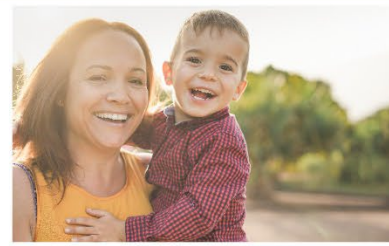


## Special Topic: Care Coordination Considerations for Children and Families Affected by Prenatal Substance Exposure





# Contents

## *Special Topic: Care Coordination Considerations for Children and Families*

<i>Affected by Prenatal Substance Exposure .....</i>	<i>0</i>
Introduction.....	2
Intended Audience.....	3
Facilitator Qualifications .....	3
Language & Terminology.....	4
Materials Needed .....	4
<i>Module 10 Description and Objectives.....</i>	<i>5</i>
<i>Presentation Slide Deck and Talking Points.....</i>	<i>6</i>
References .....	63
Resources .....	66



## Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to enhance child welfare workers knowledge and understanding about substance use and co-occurring disorders among families involved in the child welfare system. The toolkit is designed to provide foundational knowledge and skills to help advance child welfare casework practice.

The toolkit consists of ten modules—seven foundational and three special topics:

**Module 1:** Understanding the Multiple Needs of Families Involved with the Child Welfare System

**Module 2:** Understanding Substance Use Disorders, Treatment & Recovery

**Module 3:** Understanding Co-Occurring Disorders, Intimate Partner Violence & Trauma

**Module 4:** Engagement and Intervention of Co-Occurring Substance Use, Mental Disorders & Trauma

**Module 5:** Case Planning Considerations for Families Affected by Parental Substance Use & Co-Occurring Disorders

**Module 6:** Understanding the Needs of Children and Adolescents Affected by Parental Substance Use & Co-Occurring Disorders

**Module 7:** A Coordinated Multi-System Approach to Better Serve Children and Families Affected by Substance Use & Co-Occurring Disorders

**Module 8:** Special Topic: Considerations for Children and Families Affected by Methamphetamine Use

**Module 9:** Special Topic: Considerations for Children and Families Affected by Opioid Use

**Module 10:** Special Topic: Care Coordination Considerations for Children and Families Affected by Prenatal Substance Exposure

In addition, the Child Welfare Training Toolkit is designed to offer states and local jurisdictions flexibility with delivery methods—the 10 modules can be delivered as a series or as standalone in-person or virtual trainings. Note, each module is equivalent to a half day or 3-hour training which should also account for one 15-minute break for learners during instruction.





Each module contains a detailed facilitator’s guide outlining identified learning objectives, a presentation slide deck, a comprehensive reference list, and supplemental resources. To better support state and local training capacity, detailed talking points for each slide’s content have been included which can be used as a script or a starting point to help acclimate and support facilitator readiness. As with all training curricula, facilitators are also encouraged to infuse their own subject matter expertise, practice-level experience, and knowledge of state or local policy or practice to help reinforce the toolkit’s contents and learning objectives.

Lastly and more importantly, the toolkit is designed with careful attention to adult learning theory and principles to maximize child welfare workers learning experience. Each module considers the diverse learning styles and needs including auditory, visual, kinesthetic techniques, as well as individual, small, or large group transfer of learning activities or exercises.

Note, the NCSACW provides a free online tutorial titled, [\*Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals\*](#). This self-guided online tutorial complements the contents of the Child Welfare Training Toolkit. State and local jurisdictions may encourage their workforce to take the online tutorial to further supplement their knowledge; learners who successfully complete the online tutorial will be eligible for continuing education credits.

## Intended Audience

The contents of this training toolkit can be applied across the full child welfare services continuum, enriching the practice of alternative (differential) response, investigations, in-home, out-of-home, and ongoing units. State and local jurisdictions may use the toolkit to supplement their current onboarding (pre-service) or ongoing (in-service) workforce learning opportunities. Use of the training toolkit is also highly encouraged for all cross-training needs—promoting collaboration and system-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and all other family-serving entities.

## Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare practice. They should also be familiar with the laws and policies that affect child welfare agency decision-making to ensure that the information is presented in the proper context. If a facilitator does not hold knowledge in one of these identified areas, then partnering with a respective community agency is recommended to augment co-facilitation and/or subject matter expertise. All additional facilitator inquiries can be addressed to [ncsacw@cffutures.org](mailto:ncsacw@cffutures.org).



## Language & Terminology

Discipline-specific language and terminology are used throughout this 10-module toolkit. A trainer glossary has been incorporated as part of the toolkit to better support knowledge and understanding of the purpose and intended meanings of commonly referenced terms and recommended use of person-first and non-stigmatizing language.

## Materials Needed

### In-Person Training Delivery

- Laptop Computer
- A/V Projector or Smart Board
- External Speakers (if needed)
- Internet or Wi-Fi Access
- Presentation Slide Deck
- Facilitator's Guide
- Flip Chart Paper
- Pens and Markers
- Training Fidgets

### Virtual Training Delivery

- Laptop Computer
- Internet or Wi-Fi Access
- Virtual Meeting Platform (e.g., Zoom)
- Access to Free Online Word Cloud Generator (e.g., Mentimeter)
- Presentation Slide Deck
- Facilitator's Guide



## Module 10 Description and Objectives

The goal of module 10 is to provide in-depth knowledge and understanding about care coordination considerations for children and families affected by prenatal substance exposure. Child welfare workers will acquire knowledge specific to the consequences of prenatal and postnatal substance exposure and the associated risks and neurodevelopmental effects; will be able to identify the prevalence and effects of maternal morbidity and mortality including details specific to racial and ethnic disparities; describe how stigma and bias perpetuates disparate outcomes for pregnant and parenting persons with substance use disorders; identify the prevalence and leading causes of infant mortality with additional information on racial and ethnic disparities; recognize the benefits of home visiting models for children and families affected by prenatal substance exposure; and finally, understand the policy and practice components of plans of safe care and how these promote the safety, well-being, and recovery outcomes for infants, parents, and their families.

After completing this training, child welfare workers will:

- Understand the consequences of prenatal and postnatal substance exposure and the associated risks and neurodevelopmental effects
- Identify the prevalence and effects of maternal morbidity and mortality including information on racial and ethnic disparities
- Describe how stigma and bias perpetuates disparate outcomes for pregnant and parenting persons with substance use disorders
- Identify the prevalence and leading causes of infant mortality including information on racial and ethnic disparities
- Recognize the benefits of home visiting models for children and families affected by prenatal substance exposure
- Understand the policy and practice components of Plans of Safe Care and how these promote the safety, well-being, and recovery outcomes for infants, parents, and their families



## Presentation Slide Deck and Talking Points

This next section of the facilitator guide provides detailed information about the contents of each slide and is organized uniformly throughout the deck to help with your training preparation. These sections include:

- Facilitator Script: ready to use talking points that can be used in its current form or modified based on a facilitator's training capacity and subject matter expertise.
- Facilitative Prompts for Participants: content-specific inquiries developed to engage learners in further discussion and application of knowledge and skills (**bolded for easy reference**).
- Additional Facilitator Notes: contextual information to support the facilitator's knowledge and readiness, or specific mention of supplemental resources available to the learners hyperlinked within the resource section at the end of the presentation slide deck (*italicized for easy reference*).
- Underlined Content: a tool used to draw attention or emphasize specific content within the facilitator script.




## Slide 1

### ***Special Topic: Care Coordination Considerations for Children and Families Affected by Prenatal Substance Exposure***

**Special Topic:  
Care Coordination Considerations  
for Children and Families Affected  
by Prenatal Substance Exposure**

***Child Welfare Training Toolkit***



National Center on  
Substance Abuse  
and Child Welfare

#### Facilitator Script:

Hello and welcome! Thank you for creating time in your schedule for today's training discussion. The next three hours were carefully designed to be a robust learning experience. We encourage your active participation in the various adult learning exercises leading to a more in-depth understanding about care coordination considerations for children and families affected by prenatal substance exposure.






## Slide 2

### *Acknowledgement*

# Acknowledgement

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



<https://ncsacw.acf.hhs.gov> | [ncsacw@cfutures.org](mailto:ncsacw@cfutures.org)

### Facilitator Script:

Before we begin, I'd like to acknowledge that this training module was developed by the National Center on Substance Abuse and Child Welfare an initiative of the U.S. Department of Health and Human Services and is co-funded by the Children's Bureau, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration.



## Slide 3

### Learning Objectives

<h2>Learning Objectives</h2>	<p>After completing this training, child welfare workers will:</p>
	<ul style="list-style-type: none"><li>• Understand the consequences of prenatal and postnatal substance exposure and the associated risks and neurodevelopmental effects</li><li>• Identify the prevalence and effects of maternal morbidity and mortality including information on racial and ethnic disparities</li><li>• Describe how stigma and bias perpetuates disparate outcomes for pregnant and parenting persons with substance use disorders</li><li>• Identify the prevalence and leading causes of infant mortality including information on racial and ethnic disparities</li><li>• Recognize the benefits of home visiting models for children and families affected by prenatal substance exposure</li><li>• Understand the policy and practice components of Plans of Safe Care and how these promote the safety, well-being, and recovery outcomes for infants, parents, and their families</li></ul>

### Facilitator Script:

The goal of module 10 is to provide in-depth knowledge and understanding about care coordination considerations for children and families affected by prenatal substance exposure. Child welfare workers will acquire knowledge specific to the consequences of prenatal and postnatal substance exposure and the associated risks and neurodevelopmental effects; will be able to identify the prevalence and effects of maternal morbidity and mortality including details specific to racial and ethnic disparities; describe how stigma and bias perpetuates disparate outcomes for pregnant and parenting persons with substance use disorders; identify the prevalence and leading causes of infant mortality with additional information on racial and ethnic disparities; recognize the benefits of home visiting models for children and families affected by prenatal substance exposure; and finally, understand the policy and practice components of plans of safe care and how these promote the safety, well-being, and recovery outcomes for infants, parents, and their families.



## Slide 4

### *What The Data Tells Us About Infant Prenatal Substance Exposure*



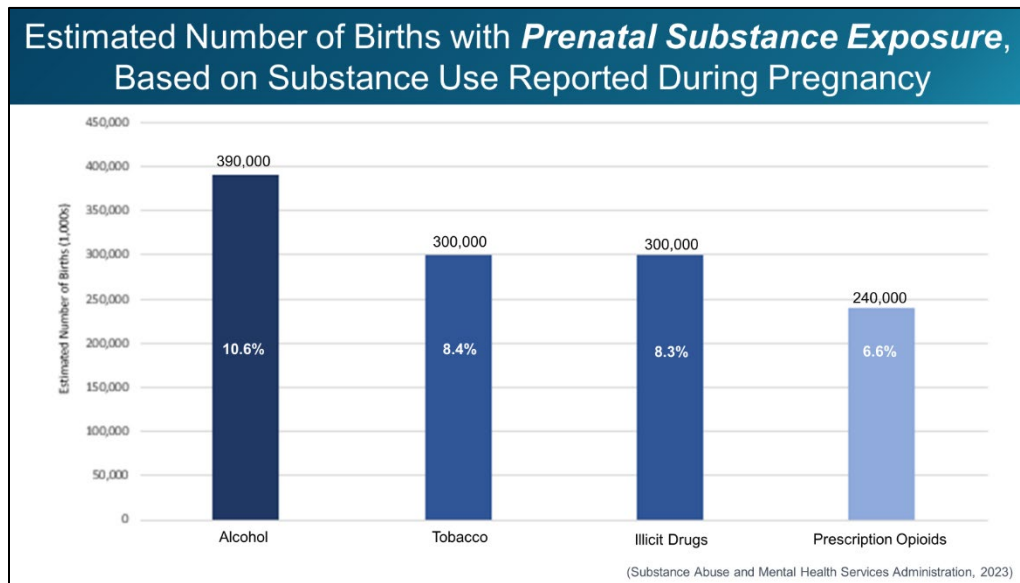
#### Facilitator Script:

Let's start today's discussion by reviewing what the data tell us about infant prenatal substance exposure...



## Slide 5

### *Estimated Number of Births with Prenatal Substance Exposure, Based on Substance Use Reported During Pregnancy*



#### Facilitator Script:

Here we have the estimated number of births with prenatal substance exposure based on substance use reported during pregnancy available through the National Survey on Drug Use and Health. You'll notice here that alcohol was estimated at 10.6% of births (or 390,000) followed by tobacco at 8.4% (or 300,000), illicit drugs at 8.3% (also roughly 300,000) and prescription opioids at 6.6% (or 240,000) births.

#### Prompts for Participants:

**Any initial reactions to these figures? Is this what you expected from the data based on your casework experience?**

As we covered in module 6 of this toolkit, Fetal Alcohol Spectrum Disorder (or FASD) is a non-diagnostic umbrella terms used to describe the range of effects caused by alcohol consumption during pregnancy. The prevalence of FASD is estimated at 9.1 per 1,000 live births, but a review of literature on in-school screening and diagnoses suggest that this rate is actually closer to 50.0 per 1,000 live births. There are many factors that influence the effect alcohol has during in-utero development— things like a pregnant person's age, genetics, overall health and well-being, amount of use, timing of in-utero exposure, and use of other substances in combination with alcohol.

Similarly, we also covered Neonatal Abstinence Syndrome (or NAS) and Neonatal Opioid Withdrawal Syndrome (or NOWS) in module 9 of this toolkit. For the purposes of this brief review, NAS is an expected and treatable condition that may follow prenatal exposure to opioids. An estimated 50-80% of affected infants will begin displaying symptoms of opioid withdrawal within the first 72 hours of birth (but in some instances this may take upwards of 5-10 days) with variability in length (ranging from days, weeks, or months) as well as severity of symptoms (with considerations to factors such as genetics, gestational age, amount and type of substance exposure, and other environmental factors).



Let's spend some more time on this topic of prenatal and postnatal exposure considerations over the next couple of slides...

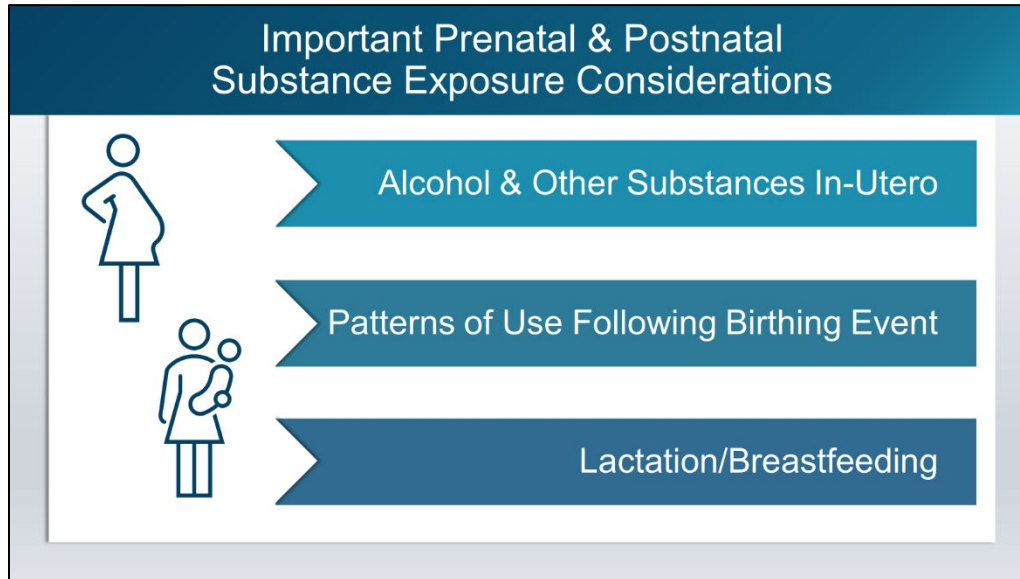
Sources: (Ko et al., 2020; Osterman et al., 2022; Substance Abuse and Mental Health Services Administration, 2023)





## Slide 6

### *Important Prenatal & Postnatal Substance Exposure Considerations*



#### Facilitator Script:

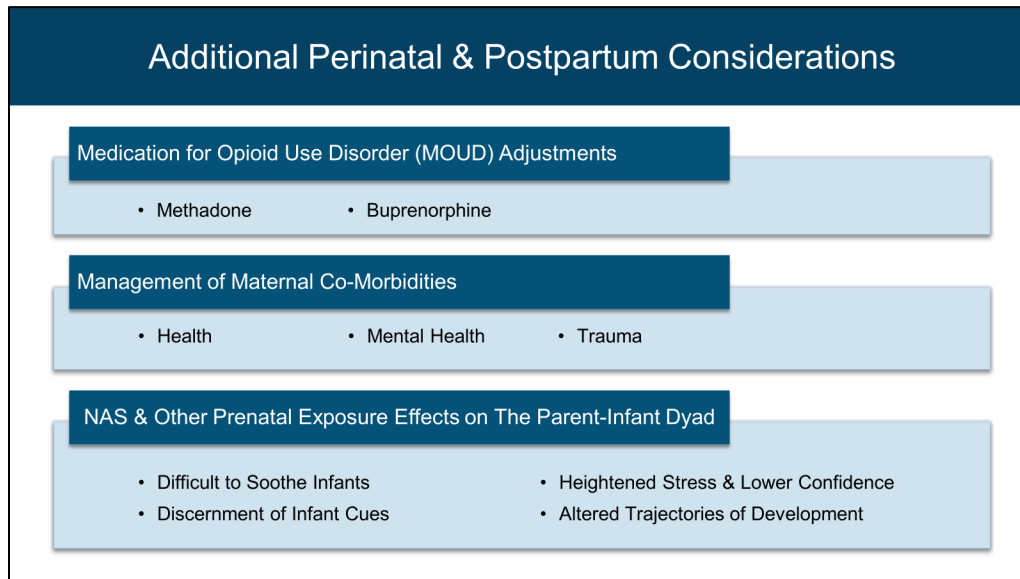
Back in module 6 of this toolkit, we also touched on the complex interplay of prenatal and postnatal factors that contribute to the predictive risk and neurodevelopmental effects for infants with substance exposure—more specifically fetal and infant brain development. For pregnant and parenting persons in either the prenatal or perinatal stage of pregnancy, this begins with understanding the full extent of alcohol or other substances consumed during gestation (and not just what was reported or indicated at time of the birthing event). Beyond the prenatal period, it is equally important that we are paying close attention to patterns of use following the birthing event (this would include post hospital discharge and through the postpartum period). Important considerations include possible maternal return to use following a period of gestational abstinence; possible increase in use in response to perinatal or postpartum stressors; as well as other environmental exposure considerations such as other primary caregiver or familial substance use in the home. In addition to second-hand environmental exposure considerations, we also have the important and often debated topic of lactation or breastfeeding best practices. As we know, there are many well documented benefits to lactation or breastfeeding—specifically around health benefits as antibodies are passed from mother to infant through breastmilk; however, there are also well documented and/or emerging risks associated with the excretion and in some cases concentration of both legal and illicit substances which will require further consultation and planning with healthcare providers and substance use disorder treatment professionals.

Source: (American College of Obstetricians and Gynecologists, 2021)



## Slide 7

### *Additional Perinatal & Postpartum Considerations*



#### Facilitator Script:

Here we have additional perinatal and postpartum considerations related to the ongoing health, well-being, and recovery outcomes for the parent-infant dyad which underscore the importance of a comprehensive care team made up of qualified professionals partnering on behalf of children and families affected by substance use disorders.

Let's begin with pregnant and parenting persons on medication for opioid use disorders, for some the perinatal and postpartum period may necessitate dosing adjustments. This is due to metabolic changes that occur during pregnancy in particular the third trimester—where a previously stable daily dose may no longer control for withdrawal symptoms and may require split dosing (followed by additional dosing adjustments following the birthing event and into the postpartum period). In comparison to methadone, buprenorphine is being found to require fewer dosing adjustments during pregnancy with emerging evidence of less severe neonatal abstinence syndrome withdrawal symptoms. Now while these specific medical decisions remain outside the scope of child welfare casework practice, it is important information for us to have in the context of understanding the potential effects of opioid withdrawal symptoms particularly maternal return to use and/or disengagement in substance use disorder treatment services during the postpartum period.

Next, we have management of maternal co-morbidities which is also significant to the ongoing health, well-being, and recovery outcomes for the parent-infant dyad. Important perinatal and postpartum considerations include whether the pregnant or parenting person has access to and is receiving comprehensive coordinated care to address their individual needs— things like engagement and retention in prenatal healthcare services, substance use disorder treatment, mental health or trauma-related services, and any other family support or social services programming.



Lastly, it is imperative that we stay attuned to how pregnant and parenting persons feel during the perinatal and postpartum periods. As we've discussed in previous modules, these periods are often marked by heightened levels of stress compounded with the challenges brought on by neonatal abstinence syndrome and other prenatal exposure effects. As you might recall from module 9, neonatal abstinence syndrome presents unique risks to the parent-infant dyad particularly involving difficult to soothe infants and subsequent discernment of infant cues— things like how to distinguish between cues related to feeding and changing versus cues specific to the infant's active withdrawal and more importantly not allowing these challenges around temperament and co-regulation to negatively affect ongoing bonding and attachment. Also of note, is that emerging evidence on the study of prenatal exposure to cannabis is mirroring similarities with neonatal abstinence syndrome albeit less defined; these findings include increased neonatal intensive care unit admissions with central nervous system effects including trembling, high-pitched crying, and poor adaptation to visual stimuli. So, like neonatal abstinence syndrome prenatal cannabis exposure can also contribute to heightened stress and lowered parenting confidence which consequently can further exacerbate altered trajectories of fetal and infant brain development (more on the specifics of these later in today's training discussion).

Let's now watch a short video summarizing the complex needs of pregnant and parenting persons with substance use disorders from John Hopkin's Center for Addiction and Pregnancy...

Sources: (American College of Obstetricians and Gynecologists, 2017; Ryan et al., 2018; Marchand et al., 2022; UMBC, 2018)



## Slide 8

### *Understanding the Complex Needs of Pregnant and Parenting Persons with SUDs*

**Understanding the Complex  
Needs of Pregnant and Parenting  
Persons with SUDs**

Permission to Use & Video Acknowledgement:  
This video was produced by UMBC Home Visiting Training Program, Department of Psychology.  
Special thanks to The Training Center Faculty, Staff & Other Health Professionals

This project was supported by the Maryland Department of Health (MDH) and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number HRSA D89MC26357, "Maryland State Maternal, Infant, and Early Childhood Home Visiting."

[Dr. Jansson, Director of Pediatrics at John Hopkins Center for Addiction and Pregnancy](#)

#### Facilitator Script:

*Facilitator Notes: Internet or Wi-Fi permitting, open the hyperlink for an 11-minute video by the Director of Pediatrics at John Hopkins Center for Addiction and Pregnancy. Proceed with facilitating a large group discussion using the following prompts:*

#### Prompts for Participants:

- **Let's start by recapping the video. Any initial thoughts or reactions to what Dr. Jansson discussed?**
- **Was there anything in this video that challenged your current understanding or views about parental substance use during pregnancy?**
- **How does the emerging evidence on cannabis use inform our casework practice moving forward with families presenting with primary cannabis use disorder?**

Video Source: UMBC Home Visiting Training Program



## Slide 9

### *Maternal Morbidity & Mortality*



#### Facilitator Script:

*Facilitator Note: Slide is intended to be a segue or transition to detailed content on next slide.*

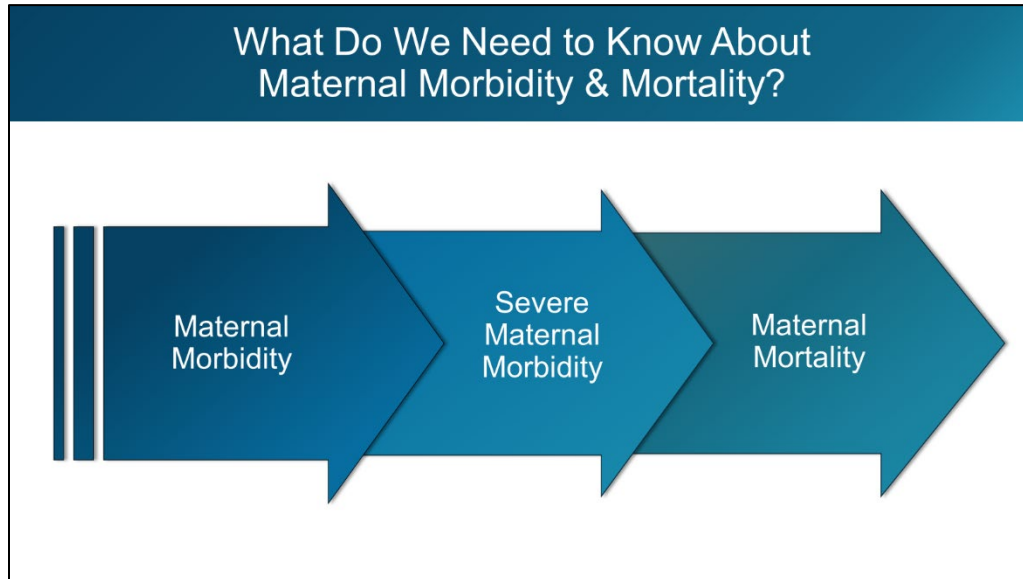
As we emphasized throughout this toolkit, recovery from substance use disorders is POSSIBLE and the perinatal and postpartum periods often represent a time of increased motivation for change. Now that we have a better understanding of the unique and often complex challenges involved with these periods, let's turn our attention to why comprehensive coordinated care is so critical to the overall health, well-being, and recovery outcomes for the parent-infant dyad— an extremely important but often less talked about reality of maternal morbidity and mortality...





## Slide 10

### *What Do We Need to Know About Maternal Morbidity & Mortality*



#### Facilitator Script:

Under the large umbrella of maternal health, we also have the stark reality of perinatal or postpartum complications that can increase a pregnant or parenting person's risk for chronic disease. The World Health Organization (or the WHO) defines maternal morbidity as "any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the [pregnant or parenting person's] well-being." Whereas the Centers for Disease Control and Prevention (CDC) defines severe maternal morbidity (SMM) as including any "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a [pregnant or parenting person's] health." And as such, severe maternal morbidity becomes a predictive risk factor for maternal mortality— "a term used to describe when a person dies from a pregnancy-related health issue or an existing health condition exacerbated during pregnancy or within 42 days of giving birth." Let's break this important topic down and its relation to our role in supporting life saving coordinated care together in this next section of slides...

Sources: (Centers for Disease Control and Prevention, 2023d; National Institute of Child Health and Human Development, 2020; Katella, 2023)



## Slide 11

### *Risk Factors Influencing Maternal Morbidity & Mortality*



- Access to Quality Prenatal Care
- Pre-Existing Health Conditions
- Perinatal & Postpartum Depression
- Substance Use Including Overdose or Death

#### Facilitator Script:

Let's start with gaining a better understanding of risk factors influencing maternal morbidity and mortality in our country...

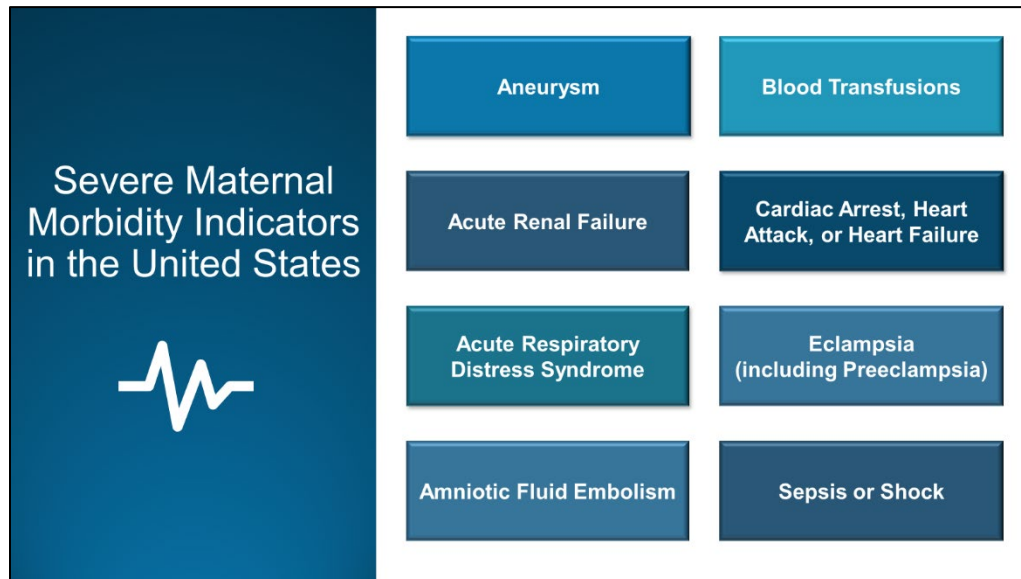
Did you know that pregnant and parenting persons who do not receive prenatal care are 3-4x more likely to die from pregnancy-related health complications? This predictive risk factor can be greatly compounded by a pregnant or parenting person's pre-pregnancy health. Data from the National Institutes for Health (or NIH) show a marked increase in the prevalence of pre-existing health conditions prior to pregnancy for women between the ages of 18-44; most notable among the data included a 31% increase in hypertension, 28% increase in type 2 diabetes, and a nearly 50% increase in obesity. Similarly, the data highlighted a 35% increase in perinatal and postpartum depression with nearly 1 in 8 pregnant or parenting persons experiencing symptoms at time of delivery. And last but certainly not least, we have the predictive risk factor involving substance use. Data on maternal substance use at time of delivery included a 133% increase for opioid use disorders. Further, substance use and co-occurring mental disorders (including accidental overdose or death by suicide) were noted as the leading cause of pregnancy-related deaths for white pregnant or parenting persons.

Source: (National Institutes of Health, n.d.)



## Slide 12

### *Severe Maternal Morbidity Indicators in the United States*



#### Facilitator Script:

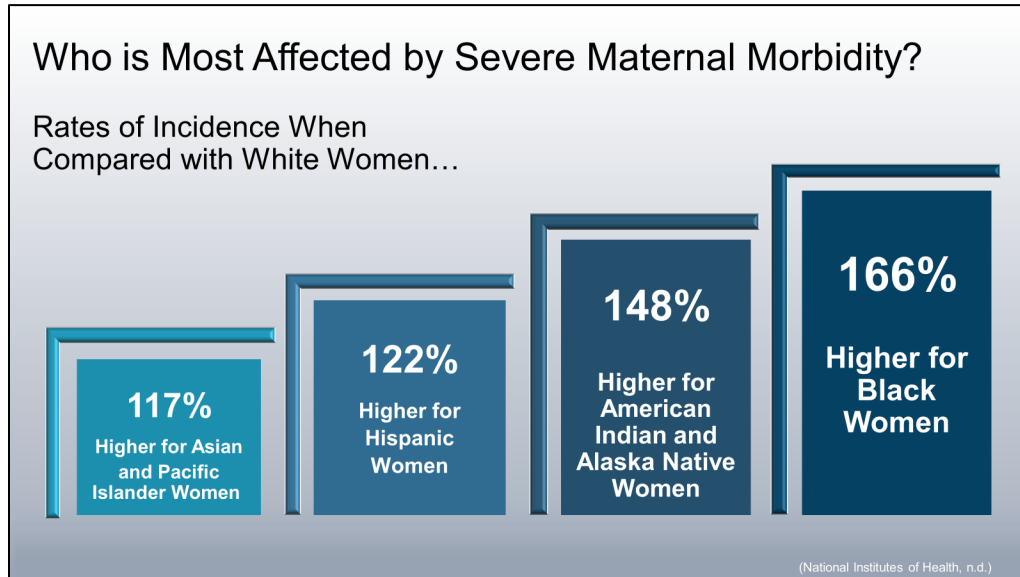
So, we know that severe maternal morbidity is a predictive risk factor for maternal mortality—but do we know more specifically the type of pregnancy-related health complications that are placing this population at greater risk for long-term health consequences (including death)? Here we have the leading indicators of severe maternal morbidity in the United States. According to the National Institutes for Health (or NIH), nearly 74% of severe maternal morbidity complications occur within the first two weeks following the birthing event and hospital discharge. This data point speaks poignantly to the importance of routine follow-up obstetric care in the weeks and months following the birthing event for pregnant and parenting persons—particularly for those who we know are most affected by severe maternal morbidity...

Sources: (Centers for Disease Control and Prevention, 2023d; National Institutes of Health, n.d.)



## Slide 13

### *Who is Most Affected by Severe Maternal Morbidity?*



#### Facilitator Script:

The rate at which pregnant and parenting persons in our country face serious health consequences due to unexpected outcomes of pregnancy or childbirth is alarming— especially when viewed within the lens of racial and ethnic disparities. Here we have data from the National Institutes for Health (or NIH) highlighting just how significant of a problem our country is facing in terms of the health and well-being of pregnant and parenting persons from racial and ethnic minority groups:

Rates of incidence for severe maternal morbidity when compared with white women...

- Is 117% higher for Asian and Pacific Islander women
- 122% higher for Hispanic women
- 148% higher for American Indian and Alaska Native women
- And 166% higher for Black women

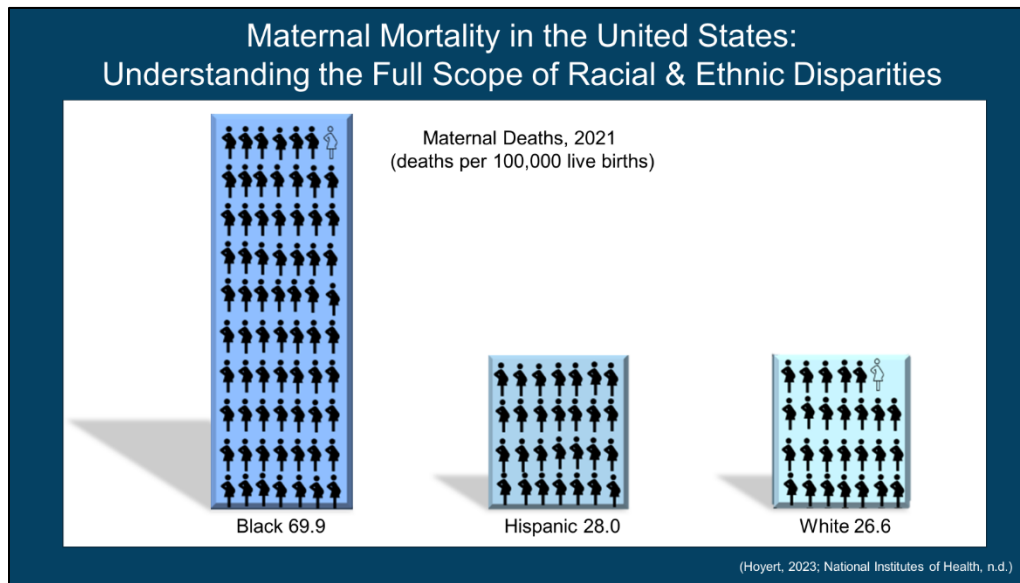
166% let's let that sink in for a moment. This means that compared to all other racial and ethnic groups, Black pregnant and parenting persons experience the highest rates for nearly all severe maternal morbidity indicators— aneurysms, embolisms, eclampsia, cardiac arrest, sepsis, shock— the list goes on and the consequences can be severe often resulting in death.

Source: (National Institutes of Health, n.d.)



## Slide 14

### *Maternal Mortality in the United States: Understanding the Full Scope of Racial & Ethnic Disparities*



#### Facilitator Script:

Let's now examine our country's maternal mortality data, but within the lens of racial and ethnic disparities. This is what a 166% higher rate of incidence for severe maternal morbidity perpetuates for Black pregnant and parenting persons in our country's healthcare system. According to data from the National Institutes for Health (or NIH), Black women are 3-4 times more likely to die from pregnancy-related complications translating to a maternal mortality ratio of 69.9 deaths per 100,000 live births (in the year 2021). As depicted here, that is nearly triple the ratio for white or Hispanic maternal deaths. To put this figure in perspective, the risk for maternal mortality for Black pregnant and parenting persons in America is comparable to that of pregnancy-related deaths in some of the world's most developing countries. Yes, that's right. Despite being one of the world's highest earning countries that spends the most on maternal healthcare we continue to hold one the highest maternal mortality rates across the globe at 32.9 per 100,000 live births for year 2021 (and for context this rate has only been increasing up from 23.8 in 2020, 20.1 in 2019, and 17.4 in 2018). And it doesn't have to be this way, because pregnancy-related deaths are PREVENTABLE—approximately 3 out of 5 to be exact according to the research. Yet, Black pregnant and parenting persons continue to die at alarmingly higher rates than other race or ethnicities. In reviewing the data for 2021, the 69.9 maternal mortality ratio for Black pregnant and parenting persons equated to 362 lives lost in the perinatal or postpartum period alone.

Sources: (Hoyert, 2023; National Institutes of Health, n.d.)

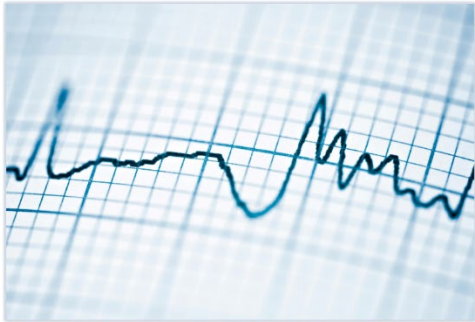




## Slide 15

### *Understanding the Root Causes of Racial and Ethnic Disparities in Maternal Health Outcomes*

Understanding the  
Root Causes of  
Racial and Ethnic  
Disparities in  
Maternal Health  
Outcomes



- Social & Economic Determinants of Health
- Access to Quality Healthcare Services
- Systemic Racism & Implicit Bias

#### Facilitator Script:

Addressing racial and ethnic disparities in maternal health outcomes (both severe maternal morbidity and mortality) begins with our understanding of the root causes in our country. To begin with, we must first recognize the inequities in social and economic determinants of health and how these serve to perpetuate disparate health outcomes for racial and ethnic minority groups—things like age, race, ethnicity, gender, socioeconomic status, neighborhood or zip code, access to transportation and healthy and affordable food, type of insurance coverage and level of healthcare access— all contribute to a range of quality-of-life outcomes and associated risks.

Similarly, equitable access to quality healthcare services is also contributing to this public health crisis as many pregnant and parenting persons from racial or ethnic minority groups encounter barriers to routine prenatal or postpartum care. For example, it is not uncommon to hear American Indian or Alaska Native pregnant and parenting persons from rural communities' report having to travel hours to the nearest prenatal healthcare clinic or labor and delivery hospital. This compounded with a myriad of other reasons (all deeply engrained in the historical trauma of our tribal communities) contributes to this population's disproportionately higher rates for severe maternal morbidity and mortality when compared to data on their white or Hispanic counterparts.

And finally, we must also recognize these contributing factors within the intersectionality of systemic racism and implicit bias in our healthcare system. As the U.S. Commission on Civil Rights highlighted, equitable access to quality healthcare services is all encompassing— it refers to the practices of physicians, nurses, and other healthcare professionals charged with the health and well-being of pregnant and parenting persons— including how they engage, make decisions and deliver care without bias while also holding the systems accountable that perpetuate inequitable access to evidence-based care (inclusive of type of insurance coverage accepted, hospital policies and practices, excessive wait times, overuse of cesarean sections, among many others).

Source: (U.S. Commission on Civil Rights, 2021)



## Slide 16

### *How Stigma & Bias Further Perpetuates Health Disparities for Pregnant and Parenting Persons with SUDs*

How Stigma & Bias Further  
Perpetuates Health Disparities  
for Pregnant and Parenting  
Persons with SUDs

Small Group Discussion

#### Facilitator Script:

*Facilitator Notes: Instruct learners to join their small groups for a discussion on how stigma and bias further perpetuates health disparities for pregnant and parenting persons with substance use disorders.*

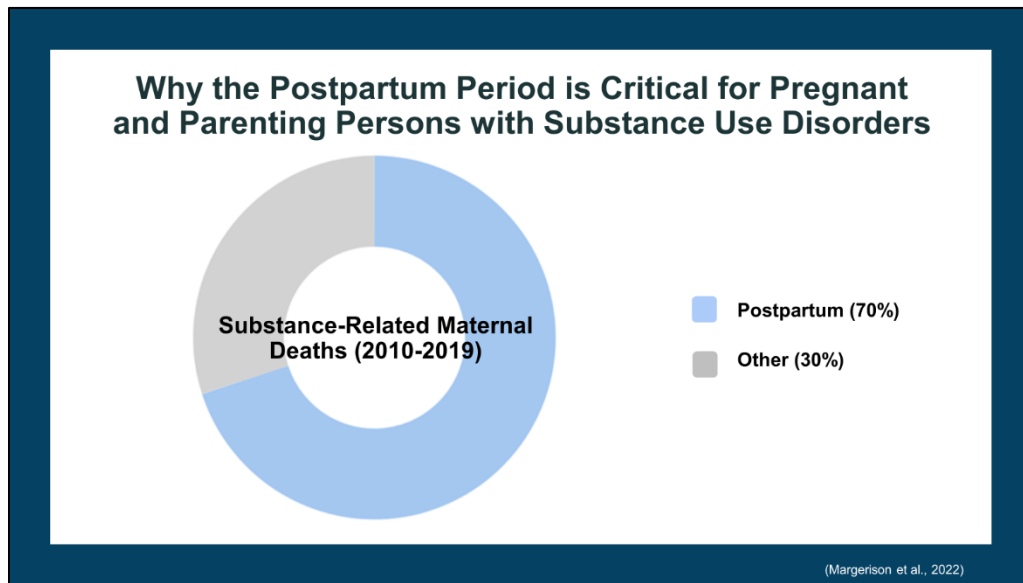
#### Prompts for Participants:

- **Based on what we have discussed today, how does stigma and bias influence the health outcomes for pregnant and parenting persons with substance use disorders?**
- **Discuss specific drivers of stigma and bias for pregnant and parenting persons within the healthcare and social services settings.**
- **Identify one actionable step you can take to disrupt stigma and bias in your work supporting comprehensive coordinated care for children and families affected by substance use disorders.**



## Slide 17

### *Why the Postpartum Period is Critical for Pregnant and Parenting Persons with Substance Use Disorders*



#### Facilitator Script:

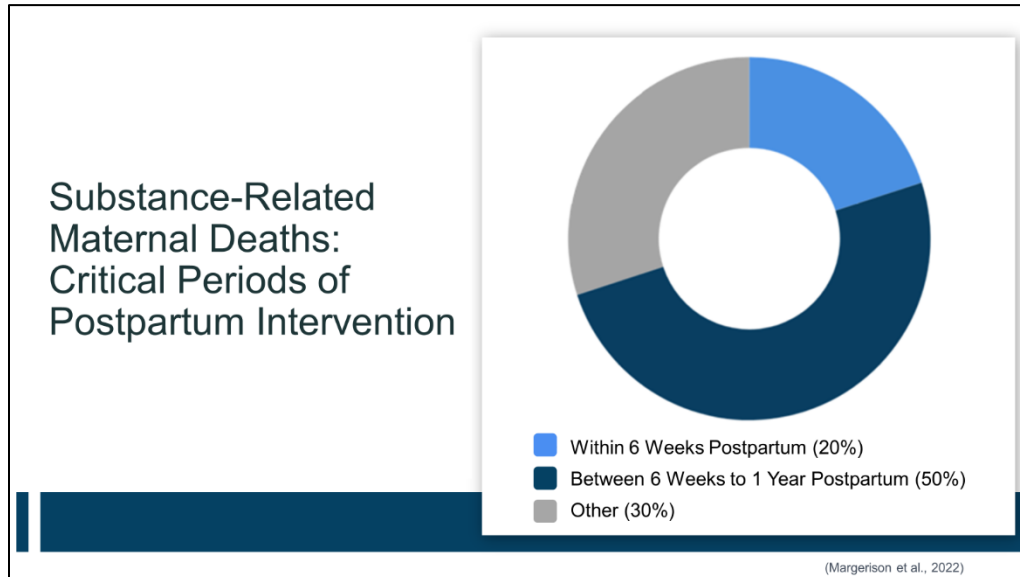
As we have been hearing throughout today's discussion, the postpartum period is critical to the ongoing health, well-being, and recovery outcomes for the parent-infant dyad. A review of data from 2010-2019 further underscores this message as upwards of 70% of substance-related maternal deaths occurred during the period of birth up to one year. Let's take a closer review of this data to better understand critical periods of intervention...

Source: (Margerison et al., 2022)



## Slide 18

### *Substance-Related Maternal Deaths: Critical Periods of Postpartum Intervention*



#### Facilitator Script:

Here we have a breakdown of the substance-related maternal deaths providing greater insight into possible trends in the data. As reflected here, 20% of the substance-related maternal deaths occurred within the first 6-weeks postpartum whereas 50% occurred between 6-weeks to 1-year postpartum.

#### Prompts for Participants:

- So, what might this data be telling us about what is going on for pregnant and parenting persons the first year postpartum?
- What questions would you be asking pregnant or parenting persons affected by substance use disorders during this critical postpartum period?
- Knowing what we know about risk factors for maternal morbidity and mortality, what strategies or techniques can we use to help ensure continuity in comprehensive services and supports?

Source: (Margerison et al., 2022)



## Slide 19

### *Infant Mortality*



#### Facilitator Script:

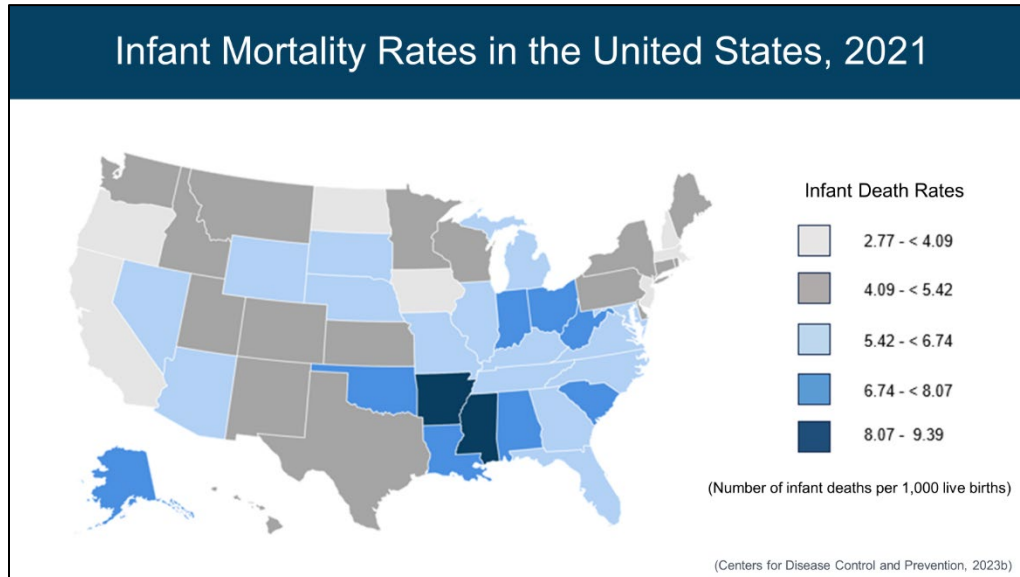
*Note: slide is intended to be a segue or transition to detailed content on next slide*

You may have caught on to some specific language I have been using today when referring to the health, well-being, and recovery outcomes for the parent-infant dyad. This was intentional knowing that we would eventually land here discussing the difficult and highly sensitive topic of infant mortality. Let's take a moment to center ourselves for this important dialogue together...



## Slide 20

### *Infant Mortality Rates in the United States, 2021*



#### Facilitator Script:

Let's ease into this discussion with a review of the data from the Centers for Disease Control and Prevention (or CDC). Here we have a heat map detailing infant mortality rates in the United States (number of infant deaths per 1,000 live births for the year 2021). To the right of the map, we have a legend breaking down the infant death rates by their respective heat map color. Light gray represents states with an infant death rate between 2.77 - 4.09; dark gray represents states with an infant death rate between 4.09 – 5.42; the light blue represents states with an infant death rate between 5.42- 6.74; the mid-range blue represents states with an infant death rate between 6.74 – 8.07; and finally, the dark blue represents states with an infant death rate between 8.07 – 9.39. Note, the state of Vermont is listed in white as no information on their death rate is available (only number of deaths which can be found on slide 24).

To help put this discussion into perspective, infant mortality refers to the death of an infant before their first birthday. In total, the United States had an infant mortality rate of 5.44 deaths in 2021. Sadly, this meant that we lost 19,928 infants in that one year alone.

Source: (Centers for Disease Control and Prevention, 2023b)





## Slide 21

### Year 2021 Infant Mortality Data Listed by State (A – K)

State	Death Rate	Number of Deaths	Death Rate Ranking (Out of 49 States)*
Alabama	7.56	439	47 <sup>th</sup>
Alaska	7.37	69	46 <sup>th</sup>
Arizona	5.47	426	26 <sup>th</sup>
Arkansas	8.59	309	48 <sup>th</sup>
California	4.07	1713	7 <sup>th</sup>
Colorado	4.99	314	18 <sup>th</sup>
Connecticut	4.65	166	12 <sup>th</sup>
Delaware	4.77	50	14 <sup>th</sup>
Florida	5.90	1275	31 <sup>st</sup>
Georgia	6.25	776	38 <sup>th</sup>
Hawaii	4.67	73	13 <sup>th</sup>
Idaho	5.13	115	20 <sup>th</sup>
Illinois	5.62	743	28 <sup>th</sup>
Indiana	6.75	540	40 <sup>th</sup>
Iowa	3.99	147	6 <sup>th</sup>
Kansas	5.30	184	22 <sup>nd</sup>
Kentucky	6.15	321	35 <sup>th</sup>

(Centers for Disease Control and Prevention, 2023b)

Year 2021 Infant  
Mortality Data  
Listed by State  
(A-K)

#### Facilitator Script:

*Facilitator Notes: This slide details state-specific infant mortality data (also from the CDC) organized alphabetically for the year 2021. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.*

Source: (Centers for Disease Control and Prevention, 2023b)



## Slide 22

### Year 2021 Infant Mortality Data Listed by State (L – N)

State	Death Rate	Number of Deaths	Death Rate Ranking (Out of 49 States)*
Louisiana	7.24	416	44 <sup>th</sup>
Maine	5.00	60	19 <sup>th</sup>
Maryland	5.99	409	33 <sup>rd</sup>
Massachusetts	3.23	223	2 <sup>nd</sup>
Michigan	6.22	653	37 <sup>th</sup>
Minnesota	4.83	311	16 <sup>th</sup>
Mississippi	9.39	330	50 <sup>th</sup>
Missouri	5.85	406	30 <sup>th</sup>
Montana	4.90	55	17 <sup>th</sup>
Nebraska	5.49	135	27 <sup>th</sup>
Nevada	5.76	194	29 <sup>th</sup>
New Hampshire	3.96	50	5 <sup>th</sup>
New Jersey	3.57	362	3 <sup>rd</sup>
New Mexico	4.77	102	15 <sup>th</sup>
New York	4.16	876	8 <sup>th</sup>
North Carolina	6.72	809	39 <sup>th</sup>
North Dakota	2.77	28	1 <sup>st</sup>

(Centers for Disease Control and Prevention, 2023b)

Year 2021 Infant  
Mortality Data  
Listed by State  
(L-N)

#### Facilitator Script:

*Facilitator Notes: This slide details state-specific infant mortality data (also from the CDC) organized alphabetically for the year 2021. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.*

Source: (Centers for Disease Control and Prevention, 2023b)



## Slide 23

### Year 2021 Infant Mortality Data Listed by State (O – W)

State	Death Rate	Number of Deaths	Death Rate Ranking (Out of 49 States)*
Ohio	7.06	916	42 <sup>nd</sup>
Oklahoma	7.13	345	43 <sup>rd</sup>
Oregon	3.79	155	4 <sup>th</sup>
Pennsylvania	5.37	712	24 <sup>th</sup>
Rhode Island	4.30	45	9 <sup>th</sup>
South Carolina	7.26	415	45 <sup>th</sup>
South Dakota	6.07	69	34 <sup>th</sup>
Tennessee	6.18	505	36 <sup>th</sup>
Texas	5.29	1977	21 <sup>st</sup>
Utah	4.58	214	11 <sup>th</sup>
Vermont	N/A*	17	N/A*
Virginia	5.96	571	32 <sup>nd</sup>
Washington	4.36	366	10 <sup>th</sup>
West Virginia	6.80	117	41 <sup>st</sup>
Wisconsin	5.36	331	23 <sup>rd</sup>
Wyoming	5.45	34	25 <sup>th</sup>

(Centers for Disease Control and Prevention, 2023b)

Year 2021 Infant  
Mortality Data  
Listed by State  
(O-W)

#### Facilitator Script:

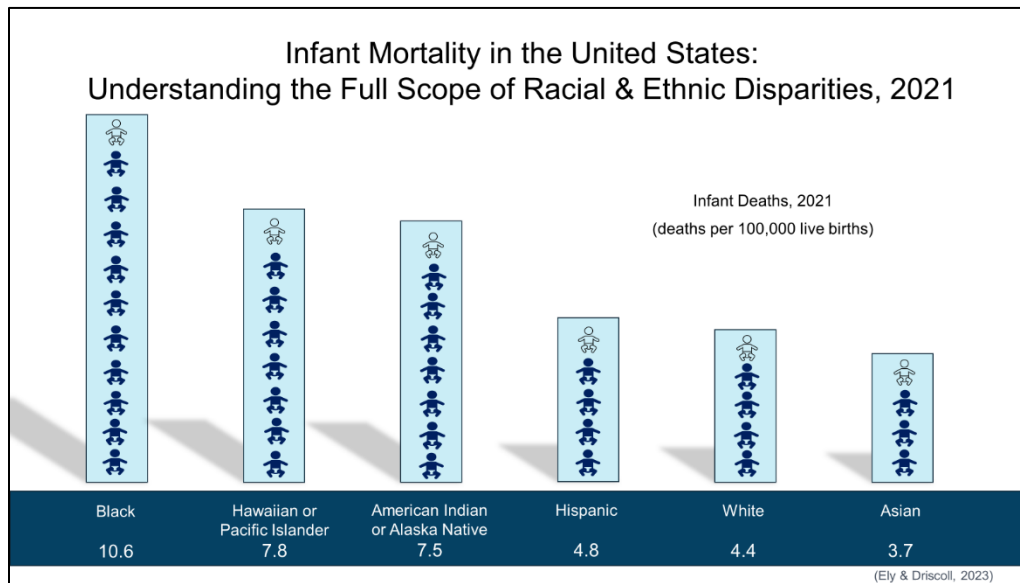
*Facilitator Notes: This slide details state-specific infant mortality data (also from the CDC) organized alphabetically for the year 2021. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.*

Source: (Centers for Disease Control and Prevention, 2023b)



## Slide 24

### *Infant Mortality in the United States: Understanding the Full Scope of Racial & Ethnic Disparities, 2021*



#### Facilitator Script:

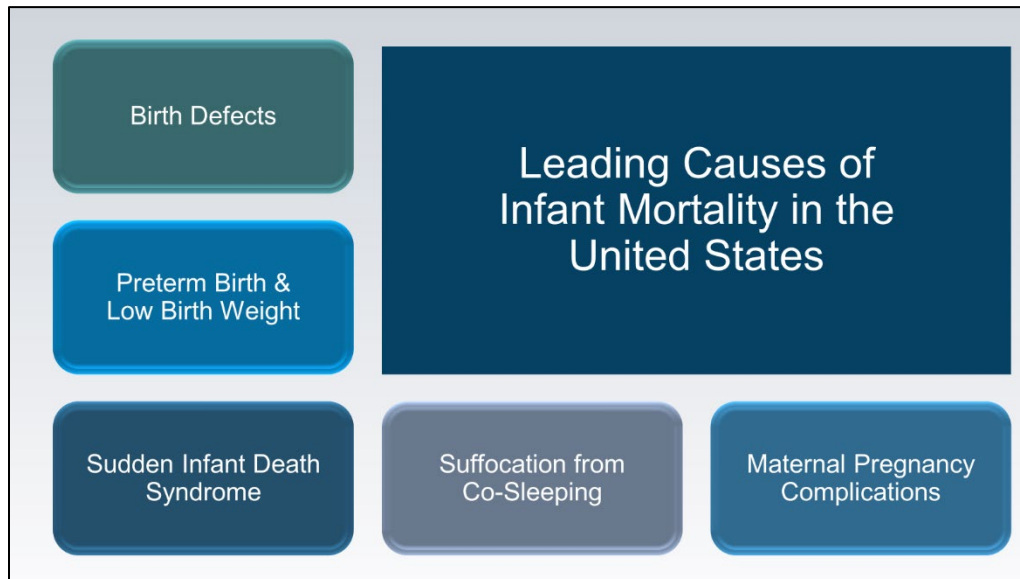
Like earlier, let's also examine infant mortality data from the lens of racial and ethnic disparities. Here we have data from the Centers for Disease Control and Prevention (CDC) detailing infant death rates for the year 2021 broken down by race and ethnicity. Similar to maternal mortality data trends, black infants are also dying at alarmingly higher rates than all other racial and ethnic groups with an infant death rate of 10.6 per 1,000 live births—more than twice that of infants born to white or Hispanic mothers and nearly three times the rate of infants born to Asian mothers. Now it's important to remember that maternal pregnancy complications (or severe maternal morbidity) are closely related to infant deaths which also further lays the context for understanding the drivers of infant health disparities in our country. To recap, this means that social and economic determinants of health, access to quality healthcare services, systemic racism and implicit bias all play a role in the health trajectories of our infants. For 5,463 Black infants in 2021, this meant not making it past their first birthday.

Source: (Ely & Driscoll, 2023)



## Slide 25

### *Leading Causes of Infant Mortality in the United States*



#### Facilitator Script:

Here we have a list of the leading causes of infant mortality in the United States. According to the Center for Disease Control and Prevention (CDC), the five leading causes of infant deaths in year 2020 were birth defects, preterm birth and low birth weight, sudden infant death syndrome (or SIDS), injury from co-sleeping specifically suffocation, and other maternal pregnancy complications. Let's spend some more time on a couple of these as they further illuminate racial and ethnic health disparities in our country.

For instance, preterm birth refers to when an infant is born too early (more specifically before the conclusion of 37 weeks gestation). Generally speaking, preterm birth affects approximately 1 in every 10 infants in the United States; however, racial and ethnic disparities in preterm birth rates continue to persist at very concerning levels. In 2021 alone, the preterm birth rate for Black pregnant and parenting persons was 14.8%; a rate nearly 50% higher than that of white or Hispanic pregnant or parenting persons at 9.5% and 10.2%, respectively.

Next, let's spend some time discussing the third and fourth bullet listed here. According to the Center for Disease Control and Prevention (CDC) there are approximately 3,400 sudden unexpected infant deaths (also referred to as SUID) in the United States. Sudden unexpected infant deaths are deaths that occur before an infant's first birthday and have no immediate obvious cause. Based on this classification, both sudden infant death syndrome and suffocation from co-sleeping fall under the umbrella of sudden unexpected infant deaths (along with those deaths of unknown cause). In the year 2020 alone, there were 1,389 deaths caused by SIDS and 905 deaths caused by accidental suffocation or strangulation from co-sleeping (and another 1,062 deaths caused by unknown reasons).



A review of SUID rates per 100,000 live births from 2016-2020 also further illuminates racial and ethnic disparities with:

- -American Indian or Alaska Native SUID rate of 213.5
- -Black SUID rate of 191.4
- -Native Hawaiian or Pacific Islander SUID rate 164.5

To put these figures into perspective, the SUID rate for white, Hispanic, and Asian infants totaled 83.6, 56.4, and 22.6, respectively.

**Prompt for Participants:**

**Knowing these figures and what we know about the neurodevelopmental effects of prenatal and postnatal substance exposure, what strategies are child welfare (or other family-serving agencies) employing to support the safety and well-being of infants during this critical postpartum period?**

Sources: (Centers for Disease Control and Prevention, 2023a; Centers for Disease Control and Prevention 2023c; Ely & Driscoll, 2023)





## Slide 26

### ***Importance of Specialized Care Coordination for Pregnant and Parenting Persons with SUDs***



#### **Facilitator Script:**

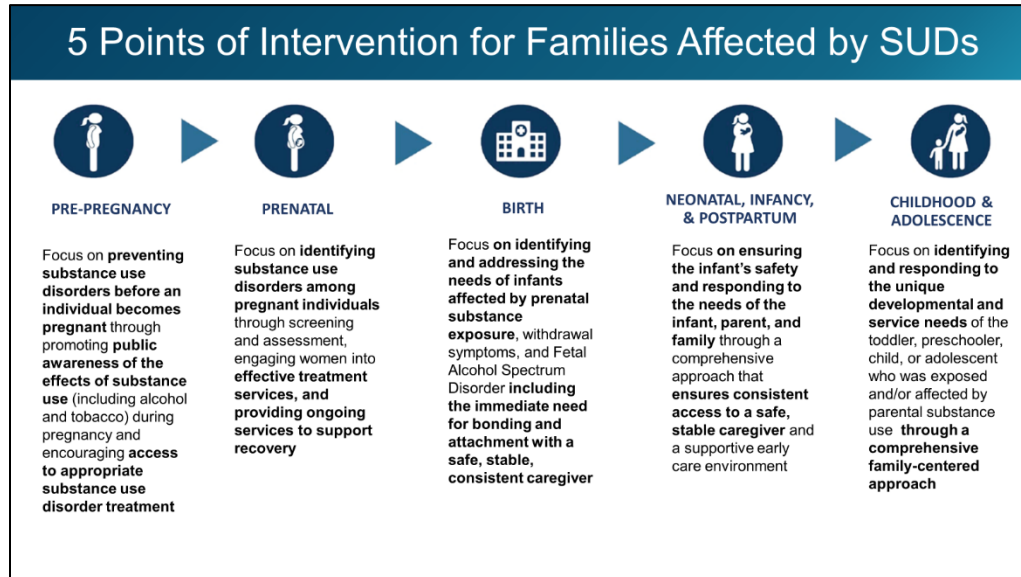
*Facilitator Note: slide is intended to be a segue or transition to detailed content on next slide.*

[As you mentioned] one such strategy is ensuring pregnant and parenting persons with substance use disorders have access to specialized care coordination to meet their family's unique and individualized needs. Let's spend this next section reviewing the 5 points of interventions with specific emphasis on the continuum of specialized care coordination...



## Slide 27

### 5 Points of Intervention for Families Affected by SUDs



#### Facilitator Script:

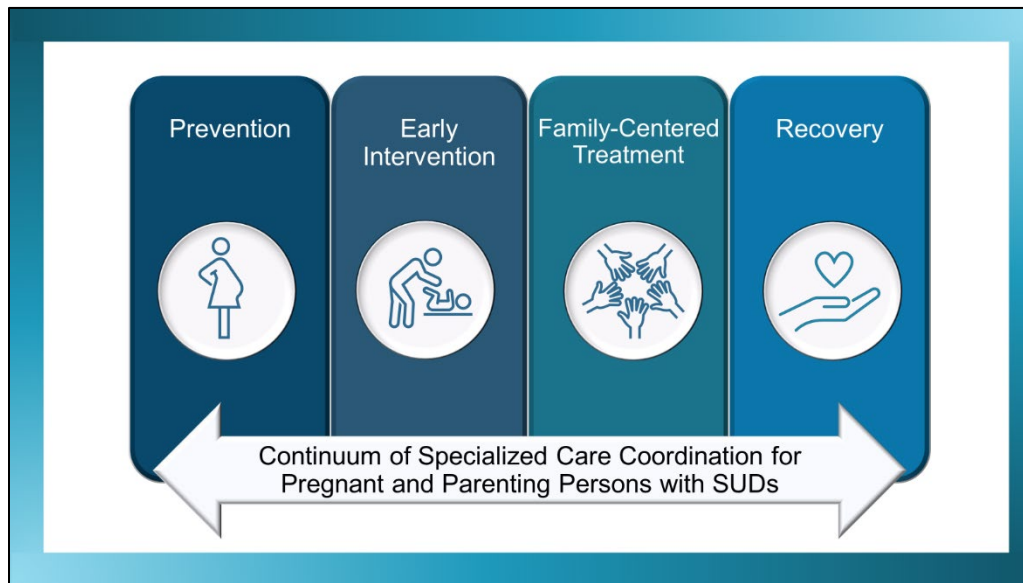
Let's start with this visual reminder of the 5 points of intervention for families affected by substance use disorders...

- Beginning with the pre-pregnancy stage— the focus is on prevention. Promoting awareness of the effects of substance use during pregnancy and encouraging access to appropriate substance use disorder treatment services.
- With the prenatal stage— the focus is on early identification through screening, assessment, and referral for effective treatment services including recovery-oriented supports for pregnant persons
- During the birth stage— the focus is on screening and identification of prenatal substance exposure, access to non-pharmacological and pharmacological treatment to promote the health and well-being of both infant and parent.
- With the neonatal, infancy, and postpartum stage— the focus should remain on meeting the comprehensive needs of the infant, parent, and family to ensure a stable and supportive early care environment.
- And lastly, the childhood and adolescence stage— the focus is on early screening and identification of developmental needs and referral to indicated services and supports.



## Slide 28

### *Continuum of Specialized Care Coordination for Pregnant and Parenting Persons with SUDs*



#### Facilitator Script:

Regardless of the specific point of intervention, specialized care coordination for pregnant and parenting persons with substance use disorders should consist of a full-service array spanning prevention, early intervention, family-centered treatment, and recovery-oriented supports and services. Let's spend some time exploring evidenced-supported prevention and early intervention programs and models known to support our work with children and families affected by substance use disorders...



## Slide 29

### *Maternal, Infant, Early Childhood Home Visiting Programs*

**Maternal, Infant, Early Childhood Home Visiting Programs**

Goals of MIECHV Programs:

- Improve maternal and infant health
- Prevent child abuse and neglect
- Reduce crime and intimate partner violence
- Increase family education level and earning potential
- Promote children's development and school readiness
- Connect families to needed resources and supports

#### Facilitator Script:

Funded by the Health Research Services Administration (or HRSA), maternal, infant, early childhood home visiting programs (or MIECHV) provide pregnant and parenting persons and their families with the “necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to succeed.” The goals of these voluntary home visiting programs include:

- Improving maternal and infant health
- Preventing child abuse and neglect
- Reducing crime and intimate partner violence
- Increasing family education level and earning potential
- Promoting children's development and school readiness
- And connecting families to needed resources and supports

Source: (HRSA Maternal and Child Health, 2024)



## Slide 30

### *Benefits of MIECHV Models*

**Benefits of MIECHV Models**

Services and Supports Targeting:

- Healthy Pregnancy Practices
- Knowledge & Awareness (safe sleep, nutrition, etc.)
- Learning & Language Development
- Positive Parenting
- Family Enrichment Planning
- Referral & Linkage

#### **Facilitator Script:**

There are many benefits to home visiting models, including services and supports targeting:

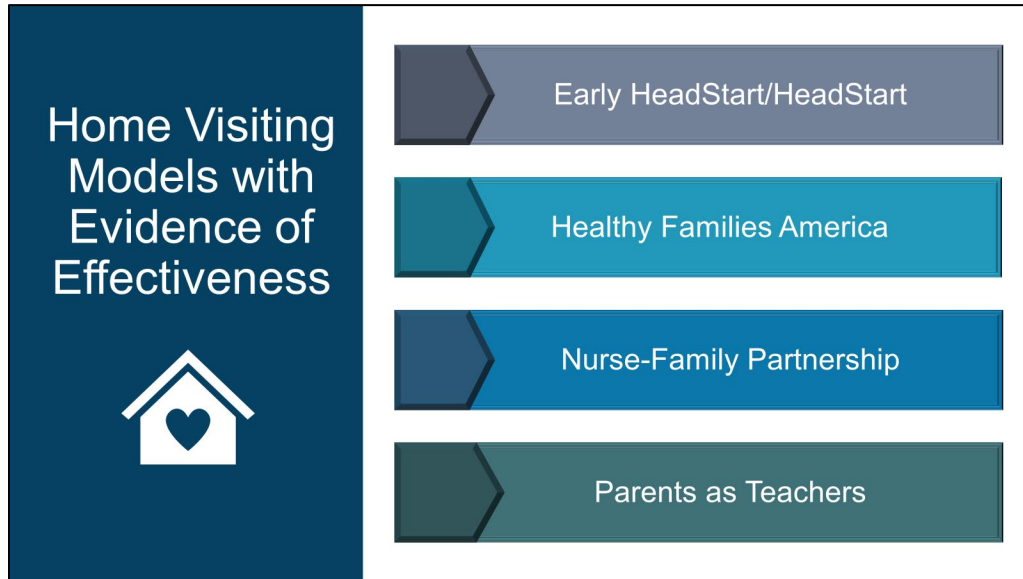
- Healthy pregnancy practices
- Knowledge and awareness (about things like safe sleep practices and healthy nutritional habits)
- Support with infant learning and language development
- Coaching and support with positive parenting techniques
- Help with family enrichment planning (things like setting goals, continuing education, or obtaining employment)
- And referral and linkage to community supports and services

Source: (HRSA Maternal and Child Health, 2024)



## Slide 31

### *Home Visiting Models with Evidence of Effectiveness*



#### Facilitator Script:

Similar to the prevention services clearinghouse, the home visiting evidence of effectiveness (or HomVEE) oversees the thorough review of home visiting program models to ensure their overall effectiveness in meeting family support needs. Currently, there are over 20 home visiting models with a HomVEE designation and here we have listed the top four in relation to our work with children and families affected by substance use and co-occurring disorders. These include:

- Early HeadStart or HeadStart
- Healthy Families America
- Nurse-Family Partnership
- And Parents as Teachers

In FY2022, home visiting models reached 138,000 parents and children totaling 840,000 home visits.

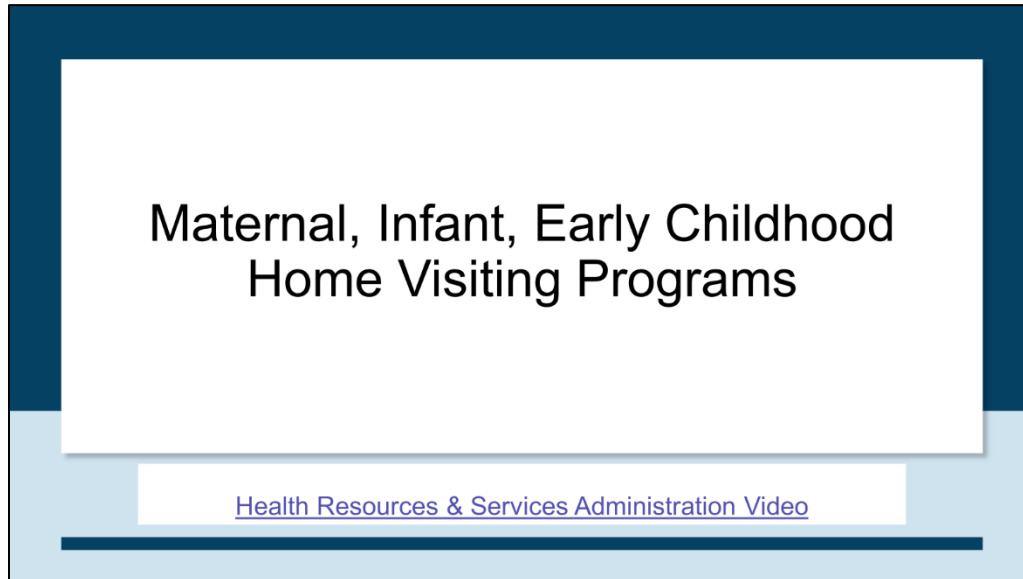
Source: (HRSA Maternal and Child Health, 2024)





## Slide 32

### *Maternal, Infant, Early Childhood Home Visiting Programs*



#### Facilitator Script:

*Facilitator Notes: Internet or Wi-Fi permitting, click on hyperlink for a 5-minute video by the Health Resources and Services Administration. Proceed with facilitating a large group discussion using the following prompts:*

#### Prompts for Participants:

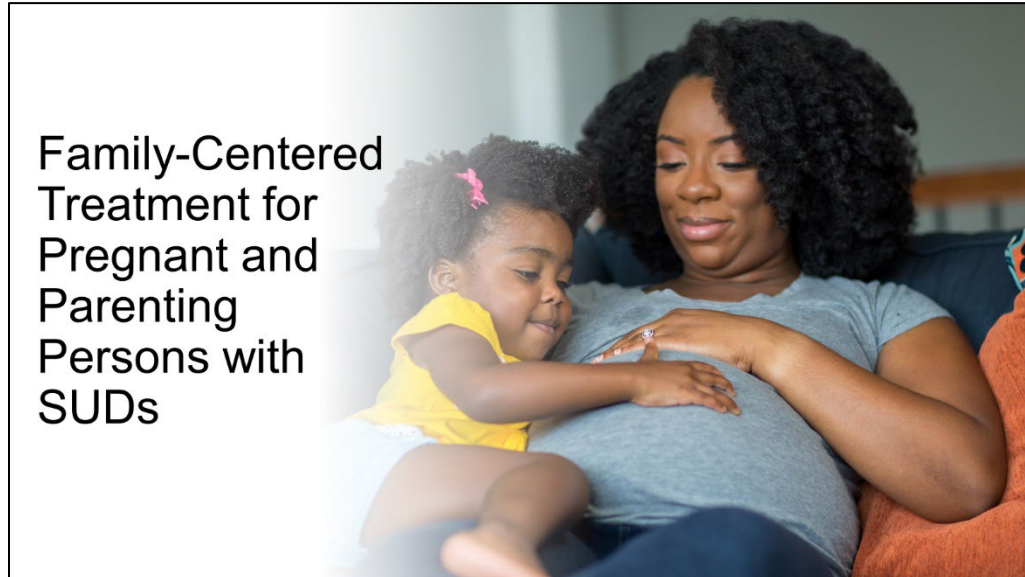
- **So, as the video mentioned, states and local jurisdictions have the discretion to select home visiting programs that best meet the needs of their specific community. Which home visiting programs are currently funded in your community?**
- **Are families affected by substance use disorders voluntarily signing up for these home visiting programs and services?**
- **For those in the room who have or currently collaborate with home visiting providers, can you share how these services have contributed to improved outcomes for the parent-infant dyad during the critical postpartum period?**

Video Source: Health Resources & Services Administration



## Slide 33

### *Family-Centered Treatment for Pregnant and Parenting Persons with SUDs*



#### Facilitator Script:

*Facilitator Notes: Slide is intended to be a segue or transition to detailed content on next slide.*

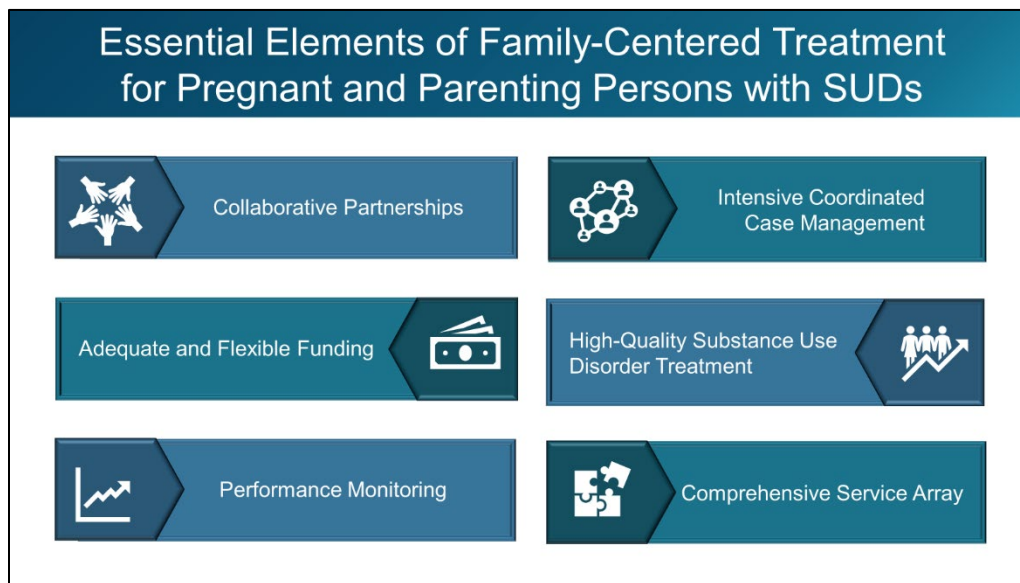
#### Prompt for Participants:

**When we say family-centered treatment for pregnant and parenting persons with substance use disorders—what does this mean to you?**



## Slide 34

### *Essential Elements of Family-Centered Treatment for Pregnant and Parenting Persons with SUDs*



#### Facilitator Script:

Family-centered treatment is the cornerstone of our work with pregnant and parenting persons with substance use disorders. Here we are highlighting essential elements of family-centered treatment organized by policy-level considerations on the left and practice-level considerations on the right.

To begin with, collaborative partnerships are the foundation to support the development of a comprehensive, community-based, and family-centered approach. Ideally, these partnerships will become an established collaborative or initiative that will continue to address barriers, support interagency communication and information sharing to benefit the safety and well-being of families.

Implementation of collaboratives or initiatives promoting new or best practices often require adequate and flexible funding for long-term sustainability. As child welfare workers we are very familiar with how funding can serve as a barrier to readily available and well-resourced services and supports in our communities.

Performance monitoring is critical to ongoing continuous quality improvement planning. This process allows partners to identify shared performance measures that are mutually beneficial with mechanisms in place to monitor progress toward family outcomes.

Intensive coordinated case management services is a process that you all are very familiar with that enables multidisciplinary partners to address the multiple and complex needs of children and families affected by substance use disorders.

Next (and at the very heart of family-centered treatment) is high-quality substance use disorder treatment— characteristic of evidence-based, gender-specific, and trauma-informed models that deliver therapeutic services and aftercare support. Examples of high-quality substance use



disorder treatment include family-based recovery programs that allow families to reside together during the therapeutic intervention period (options include family-based residential treatment programs, or mother and infant residential treatment programs, intensive outpatient programs that include on-site childcare services or those that allow and encourage parent-infant programming).

And finally, the last essential element to family-centered treatment includes the provision of a comprehensive service array– to include access to indicated services that address the needs of the entire family (as defined by them) supporting the overall health, well-being, and recovery outcomes for children and families affected by substance use disorders.



## Slide 35

### *Meeting the Neurodevelopmental Needs of Children and Adolescents with Prenatal Substance Exposure*



#### Facilitator Script:

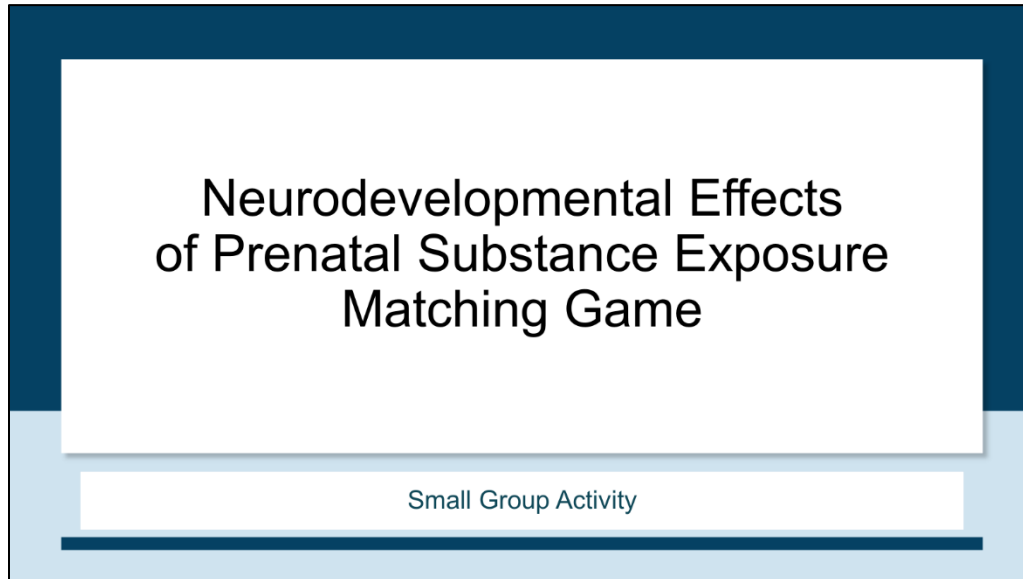
*Facilitator Note: slide is intended to be a segue or transition to detailed content on next slide.*

Meeting the neurodevelopmental needs of children and adolescents begins with our general understanding and differentiation of both short-term and long-term effects of prenatal substance exposure. Let's convene in our small groups for an exercise to help reinforce our learning from all previous modules including today's content...



## Slide 36

### *Neurodevelopmental Effects of Prenatal Substance Exposure Matching Game*



#### Facilitator Script:

*Facilitator Notes: Ask learners to reconvene in their small groups for an activity titled Neurodevelopmental Effects of Prenatal Substance Exposure Matching Game. Using pre-filled large easel paper that lists de-identified descriptions of neurodevelopmental effects of prenatal substance exposure and pre-filled post-it notes with names of different types of substances (nine total– alcohol, tobacco, cannabis, prescription opioids, heroin, cocaine, methamphetamine, inhalants, MDMA). Ask learners to work with their team members to quickly and accurately match the descriptions. Set a timer for 5 minutes and track to see which group completes the task first. Ask them to walk through their answers with the larger group and verify that all matches are correct; use this as an opportunity to redirect to another group should there be any incorrect matches identified.*

Answer Key:

#### Alcohol:

Facial abnormalities; growth problems; central nervous system problems including problems with the heart, kidneys or bones; challenges with learning, memory, attention, vision and/or hearing; challenges with social interactions, intellectual disabilities and/or behavioral problems.

#### Tobacco:

Hypertonicity (tense muscles); attention and/or hyperactivity challenges; behavioral challenges including negative and externalizing behaviors; language delays and learning difficulties including deficits in reading, speech, math, and spelling; no consistent effects on somatic growth after 24 months.





Cannabis:

Challenges with attention, impulsivity, memory, and problem solving throughout development; learning difficulties specifically with deficits in reading and spelling; increased rates of depression and aggressive behaviors.

Prescription Opioids:

Premature birth, low birth weight, and birth defects; small head circumference; increased risk of sudden infant death syndrome; blotchy skin coloring, diarrhea, excessive crying or pitched crying, excessive sucking, hyperactive reflexes, tremors, irritability, poor feeding, rapid breathing, seizures, and sleep challenges.

Heroin:

Attention and behavioral challenges; later onset for girls than boys.

Cocaine:

Fussy and difficult temperament; irritability and lability; decreased behavioral/autonomic regulation; slower psychomotor development; language delays in early childhood with some evidence of learning disabilities; attention deficit and hyperactivity; oppositional defiant behavior.

Methamphetamine:

Limited and emerging data show increased risk for a lower IQ by age 4; violent behavior by age 8; challenges with attention and high emotional reactivity.

Inhalants:

Hypertonicity; delays in gross motor skills and other physical abilities.

MDMA:

Delays in motor development during first year of development; increased risk for heart problems or stroke; learning difficulties.

---

*\*Alternative Instructions for Virtual Training*

*Use your virtual platform's polling feature to create the following prompts:*

- 1) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Facial abnormalities; growth problems; central nervous system problems including problems with the heart, kidneys or bones; challenges with learning, memory, attention, vision and/or hearing; challenges with social interactions, intellectual disabilities and/or behavioral problems.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Alcohol



- 2) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Hypertonicity (tense muscles); attention and/or hyperactivity challenges; behavioral challenges including negative and externalizing behaviors; language delays and learning difficulties including deficits in reading, speech, math, and spelling; no consistent effects on somatic growth after 24 months.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Tobacco

- 3) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Challenges with attention, impulsivity, memory, and problem solving throughout development; learning difficulties specifically with deficits in reading and spelling; increased rates of depression and aggressive behaviors.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Cannabis

- 4) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Premature birth, low birth weight, and birth defects; small head circumference; increased risk of sudden infant death syndrome; blotchy skin coloring, diarrhea, excessive crying or pitched crying, excessive sucking, hyperactive reflexes, tremors, irritability, poor feeding, rapid breathing, seizures, and sleep challenges.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine



7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Prescription Opioids

- 5) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Attention and behavioral challenges; later onset for girls than boys.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Heroin

- 6) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Fussy and difficult temperament; irritability and lability; decreased behavioral/autonomic regulation; slower psychomotor development; language delays in early childhood with some evidence of learning disabilities; attention deficit and hyperactivity; oppositional defiant behavior.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Cocaine

- 7) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Limited and emerging data show increased risk for a lower IQ by age 4; violent behavior by age 8; challenges with attention and high emotional reactivity.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin



6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Methamphetamine

- 8) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Hypertonicity; delays in gross motor skills and other physical abilities.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

Answer: Inhalants

- 9) Match the neurodevelopmental effects of prenatal exposure to its respective substance (Choose one answer)

Delays in motor development during first year of development; increased risk for heart problems or stroke; learning difficulties.

1. Alcohol
2. Tobacco
3. Cannabis
4. Prescription Opioids
5. Heroin
6. Cocaine
7. Methamphetamine
8. Inhalants
9. MDMA

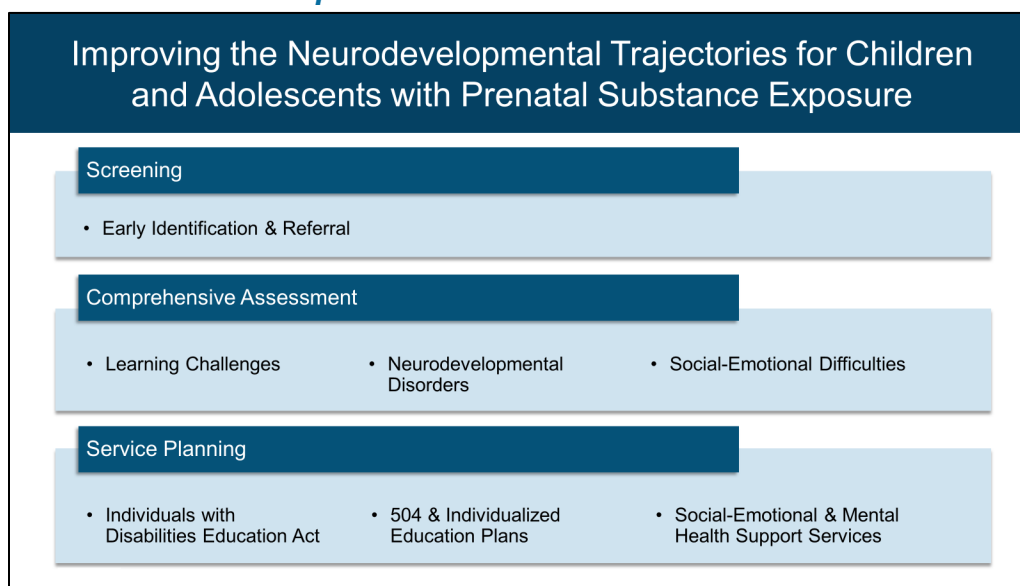
Answer: MDMA

Source: (UMBC Home Visiting Training Program, 2023)



## Slide 37

### *Improving the Neurodevelopmental Trajectories for Children and Adolescents with Prenatal Substance Exposure*



#### Facilitator Script:

Early identification and referral for comprehensive assessment are effective strategies for improving the neurodevelopmental trajectories for children and adolescents with prenatal substance exposure. As we know, timely intervention is critical especially for children and adolescents whose neurodevelopmental needs have gone undiagnosed or untreated despite known or suspected histories of prenatal substance exposure.

As such, a comprehensive assessment can identify delays in development, including potential learning challenges, neurodevelopmental disorders, and social-emotional difficulties that may be contributing to challenges in the home and school settings.

Results from the comprehensive assessment will inform service planning related to the Individuals with Disabilities Education Act (or IDEA). IDEA governs the provision of early intervention, special education, and related services to more than 7.5 million eligible infants, toddlers, children, and adolescents with known disabilities. More specifically, infants and toddlers with disabilities (age 0-2) receive early intervention services under IDEA part C; whereas children and adolescents with disabilities (age 3-21) receive special education and related services under IDEA part B.

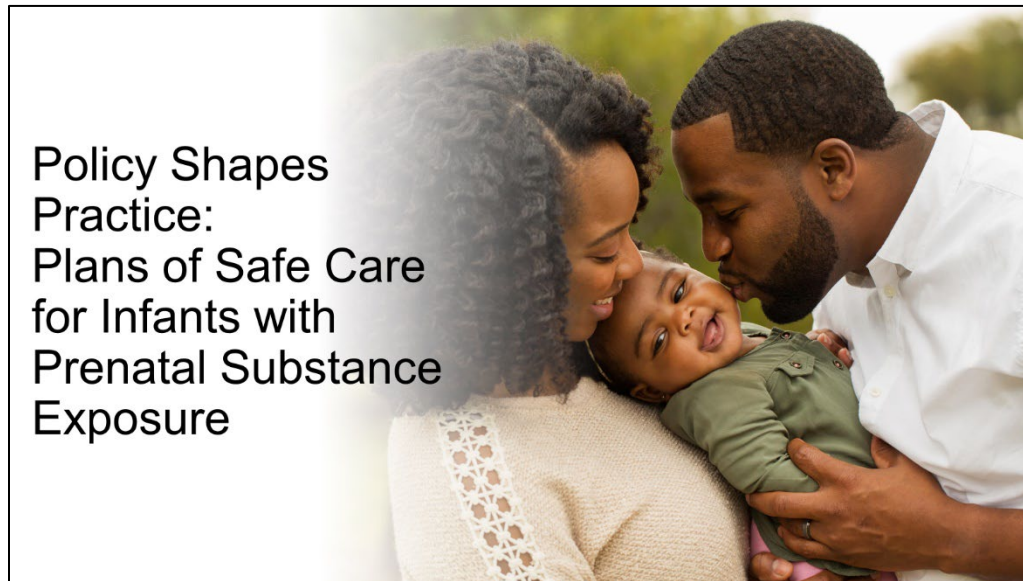
Additional steps in neurodevelopmental service planning will include decisions related to a child or adolescent's educational needs. For reference, 504 plans are designed to provide classroom and learning accommodations in the absence of specialized instruction versus individualized education plans (or IEPs) that provide additional intentional interventions through specialized instructional goals and objectives. Depending on the type of disability, this may also include decisions related to supporting the social-emotional health and well-being of students and may include on-site therapeutic services aimed at promoting adaptive coping for increased academic success.

Source: (Individuals with Disabilities Education Act, n.d.)



## Slide 38

### *How Policy Shapes Practice: Plans of Safe Care for Infants with Prenatal Substance Exposure*



#### Facilitator Script:

#### Prompts for Participants:

**Who here is familiar with Plans of Safe Care? Does anyone want to take a shot at defining what this is for your peers in the room?**

[That's great, thank you for volunteering.]

So yes, plans of safe care are individually designed care plans for infants and families affected by prenatal substance exposure. Goals of plans of safe care include infant safety and strengthening of the family unit through multi-system collaboration and are guided by key federal policies. Before we jump in, let's begin with an expert video series introducing the plan of safe care...



## Slide 39

### *Expert Video Series: Introduction to the Plan of Safe Care*



#### Facilitator Script:

*Facilitator Notes: Internet or Wi-Fi permitting, open the hyperlink for a 3-minute video by the Director of the Vanderbilt Center for Child Health Policy. Proceed with facilitating a large group discussion using the following prompts:*

#### Prompts for Participants:

- **Any initial thoughts or reactions to what Dr. Patrick discussed in the video?**
- **What about the substance-related data he highlighted regarding 1 out of 10 pregnancies affected by prenatal substance use. Reactions to this and any other figures highlighted in the video?**
- **With what we know about the perinatal and postpartum periods, how can plans of safe care help to prevent maternal overdoses and/or reduce the number of out-of-home entries for children aged 0-1?**

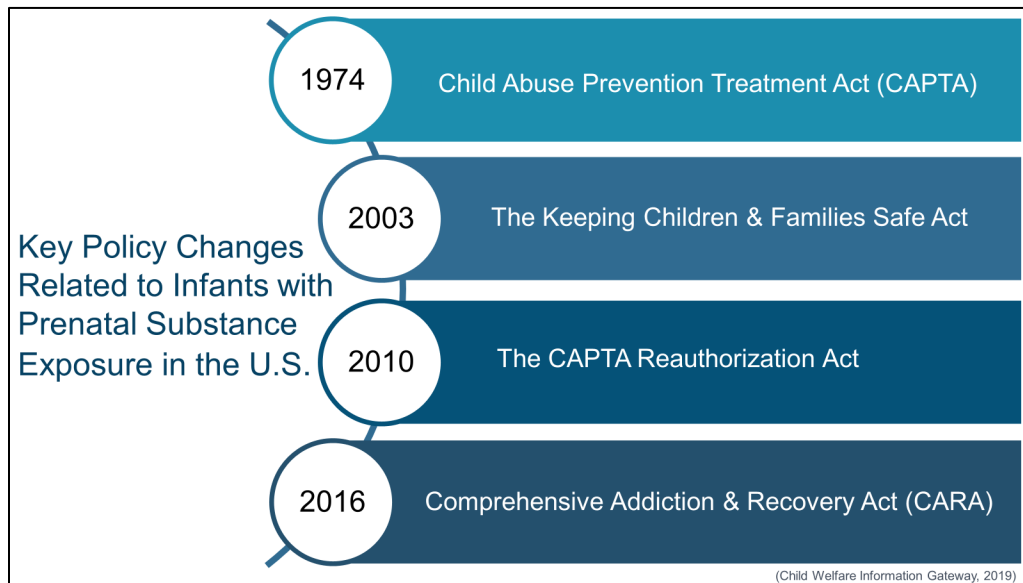
Video Source: National Center on Substance Abuse and Child Welfare





## Slide 40

### *Key Policy Changes Related to Infants with Prenatal Substance Exposure in the U.S.*



#### Facilitator Script:

As mentioned by Dr. Stephen Patrick, here we have a summary of key policy changes related to infants with prenatal substance exposure in the United States...

To begin with, we have the Child Abuse Prevention and Treatment Act (or CAPTA) dating back to 1974 which covers many elements of funding, education, research and policy related to child abuse and neglect.

Fast forward to 2003, and we have the Keeping Children and Families Safe Act which included the provision of a healthcare notification regarding prenatally exposed infants to child welfare along with an identified plan of safe care outlining service engagement and care coordination.

Year 2010 marked the CAPTA Reauthorization Act which amended the criteria to include infants with fetal alcohol spectrum disorders (or FASDs) to notification and plan of safe care requirements.

And more recently, the Comprehensive Addiction and Recovery Act (or CARA) of 2016 included more robust amendments including:

- Further clarification regarding target population by removing reference to the term 'illegal,' effectively expanding eligibility to infants who may have had an exposure at time of birth but with no child abuse or neglect allegation; examples may include infants with prenatal cannabis exposure with no immediate safety or risk concerns; or infants with prenatal methadone exposure resulting from medication for opioid use disorder also absent of any immediate safety or risk concerns.
- An additional amendment included changes to the language thereby expanding the plan of safe care to include the needs of the affected caregiver and family. As such, an increasing number of states and local jurisdictions are adopting new language such as



Family Care Plans or Family Wellness and Support Plans, as part of a targeted strategy to reduce stigma and further reduce barriers to equitable access to substance use disorder treatment services.

- Closing out the summary of key policy changes in 2016 included the addition of increased monitoring and oversight required of states to ensure the successful implementation of plans of safe care including access and utilization of all indicated services and supports.

Source: (Child Welfare Information Gateway, 2019)



## Slide 41

### *How Families Benefit from Plans of Safe Care*



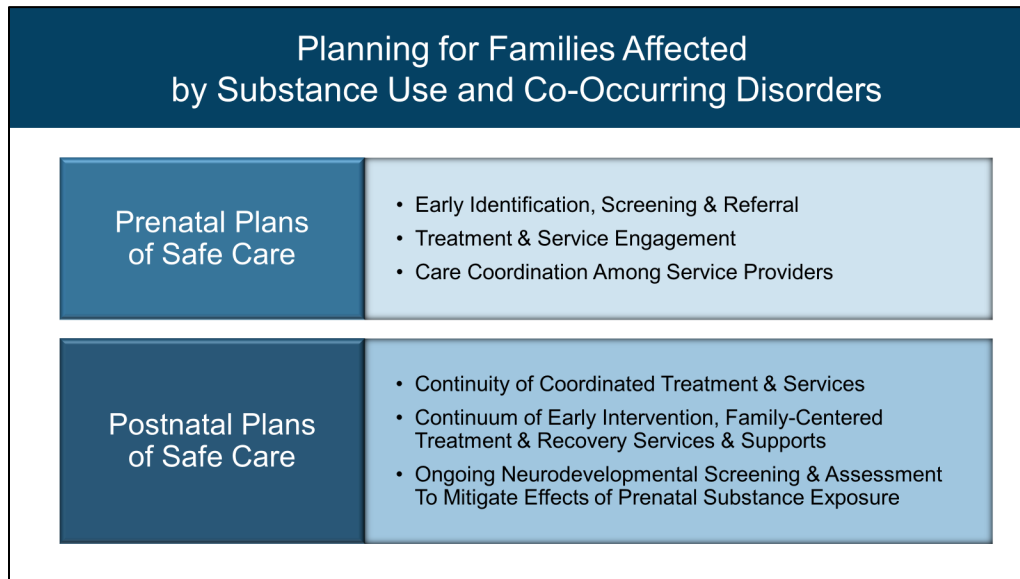
#### **Facilitator Script:**

A plan of safe care is an opportunity to collaborate and serve a family of an infant with prenatal substance exposure. The plan itself provides an opportunity to engage the family in services prior to the birthing event, further reducing the likelihood of a crisis. For instance, a plan that is developed and in place prior to the infant's birth could ensure that the necessary services are in place and that any concerns for infant safety have been mitigated. Plans of safe care also promote healthy parent-infant dyad development through coordinated case management helping to ensure timely referral and access to all indicated services for the infant, affected caregiver, and family members. And finally, the level of intensive care coordination that occurs with plans of safe care helps to ensure the ongoing safety and well-being of families affected by substance use disorders, further reducing maternal and infant mortality rates.



## Slide 42

### *Planning for Families Affected by Substance Use and Co-Occurring Disorders*



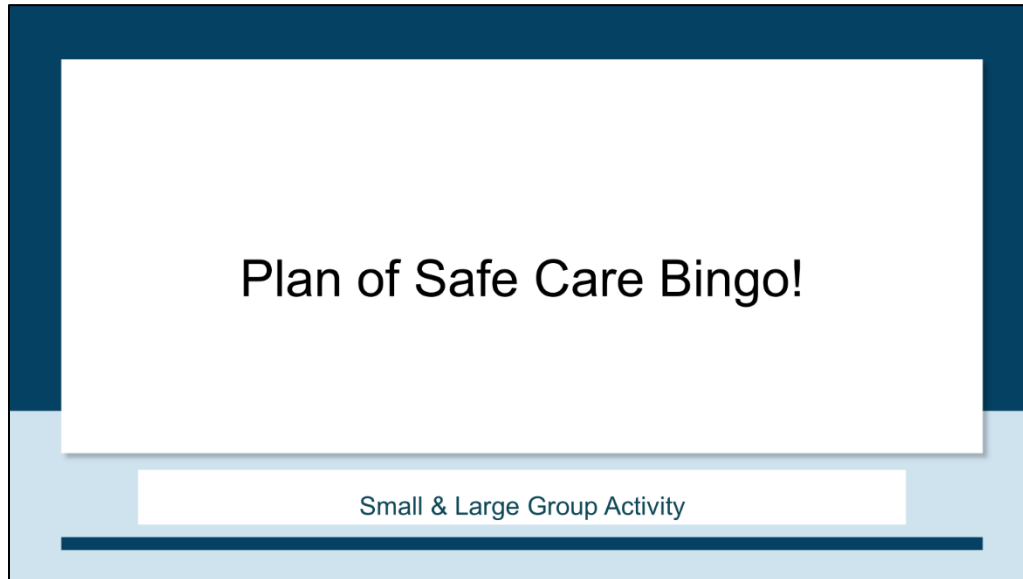
#### Facilitator Script:

Plans of safe care provide different points of intervention for families affected by substance use and co-occurring disorders. Here we break down how plans of safe care can ensure access to services (and care coordination among service systems) before and after the birthing event. Ideally, families are engaged into services before the infant's birth (hence prenatal plan of safe care); and the postnatal plan of safe care can ensure continuity of services, particularly during the critical postpartum phase. Let's now apply what we have learned with an activity...



## Slide 43

### *Plan of Safe Care Bingo!*



#### Facilitator Script:

Now that we have a general understanding of the purpose and intent of plans of safe care, let's spend some time thinking about the types of information needed from families to help develop a comprehensive and detailed plan.

#### *Additional Notes:*

*Instruct small groups to develop their POSC bingo card (one card per small group) filling each box on their card with information needed to inform a family's plan of safe care. Groups should consider and add information from all four of the categories listed below to increase their chances of Bingo during the large group portion of the activity:*

1. *Infant's Medical Care*
2. *Mother's Medical Care*
3. *Parent's Substance Use and/or Mental Health Needs*
4. *Family/Caregiver History and Needs*

*Bring small groups back for a round of POSC bingo using a randomized drawing method for all the possible responses below:*

#### *Infant's Medical Care*

1. *Prenatal Exposure History*
2. *Details of Hospital Care (e.g., NICU, length of stay, diagnosis)*
3. *Other medical or developmental concerns*
4. *Pediatric Care and Follow-Up*
5. *Referrals to Early Intervention and Other Services*



*Mother's Medical Care*

1. *Prenatal Care History*
2. *Pregnancy History*
3. *Other Medical Concerns*
4. *Follow-Up Care with OB/GYN*
5. *Referrals to Other Healthcare Services*

*Parent's Substance Use and Mental Health Needs*

1. *Substance Use & Mental Health History*
2. *Current or Past Treatment and Services*
3. *Current or Past Medication History*
4. *Referrals to Family-Centered Treatment and Recovery-Oriented Supports and Services*

*Family/Caregiver History and Needs*

1. *Family History*
2. *Parent-Child Dyad (Level of Bonding and Attachment)*
3. *Current Living Arrangements*
4. *Past or Current Child Safety or Risk Concerns (Including Prior Child Welfare Involvement)*
5. *Current or Other Needed Services*



## Slide 44

### *Effective Implementation of Plans of Safe Care Requires Cross-System Collaboration*



#### Facilitator Script:

So, now that we have an idea about the type of information that is needed to inform the plan of safe care, we'll also need to think about strategies to support their effective implementation. As we've mentioned throughout this training toolkit, we know no single agency can tackle this issue on its own; it requires a coordinated response that draws on the expertise and resources of many agencies and providers to promote the safety, permanency, well-being, and recovery outcomes for children and families affected by substance use and co-occurring disorders which also extends to the effective implementation of plans of safe care. The comprehensive care team for pregnant and parenting persons, their infants, and affected family members make up a multidisciplinary group of professionals from maternal and child health, early childhood, substance use and mental health treatment, child welfare, and other family-serving agencies who are all coming together with the common goal of enhancing the lives of children and families. Here we have highlighted six important components to effective implementation of plans of safe care which emphasize the need for cross-system collaboration:

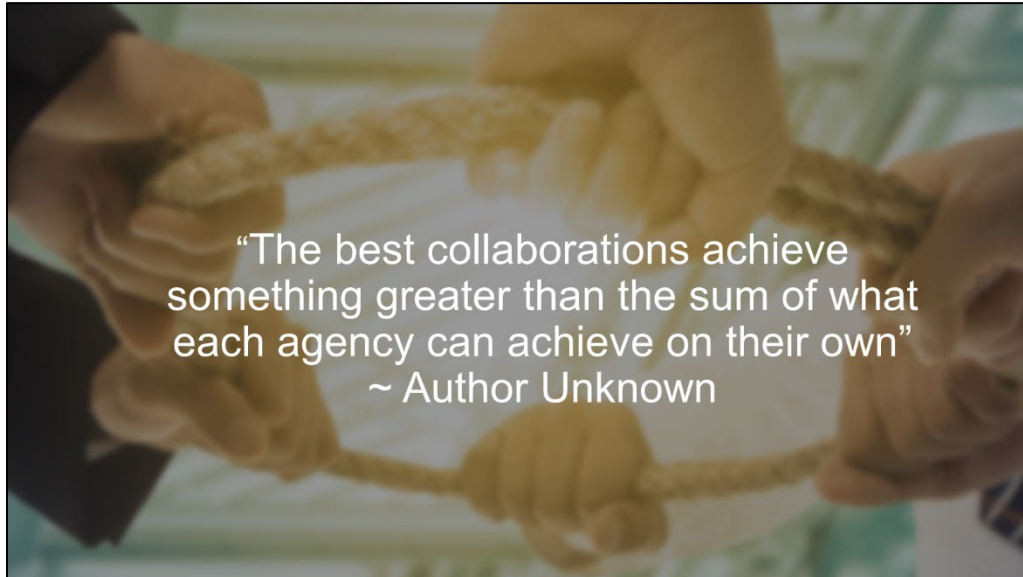
1. Identify who is responsible for completing and monitoring the plan,
2. Develop shared definitions and terminology across systems,
3. Enhance cross-systems communication for information and data sharing,
4. Develop a flexible approach using an array of services and supports,
5. Improve timely access to indicated services and supports, and
6. Discuss implementation progress including areas of practice and policy improvements





## Slide 45

### *The Best Collaborations...*



#### Facilitator Script:

So, as we wrap up today’s training discussion (and the conclusion of the Child Welfare Training Toolkit), it only seems fitting to end with this reminder from module 7 that we simply cannot do this work alone– only together can we truly help children and families thrive. Thank you all so much for your hard work and dedication to children and families affected by substance use and co-occurring disorders. It’s been a pleasure to be a part of this learning opportunity with you!



## Slide 46


### Contact the NCSACW TTA Program

**Contact the NCSACW  
Training and Technical  
Assistance (TTA) Program**

Connect with programs that are developing tools and implementing practices and protocols to support their collaborative

Training and technical assistance to support collaboration and systems change

**National Center on  
Substance Abuse  
and Child Welfare**

 <https://ncsacw.acf.hhs.gov/>

 [ncsacw@cffutures.org](mailto:ncsacw@cffutures.org)

 Toll-Free @ 1-866-493-2758

### Facilitator Script:

Alright, this wraps up the instructional content for module ten. If you have any follow up questions from today's training, feel free to reach out to the National Center on Substance Abuse and Child Welfare at [ncsacw@cffutures.org](mailto:ncsacw@cffutures.org) or toll free at 1-866-493-2758. Thank you all for our rich discussion today and for your continued work on behalf of children, parents, and families affected by substance use and co-occurring disorders. Take care, everyone!



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## Resources

- American College of Obstetricians and Gynecology: [\*Marijuana and Pregnancy\*](#) (2023)
- National Center on Substance Abuse and Child Welfare: [\*Fetal Alcohol Spectrum Disorder: Bending the Trajectory Webinar\*](#) (2023)
- National Center on Substance Abuse and Child Welfare: [\*How States Serve Infants and Their Families Affected by Prenatal Substance Exposure Series\*](#) (2021)
- National Center on Substance Abuse and Child Welfare: [\*Infants and Families Affected by Prenatal Substance Exposure: Five Points of Family Intervention\*](#) (2023)
- National Center on Substance Abuse and Child Welfare: [\*Plan of Safe Care Expert Video Series\*](#) (2023)
- National Center on Substance Abuse and Child Welfare: [\*Plans of Safe Care Learning Modules Series\*](#) (2020)
- National Center on Substance Abuse and Child Welfare: [\*Supporting Pregnant and Parenting People with Substance Use Disorders Series\*](#) (2023)
- National Center on Substance Abuse and Child Welfare: [\*Understanding Fetal Alcohol Spectrum Disorders: Child Welfare Practice Tips\*](#) (2022)
- National Institutes of Health: [\*Maternal Morbidity and Mortality: What Do We Know? How Are We Addressing It?\*](#) (n.d.)