are implemented and that families have access to appropriate services

Funding for CAPTA

- Appropriation for many years has been $25 Million
- **Omnibus Budget Act of 2018**
  - Appropriated an additional $60 Million to CAPTA with priority to implement Plans of Safe Care
  - Funds distributed to States using the usual allocation formula by September 30, 2018
- **Health, Education, Labor and Pensions – April 11, 2018 Hearing**
  - S.2680 Passed out of Committee and is headed to Full Senate – “Opioid Crisis Response Act”
    - Authorizes $60 Million per year through 2024 directed to implementing Plans of Safe Care at $500,000 per state and per capita based on births

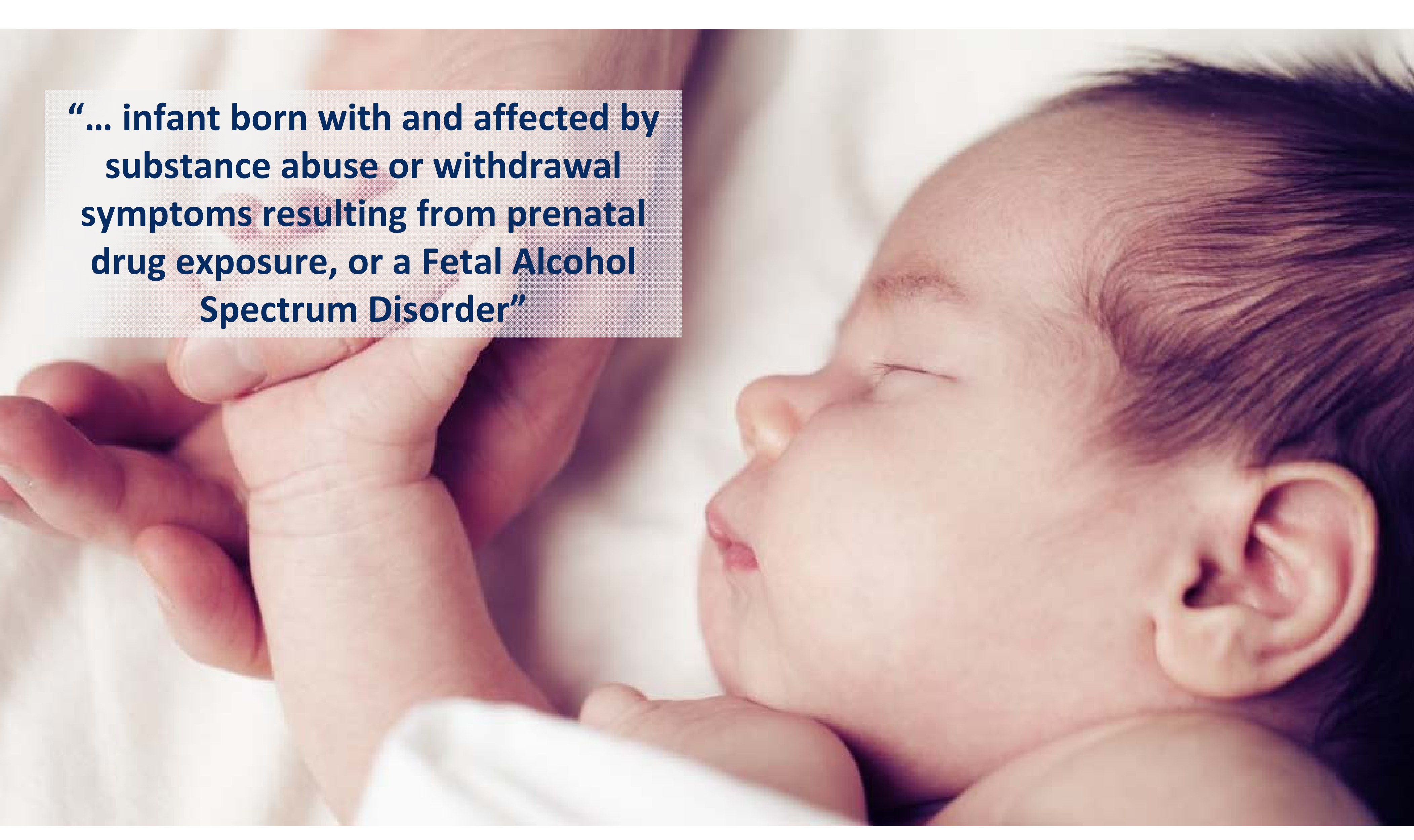
THE OPPORTUNITY
Families First Prevention Services Act

Family First Prevention Services Act (2018)

- Historic changes to federal **child welfare financing**
  - Information memo was released by the Children's Bureau April, 2018
- Allows title IV-E foster care payments for up to 12 months for an eligible child placed with a parent in a licensed residential family-based substance abuse treatment facility.
  - ***Implementation Date: October 1, 2018***
  - Facility services must include parent skills training, parent education, individual and family counseling and services must be trauma-informed
- Provides optional Title IV-E funding for time-limited (one year) prevention services for mental health/substance abuse and in-home parent skill-based programs for families and the children who are candidates for foster care.
  - ***Implementation Date: October 1, 2019***
  - Programs or services used must be on ACF's public clearinghouse of evidence based programs as promising, supported, well supported practices.
- Reauthorization of Regional Partnership Grants
  - ***FY 2019 Grants***
  - State Child Welfare and SSA must be a Partner in the Application, and if RPG is to serve children in out-of-home care, the Court is a required partner and requires grants be dispersed in two phases: planning and implementation.

PLANS OF SAFE CARE
Lessons from the National Center on
Substance Abuse and Child Welfare (NCSACW)

Who
are Plans of Safe Care
for?


"… infant born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder"

Three Potential Populations

1

Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and does not have a substance use disorder

2

Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is actively engaged in treatment for a substance use disorder

3

Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, not actively engaged in a treatment program

Who
could do
Plans of Safe Care?
• Multi-agency
• Well-trained
• Shared trust and knowledge
• Supportive hand-offs
(Sloper, 2004)

Who Could Do This?

1

Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and **does not have a substance use disorder**

Lead Agency/Provider	
Prenatal Period	Identification at Birth & Infant Affected
Prenatal Care Provider in concert with pain specialist or other physician	**Maternal and Child Health Service Provider** (i.e. home visiting, early childhood intervention,, etc.)

Who Could Do This?

2

Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is **actively engaged in treatment** for a substance use disorder

Lead Agency/Provider	
Prenatal Period	Identification at Birth & Infant Affected
Prenatal Care Provider in concert with Opioid Treatment Provider or waivered prescriber and/or therapeutic treatment provider	**Therapeutic Substance Use or Opioid Use Disorder Treatment Provider with support from Maternal and Child Health Provider OR Child Welfare Services**

Who Could Do This?

3

Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, **not actively engaged in a treatment program**

Lead Agency/Provider	
Prenatal Period	Identification at Birth & Infant Affected
Prenatal Care Provider or **High Risk Pregnancy Clinic** in concert with substance use disorder treatment agency and Child Welfare Services, if available prenatally	**Child Welfare Services**

What
is a Plan of Safe Care?
• Key Components

CWS Safety Plan
SUD Treatment Plan
Hospital Discharge Plan
How is *Plan of Safe Care* Different?

Domains that might be in a Plan of Safe Care

- Primary, Obstetric and Gynecological Care
- Substance Use and Mental Health Disorder Prevention and Treatment
- Parenting and Family Support
- Infant Health and Safety
- Infant and Child Development

No one template fits the needs of all communities, settings or families

Plans of Safe Care benefit from being…

- *Interdisciplinary* across health and social service agencies
- Based on the results of a *comprehensive, multidisciplinary assessment*
- *Family focused* to meet the needs of each family member as well as overall family functioning and well-being
- Completed, when possible, in the prenatal period to facilitate *early engagement* of parent(s) and communication among providers
- *Easily accessible* to relevant agencies
- Grounded in *evidence-informed practices*

Preparing for baby's safe arrival and beyond

When
could Plans of Safe Care
be developed?

New Beginnings

- Motivation to make health related changes is enhanced during pregnancy
- Prenatal care is a touch point to services

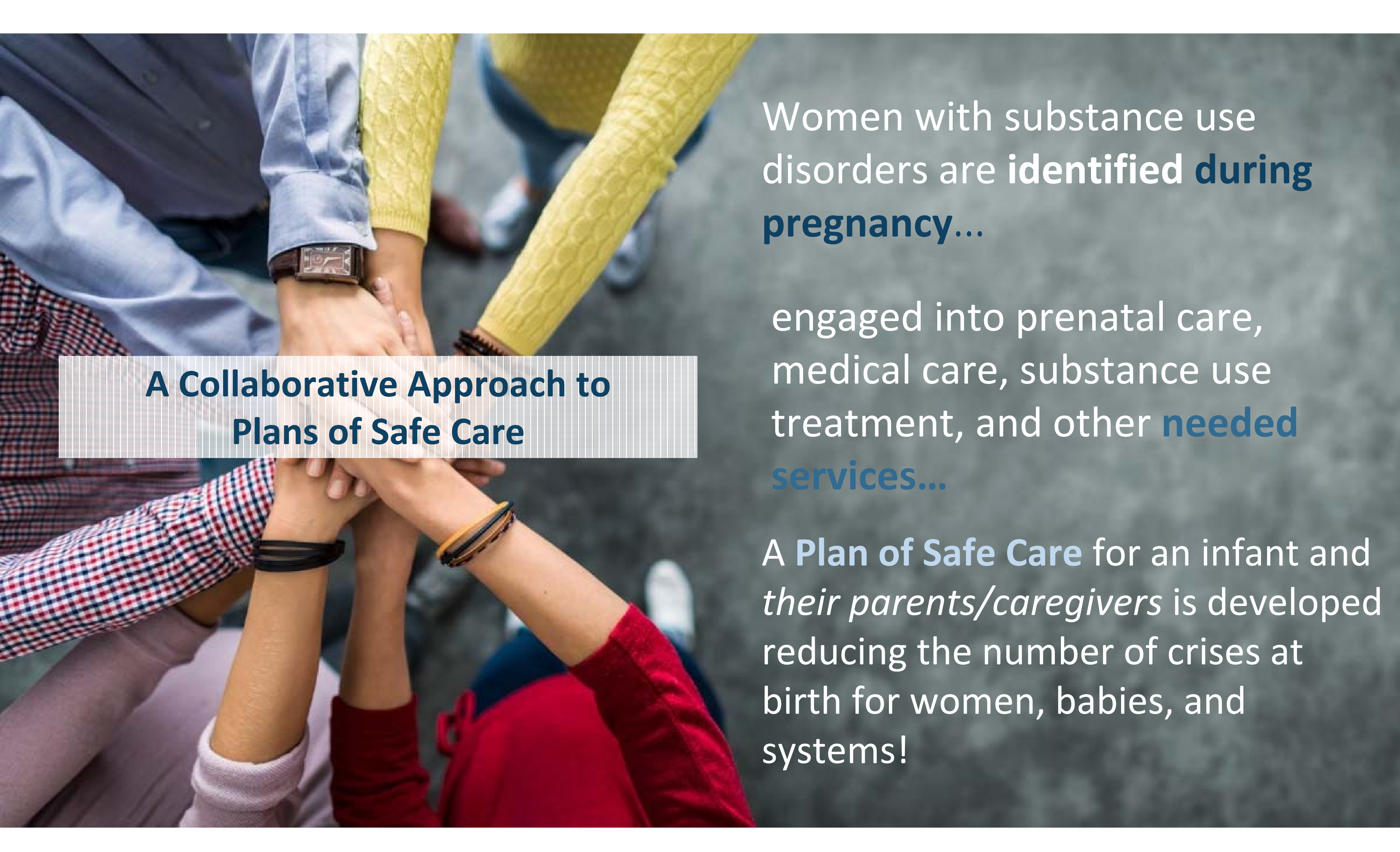
(Edvardsson et al., 2011; Crittenden et al., 1994)

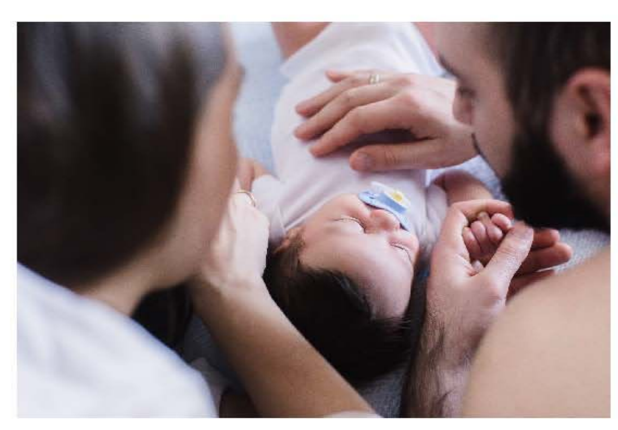
Child Welfare will generally not be involved with a family in the prenatal period unless there is another child with an open case.

Partners are important for early engagement of pregnant women in treatment and prenatal care to improve the health and well-being outcomes for mother and the infant.

Kitzman, 2010

Who
could do
Plans of Safe Care?
• Multi-agency
• Well-trained
• Shared trust and knowledge
• Supportive hand-offs
(Sloper, 2004)


A Collaborative Approach to
Plans of Safe Care
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 an infant and their parents/caregivers is developed reducing the number of crises at birth for women, babies, and systems!



A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care

February 2018

PLAN OF SAFE CARE PLANNING GUIDE TA TOOL (2018)

Designed as a planning guide that NCSACW can use with you to further your communities' efforts in developing a comprehensive approach to implementing Plans of Safe Care

ncsacw@cffutures.org

Developing a Comprehensive Approach to Plans of Safe Care

Step 1: Understand CAPTA and CARA Legislation

Step 2: Know your State System

Step 3: Determine who receives a Plan of Safe Care

Step 4: Identify Partners for a Comprehensive Plan of Safe Care Approach

Step 5: Define Plans of Safe Care

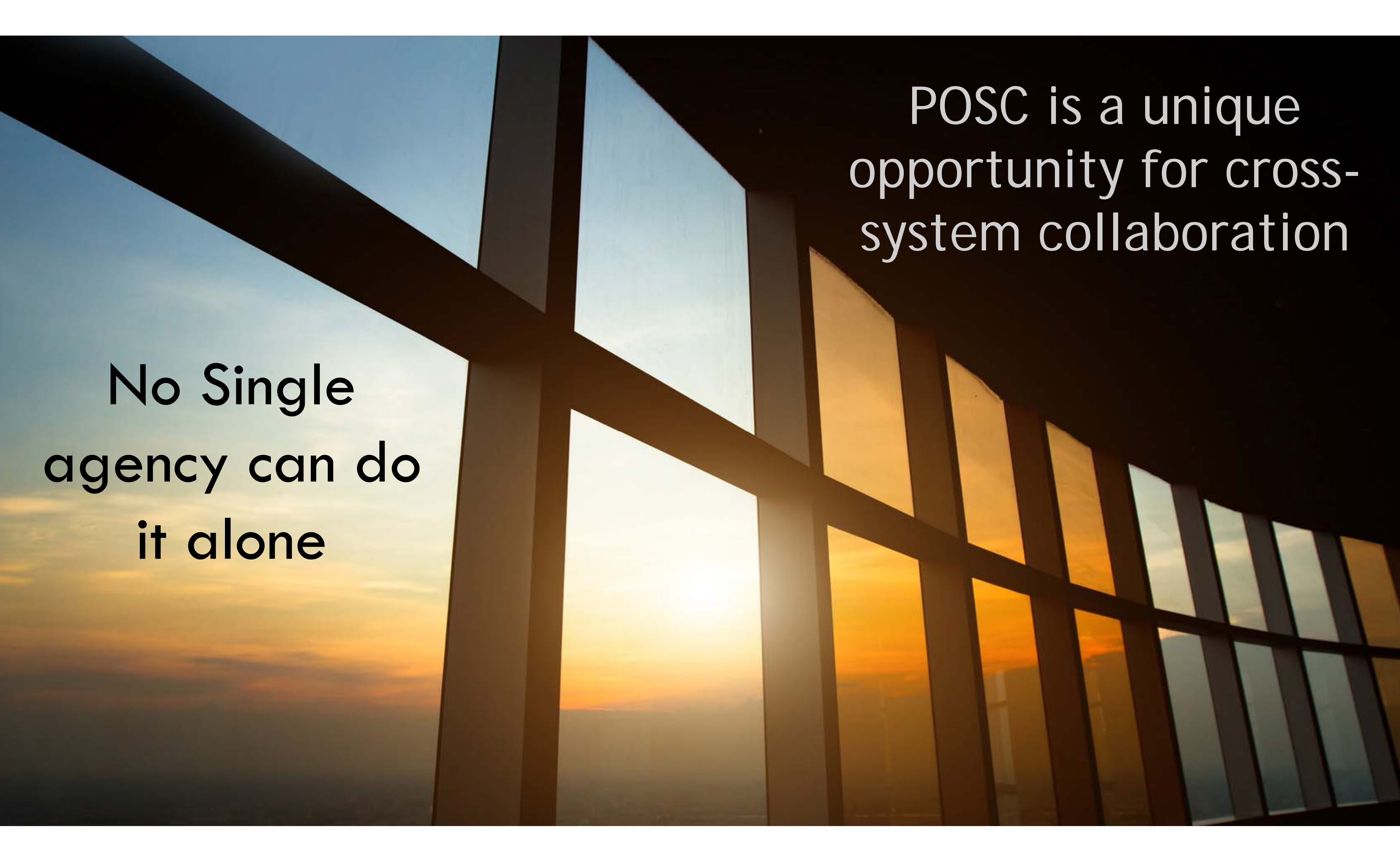
Step 6: Create a Notification System and Protocol for Plans of Safe Care

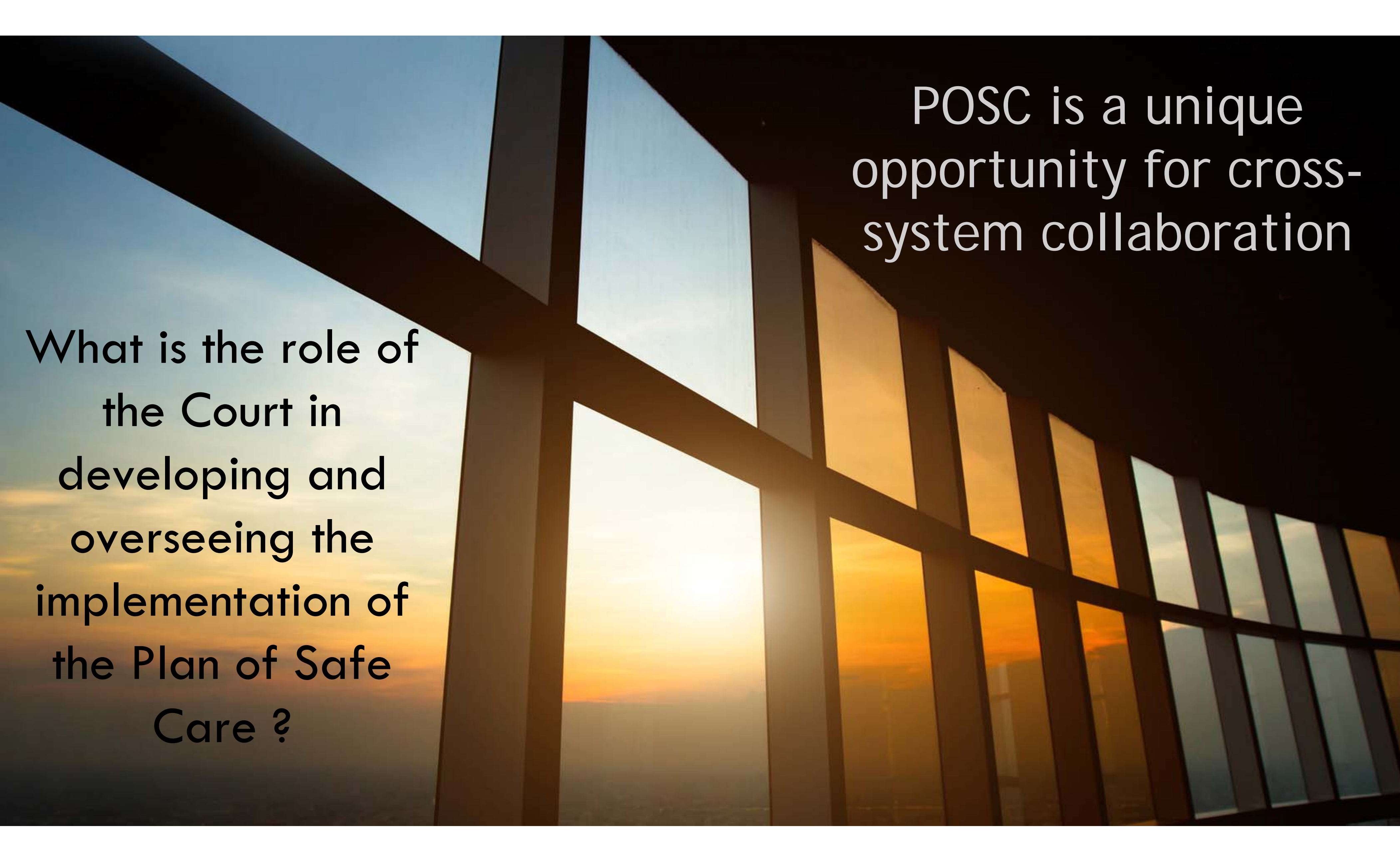
Step 7: Assess Needs to Guide Individual Plans of Safe Care

Step 8: Develop and Implement Individual Plans of Safe Care

Step 9: Manage Individual Plans of Safe Care

Step 10: Oversee State Systems and Report Data on Plans of Safe Care


POSC is a unique opportunity for cross-system collaboration
No Single agency can do it alone


POSC is a unique opportunity for cross-system collaboration
What is the role of the Court in developing and overseeing the implementation of the Plan of Safe Care ?

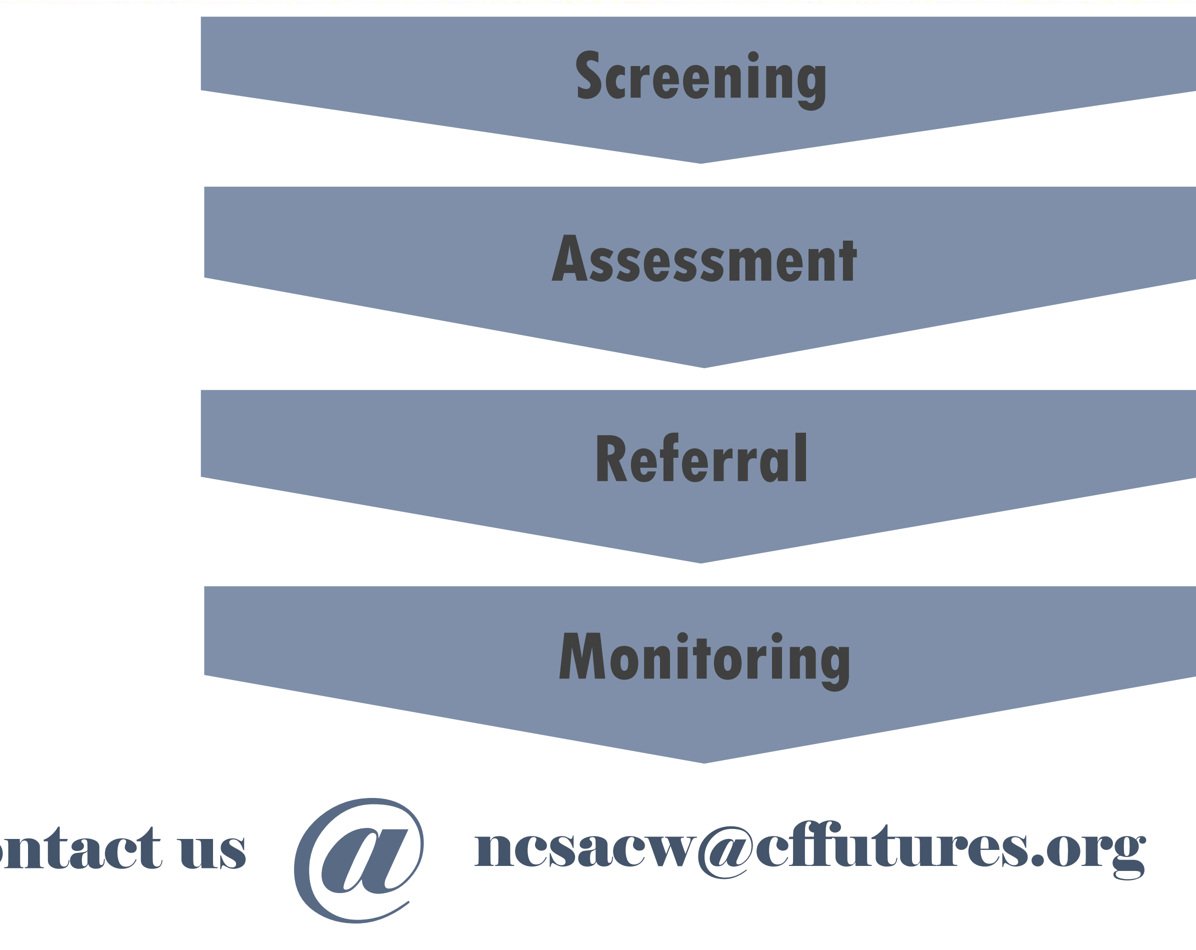
Download the Cross-Systems Guide

- Use these system specific guides to help establish a baseline understanding of the practices and policies used across systems.

https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

Conduct an Systems Walk-Through

Flow Chart: Child Welfare Involved Families With Substance Use Disorders



Contact us @ ncsacw@cffutures.org

View and Discuss Related Webinars

A Collaborative Approach
Addressing the needs of pregnant women with opioid use disorders, their infants and families.

Partnering to Treat Pregnant Women
Lessons Learned from a Six Site Initiative will provide an overview and share lessons from the SAMHSA-funded initiative, Substance Exposed Infants In-Depth Technical Assistance program.

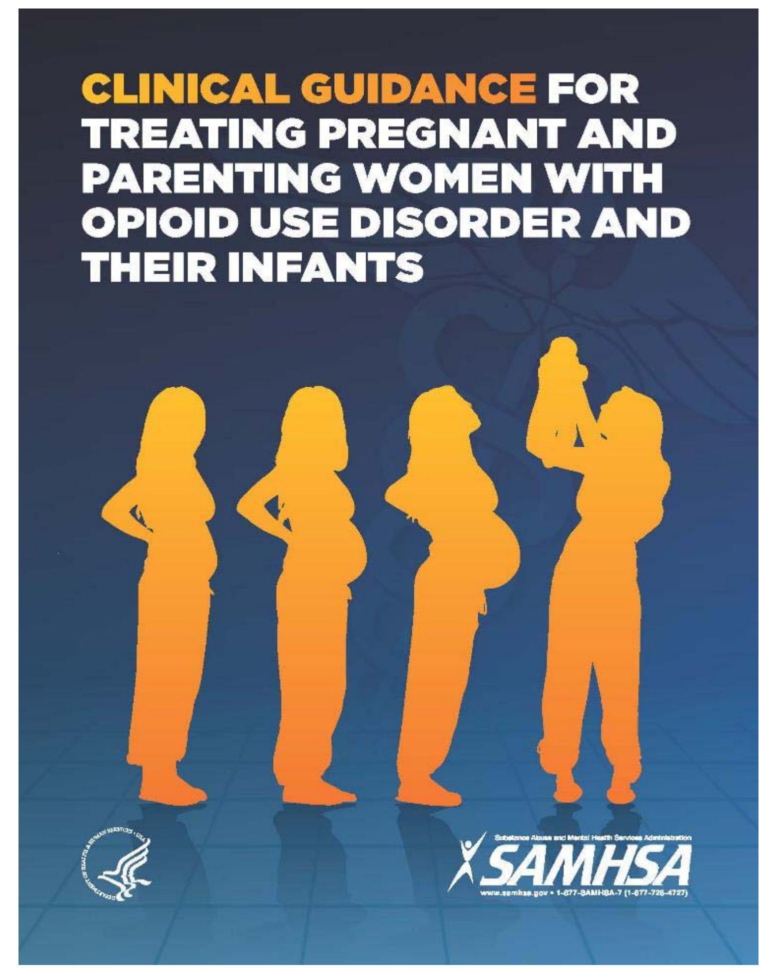
A Framework for Intervention for Infants with Prenatal Exposure and Their Families
Identifies points of intervention for comprehensive reform to prevent prenatal exposure and respond to the needs of pregnant women, mothers, their families and infants.

Contact the NCSACW TTA Program

- Connect you with programs that are developing tools and implementing practices and protocols to support their powerful collaborative
- Training and technical assistance to support collaboration and systems change

Get Engaged in Current Collaborative Work

RESOURCES



Comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorders and their infants.

The Clinical Guide helps healthcare professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

Available for download here: https://store.samhsa.gov/shin/content//SMA18-5054/SMA18-5054.pdf

A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS

Practice and Policy Considerations for Child Welfare, Collaborating Medical, & Service Providers

Purpose: Support the efforts of States, Tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

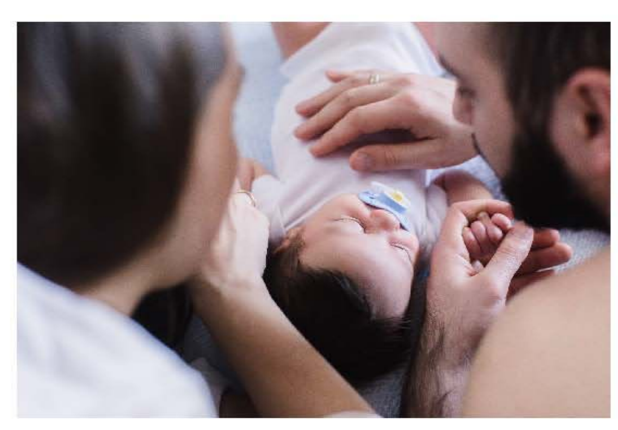
Audience

- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

National Workgroup

- 40 professionals across disciplines
- Provided promising and best practices; input and feedback over 24 months

Available for download here: https://www.ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf



A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care

February 2018

Plan of Safe Care Planning Guide TA Tool (2018)

Designed as a planning guide that NCSACW can use with you to further your communities' efforts in developing a comprehensive approach to implementing Plans of Safe Care

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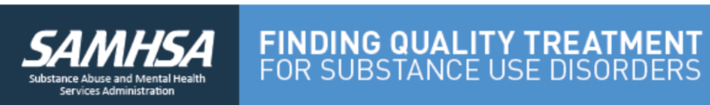


THREE STEPS TO ACCESSING CARE

1. **If you have insurance:** Contact your insurer. Ask about your coverage and whether they have a network of preferred providers for you to use.

   If you don't have insurance: Each state has funding to provide treatment for people without insurance coverage. Find where to call for information about payment for services at: samhsa.gov/sites/default/files/ssa-directory.pdf
2. Review the websites of the providers and see if they have the five signs of quality treatment detailed below.
3. Call for an appointment. If they can't see you or your family member within 48 hours, find another provider. One indicator of quality is the ability to get an appointment quickly. Many programs offer walk-in services. Look for programs that can get you or a family member into treatment quickly.

TREATMENT LOCATORS

Substance Use and Mental Health Treatment Locator:
findtreatment.samhsa.gov/
1-800-662-HELP (4357)
1-800-487-4899 (TTY)

Alcohol Treatment Navigator:
alcoholtreatment.niaa.nih.gov/

FIVE SIGNS OF QUALITY TREATMENT

You can use these questions to help decide about the quality of a treatment provider and the types of services offered. Quality programs should offer a full range of services accepted as effective in treatment and recovery from substance use disorders and should be matched to a person's needs.

1. **Accreditation:** Has the program been licensed or certified by the state? Is the program currently in good standing in the state? Are the staff qualified? Good quality programs will have a good inspection record and both the program and the staff should have received training in treatment of substance use and mental disorders and be licensed or registered in the state. Does the program conduct satisfaction surveys? Can they show you how people using their services have rated them?
2. **Medication:** Does the program offer FDA approved medication for recovery from alcohol and opioid use disorders? At this point in time, there are no FDA approved medications to help to prevent relapse from other problem substances.
3. **Evidence-Based Practices:** Does the program offer treatments that have been proven to be effective in treating substance use disorders including medication management therapies, such as motivational therapy, cognitive behavioral therapy, drug and alcohol counseling, education about the risks of drug and alcohol use, and peer support? Does the program either provide or help to obtain medical care for physical health issues?
4. **Families:** Does the program include family members in the treatment process? Family members have an important role in understanding the impact of addiction on families and providing support.
5. **Supports:** Does the program provide ongoing treatment and supports beyond just treating the substance issues? For many people addiction is a chronic condition and requires ongoing medication and supports. Quality programs provide treatment for the long term which may include ongoing counseling or recovery coaching and support, and helps in meeting other basic needs like sober housing, employment supports, and continued family involvement.

FOR A DRUG OR ALCOHOL USE EMERGENCY, CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov

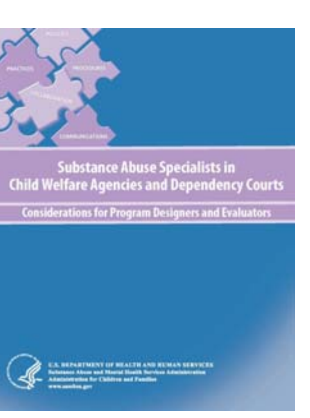
PEP18-TREATMENT-LOC

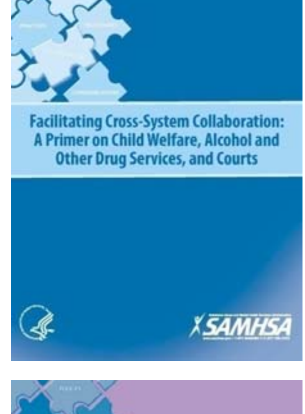
This fact sheet serves as a guide for individuals seeking substance use disorder treatment.

It provides three steps to complete prior to using a treatment center and the five signs of a quality treatment center.

Available for download here: https://store.samhsa.gov/product/Finding-Quality-Treatment-for-Substance-Use-Disorders/PEP18-TREATMENT-LOC

NCSACW Resources



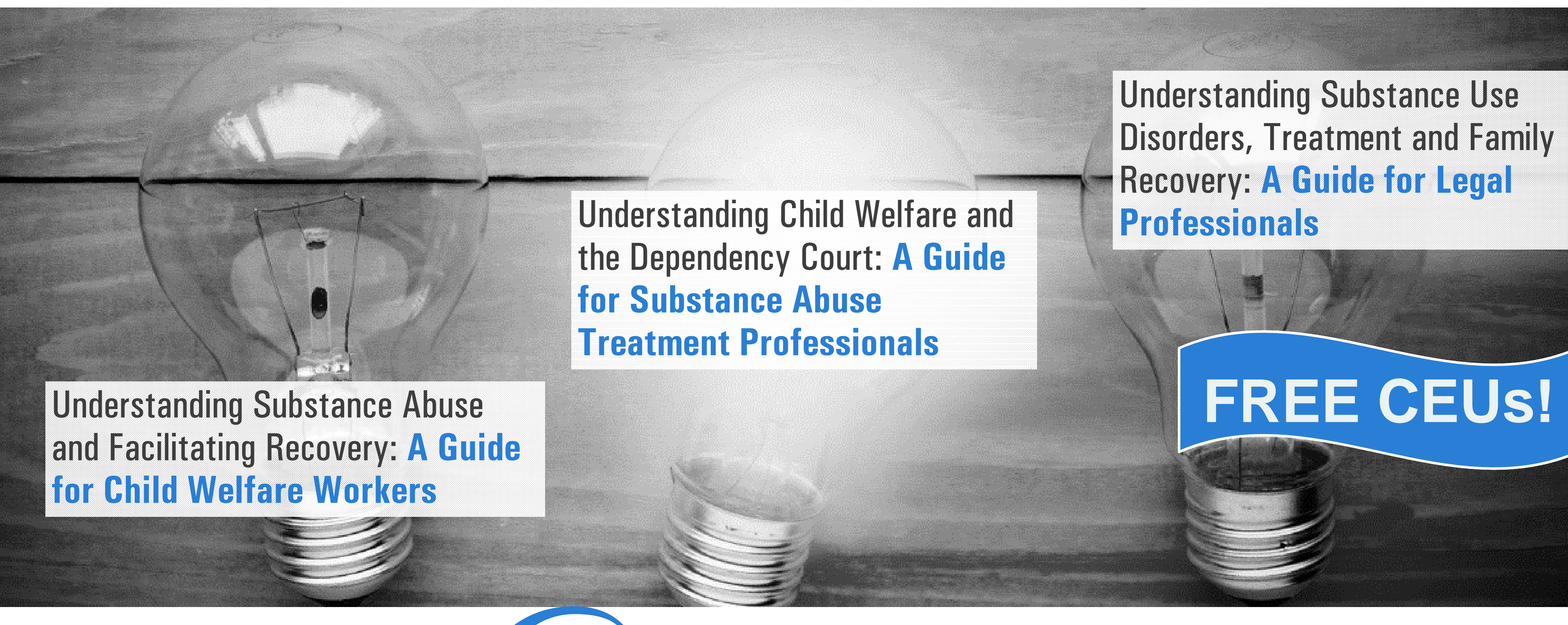


- Publications
- Online Resource Inventory
- Webinars
- Online Tutorials
- Toolkits
- Video

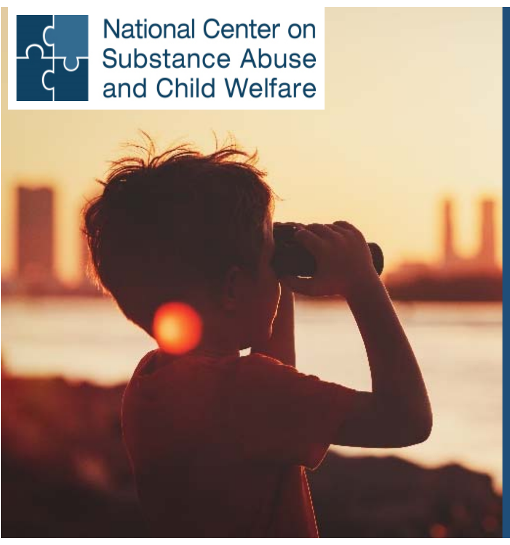
Please visit:

http://www.ncsacw.samhsa.gov/

NCSACW Online Tutorials Cross-Systems Learning



@ www.ncsacw.samhsa.gov/.org



Resources To Help Address The Opioid Crisis

For Families Involved in the Child Welfare System

In-Depth Technical Assistance

https://ncsacw.samhsa.gov/technical/sei-idta.aspx

- 18 months of technical assistance to strengthen collaboration and linkages across systems focused on infants with prenatal substance exposure
- 11 sites: Connecticut, Delaware, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, North Carolina, Virginia, West Virginia

Web-based Resource Directory

https://ncsacw.samhsa.gov/resources/videos-and-webinars/webinars.aspx

- Includes research, training materials, webinars and videos, site examples and other resources
- Topics include medication-assisted treatment, neonatal abstinence syndrome, infants with prenatal substance exposure, and supporting families with opioid use disorders

Technical Assistance : Developing a Comprehensive Approach to Plans of Safe Care

- Identifying planning steps for developing a comprehensive approach to Plans of Safe Care
- Questions to engage partners in considering a communities Plan of Safe Care approach
- Examples of state and local legislation, policies and templates

ncsacw@cffutures.org I 1-866-493-2758 I https://ncsacw.samhsa.gov/

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Strengthening Partnerships
NATIONAL FAMILY DRUG COURT
TTA Program

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