2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families and Caregivers

Summary 2017 Policy Academy Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families and Caregivers

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Purpose

The Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families (ACYF), Children's Bureau (CB) held the 2017 Policy Academy*: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families and Caregivers* on February 7-8, 2017 in Baltimore, Maryland. Fifteen state teams composed of cross-systems partners convened to enhance their capacity to meet the needs of pregnant and postpartum women with opioid use disorders (OUDs), their infants born with and affected by prenatal substance exposure, and other family members or caregivers. The 2017 Policy Academy supported teams to create a state-specific policy agenda and action plan and strengthen collaboration across systems to address the multiple and complex needs of this population. Participation in the 2017 Policy Academy provided state teams with federal guidance, subject matter experts, and technical assistance through the National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW is a technical assistance resource center jointly funded by SAMHSA and the Administration on Children, Youth and Families (ACYF), Children's Bureau (CB).

This summary briefly reviews the scope of the underlying issues, the current policy and practice environment, and information presented and discussed at the 2017 Policy Academy. It previews the work undertaken by the state teams as they begin their action planning.

Background

The rate of opioid misuse and dependence is escalating in many communities. Child welfare systems are reporting increases in caseloads, primarily among infants and young children coming into care. Hospitals are reporting increases of infants born with Neonatal Abstinence Syndrome (NAS), often manifesting withdrawal symptoms resulting from in-utero opioid exposure. Initially, the concentration of NAS was focused in some regions of the country, such as the northeast corridor, the Appalachia bordering states, and mid-south east.[1] Data from SAMHSA's National Survey on Drug Use and Health show that between 2007 and 2014, the numbers of persons who misuse prescription drugs, new users of heroin, and people with heroin dependence increased significantly.[2] As the rates of opioid use and persons with substance use disorders (SUDs) increased among individuals of all ages and backgrounds, it is not surprising that the rates also increased among pregnant women and women of child-bearing age. Since 2009, states report a 19.4% rate of increase in parental alcohol or drug use as factors in the child's removal. Of the nearly 268,000 children who entered out-of-home care in 2015, the largest group were infants.[3] These data, combined with widespread state-level reporting, indicate the likely impact of OUDs on the foster care population.

As a result of the increasing number of infants with prenatal exposure and the growing concerns from states about opioid use during pregnancy, NCSACW developed the Substance-Exposed Infant, In-Depth Technical Assistance (SEI-IDTA) initiative in 2014. The initiative was designed to help states respond to growing concerns with opioid use during pregnancy, the increasing number of infants with prenatal exposure, particularly NAS, and the lack of engagement and ongoing services needed to support infants and caregivers during the critical postpartum and infancy period. Funding from SAMHSA and the Children's Bureau supported In-Depth Technical Assistance (IDTA) for 18 months for six states or jurisdictions. After a competitive application process, Connecticut, Kentucky, Minnesota (with a focus on tribal

communities), New Jersey, Virginia, and West Virginia were selected to participate. Delaware and New York were awarded participation in October 2016. In addition to the focus on opioid use during pregnancy and the recovery of pregnant and parenting women and their families, the SEI-IDTA initiative supports states in strengthening collaboration and linkages across child welfare, substance use and mental health treatment, maternal and infant health care providers, early intervention and early care and education systems, family courts, and other key stakeholders serving families to implement the provisions of the Child Abuse Prevention and Treatment Act (CAPTA) to improve outcomes for infants with prenatal exposure, their mothers, and families.

The SAMHSA Publication, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical and Service Providers* along with other tools developed by NCSACW and Children and Family Futures (CFF) informed Technical Assistance (TA) provided to the states. While states used SAMHSA's **Five-Points of Intervention Policy and Practice Framework**[4] (Pre-Pregnancy, Prenatal, Birth, Neonatal, Throughout Childhood and Adolescence) to help identify and develop intervention opportunities across the continuum from pre-pregnancy through childhood and adolescence, most states focused on identifying challenges and barriers, and developing interventions during pregnancy, at birth, and the postpartum period.

In March 2016, Connecticut, Kentucky, Minnesota, New Jersey and Virginia received an additional six months of technical assistance to continue their work. During the latter part of the TA engagement with these states ***P.L. 114-198, "Comprehensive Addiction and Recovery Act of 2016" (CARA),*** went into effect including Title V, Section 503, "Infant plan of safe care." The legislation, which passed on July 22, 2016, made several changes to CAPTA:

- Removing the term, "illegal" in regard to substance abuse
- Requiring that the plan of safe care address the needs of both the infant and the affected family or caregiver
- Specifying data to be reported by states, to the maximum extent practicable on the affected infants and the plans of safe care:
    - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder (FASD)
    - 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
- Requiring that states develop and implement 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

As a result of these changes in CAPTA, SEI-IDTA states were provided additional TA to understand the critical components of the statute and actions needed to be in compliance. These states participated in the 2017 Policy Academy as Mentor Sites for state teams, sharing the challenges and barriers they identified as they evaluated current practices and policies, and

progress made toward improving the safety, health, permanency, and well-being of infants born and affected by prenatal substance exposure, primarily opioids, and the recovery of pregnant and parenting women and their families.

2017 Policy Academy Participants

States and Tribal Consortia were invited to apply to attend the 2017 Policy Academy. Ten state teams of eight members were selected with lead agencies from health, alcohol and drug treatment, and child welfare.[5] In addition to the ten state teams, three members from SEI-IDTA sites participated as Mentor Sites.[6] Public health, including early intervention (i.e. IDEA Part C) and maternal health, represented 23% of the attendees. Other agencies consisted of public policy/advocacy, child welfare, mental health, and early care and education (i.e. Early Head Start, Head Start). Participants in the 2017 Policy Academy attended plenary sessions on treatment during pregnancy, family treatment, the lessons presented by prior sites, and the background of the 2017 Policy Academy's technical assistance efforts. Breakout sessions allowed the state teams to begin their work in developing action plans.

Lessons from First-Round Mentor Sites

Project Liaisons from the Mentor Sites participated in a panel discussion, reflecting on their shared experiences, lessons and key accomplishments from the SEI-IDTA work. The following key lessons emerged:

The Importance of a Collaborative Structure

Positive outcomes for families affected by SUDs require cross-system linkages between SUD treatment, child welfare, public health, healthcare providers, early intervention, and other service systems. All sites experienced challenges with developing and retaining the full array of partners needed for this work. Strategies to address these barriers included identifying champions from critical partner ***s***ystems, establishing an Oversight Committee, and dedicating a lead agency project liaison who can cultivate change through dedication of sufficient time, being accountable for results, and nurturing relationships that multiply resources.

Addressing the Treatment Needs of Pregnant and Parenting Women

Barriers exist for treatment for pregnant and parenting women with SUDs, particularly OUDs. Limited access to treatment for pregnant women with SUDs due to lack of Medicaid coverage, insufficient residential treatment programs, and evidence-based and comprehensive Medication Assisted Treatment (MAT) for pregnant and parenting women, especially in rural areas are some of the barriers that sites uncovered. Strategies to address these barriers included: working with Medicaid Directors and Managed Care Systems to address gaps in coverage; expanding MAT programs that serve pregnant women; and creating wraparound models with a network of community providers to address the comprehensive needs of pregnant and parenting women and their children, especially in areas that do not have residential programs for women and children. After completing a survey of all opioid treatment providers (OTPs), the Virginia site is working with providers to draft best practices guidance documents for OTPs and other treatment providers. These models integrate intensive case management with medical, childcare, housing, education and vocational services, and recovery supports.

Early Identification and Screening

Despite the American College of Obstetricians and Gynecologists (ACOG) recommendation for universal screening of all pregnant women for substance use disorders, sites reported screening for substance use is typically done without the use of a standardized screening tool; is selective or targeted and not universal; or does not occur. Barriers to early identification and screening of pregnant women for substance use included concerns by providers that if a woman reveals substance use during pregnancy, this may result in losing custody of her child at birth. Prenatal care providers also reported a lack of understanding about treatment options, including how to refer and connect pregnant women to appropriate treatment if she did have a positive screen. Fear of liability for not connecting the woman to services may result in providers not screening.

Strategies to address these barriers include the development of statewide hospital protocols to promote consistent identification of and services for infants with NAS and conducting comprehensive hospital assessments to inform Plans of Safe Care for infants, their families, and caregivers.

Development and Implementation of Plans of Safe Care

States identified a number of practice, policy and legislative barriers that challenged the development and implementation of Plans of Safe Care. Child welfare systems noted that they have no direct authority over health care providers (e.g. hospitals, infant and maternal health practitioners) who are required to notify the child protective service system under CAPTA. The most frequently cited challenges and barriers included: the lack of clearly defined state policies and protocols to guide consistent and appropriate responses from child welfare, hospitals, and other partners for infants born with and affected by prenatal exposure, including CAPTA reporting; the lack of accurate and timely data collection and reporting on this population of women and infants, and state legislation potentially at odds with the goals of CAPTA and treatment priority for women and their infants.

Strategies to address these barriers include surveys of healthcare providers or hospitals to understand current practices related to screening of pregnant women, identification of affected infants and notification to child protective services; cross-systems training for child protective services staff and other community partners on MAT, CAPTA notification requirements, confidentiality requirements and information sharing; and, developing statewide plans for consistent notification of infants with prenatal exposure, not just illegal drug exposure, and the development of a plan of safe care for these infants, their mothers, and families.

Ohio's SACWIS Changes

In addition to the panel presentations from the Mentor Sites, a staff member from Ohio's Department of Job and Family Services presented an overview of Ohio's changes to their State Automated Child Welfare Information System (SACWIS), aligning their statewide system with the updated CAPTA reporting requirements. Ohio's SACWIS changes to their intake/screening processes, requires workers to ask about parental or caregiver substance abuse, how the reporter became aware of the substance abuse, and the type of substance involved. Ohio is piloting evidence-based screening instruments in 11 counties, with SACWIS now collecting data on the administration of those instruments. All counties are required to submit data on infants identified as affected by substance use (positive toxicology screen at birth), having withdrawal symptoms from prenatal drug exposure, and diagnosed with Fetal Alcohol Spectrum Disorder

(FASD). Ohio is reporting an increase in intakes for infants with documented fetal exposure since making these required data elements.

Collaborative Approach to Treatment for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants and Families

The 2017 Policy Academy included plenary presentations by expert consultants focused on the collaborative approach to treatment for pregnant and postpartum women with OUDs and their infants and families. Prioritizing access to substance use disorder treatment for women during pregnancy, birth and the postnatal period is essential to improving health outcomes for infants and their parents. While pregnant women are a priority population in publically funded treatment systems, state teams identified several barriers in implementing such a priority. A major gap is access to effective, family-centered treatment for pregnant women with substance use disorders, and in particular, for women with children requiring residential treatment.

Treatment During Pregnancy

Dr. Mishka Terplan[7] presented an overview of best practices in managing prenatal care and SUD treatment during pregnancy, at birth and beyond the birth event for families. Pregnant women with SUDs have a unique set of needs across multiple domains that affect both obstetric health and outcomes, and treatment for SUDs. Comprehensive prenatal care requires close collaboration between the prenatal care and substance use disorder treatment providers. Best practice includes universal screening of all pregnant women using a validated screening tool as early in the pregnancy as possible.[8] Toxicology screening of women should not be the sole screening method. Treatment should be integrated to include Medication Assisted Treatment in addition to behavioral interventions guided by a trained clinician. Treatment of women needs to be compassionate and non-judgmental, coordinated with the prenatal care provider to improve health outcomes for both the woman and the infant. Dr. Terplan emphasized that infants are not born addicted (because addiction is partially defined by drug seeking behavior), and that NAS is a withdrawal syndrome associated with a physical dependence on substances, typically opioids, which is a treatable consequence of opioid exposure in utero.

Family Centered Treatment

Dr. Hendrée Jones[9] presented on the key concepts of family-centered treatment for the mother, infant, family, and other caregivers. She emphasized that treatment that supports the family as a unit has proven to be effective for maintaining maternal drug abstinence and child well-being.[10] Family-centered treatment incorporates: 1) the mother's and father's need for clinical treatment for substance use and mental health disorders; 2) appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure; and, 3) clinical and community services and supports that strengthen the parents' capacity to nurture and care for the infant and to ensure continued safety and well-being.

CAPTA Requirements

In addition, Elaine Stedt, (Director, Office of Child Abuse and Neglect), presented information and addressed questions on the "Comprehensive Addiction and Recovery Act of 2016" (CARA), Public Law 114-198, which amended CAPTA by: 1) removing the term, "illegal" in regard 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; 2) requiring that

the Plan of Safe Care address the needs of both the infant and the affected family or caregiver; 3) specifying data to be reported in Annual State Data Reports to be completed by states; and, 4) requiring 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 referrals to and delivery of appropriate services for the infant and affected family or caregiver.

Ms. Stedt also discussed the Children's Bureau Program Instructions, ACYF-CB-PI-17-02, regarding the requirements for implementing and monitoring the provisions in CAPTA. The program instructions further reinforce the need for collaboration across multiple systems in the development and monitoring of Plans of Safe Care, stating:

> "When the state reviews and modifies its policies and procedures to incorporate the new safe care plan requirements in CARA, the state may wish to revisit its procedures regarding which agency develops the plan of safe care, including any role for agencies collaborating with CPS in caring for the infant and family."

The discussion and clarification of CAPTA requirements was particularly important as many of the 2017 Policy Academy teams identified goals relating to CAPTA requirements in their action plans.

State Team Action Planning

The State Team Action Planning sessions provided states an opportunity to refine goals and strategies from their 2017 Policy Academy application and prioritize policy and practice issues to be addressed following the 2017 Policy Academy. State teams participated in two action planning breakout sessions facilitated by NCSACW's TA staff. State teams discussed:

- Collaborative structure and roles and responsibilities of the State Team members;
- Identification of missing partners and existing initiatives pertinent to their goals; and,
- Best practices for development of Plans of Safe Care

The teams reviewed and revised their original goals from their 2017 Policy Academy application to ensure consensus among the team on the goals and strategies. State teams also developed additional goals based on what they learned during the 2017 Policy Academy. Action steps were developed for each goal with a proposed time frame and/or deadline for completion for each specific task. Table 1 summarizes the seven highest priority goals developed by the states.

Table 1: State Team Goals

State Team Goals	# of States
Plans of Safe Care Develop best practices for development of Plans of Safe Care and respond to the requirements of CARA	9
Treatment Services Strengthen treatment for pregnant and parenting women; improve family-centered treatment and gender-specific treatment; increase use of peer supports; improve services to families	9
Care Coordination	8

Develop standards of care; improve service delivery across systems; better integrate services; break down silos between systems; improve resource allocation	
Collaborative Structure, Cross-Systems Collaboration and Strategic Planning Develop a cross-systems collaborative; develop strategic/action plans to improve services; strengthen existing initiatives; enhance collaboration; develop MOUs	7
Data Collection and Information Sharing Agreements Develop data systems to improve data collection, analysis and reporting; improve data collection to address CARA; better track outcomes	7
Prevention Provide services and activities that include education and awareness to pregnant and parenting women and women of childbearing age regarding prenatal substance exposure	6
Screening Improve screening and identification of substance use disorders during pregnancy	6

States' Strengths and Challenges

Several states plan to develop and implement strategies based on the intervention points of SAMHSA's Five-Point Intervention Framework (Pre-Pregnancy, Prenatal, Birth, Neonatal, Throughout Childhood and Adolescence) to reduce the potential harm of prenatal substance exposure. States will focus more immediately in the months following the 2017 Policy Academy on implementing the requirements of CAPTA for infants affected by prenatal exposure and ensuring appropriate services exist for these infants, their families, and caregivers.

Teams are working with their partners to strengthen and improve substance use disorder treatment services, including the use of a family centered treatment approach and peer and recovery supports to improve outcomes. Teams discussed the need to develop standards of care, including care coordination and integration of substance use disorder treatment and maternal and infant healthcare services.

All teams recognized the importance of establishing a collaborative approach, including the engagement of additional team members from multiple systems, the willingness of all partners to commit to strategic planning and implementation, and the development of an integrated system of care to deliver preventive, treatment, and recovery services for pregnant and postpartum women, their infants with prenatal substance exposure, and other family members and caregivers. Teams with prior experience working together already have a foundation for the cross-system collaboration needed to achieve their goals. State teams' either have or are in the process of developing the diverse partnerships needed to respond to the needs of infants and their families.

States consistently articulated challenges with having policies and procedures in place to implement the CARA amendments to CAPTA that would enable them to submit the Governor's Assurance Statement for the Child Abuse and Neglect State Plan, as required in the Children's Bureau Program Instruction ACYF-CB-PI-17-02. Despite challenges experienced, these teams expressed a strong commitment to work collaboratively to implement a consistent notification process and develop Plans of Safe Care that address the safety, health and well-being of infants and the health and substance use disorder treatment needs of the affected family.

The CARA amendments to CAPTA added new data reporting requirements on the number of infants identified as being affected by prenatal substance exposure or FASD, the number of infants for whom a Plan of Safe Care was developed, and the number of infants for whom a referral was made for appropriate services. Many states expressed they do not collect baseline data on the prevalence of infants affected by substance abuse, withdrawal or NAS. Over half the teams identified data collection as one of the focus areas of their work, including how to collect these data from agencies other than child welfare who may have the lead responsibility for implementing a Plan of Safe Care.

Conclusion

This 2017 Policy Academy provided technical assistance and support to ten state teams to enhance their capacity to meet the needs of pregnant and postpartum women with OUDs, their infants born with and affected by prenatal substance exposure, withdrawal symptoms or fetal alcohol spectrum disorder, and other family members or caregivers. With ongoing technical assistance provided by the NCSACW, states are continuing the development and implementation of policy and practice changes that will respond to the increasing numbers of infants with prenatal exposure, the impact of the opioid epidemic on the child welfare system, and the need for expanded substance use disorder treatment for affected caregivers and their families. A long-term commitment from state teams will be essential to respond to the complexities of the healthcare needs of infants and their families, in view of the challenge of engaging multiple partner agencies to address the safety, well-being and healthcare needs of infants and families. Ongoing efforts well beyond the duration of the 2017 Policy Academy and follow-up technical assistance will be needed to develop hospital protocols for screening infants and mothers for the effects of substance use or abuse, standardize notification procedures to child protection services, implement Plans of Safe Care for infants and their families, and expand and fund family-centered treatment services on a system-wide basis. SAMHSA and the Children's Bureau are committed to continue supporting states' efforts to improve outcomes for infants and families affected by prenatal substance exposure.

Contact Information

Ken DeCerchio, MSW, CAP
Program Director
In-Depth Technical Assistance Program
Children and Family Futures
National Center on Substance Abuse and Child Welfare
kdecerchio@cffutures.org
1-866-493-2758

NOTES

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[4] Young, N. K., Gardner, S., Otero, C., Dennis, K., Chang, R., Earle, K., & Amatetti, S. *Substance-Exposed Infants: State Responses to the Problem.* HHS Pub. No. (SMA) 09-4369. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

[5] *Table 2: Policy Academy State Teams*

State	Lead Agency
Delaware	Child Protection Accountability Commission
Florida	Department of Children and Families
Georgia	Division of Family and Children Services
Maryland	Behavioral Health Administration
Massachusetts	Department of Public Health
Michigan	Department of Health and Human Services
New York	State Office of Alcoholism and Substance Abuse Services
North Carolina	Mental Health, Developmental Disabilities and Substance Abuse Services
Pennsylvania	Department of Human Services - Office of Children, Youth and Families
Vermont	Department of Health

[6] *Table 3: SEI-IDTA Mentor Sites*

State	Lead Agency
Connecticut	Department of Children and Families
Kentucky	Department for Behavioral Health, Developmental and Intellectual Disabilities
Minnesota	Department of Human Services-Chemical and Mental Health Services Administration
New Jersey	Department of Human Services-Division of Mental Health and Addiction Services
Virginia	Department of Behavioral Health and Developmental Services Office of Substance Abuse Services

[7] Dr. Terplan is board certified in obstetrics, gynecology and addiction medicine. He is a Professor in both Obstetrics and Gynecology and Psychiatry and the Associate Director of Addiction Medicine at Virginia Commonwealth University.

[8]Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. 2017; 130: 81-94. Retrieved August 1, 2017 from https://www.acog.org/

clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

[9] Dr. Hendree Jones is a Professor in the Department of Obstetrics and Gynecology, School of Medicine at the University of North Carolina, Chapel Hill and Executive Director of Horizons, a comprehensive drug treatment program for pregnant and parenting women and their children with prenatal drug exposure.

[10] Family-Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges, 2007. Retrieved May 1, 2017 from https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf