New York State Technical Assistance – Pregnant & Parenting Women with Opioid Dependence

Site Visit
Albany, NY
August 27, 2015

Agenda

• National Center on Substance Abuse and Child Welfare
  Opioid Related Projects
• State and National Perspective
• Why is Collaborating Across Multiple Systems Essential?
• Lessons Learned from Six IDTA-SEI States
• Weaving Together a Coordinated Response
• Resources
A Program of the
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

and the
Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

In-Depth Technical Assistance (IDTA) Sites: 24 Sites

IDTA Sites
State: 19
Counties: 2
Tribal Communities: 3
In-Depth Technical Assistance Goal

To work with state, tribal, local child welfare, substance abuse, and dependency court professionals to improve outcomes for families that are affected by substance use disorders and involved in the child welfare system by:

- *Facilitating cross-system collaboration*
- *Developing effective policy, practice and organizational changes*
- *Facilitating implementation in pilot sites*
- *Monitoring implementation and initial outcomes and facilitating changes and adaptations as needed.*

What is In-Depth Technical Assistance (IDTA)?

**IDTA is:**

- Application and SOW – approval by FPOs/CORs
- 18-24 month program facilitated by a Change Leader (CL)

**IDTA can:**

- Set priorities for practice and policy changes
- Identify expected outcomes and how they will be measured
- Use data to inform, implement and monitor policy and practice changes
- Develop cross-system protocols and implementation plans
IDTA Substance Exposed Infants (IDTA-SEI): 6 States

- Connecticut
- Kentucky
- Minnesota
- New Jersey
- West Virginia
- Virginia

National and State Data
Setting the Stage
### Trends in Opioid Use

- **Initiates**
  - The overall rate of heroin initiation increased for women from .06% in 2002-2004 compared to .10% in 2009-2011

- **Dependence**
  - 50% increase of persons 12 or older who are dependent on heroin
  - 180,000 in 2007 compared to 370,000 in 2011

- **Deaths**
  - Over 500% increase among women in opioid pain reliever overdose deaths since 1999
  - Opioid overdoses surpasses motor vehicle accidents as a leading cause of death


### Percent Pregnant Women Reporting Heroin at Treatment Admission, 2003-2012

![Percent Pregnant Women Reporting Heroin at Treatment Admission, 2003-2012](chart)

SAMHSA Treatment Episode Data Set
PERCENT PREGNANT WOMEN REPORTING HEROIN AT TREATMENT ADMISSION, BY U.S. REGION, 2012

- Northeast: 39.2%
- Midwest: 23.1%
- South: 17.4%
- West: 16.5%

SAMHSA Treatment Episode Data Set

Pregnancy and Prescription Opioid Abuse Among Substance Abuse Treatment Admissions

- Increase from 2% to 28% among pregnant treatment admissions for any prescription opioid abuse.
- Increase from 1% to 19% among pregnant treatment admissions for prescription opioids as the primary substance of abuse.

Proportion Reporting Any Prescription Opioid Use Among Pregnant Admissions

NAS occurs with notable variability, with 55-94% of exposed infants exhibiting symptoms. Medication is required in approximately 50% of cases.

**Symptoms begin within 1-3 days after birth, or may take 5-10 days to appear**

- Symptoms include blotchy skin, difficulty with sleeping and eating, trembling, and irritability
- Timing of onset is related to characteristics of drug used by mother and time of last dose
- Most opioid exposed babies are exposed to multiple substances

**Neonatal Abstinence Syndrome**


Incidence of Neonatal Abstinence Syndrome

Nationally, the incidence of NAS increased from hospital births in 2000 to 3.39 per 1,000.

A 38-state study found the rate of neonatal hospital stays involving substance use had a cumulative increase of 71% between 2006 and 2012, from 5.1 to 8.7 per 1,000.

In a study of 299 neonatal intensive care units (NICU) across the country, the rate of NICU admissions for infants with NAS increased from 7 cases per 1,000 admissions in 2004 to 27 cases per 1,000 admissions in 2013.


2006 and 2012 hospital costs for neonatal stays related to substance use had a cumulative increase of 135%, from $253.4 million in 2006 to $594.6 million in 2012.

The mean length of stay for infants with NAS is 16.4 days at an average cost of $53,000.

Neonatal Costs

Of the 30,653 neonatal hospital stays related to substance use in 2012, most involved neonatal drug withdrawal or unspecified narcotics.

- 60.3% NAS/withdrawal
- Estimated 18,000 infants = $356-$950 million

- 23.0% unspecified narcotics
- 16.7 percent of neonatal stays involved specific substances:
  - 8.6% cocaine
  - 4.5% hallucinogens
  - 2.1% multiple substances or conditions, or
  - 1.5% fetal alcohol syndrome

Primary Payer

Compared with all other neonatal stays in 2012, Medicaid was more likely and private insurance was less likely to be the expected primary payer among neonatal stays related to substance use.

- In 2012, Medicaid was the expected primary payer for 79.9 percent of neonatal stays related to substance use compared with 46.2 percent of all other neonatal stays.
- Substance-related neonatal stays were also more likely to be uninsured, compared with all other neonatal stays (5.6 vs. 3.9 percent).
- In contrast, private insurance was the expected primary payer for 11.8 percent of neonatal stays involving substance use versus 46.4 percent of all other neonatal stays.

Substance Use During Pregnancy

- Rate of maternal hospital stays involving substance use had a cumulative increase of 33 percent, from 13.4 per 1,000 maternal stays in 2006 to 17.9 per 1,000 maternal stays in 2012.
  - From 2006 to 2012, the rate of maternal stays related to opioids increased by 135%, from 2.3 to 5.4 per 1,000 hospital stays.
- Mental disorders were indicated in one-fourth of maternal stays related to substance use in 2012 compared with 4 percent of other maternal stays.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) from 38 States, 2006–2012

87% characterize the size of the opiate use/addiction problem in their community as a significant problem.

87% said that the incidence of opiate misuse has increased in their community over the past two years.

54% reported an increase in infants with positive opiate toxicology.

83% reported an increase in CPS reports involving opiate misuse by parents.
  – 33% increase involving opiate misuse by minors

73% increase in Preventive Services
  – 37% increase involving opiate misuse by minors

66% increase in Foster Care placements
  – 22% increase involving minors’ opiate misuse
Pregnant Women Admitted to Opioid Treatment Program

- 2013: 60 pregnant women
- First Half of 2015: 41 pregnant women
New York State Newborn Drug-Related Diagnosis Rate per 10,000 Newborn Discharges, 2010-2012

Better Together: Developing a Coordinated Response for Families Affected by Substance Use Disorders

Why is collaboration across multiple systems essential?

Identified Barriers in Working with Parenting and Pregnant Women with Opioid Dependence

- Treatment Gaps: Lack of Medication Assisted Treatment and Comprehensive, Long-Term Treatment for Women and Their Children
- Variation in Child Welfare and Dependency Court Response: Decisions on case opening, child removal, reunification, etc.
- Timing differences in service systems
- Lack of Collaboration Across Multiple Systems - Including Agreement on & Ability to Track Shared Outcomes
- Knowledge and Practice Gaps in Screening and Assessment: Opioid Dependence, Prenatal Exposure, Neonatal Abstinence Syndrome
- Intervention and prevention needs of children
- Data and information gaps
- Stigma Across Systems on Medication Assisted Treatment
- Categorical and rigid funding streams
- Knowledge Gaps in Understanding the Treatment of Opioid Dependence
- Differences in values and perceptions of primary client
- Lack of tools for effective engagement & retention in services
Rates are calculated by dividing the number of unique victims by the child population and multiplying by 1,000. This is done separately for each age. A victim is defined as a child for whom the state determined at least one maltreatment was substantiated or indicated, or the child received a disposition of alternative response victim.

Percentages are calculated by dividing the number of maltreatment types experienced by the number of unique victims. This is done separately for each age group. A child may have been the victim of more than one type of maltreatment or the same maltreatment type reported several times. Therefore, the maltreatment type is a duplicate count and percentages total more than 100.

These analyses were conducted on the NCANDS Child File and do not include children of an unknown age, unborn, and children ages 18-31. These data may be different from analyses published in the annual Child Maltreatment report. A victim is defined as a child for whom the state determined at least one maltreatment was substantiated or indicated, or the child received a disposition of alternative response victim. States may code any maltreatment as “Other” if it does not fit in one of the NCANDS categories. Examples of “Other” include “threatened abuse,” “parent’s drug/alcohol abuse,” and “safe relinquishment of a newborn.”

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Rates are calculated by dividing the number of child fatalities by the child population and multiplying by 100,000. This is done separately for each age. A fatality is defined as the death of a child as a result of abuse and neglect, because either an injury resulting from the abuse and neglect was the cause of death, or abuse and neglect were contributing factors to the cause of death.

Source: AFCARS Data, 2013
Age of Children in Foster Care as of September 30, 2013 (National)

N=402,378

Source: AFCARS Data, 2013

Parental AOD as Reason for Removal in the United States, 1998-2013

Source: AFCARS Data, 2013
Parental AOD as Reason for Removal, 2013

National Average: 31%

Percent of Children Removed from Parents’ Custody with Parental Alcohol and/or Drug Use as a Reason for Removal by Age, 2013

Source: AFCARS Data, 2013
Children Go Home or Stay Home

Annually, there are approximately 740,000 instances of child maltreatment in the United States.¹

Approximately 65% of these children will remain at home.

Another 20% to 25% will be returned home following a removal.

Total of 80% to 85% of children remaining at or returning home.

The Issues are Complex

- Knowledge gaps are compounded (in some states) by laws designed to criminalize drug use during pregnancy, women's fears that they might lose custody of their children, and the social stigma experienced by women who abuse alcohol or use illicit drugs.

- Professionals across systems lack do not have a good understanding of substance use disorders as a chronic, progressive disease; or an understanding of MAT as an evidence-based practice for opioid dependence.

• Communicating about difficult issues takes time, requires skills, and is poorly reimbursed by procedure-oriented insurance coverage.

• Physicians (and hospitals) are concerned about the consequences of legally mandated reporting, lack familiarity with treatment resources, and do not have the extensive time and understanding of resources needed to make an appropriate referral.

• Terminology matters---Infants may be born “dependent” but they are not born “addicted”.

Different Populations of Women Can Give Birth to Infants with NAS Symptoms

Adapted from Dr. Cee Spitznas, White House Office of National Drug Control Policy
A Collaborative Approach

- Women with opioid use are identified during pregnancy…
- Engaged into prenatal care, medical care, substance use treatment, and other needed services…
- A case plan or plan of safe care for mother and baby is developed…
- Reducing the number of crises at birth for women, babies, and the systems.

Outcomes Affect Children

- They arrive at kindergarten not ready for school
- They are in special education caseloads
- They are disproportionately in foster care and are less likely to return home
- They are in juvenile justice caseloads
- They are in residential treatment programs
VIDEO

- http://addictionsunplugged.com/2013/05/27/methadone-removing-the-stigma/

Unraveling the Knot:
Lessons Learned from Six IDTA-SEI States

NCSACW Tools
Gaps & Barriers
Emerging Lessons & Themes
National Work Group: A Collaborative Approach

Develop guidance that will:

- Articulate the questions and policy considerations that guide practice for a wide range of professionals working with pregnant opioid dependent women, their infants and families

- Provide possible approaches for working together on behalf of the woman and her child, that reflects the input of this working group and identified supportive practices

- Intended audience at the State and local level:
  - Child Welfare agencies
  - Family Courts
  - Medical and nursing professionals serving women and children affected by these issues
  - Substance Abuse Treatment providers

Areas of Primary Responsibility
Does the community need public education to decrease the stigma faced by women seeking treatment?

The common response to a pregnant woman who is using is “how could she do that to her unborn child?” We need to educate people on addiction.

Are our system practices and policies designed to reduce stigma, minimize barriers, and improve access to services and outcomes? If so, list some of the practices and policies that exemplify this.

Walk in policy where no person is turned away due to inability to pay, work directly with Child Welfare to provide continuity of care.

We implemented the same day scheduling in November 2014 and have had much success with increasing our show rates.
Are pregnant and parenting women discouraged from seeking or obtaining Medication-Assisted Treatment (MAT) when it is indicated?

![Bar chart showing the responses to the question.]

Some criminal justice/social service programs/policies consider using MAT as a violation of probation or grounds for sanctions/action.

*Probably due to the lack of knowledge by the community, stigma if getting MAT and the lack of support groups exclusively for pregnant women and mothers.*

New York State Alcohol & Substance Abuse Providers (ASAP) Women and Families Committee
Medication Assisted Treatment Survey

**16. Do you provide services to pregnant and parenting women?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Response Count</th>
<th>Response Percent</th>
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<tbody>
<tr>
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<td>33</td>
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<tr>
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<td>17.5%</td>
<td>7</td>
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**What types of services are offered to pregnant women?**

- We accept pregnant women, but do not take children.
- Linkages with child care, pre school, prenatal health care.
- Supportive living apartment for single women and their children.
- Parenting skills, mental health, rehabilitation program.
What are some of the barriers?

- Insufficient prescribers
- Legal entities at times disagree with MAT.
- Not at this time, however, our local Drug Court is considering if they should allow the use of Suboxone. We have experienced problems with Child Protective Services not wanting clients on Suboxone.
- Sober housing in area does not permit Suboxone.
- Parole does not routinely support MAT.

There is variance in policies that exist and how they are implemented. Personal bias may often cloud the actual policy....it's not just what you present to someone, it's how you do it and that can greatly impact the consumer.

Many women feel that being on methadone and delivering their child while having negative drug test will result in child welfare involvement and removal of the infant. They are right - each child born exposed to methadone/opioids is called into child welfare even if there has been proof that mom has been in treatment.

• Many cited taking [opiate exposed] newborns into placement; also pre-school children due to safe factors.

• Several mentioned that opiate treatment takes so long, usually involves relapse, and children are in care past the time limits of the Adoption and Safe Families Act. Often ends in Terminated Parental Rights.

Is priority access to treatment for pregnant women (as required by the Substance Abuse Prevention and Treatment Block Grant funded by the Substance Abuse and Mental Health Services Administration) monitored and enforced?

Where are we going to send them if facilities are at capacity? Not enough facilities!
Can we be reimbursed for treating mothers and their families?

In theory yes but saying services are covered by Medicaid and services actually being approved and covered by Medicaid are two different things.

Do we have a formal referral network with professionals in our system and other systems to facilitate seamless coordination of care?

There appears to be lots of agencies and individuals working with a common goal but connecting the pieces on a single patient level to get all needed services is still unclear and leaves all the professionals involved frustrated and looking for solutions to improve the system…
ASAP Women and Families Committee
Medication Assisted Treatment Survey


- Differences in whether substance use treatment is available – some service areas have a provider in the same building or nearby and some have treatment available only for TANF recipients.

- Non-existent or far away detox, methadone, Suboxone, or inpatient treatment.
  - A rural county noted that most services are more than 100 miles away.

- Physicians not willing to become Suboxone-approved prescriber

- 75% reported not enough foster parents who have been specially trained to provide care for children affected by opiates.
Do we need to create collaborative agreements to facilitate seamless referrals and continuity of care from pregnancy through birth and beyond?

There is a real disconnect between primary care providers, prenatal care providers and treatment facilities. There is no real coordination of care of pregnant women with substance use disorders. There are providers prescribing opiate replacement without any supportive therapy and without the knowledge of the prenatal care providers.

ASAP Women and Families Committee Medication Assisted Treatment Survey

11. Do you have linkage agreements with agencies that offer specialized services for women?

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<tbody>
<tr>
<td></td>
<td>Percent</td>
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<tr>
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<td>54.5%</td>
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<tr>
<td>No</td>
<td>45.5%</td>
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Describe the type of service for which you have linkage agreements:

- Healthcare (OBGYN, in addition to other health issues), mental health, housing for women and children/families.
- Prenatal/perinatal, other treatment programs
- Parenting classes, women’s groups
- Educational, vocational, medical, psychiatric, children’s issues, clothing, food, HIV
Do State and local agencies and the collaborative partners track and share data to monitor outcomes?

There are some state data collection processes, but compiling and sharing that data is not consistent.

Policy and Practice Framework: Five Points of Intervention

1. Pre-pregnancy awareness of substance use effects
2. Prenatal screening and assessment
3. Identification at Birth
4. Ensure infant's safety and respond to infant's needs
5. Identify and respond to the needs of
   - Infant
   - Preschooler
   - Child
   - Adolescent

Initiate enhanced prenatal services
Respond to parents' needs
System Linkages
Identified Gaps and Barriers

Early Identification and Screening
- **EARLY** Screening, assessment and testing in prenatal period, throughout trimesters is **NEEDED.**
- “Drug testing is not being done…we are “missing” large group of users by not testing.”

Limited Community Knowledge
- “In our offices familiar with MAT they are supportive, but some staff who may not be aware or not informed well may not always fully support this EBP.”

Stigma and Fear
- “We treat addiction and substance abuse as a crime and not a disease.”
- “Medication assisted treatment is the gold-standard for opiate addiction, but many courts, doctors, jails, social workers etc. do not agree with its use.”

Identified Gaps and Barriers

Insufficient Medical Coverage
- “Some patients do fall through the cracks when they are denied Medicaid or the premium with expanded Medicaid is too high for people to afford.”

Fragmented Service Delivery
- “…focus is on the baby and mom is left to care for herself in the middle of a crisis”

Limited Access to Resources and Services for Mothers/Infants
- “Not enough providers, not enough facilities, not enough resources…”
- “Access to service is limited due to 1)transportation issues of clients, 2)location of specialty clinics is too far away, and 3)core guidelines and private provider recommendations do not match.”
- “Barriers exist especially in rural areas with having enough providers and transportation issues.”
- “Infants are not always referred or qualify for services.”
Emerging Themes and Strategies

- Universal screening of pregnant women for substance use
- Protocol for screening, assessment and referral to treatment—consistently applied
- Consistent definition of and protocol for identification of and referral for infants prenatally exposed
- Standards for treatment and discharge of NAS infants

- Appropriate level of care and access to EB, high-quality services for pregnant/postpartum women
- Education across all systems about the needs of pregnant women with substance use disorders (especially opioid) and their infants
- Work with insurance carriers to establish a continuum of reimbursable services for this population across funding streams
Weaving Together a Coordinated Response
Will you Join?

ASAP Women and Families Committee Medication Assisted Treatment Survey

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<th>6. Have you worked to overcome the barriers and stigma associated with the use of addiction medication?</th>
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<tr>
<td><strong>Response</strong></td>
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<tr>
<td>Yes</td>
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Impact of Heroin and Other Opiate Use on Child Welfare Services:
New York State OCFS Survey of LDSS and Tribal Nations
March-May 2014

Half of respondents indicated willingness to serve on a workgroup to examine case practice issues related to opiate or other substance abuse issues

Suggestions
- Coordinate across state agencies to establish common goals and universal strategies
- Statewide collaborative initiative
- Community forums
- Develop educational and prevention materials

Implemented Strategies
- Develop trainings and materials – “tip cards”
- Offered programs for CMEs to local physicians and hospital workers, sit on community task forces, offer inservices for agencies and medical offices.
- Education and community outreach – staff, client and community and across systems
New York State TA: Develop goals and determine capacity in working with pregnant and parenting women with opioid dependence

- Orientation Call: June 2015
- Site Visit: August 27, 2015
  - Intended for systems seeking to improve outcomes for pregnant and parenting women with opioid dependence
  - Shared understanding of goals and capacity to achieve goals

Suggested Strategies

- Cross-System Survey
- Service & Financial Mapping
- Examine legislation, policies and procedures
- System Walk Through
- Case File Review & Drop-off Analysis
- Training Inventory
Moving Forward

Identify key stakeholders and their role in the project

- Oversight Committee
- Advisory Committee
- Core Team
- Workgroup

Team Structure and Functions

OVERSIGHT COMMITTEE

CORE TEAM

ADVISORY COMMITTEE

Scope of Work to Achieve Priority Outcomes

WORKGROUP

WORKGROUP

WORKGROUP

WORKGROUP

NCSACW VIA CONSULTANT
Resources

Webinar Series

1) Medication Assisted Treatment for Families Affected by Substance Abuse Disorders
   http://www.cffutures.org/presentations/webinars/medication-assisted-treatment-families-affected-substance-abuse-disorders

2) Medication Assisted Treatment During Pregnancy, Postnatal and Beyond

3) Opioid Use in Pregnancy: A Community’s Approach, The Children and Recovery Mothers (CHARM) Collaborative

4) The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update
   https://cft-ncsacw.adobeconnect.com/p5okpdezt3l/

5) Substance Use in Pregnancy, The OB/GYN Perspective
   http://www.cffutures.org/presentations/webinars/substance-use-pregnancy-obgyn-perspective

6) Opioid Use Disorders and Treatment During Pregnancy

Additional Resources

www.ncsacw.samhsa.gov
There are only two lasting bequests we can hope to give our children. One is these roots; the other is wings.

-Johann Wolfgang Van Goethe

Contact Information

Linda Carpenter, M.Ed.
Program Director
National Center on Substance Abuse and Child Welfare
In-Depth Technical Assistance
lcarpenter@cffutures.org

Hanh Dao, MSW
Technical Assistance Manager
National Center on Substance Abuse and Child Welfare
hdao@cffutures.org