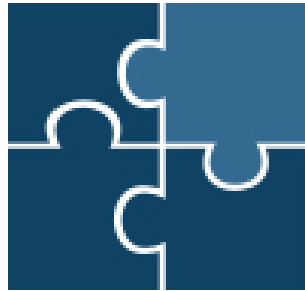




## A Plan of Safe Care Approach: What You Need to Know about Serving Pregnant and Parenting Women with Opioid Use Disorders and their Infants

Nancy Young, PhD | Children and Family Futures | MCHAP April 2019

# Acknowledgement



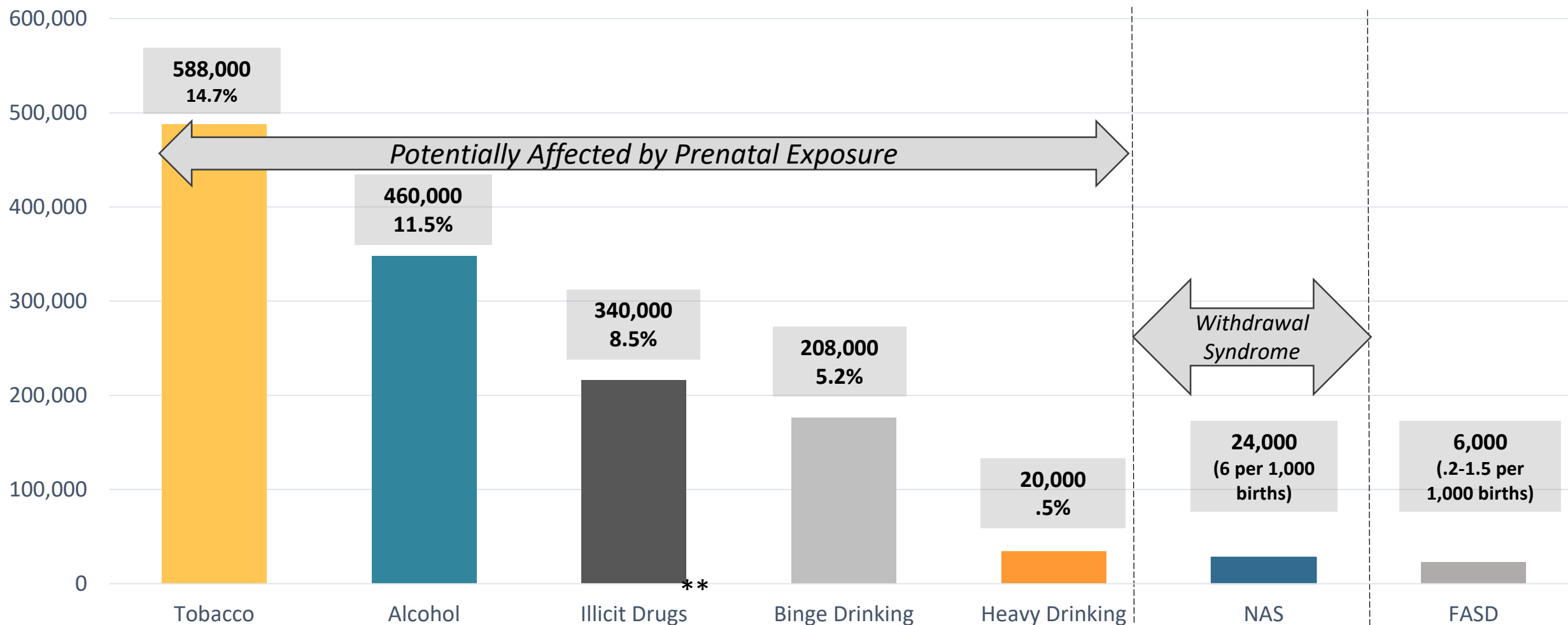
National Center on  
Substance Abuse  
and Child Welfare

*A program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families (ACF), Children's Bureau*



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# Estimated Number of Infants\* Affected by Prenatal Exposure, by Type of Substance and Infant Disorder, 2017

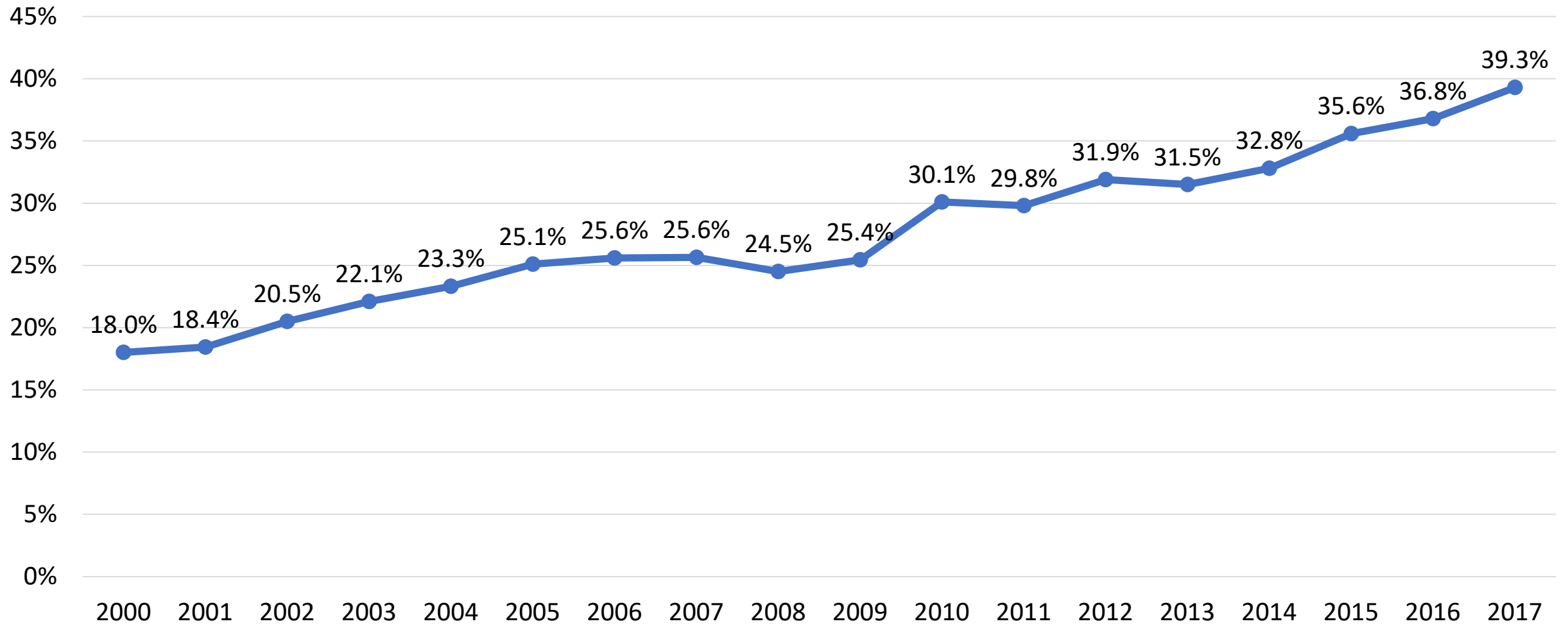


\*Approximately 4 million (3,855,500) live births in 2017; National Vital Statistics Report, Vol. 67, No. 8; [https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67\\_08-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf)

Estimates based on rates of past month drug use: National Survey on Drug Use and Health, 2017; <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf>

\*\* Includes nine categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine, as well as the non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives

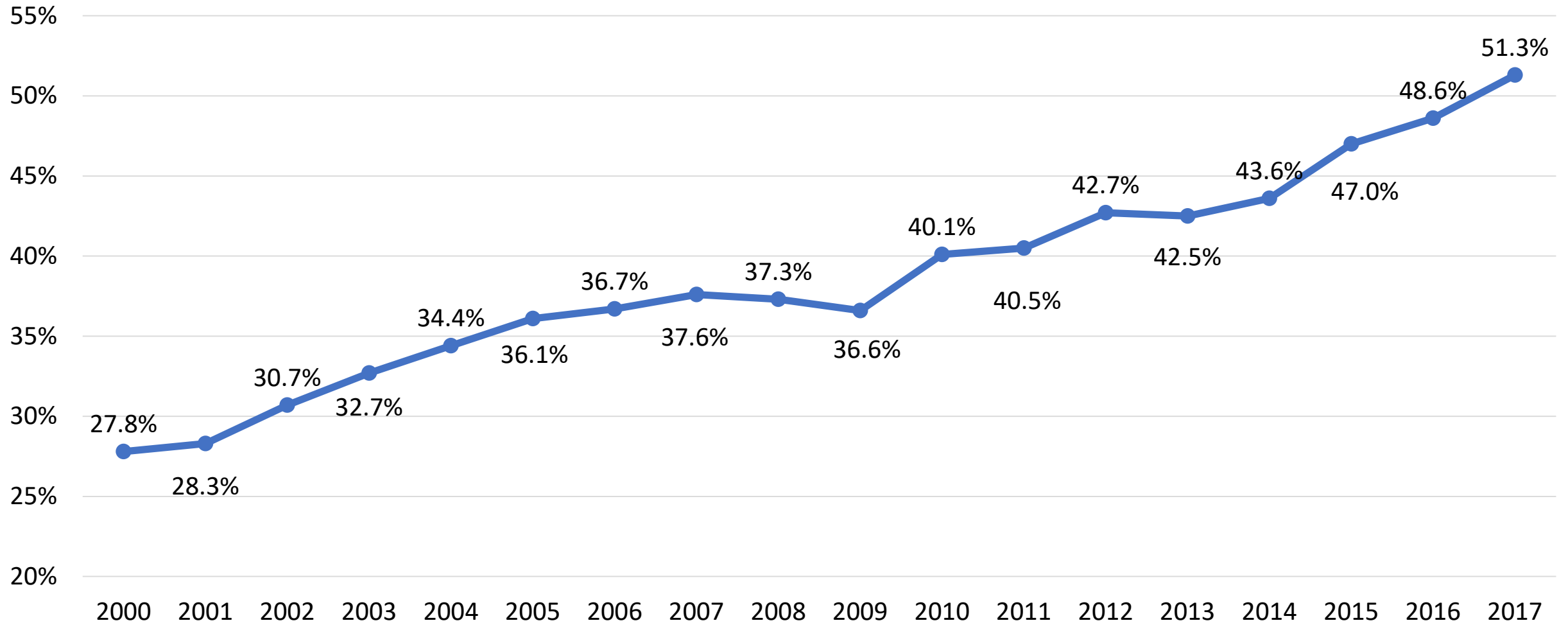
# Incidence of Parental Alcohol or Other Drug Use as a Reason for Removal in the United States, 2000 to 2017



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

Source: AFCARS Data, 2000-2017

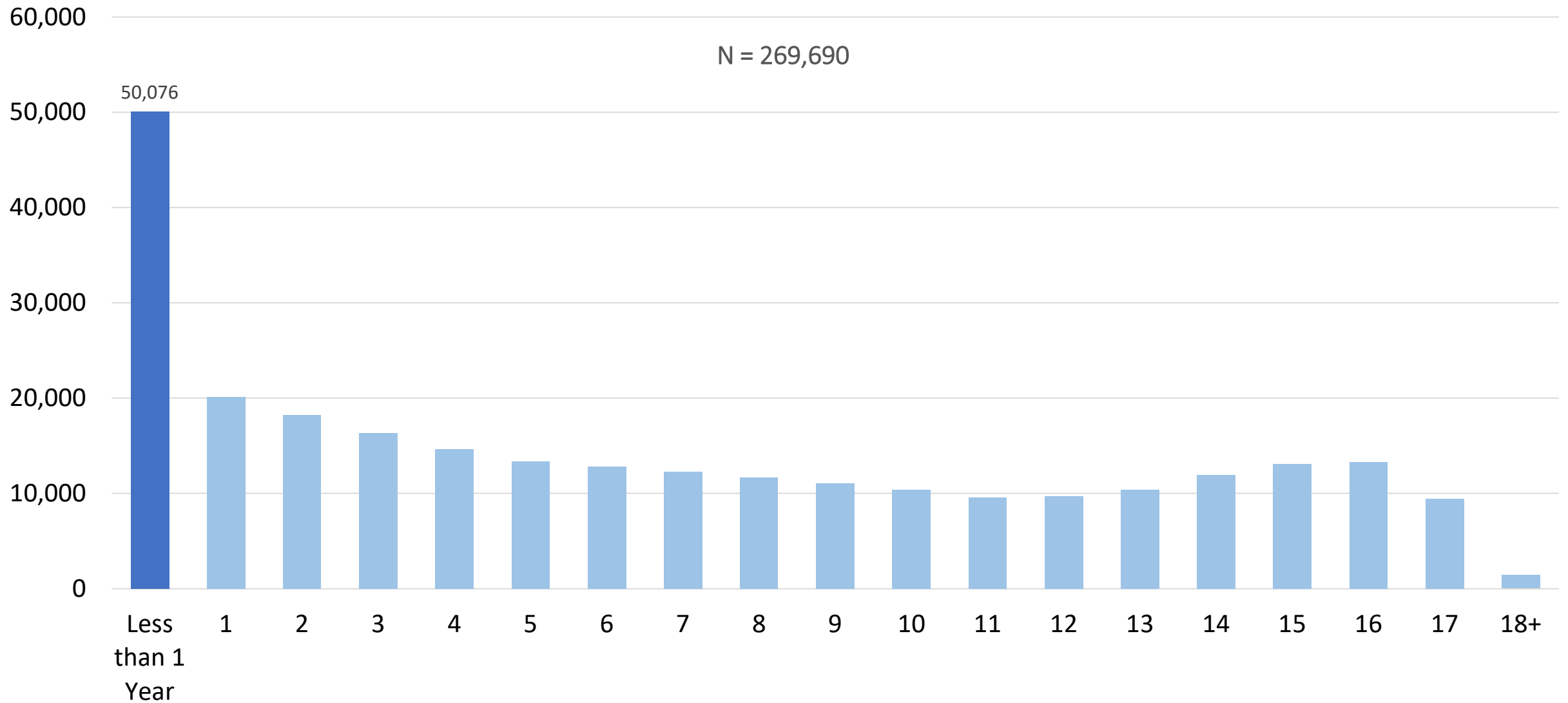
# Percent of Children Under Age 1 with Parental Alcohol or Other Drug Use as a Reason for Removal in the United States, 2000 to 2017



Note: Estimates based on children under age 1 who entered out of home care during Fiscal Year

Source: AFCARS Data, 2000-2017

# Number of Children who Entered Foster Care, by Age at Removal in the United States, 2017



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

Source: AFCARS Data, 2017

# Effects of Prenatal Substance Exposure

## American Academy of Pediatrics Technical Report

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



### Short-Term

Birth Anomalies  
Fetal Growth  
Neurobehavioral  
Withdrawal



### Long-Term



Achievement  
Behavior  
Cognition  
Growth  
Language

# Short-Term Effects of Prenatal Substance Exposure

	Growth	Anomalies	Withdrawal	Neurobehavioral
<b>Alcohol</b>	<b>Strong Effect</b>	<b>Strong Effect</b>	No Effect	Effect
<b>Nicotine</b>	Effect	No consensus	No Effect	Effect
<b>Marijuana</b>	No Effect	No Effect	No Effect	Effect
<b>Opiates</b>	Effect	No Effect	<b>Strong Effect</b>	Effect
<b>Cocaine</b>	Effect	No Effect	No Effect	Effect
<b>Methamphetamine</b>	Effect	No Effect	<b>Lack of Data</b>	Effect



# Long-Term Effects of Prenatal Substance Exposure

	Growth	Behavior	Cognition	Language	Achievement
<b>Alcohol</b>	<b>Strong Effect</b>	<b>Strong Effect</b>	<b>Strong Effect</b>	Effect	<b>Strong Effect</b>
<b>Nicotine</b>	<b>No consensus</b>	Effect	Effect	Effect	Effect
<b>Marijuana</b>	No Effect	Effect	Effect	No Effect	Effect
<b>Opiates</b>	No Effect	Effect	<b>No consensus</b>	<b>Lack of Data</b>	<b>Lack of Data</b>
<b>Cocaine</b>	<b>No consensus</b>	Effect	Effect	Effect	<b>No consensus</b>
<b>Methamphetamine</b>	<b>Lack of Data</b>	<b>Lack of Data</b>	<b>Lack of Data</b>	<b>Lack of Data</b>	<b>Lack of Data</b>

# Complex Interplay of Factors

## Interaction of various prenatal and environmental factors:

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



# The reporting of neonatal abstinence syndrome has increased over the past 15 years

A number of data sources have looked at the incidence of neonatal abstinence syndrome. While it appears that the incidence is rising due to the opioid epidemic, it is unclear whether this rise is due to increased attention to neonatal abstinence syndrome and improvements in identification, or an increase in infants being born with neonatal abstinence syndrome.

In 2000, 1.2 per 1000 hospital births were diagnosed as having Neonatal Abstinence Syndrome

(Patrick et al., 2012)

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

(Milliren et al., 2017)

**Promising Practice:**  
**A Revised Approach**  
**to NAS Treatment from**  
**a Multi-Year**  
**Improvement Effort**  
**at Yale New Haven**  
**Children's Hospital**



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



...substantial and sustained **decreases** in average **length of stay**, proportion of **infants treated with morphine**, and **hospital costs**.

(Grossman et al., 2017)

# *What was different?*

- Used **eat, sleep** and **console** assessment
- No automatic transfer to NICU
- No automatic prescribing
- Moms and babies were transferred and **stayed together** on the general hospital floor





## Changes from this program affected hospital culture including...

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

# *Benefits of the Approach*



## ***Significant Decreases in...***

Length of hospital stay for infants

**From 22.4 to 5.9 days**

Infants receiving pharmacological  
treatment

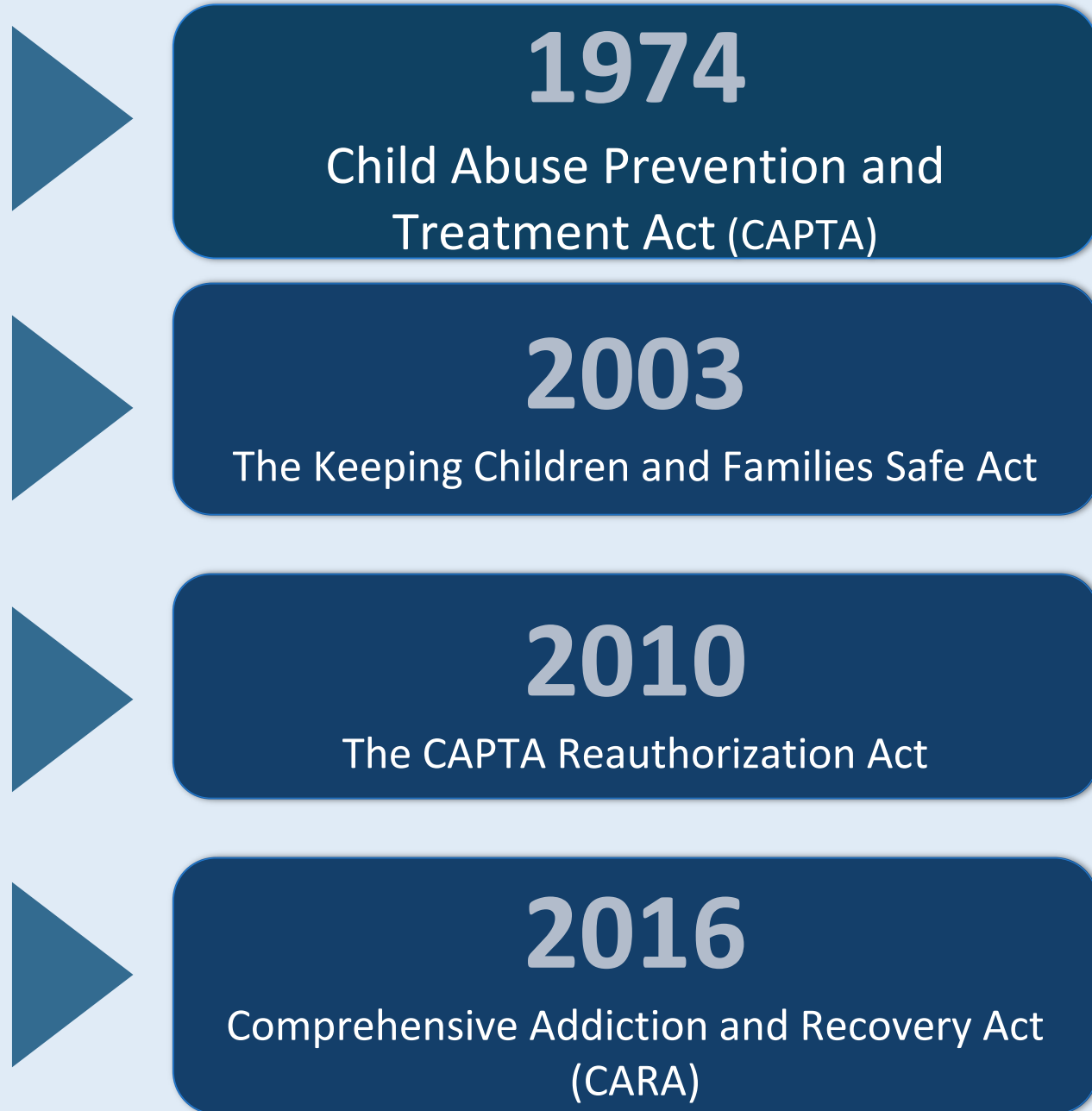
**From 98% to 14%**

Hospital costs per family

**From \$44,824 to \$10,289**

(Grossman et al., 2017)





Primary  
Changes in  
**CAPTA**  
Related to Infants  
with Prenatal  
Substance  
Exposure

# CARA's Primary Changes to CAPTA in 2016

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



CWS  
Safety  
Plan

SUD  
Treatment  
Plan

Hospital  
Discharge  
Plan

How is *Plan of Safe Care* Different?



# Domains that might be in a Plan of Safe Care

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

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

# Plans of Safe Care benefit from being...

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

**Preparing for baby's safe arrival and beyond**

# CAPTA Plan of Safe Care

## Preparing for Baby's Arrival and Beyond

- Ideally, developed prior to birth of infant
- Comprehensive multi-disciplinary assessment
- Multiple intervention points: pregnancy, birth and beyond
- Addresses needs of infant and family/caregiver
- Structure in place to ensure coordination of, access to, and engagement in services

Populations of Women	Lead Agency/Provider	
	<i>Prenatal Period</i>	<i>Identification at Birth &amp; Infant Affected</i>
<p>1. Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and <b><i>does not have a substance use disorder</i></b></p>	<p><b>Prenatal Care Provider</b> in concert with pain specialist or other physician</p>	<p><b>Maternal and Child Health Service Provider</b> Home visiting, early childhood intervention, new parent education, etc.</p>
<p>2. Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or <b><i>is actively engaged in treatment</i></b> for a substance use disorder</p>	<p><b>Prenatal Care Provider</b> in concert with <b>Opioid Treatment Provider</b> or waived prescriber and/or <b>therapeutic treatment provider</b></p>	<p><b>Therapeutic Substance Use or Opioid Use Disorder Treatment Provider</b> with support from Maternal and Child Health or Child Welfare</p>
<p>3. Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, <b><i>not actively engaged in a treatment</i></b> program</p>	<p><b>Prenatal Care Provider or High Risk Pregnancy Clinic</b> in concert with <b>substance use disorder treatment agency</b></p>	<p><b>Child Welfare Services</b></p>

A photograph of a modern building's exterior, featuring a series of large, dark-framed glass windows. The sun is setting behind the building, creating a warm, golden glow that filters through the glass panes. The sky is a mix of orange, yellow, and blue. The text is overlaid on the left side of the image.

**No single  
agency can  
do it alone**

POSC is a unique  
opportunity for cross-  
system collaboration







# Contact Information

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Executive Director

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National Center on  
Substance Abuse  
and Child Welfare

*Bringing Systems Together for  
Family Recovery, Safety and  
Stability*

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