IN-DEPTH TECHNICAL ASSISTANCE: INFANTS WITH PRENATAL SUBSTANCE EXPOSURE

WORKING TOGETHER TO ADDRESS THE NEEDS OF INFANTS WITH PRENATAL SUBSTANCE EXPOSURE, THEIR FAMILIES, AND CAREGIVERS

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Children's Bureau

National Center on Substance Abuse and Child Welfare

SAMHSA
Substance Abuse and Mental Health Services Administration

The National Center on Substance Abuse and Child Welfare (NCSACW) is a national resource center of the Department of Health and Human Services, which is jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau, Office on Child Abuse and Neglect.

INTRODUCTION

In September 2014, NCSACW embarked on an initiative to advance the capacity of states to improve the safety, health, permanency, and well-being of infants born with and affected by prenatal substance exposure, and the recovery of pregnant and parenting women and their families. Using the NCSACW In-Depth Technical Assistance (IDTA) model, NCSACW staff and consultants provided technical assistance to six states (Connecticut, Kentucky, Minnesota, New Jersey, Virginia, and West Virginia). Initially, these sites addressed two emerging concerns related to the opioid epidemic—the growing number of infants with prenatal substance exposure, particularly neonatal abstinence syndrome, and the number of women with an opioid use disorder as a result from using or misusing both legal and illegal opioids during pregnancy. This initiative was subsequently referred to as In-Depth Technical Assistance-Infants with Prenatal Substance Exposure (IDTA-IPSE).

IDTA Sites

2014-2016
Connecticut
Kentucky
Minnesota
New Jersey
Virginia
West Virginia

2016-2018
Delaware
Minnesota
New York

The 2014–2016 IDTA-IPSE sites focused on building collaboration and linkages across child welfare, mental health, and substance use treatment, medical communities, and early intervention systems, and they included other key stakeholders. The objective was to improve outcomes for infants with prenatal substance exposure, their mothers, and families.

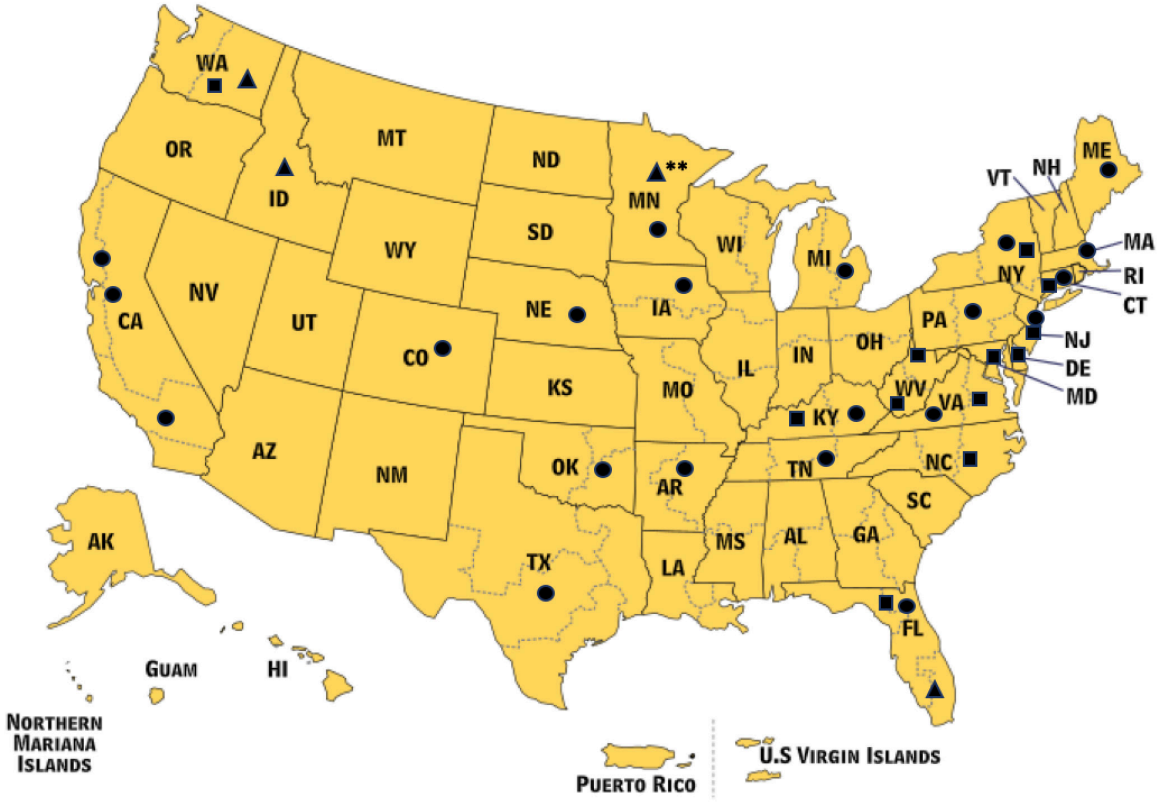
In September 2016, Delaware and New York were selected as IDTA-IPSE sites (2016–2018), and Minnesota was given an extension to continue working with designated tribal communities. **Figure 1** shows the sites that have participated from program inception in 2003 through 2015, and the sites that began in 2014 and sites that are currently engaged.

"The Comprehensive Addiction and Recovery Act of 2016" (CARA) (P.L. 114-198) went into effect July 22, 2016. This legislation includes Title V, Section 503, "*Infant Plan of Safe Care*," which is designed to help states address the effects of substance abuse disorders and prenatal substance exposure on infants, children, and families. This legislation amended the Child Abuse and Treatment Act (CAPTA) for infants with prenatal substance exposure by removing the word "illegal" when referring to substance abuse that affects infants, by requiring the Plan of Safe Care to include the needs of both the infant and family/caregiver, by specifying the data to be reported by states, and by increasing the level of monitoring by states.

[1] For more information about these IDTA sites, refer to https://ncsacw.acf.hhs.gov/technical/idta.aspx.

In response to these CAPTA amendments, engagement with the Delaware and New York teams also focused on developing policies and protocols to successfully implement these CAPTA requirements, especially those that pertain to hospital notifications to Child Protective Services, Plans of Safe Care, and data collection and reporting. This brief summarizes the accomplishments, key findings, and conclusions that emerged from these three states.

FIGURE 1. IDTA SITES (2003 - 2019)



LEGEND

IDTA (2003-2015) ●
IDTA-IPSE* (2014-present) ■
Tribal Site ▲

** This program is now known as IDTA-IPSE (Infants with Prenatal Substance Exposure).*

*** Technical Assistance was provided to five tribes in Minnesota, under one IDTA-IPSE engagement.*

SNAPSHOT OF SITES

In Delaware, the lead agency responsible for the IDTA-IPSE initiative is the Child Protection Accountability Commission. Key partners are as follows:

- Delaware Health and Human Services
- Division of Family Services
- Office of Child Advocate
- Child Death Review Commission
- Fetal and Infant Mortality Review Commission
- Division of Substance Abuse and Mental Health
- March of Dimes
- Community birthing hospitals and health-care systems
- Medication-assisted treatment and other community treatment programs

Table 1 delineates the goals that the Delaware program has established and the accomplishments that are tied to each goal.

TABLE 1. DELAWARE IDTA-IPSE GOALS AND ACCOMPLISHMENTS RELATED TO EACH GOAL

GOALS	ACCOMPLISHMENTS
Universally screen pregnant women for substance use and link women and families to appropriate services.	Developed materials to promote screening tools and to explain the legislation that requires prenatal care providers to discuss substance use in pregnancy. These materials include a website called http://www.HelpIsHereDE.com, which provides screening tools, information on addiction, and access to treatment.

TABLE 1. DELAWARE IDTA-IPSE GOALS AND ACCOMPLISHMENTS RELATED TO EACH GOAL, *continued*

GOALS	ACCOMPLISHMENTS
Build a system of care and provide resources that enable all providers to address prevention, identification, and treatment of substance use disorders. Build a system of care and provide resources that enable all providers to address prevention, identification, and treatment of substance use disorders.	Delaware was awarded a 5-year Regional Partnership Grant to continue to develop and implement the Delaware Healthy Outcomes with Parent Engagement (HOPE) model for women in medication-assisted programs and their infants with prenatal substance exposure. The DE HOPE initiative provides services and supports throughout pregnancy and up to two years after delivery, implementing three evidence-supported models: Healthy Families America, Peer Recovery Coaching, and Nurturing Parenting Program
Implement a statewide protocol for Plans of Safe Care.	Plans of Safe Care are fully implemented at all birthing hospitals in the state. Child Protective Services investigators are co-located in hospitals to develop Plans of Safe Care. Plans of Safe Care data elements are tracked to align with CAPTA requirements and child fatalities and near fatalities. Awarded contract to a community agency to implement Plans of Safe Care for families that the Department of Family Services determined to be low risk through a screening process.
Maintain an awareness of the effects of stigma.	Used recovery coaches to support Plans of Safe Care. Integrated child welfare and medication-assisted treatment provider training. Deployed child welfare protective investigators to meet with clients and staff at medication-assisted treatment programs.

Table 2 describes additional accomplishment for this state.

TABLE 2. ADDITIONAL ACCOMPLISHMENT FOR DELAWARE

House Bill 140: Aiden's Law (June 7, 2018). This bill formalizes a uniform, collaborative response protocol for developing a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers. For more information, refer to https://legis.delaware.gov/BillDetail/25646.

MINNESOTA

- In Minnesota, the lead agency responsible for the IDTA-IPSE initiative is the Department of Human Services, Alcohol and Drug Abuse Division, American Indian Section. Key partners are as follows:
- Department of Human Services, Chemical and Mental Health—Alcohol and Drug Abuse, American Indian Section, Women Services, Methadone Authority
- Department of Human Services, Child Welfare—American Indian Disparities, Child Permanency & Safety
- Department of Health—Maternal & Child Health, Home Visiting, Policy Development, American Indian Health
- American Indian Advisory Councils—Mental Health, Chemical Dependency, Child Welfare
- Minnesota Tribes
    - Boise Fort Band of Chippewa
    - Fond du Lac Band of Chippewa*
    - Grand Portage Band of Chippewa
    - Leech Lake Band of Ojibwe*
    - Lower Sioux Community
    - Mille Lacs Band of Ojibwe*
    - Red Lake Nation*
    - Upper Sioux Community
    - White Earth Nation*

**Indicates an Integrated Care for High Risk Pregnancies (ICHRP) grantee*

Table 3 delineates the goals that the Minnesota program has established and the accomplishments that are tied to each goal.

TABLE 3. MINNESOTA IDTA-IPSE GOALS AND ACCOMPLISHMENTS RELATED TO EACH GOAL

GOALS	ACCOMPLISHMENTS
Screening and Assessment: Pregnant women, infants with prenatal exposure, and their families will be identified in a consistent, uniform, and timely manner across all systems.	The core team and key stakeholders developed a set of recommendations for American Indian women with opioid use disorders, their infants, and families that were integrated into a comprehensive substance abuse system reform package. Following these recommendations resulted in increased reimbursement rates for screening and assessment and expanded support for tribal outreach and engagement activities.
Joint Accountability and Shared Outcomes: A collaborative practice approach will be used to serve infants with prenatal exposure and their families, intersecting each of the systems in which they are involved.	Five northern tribes received state funding to pilot a collaborative, cross-sector, community-driven approach in each of their reservations to implement the Integrated Care for High-Risk Pregnancies program. An array of treatment services includes substance use disorders treatment and wrap-around services, all designed to improve birth, health, and recovery outcomes.
Services for Pregnant Women, Infants with Prenatal Exposure, and their Families: Partners will agree on evidence-based practices and programs that meet the needs of the target populations and have processes in place for monitoring the implementation and effectiveness of these programs.	The Department of Human Services developed a comprehensive resource guide that details programs and services for American Indian women and families in each tribal community, as well asin the Minneapolis-St Paul area. This guide is intended improve referral linkages and overall access to culturally responsive care.

Table 4 describes an additional accomplishment for Minnesota.

TABLE 4. ADDITIONAL ACCOMPLISHMENT FOR MINNESOTA

"Tapping Tribal Wisdom." Listening sessions were conducted in five tribal communities to gather information about the challenges, successes, and lessons learned from these communities as they implemented their collaborative care models for high-risk pregnancies. These sessions culminated in a summary report of the findings. https://ncsacw.acf.hhs.gov/files/tapping_tribal_wisdom_508.pdf

NEW YORK

In New York, the lead agency responsible for the IDTA-IPSE initiative is the Office of Alcoholism and Substance Abuse Services (OASAS). Key partners are as follows:

- Office of Alcoholism & Substance Abuse Services—Bureau of Women, Children, and Adolescent Services
- Office of Children and Family Services—Division of Child Welfare and Community Services
- Department of Health—Division of Family Health, Bureau of Women, Infant and Adolescent Health; AIDS Institute; and Division of Hospitals and Diagnostic Treatment Centers
- Perinatal Quality Collaborative
- American College of Obstetricians & Gynecologists (ACOG), District II
- Community hospitals, treatment partners, and other community providers in implementation counties: Essex, Onondaga, Saratoga, Washington, and Warren

Table 5 delineates the goals that the New York program has established and the accomplishments that are tied to each goal. **(Next page)**

TABLE 5. NEW YORK IDTA-IPSE GOALS AND ACCOMPLISHMENTS RELATED TO EACH GOAL

GOALS	ACCOMPLISHMENTS
Increase universal screening for substance use of all women of childbearing age—with a primary focus on pregnant women.	ACOG District II partnered with the Department of Health, OASAS, and others to ensure Screening, Brief Intervention and Referral to Treatment (SBIRT) is standard practice for pregnant women and women of childbearing age.
Increase identification and engagement in substance use treatment of women and their infants, and increase the level of outreach to women in marginalized groups.	OASAS and Office of Children and Family Services conducted cross-system training for staff/providers on stigma, medication-assistedtreatment, and Plans of Safe Care. OASAS and ACOG developed a training vignette to help obstetricians-gynecologists discuss opioid and other substance use. OASAS developed a marketing campaign, *Pregnancy and Addiction*, to encourage women to seek help.
Promote the use of peer-recovery support services for pregnant and parenting women with substance use disorders.	Peer supports are being used at doctor's offices, in hospitals, in wraparound programs, and in other locations to engage women in substance use disorders treatment and other services.
Identify and implement policy and practice changes as needed to comply with CAPTA requirements and to promote child and family wellbeing.	Two-track CAPTA policy and protocols were implemented for affected infants with safety concerns and those with no safety concerns. OASAS is training treatment providers on CAPTA changes and Plans of Safe Care. The Department of Health is training birthing hospitals on CAPTA amendments and Plans of Safe Care. Multidisciplinary teams in implementation counties are developing Plans of Safe Care during pregnancy.

KEY FINDINGS ACROSS IDTA-IPSE SITES

Syntheses of key findings were generated by reviewing site visit and technical assistance reports, site surveys, peer-to-peer webinars, and presentations as well as from engaging with individuals who are involved with the work at these sites. These reviews yielded many lessons related to partnerships and collaboration as well as to practices and policies that affect outcomes for infants and families. Some of the most salient findings and lessons from this round of IDTA-IPSE are set out below. The findings from these three sites are also consistent with findings from NCSACW's work with other states and communities that endeavor to improve outcomes for women with substance use disorders, their infants, and families.

Following each of the findings are key components that have shown to be effective in addressing each challenge or barrier. Note that the information below is not an all-inclusive list of challenges, barriers, and strategies. Rather, it is intended to provide guidance to states and communities that need to address these issues, with or without the assistance of NCSACW.

1. Cross-System Collaboration is Essential

Cross-system linkages between child welfare, substance use treatment, public health, medical, early intervention, the courts, and other systems are essential for achieving positive outcomes for pregnant and parenting women with substance use disorders, their infants, families, and other caregivers. No system can achieve these outcomes alone. Meaningful collaboration requires a commitment of time, resources, and purposeful participation from individuals committed to working beyond agency boundaries and silos. All partners must perceive their participation as having value for their organization and the people they serve. Partners need to agree on common goals and shared outcomes that can be achieved together. Sites that have support and involvement from top-level administrators in each partner agency can break through challenges more quickly and keep issues elevated to the highest level of state government.

KEY COMPONENTS FOR EFFECTIVE COLLABORATION

- Have top-level administrators from each partner agency participate on an oversight or steering committee (new or existing) to ensure issues are addressed and implementation is successful.
- Ensure that all partners have a vested interest in the issue, a willingness to participate, and decision-making authority to plan and implement strategies.
- Ensure that partners have a shared vision, goals, definition of participant success, and an agreement that collaboration is a means to better serving families.
- Build on existing initiatives across systems; discuss how they relate, overlap, and can enhance each other's efforts. Initiatives include Perinatal Quality Collaborative; CAPTA; and SBIRT.
- Keep questioning whether other collaborators should be included; this will help ensure critical partners are not overlooked.
- Have a neutral facilitator to keep the process moving forward and manage difficult conversations.

2. Systems Need to Address Stigma and Differences in Values and Perceptions

IDTA sites have identified stigma and the differences in values and perceptions that the various systems have shown toward pregnant and parenting women with substance use disorders as a major barrier to effectively engaging women in services and in working collaboratively across systems. Although none of the states involved in this initiative have laws or policies that penalize women for substance use during pregnancy, partners agreed that pregnant women still fear that they will be condemned, punished, or that their child will be removed from them at birth. These perceptions often cause them to avoid prenatal care and substance use disorders treatment and to isolate themselves further from family, friends, and community services.

KEY COMPONENTS FOR ADDRESSING STIGMA

- Understand and address values and perceptions, cross-systems policies and practices, and the culture within each organization in order to establish trust and bring about positive change. To establish trust, services need to be family-centered, accessible, and non-judgmental.
- Use non-judgmental language so women feel safe when discussing substance use and related problems. For example, use terminology such as "women with substance use disorders," not "addicts"; "infants with prenatal exposure," not "addicted babies."
- Encourage all partners to discuss their perspectives and practices regarding women with substance use disorders openly and honestly—especially during pregnancy. Using the NCSACW Collaborative Values Inventory can facilitate this dialogue. For more information on this tool, refer to https://ncsacw.acf.hhs.gov/collaborative/default.aspx.
- Ensure all partners have a common understanding of substance use disorders, especially opioid use and the complicated reasons opioid use has become a national epidemic; CAPTA requirements; medication-assisted treatment; and breastfeeding while on medication-assisted treatment.

3. Barriers That Inhibit Access to Services for Women and Their Families

Barriers that inhibit access to services for women and their families were identified along these intervention points: pregnancy, the birth event, and the critical postnatal/postpartum period. Despite the ACOG recommendations for universal screening for substance use during pregnancy, screening is often conducted selectively, or it does not occur until late in pregnancy. Prenatal care providers often lack knowledge and understanding about treatment options and how to connect women to treatment. As a result, treatment and medical providers may fail to discuss CAPTA requirements, including situations when child welfare needs to be notified, and the implications of prenatal exposure with women prior to delivery. Other common barriers to accessing appropriate and timely services include insufficient understanding of medication-assisted treatment and protocols that promote mother-infant bonding, as well as inconsistencies in hospital notifications to child welfare, and child welfare responses to infants with prenatal substance exposure. Failure to identify other mental health issues, such as depression and anxiety during the postpartum period, or limited or no access to critical home visiting and early intervention services also places vulnerable infants and their families at risk of poor outcomes.

KEY COMPONENTS FOR ADDRESSING BARRIERS TO SERVICES

- Identify existing practices that inhibit families from accessing needed services: failure to screen, failure to refer to Child Protective Services or to treatment, and automatic removal of infant.
- Screen all pregnant women using a validated instrument to increase the chance that they will be identified early and connected to treatment. Plans of Safe Care are developed during pregnancy.
- Use peers to engage and retain women and families in treatment, home visiting, and other services.
- Make medication-assisted treatment and family-centered care for women and children available and accessible.
- Ensure that hospitals, child welfare, and other partners develop and consistently implement protocols for identifying and treating infants with prenatal substance exposure. This includes promoting mother-infant bonding, notifying Child Protective Services, and developing Plans of Safe Care following the birth of an infant.
- Ensure that mothers, infants, and family members know they are eligible for and can access home visiting and early intervention services.
- Provide care coordination and enhanced support during the postpartum period and during the first year of the infant's life.

4. Implementation Strategies and Challenges

Statewide implementation and putting policy into practice requires local partners and stakeholders to carry out the work that was initiated at the state level. Successful implementation requires investing the time to know and engage local team members, foster collaboration, and support local teams as they grapple with the intricacies of ensuring open and ongoing communication, adhering to confidentiality requirements, and collecting relevant data across multiple systems. Phasing-in policy and practice changes in identified implementation counties or regions, prior to statewide implementation, is likely to help partners gain better insight into requirements and adhere to practice changes.

Collecting and reporting data within and across systems, especially baseline data, was a major challenge. This is a significant barrier because data are foundational for understanding the need for and function of changes prior to implementing changes, and for later determining whether intended outcomes have been achieved. In addition to CAPTA reporting requirements, partners need to understand the other data elements each system collects, or needs to collect, for this population of women and infants. In summary, a cross-system commitment to data collection, reporting, and data sharing is essential to being able to demonstrate improved outcomes for women, infants, their families, and the communities in which they live.

KEY COMPONENTS FOR EFFECTIVE IMPLEMENTATION

- State protocols or guidance documents should provide templates for developing CAPTA notification systems and Plans of Safe Care, but provide leeway for local level adaptations.
- Using implementation sites allows partners to test innovations and practice changes before implementing them statewide.
- Ongoing dialogue among state partners, local teams, and tribal communities is essential—whether through onsite meetings, webinars, or phone consultations. Local teams need to ask questions and discuss concerns.
- Mapping community resources and conducting walkthroughs and case studies can solidify knowledge of existing programs, gaps, and barriers as well as the roles of each partner agency.
- Plans of Safe Care for low-risk or non-child-welfare-involved infants and families may be implemented through different options. These include alternative response systems or through referrals to contracted community providers.
- Data should be reviewed across all systems to determine the entity responsible for providing specific data elements. This includes pregnant women screened for substance use disorders, pregnant women in treatment programs, Plans of Safe Care developed during pregnancy and at birth, infants with prenatal substance exposure and the type of exposure, hospital notifications, and infants remaining with mothers and families upon discharge and at follow-up.
- Data dashboards or annual cross-system data reports support continuous monitoring and quality improvement. They can illustrate the achievements of states and local communities, in the areas of prevention through treatment, recovery, and reunification when systems collaborate to address a significant problem, such as the opioid epidemic.

CONCLUSIONS

These IDTA-IPSE sites reinforced that this work is developmental in nature and that the sites' accomplishments can be attributed to multiple factors. Success in the program requires a multi-year commitment to enact, adopt, and implement statewide practice and policy changes, especially since this program is expanding collaboration and coordinating care among health care, child welfare, substance use disorder treatment, public health, mental health, the courts and other family-serving agencies. Building trust and a long-term commitment from multiple partner agencies working at multiple intervention points and across the lifespan is essential to achieving the safety, wellbeing, and health-care needs of these infants, their mothers, and their families or caregivers. The technical assistance NCSACW provided was deemed to be effective in helping these sites build or enhance collaborative relationships, initiate practice changes, and develop systems that are likely to improve specific outcomes for women, their families, and communities, such as changes in opioid prescribing practices, early engagement in prenatal care, early engagement in appropriate treatment, and increased occurrences of infants with prenatal exposure who are discharged with mothers to safe home environments.