



Opioid Use in Pregnancy: A Community's Approach, The Children and Recovering Mothers (CHARM) Collaborative

Nancy K. Young, PhD
Sally Borden, MEd
Karen Shea, MSW



Agenda

- Overview of the Issue
- Medication Assisted Treatment
- Considerations for Policy and Practice
- The CHARM Collaborative
- Teaming for Success: The Role of Child Welfare



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



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families
www.samhsa.gov

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

Between 2007-2011,
the numbers of past
year heroin initiates
and heroin
dependence have
{increased
significantly}.

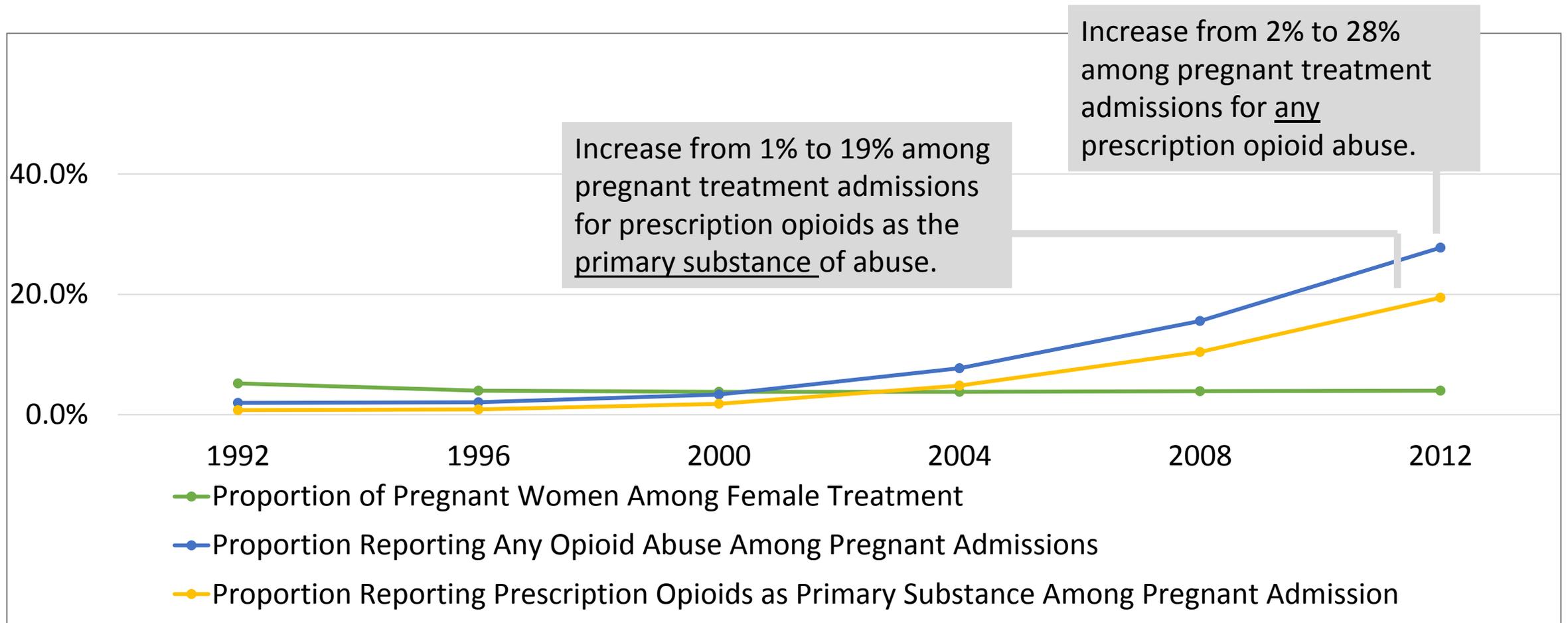
Substance Abuse and Mental Health Services Administration, (2013). Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD.
Centers for Disease Control and Prevention Chen LH, Hedegaard H, Warner M. Drug-poisoning deaths involving opioid analgesics: United States, 1999–2011. NCHS data brief, no 166. Hyattsville, MD: National Center for Health Statistics. 2014.



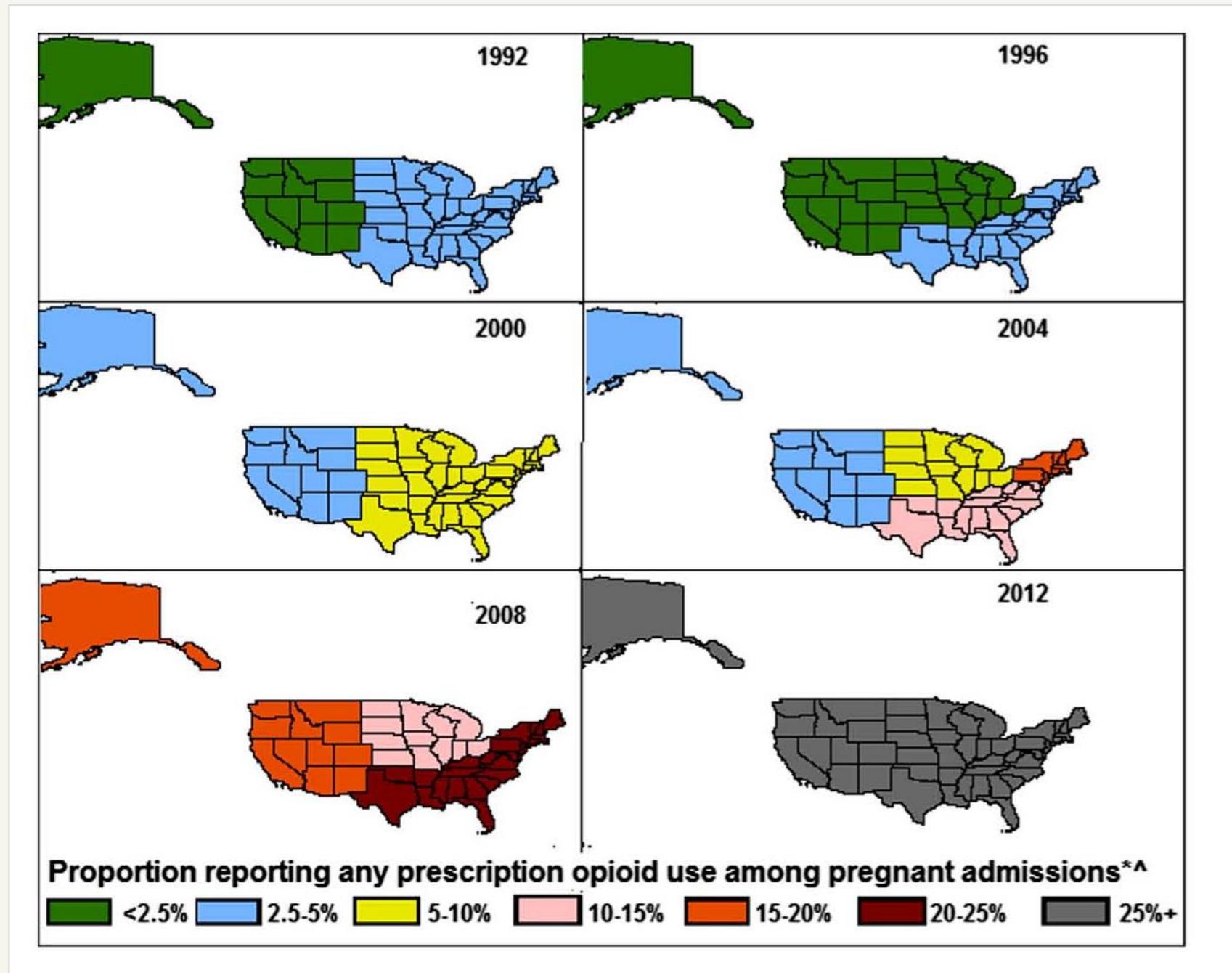
Non-Medical Use of Prescription Pain Relievers and Heroin Use

- A strong association exists between prior nonmedical use of pain relievers and subsequent past year initiation of heroin
- Heroin incidence rates were 19 times higher among those who reported prior nonmedical use of pain relievers

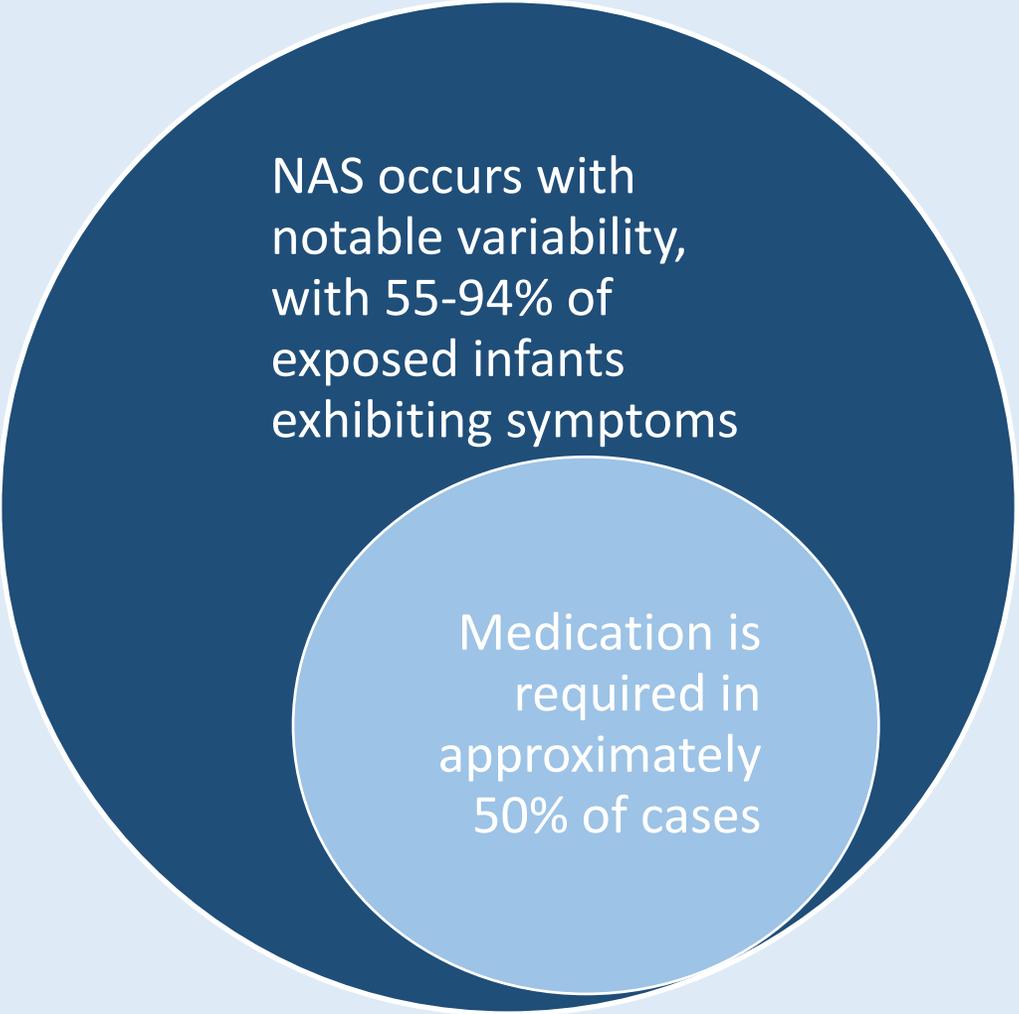
Pregnancy and Prescription Opioid Abuse Among Substance Abuse Treatment Admissions



Proportion Reporting Any Prescription Opioid Use Among Pregnant Admissions



Neonatal Abstinence Syndrome



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



Long-Term Impact

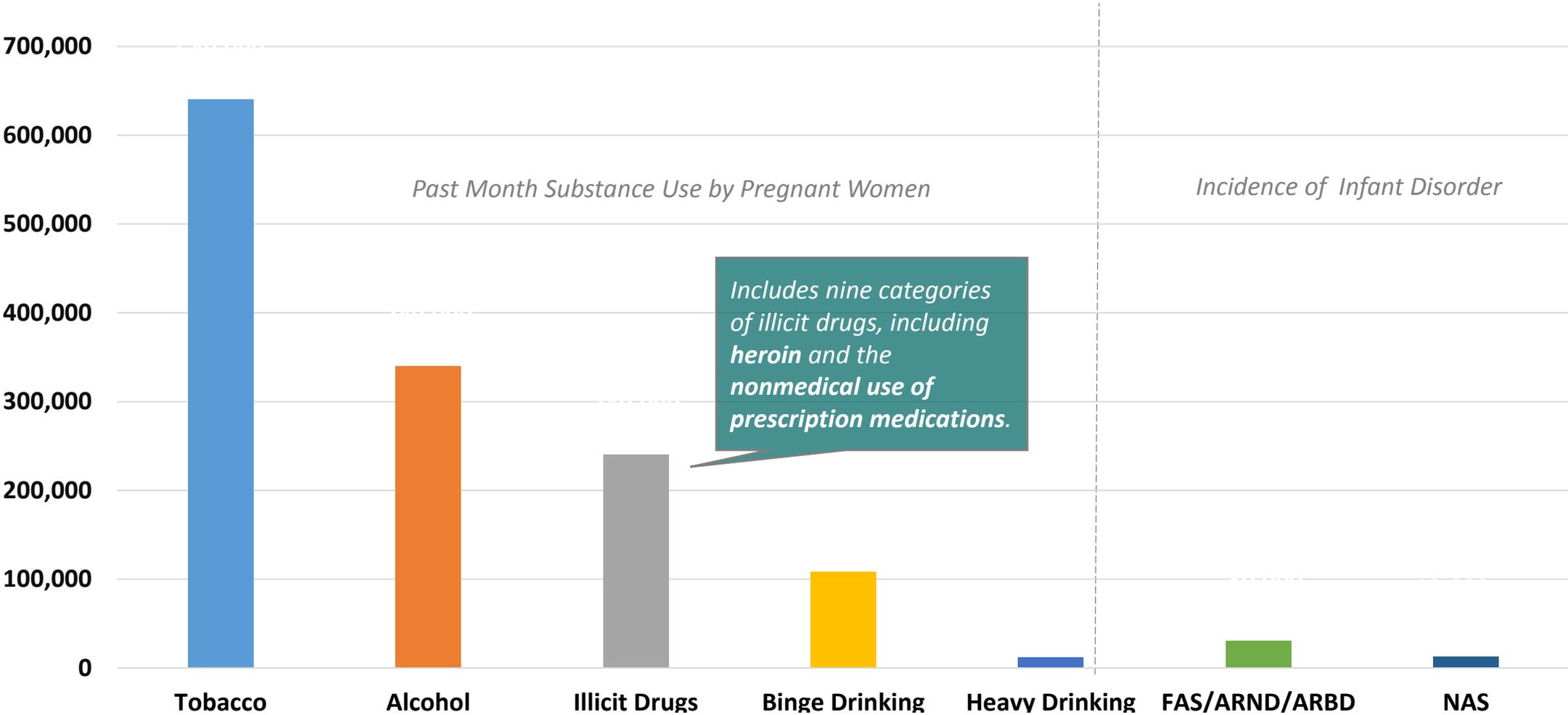
- Studies demonstrate cognitive development to be within the normal range up to age 5
- Family characteristics, improved prenatal care, exposure to multiple substances, and other medical and psychosocial factors have a significant impact on long-term outcomes

The American College of Obstetricians and Gynecologists. (2012) Committee Opinion No. 524: Opioid Abuse, Dependence, and Addiction in Pregnancy. Obstetrics & Gynecology, 119(5), 1070-1076.

Emmalee, S. B. et al. (2010) Prenatal Drug Exposure: Infant and Toddler Outcomes. Journal of Addictive Diseases, 29(2), 245-258.

Baldacchino, A., et al. (2014). Neurobehavioral consequences of chronic intrauterine opioid exposure in infants and preschool children: a systematic review and meta-analysis. BMC Psychiatry, 14(104).

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

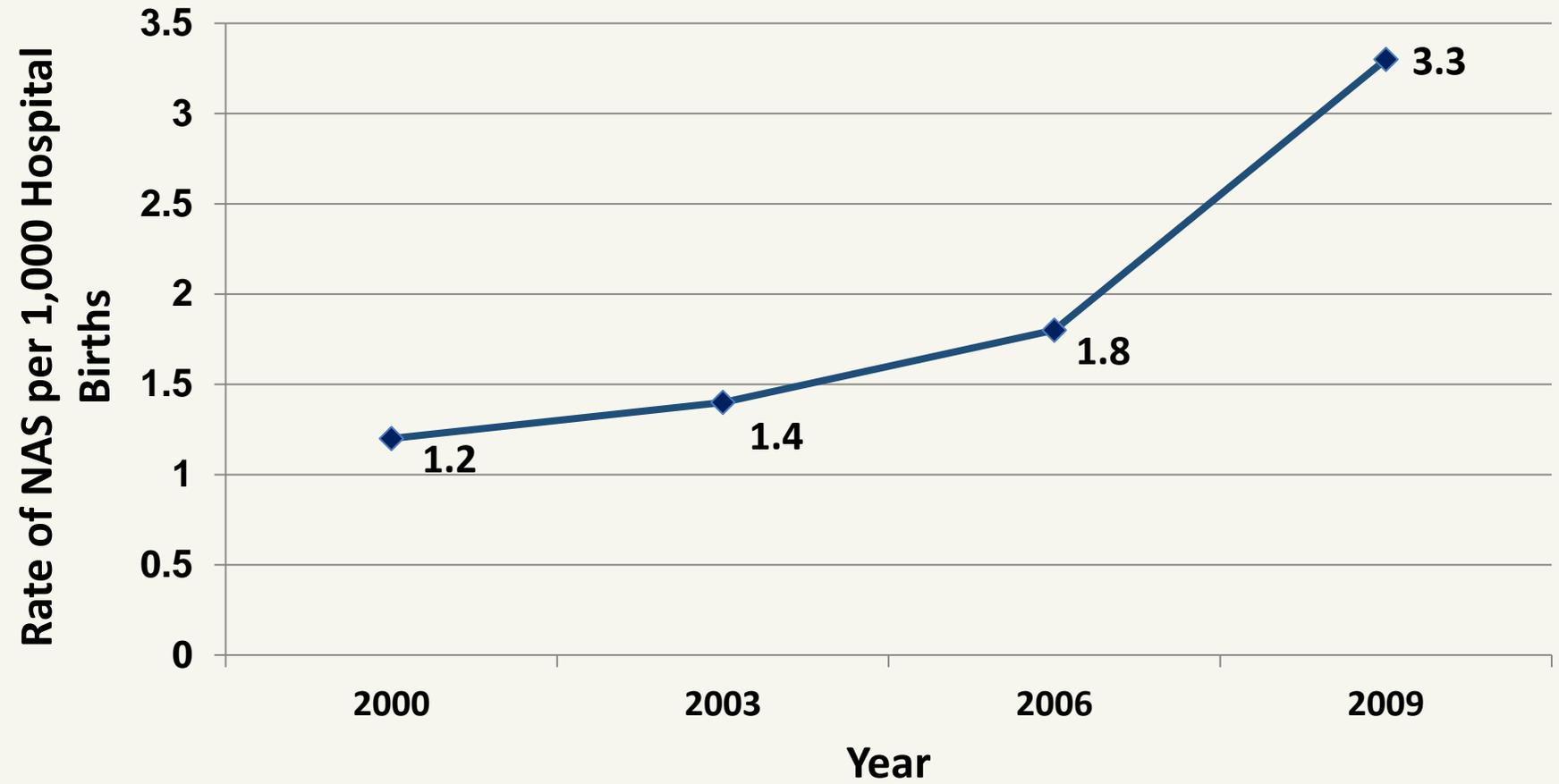


*Approximately 4 million (3,952,841) live births in 2012

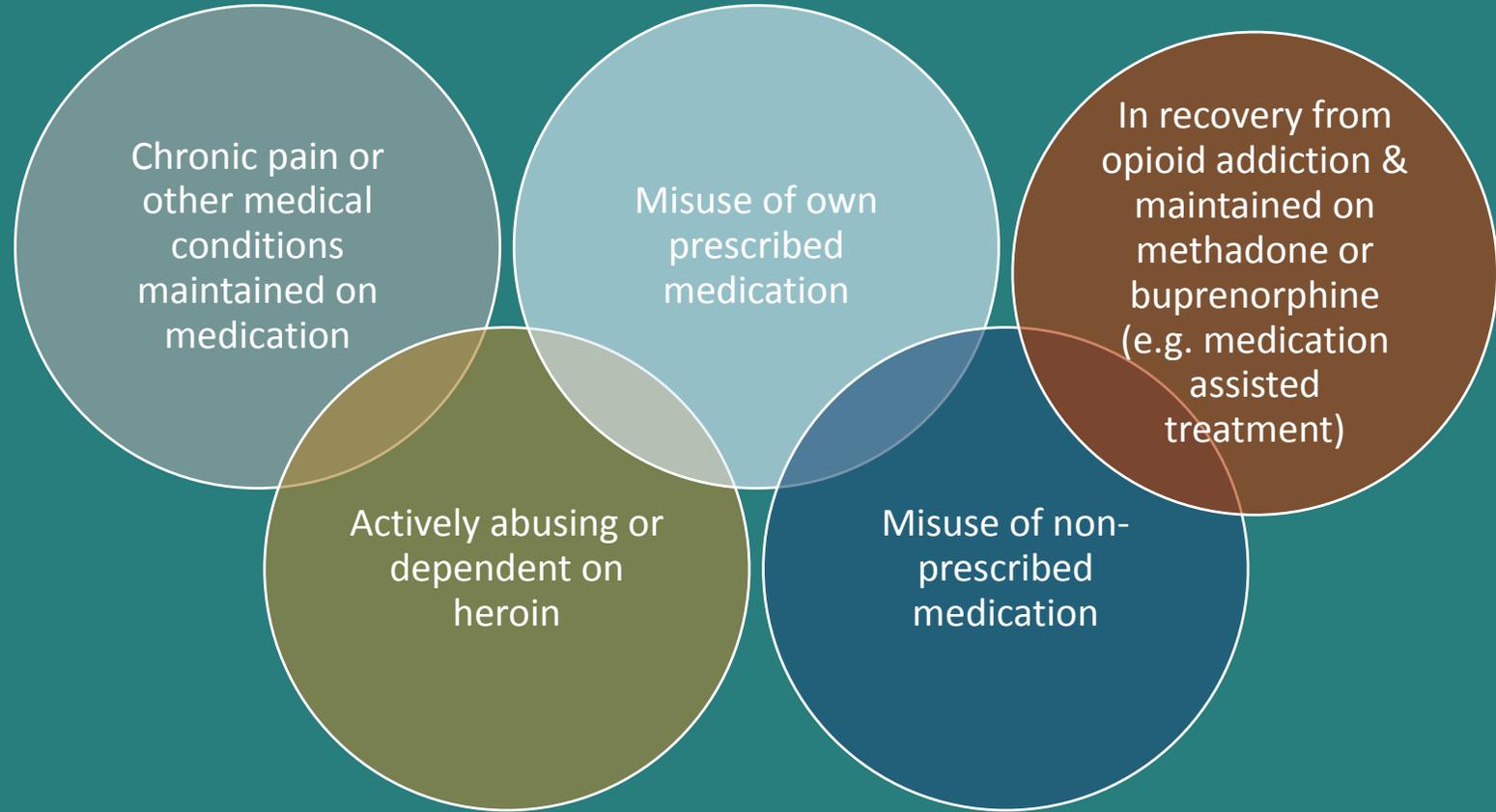
Estimates based on: National Survey on Drug Use and Health, 2012; Martin, Hamilton, Osterman, Curtin & Mathews. Births: Final Data for 2012. National Vital Statistics Report, Volume 62, Number 9; Patrick, Schumacher, Benneyworth, et al. NAS and Associated Health Care Expenditures. Journal of the American Medical Association (JAMA) 2012; 307(18):1934-1940. doi: 10.1001/jama.2012.3951; May, P.A., and Gossage, J.P.(2001).Estimating the prevalence of fetal alcohol syndrome: A summary.Alcohol Research & Health 25(3):159-167. Retrieved October 21, 2012 from <http://pubs.niaaa.nih.gov/publications/arh25-3/159-167.htm>

Incidence of Neonatal Abstinence Syndrome Over Time

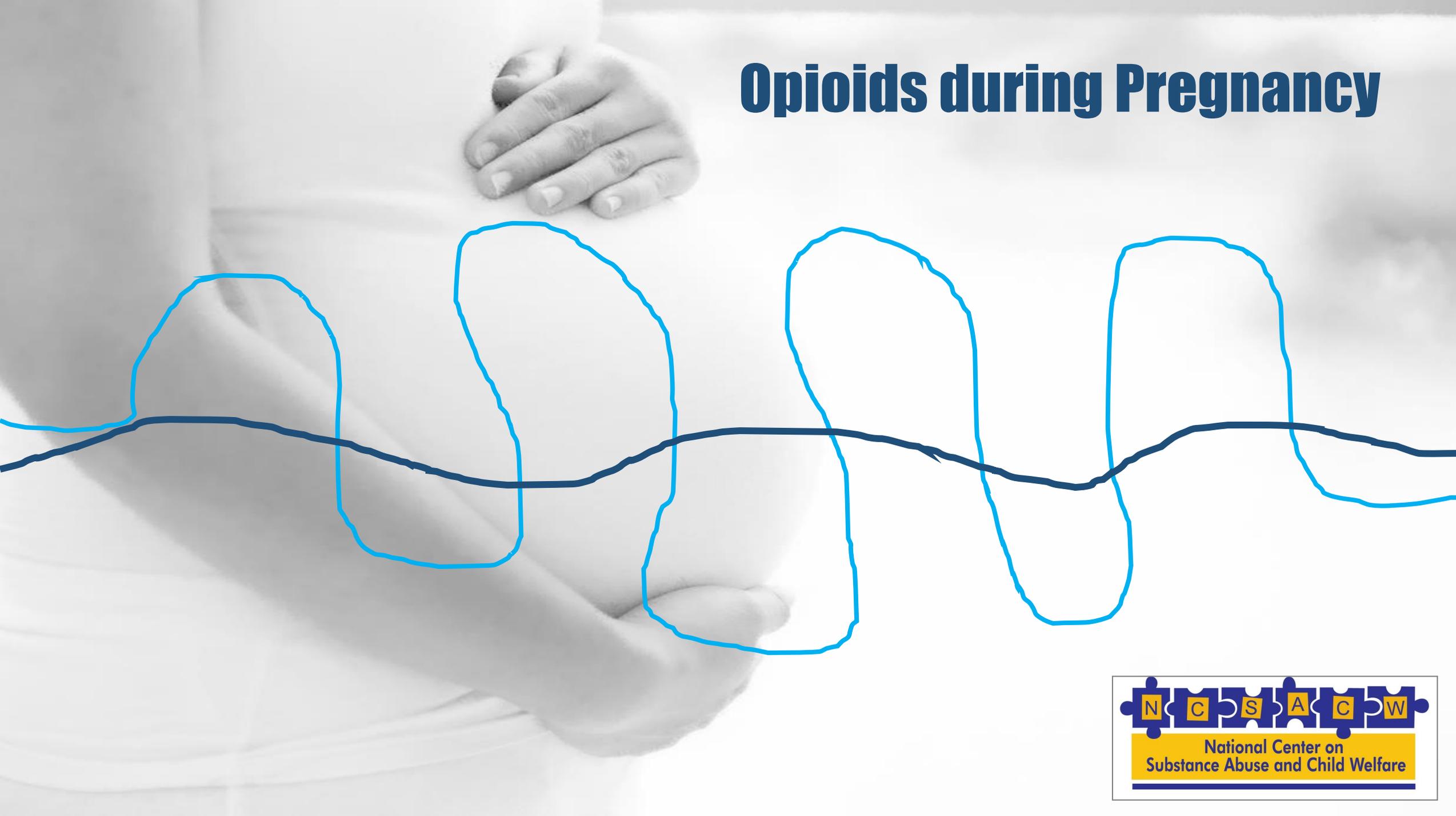
The mean length of stay for infants with NAS is 16.4 days at an average cost of \$53,000.



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



Opioids during Pregnancy





Medication Assisted Treatment for Opioid Dependence

Principles of Effective Drug Addiction Treatment

- Addiction is a complex but treatable disease that affects brain function and behavior
- No single treatment is appropriate for everyone
- Treatment needs to be readily available
- Effective attends to multiple needs of the individual
- Remaining in treatment for an adequate period of time is critical
- Behavioral therapies are the most commonly used forms of drug abuse treatment

{ Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies }

- An individual's treatment and services plan must be continually assessed and modified
- Many drug-addicted individuals also have other mental disorders
- Medically assisted detoxification is only the first stage of addiction treatment
- Treatment does not need to be voluntary to be effective
- Drug use during treatment must be monitored continuously as lapses do occur
- Treatment programs should test patients for infectious diseases

Medication Assisted Treatment (MAT) for Opioid Dependency

As part of a comprehensive treatment program, MAT has been shown to:

- Increase retention in treatment
- Decrease illicit opiate use
- Decrease criminal activities
- Decrease drug-related HIV risk behaviors
- Decrease obstetrical complications

Methadone has been in use for over {60} years to treat opioid dependency.

MEDICATIONS USED TO TREAT OPIOID DEPENDENCY

<i>Medication</i>	<i>Primary Use</i>	<i>Formulation</i>	<i>Treatment Setting</i>	<i>Administration</i>
Methadone	<ul style="list-style-type: none"> • Agonist: Suppresses cravings and withdrawals • Detoxification • Maintenance 	<ul style="list-style-type: none"> • Liquid • Tablet/Diskette • Powder 	<ul style="list-style-type: none"> • SAMHSA Certified Opioid Treatment Program (OTP) 	<ul style="list-style-type: none"> • Daily at OTP • Some individuals may qualify for take-home prescriptions lasting up to 30 days
Buprenorphine (Subutex or Suboxone)	<ul style="list-style-type: none"> • Partial Agonist: Suppresses cravings and withdrawals; partial stimulation of brain receptors • Detoxification (Subutex) • Maintenance (Suboxone) 	<ul style="list-style-type: none"> • Tablet • Film (Suboxone) 	<ul style="list-style-type: none"> • Physicians or psychiatrists granted a DATA waiver • Some SAMHSA Certified OTPs 	<ul style="list-style-type: none"> • Daily • Individuals can be prescribed a supply to be taken outside of the treatment setting
Naltrexone	<ul style="list-style-type: none"> • Antagonist: Blocks effects of opioids • Maintenance 	<ul style="list-style-type: none"> • Injection (primarily) 	<ul style="list-style-type: none"> • Any healthcare provider licensed to prescribe medications 	<ul style="list-style-type: none"> • Monthly, following medically supervised detoxification

Summary Points

- Each medication varies in its ability to:
 - Prevent or reduce withdrawal symptoms
 - Prevent or reduce drug craving
- Medical doctors determine the appropriate type of medication, dosage and duration based on each person's:
 - Biological makeup
 - Addiction history and severity
 - Life circumstances and needs



Summary Points

OTP Certification guidelines include:

- Medical Director licensed to practice medicine and has experience in addiction medicine. Responsible for monitoring and supervising all medical services.
- Provision of adequate medical, counseling, vocational, educational, and other assessment and treatment services.
- Special services for pregnant patients, including priority access and provision of or referral for prenatal care and other gender specific services.



Standards of Care

- The current standard of care for pregnant women with opioid dependence is opioid assisted therapy with methadone.
- Buprenorphine is an effective option for pregnant women who are new to treatment or maintained on buprenorphine pre-pregnancy.
- Maternal outcomes, pain management considerations and breastfeeding recommendations are similar between medications.

A National Institute of Health consensus panel recommended methadone maintenance as the {standard of care} for pregnant women with opioid dependence.

The American College of Obstetricians and Gynecologists. (2012) Committee Opinion No. 524: Opioid Abuse, Dependence, and Addiction in Pregnancy. Obstetrics & Gynecology, 119(5), 1070-1076.

Hendree Jones, Presented at the NADCP Annual meeting, May 28, 2014, Anaheim, CA.



Standards of Care

- During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies
- Neonatal Abstinence Syndrome is an expected and treatable condition that follows prenatal exposure to opioids.

The American College of Obstetricians and Gynecologists. (2012) Committee Opinion No. 524: Opioid Abuse, Dependence, and Addiction in Pregnancy. Obstetrics & Gynecology, 119(5), 1070-1076.

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Child Abuse and Prevention Treatment Act

Referral to child
welfare of
substance-exposed
infants.

Development of a
plan of safe care.

- Policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants except that such notification shall not be construed to establish a definition under Federal law of what constitutes child abuse or neglect
- The development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal.

Barriers to Best Practice



Variation in Child Welfare
Response

Lack of
Medication
Availability

Lack of Collaboration

Lack of Sufficient, Comprehensive,
Long-Term Treatment for Women
and Their Children

Knowledge and Practice Gaps in Best Practices in
Screening and Assessment: Pregnancy, Post
Pregnancy, Neonatal Abstinence Syndrome

A Collaborative Approach

- Women with opioid use are identified during pregnancy
and
- Engaged into prenatal care, medical care, substance use treatment, and other needed services
and
- 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!

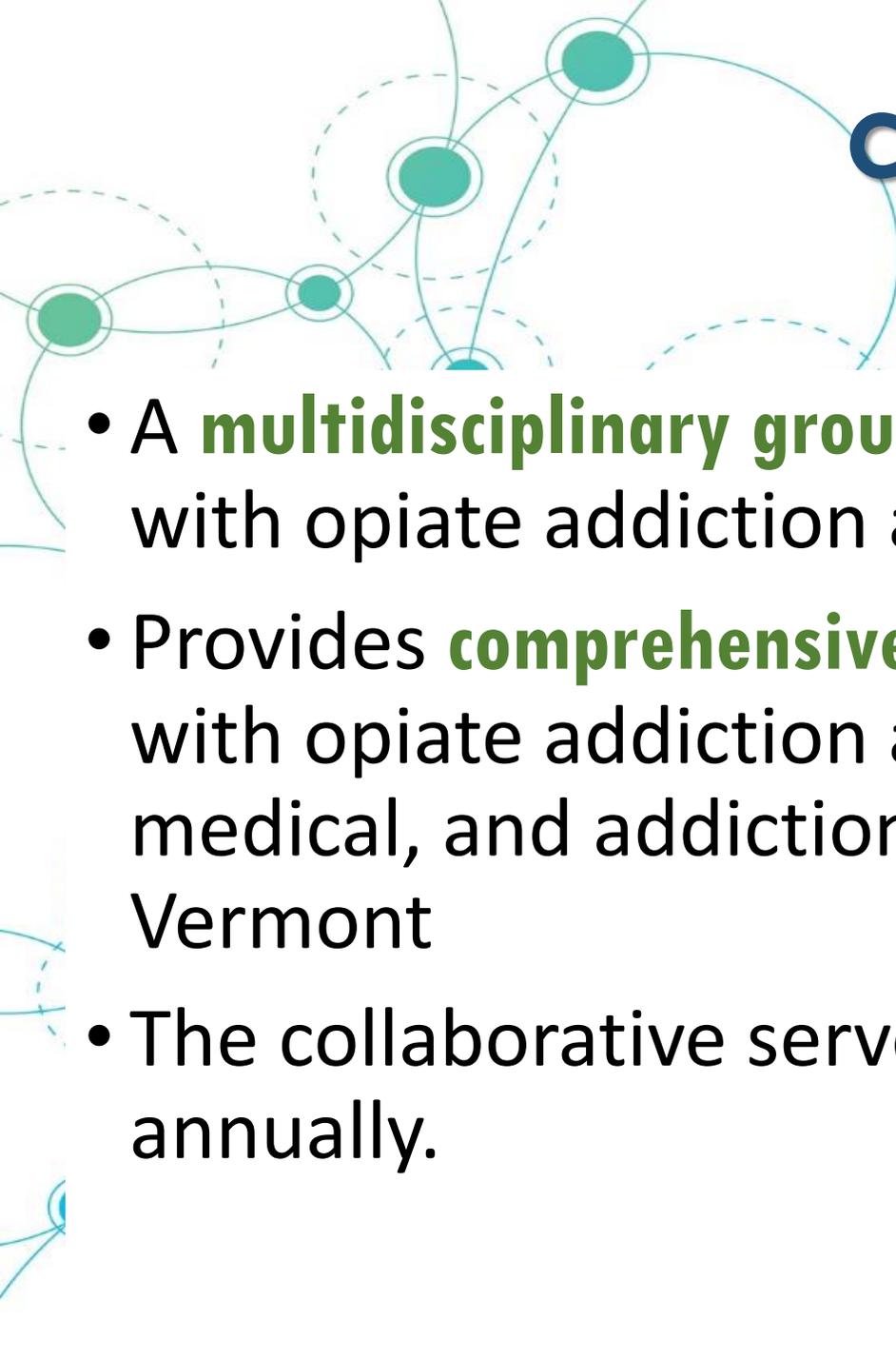




**Opioid Use in Pregnancy,
Collaborative Considerations
for Working with Mother and
Newborn**

**The Children and Recovering Mothers
(CHARM) Collaborative**

Sally Borden, MEd



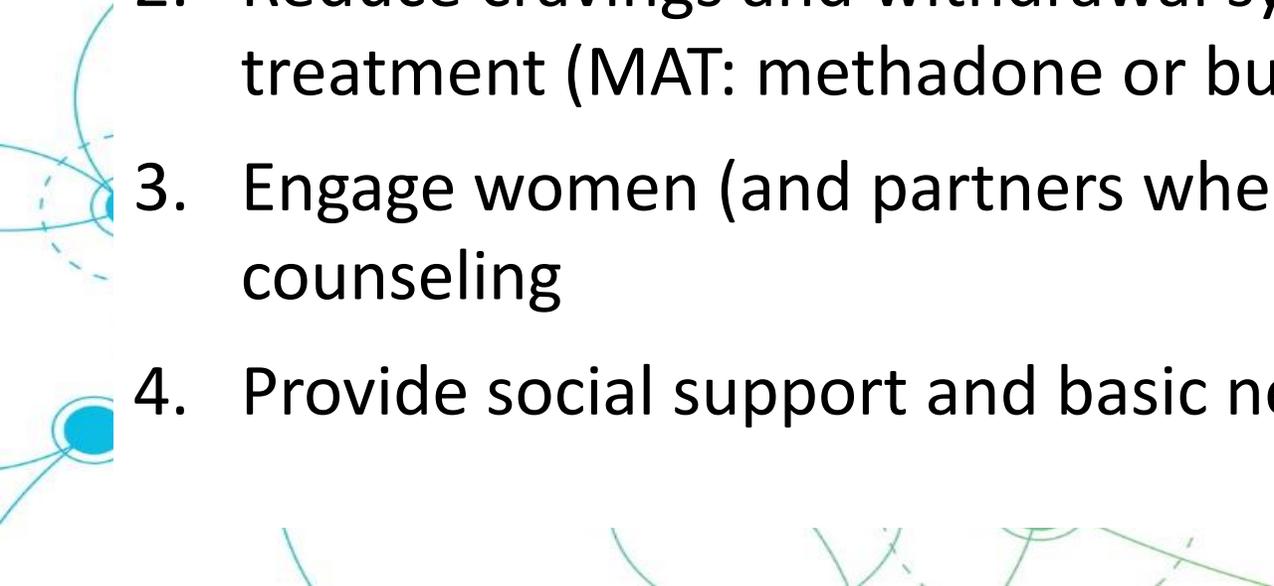
Children and Recovering Mothers (CHARM) Overview

- A **multidisciplinary group** of agencies serving pregnant women with opiate addiction and their infants
- Provides **comprehensive care coordination** for pregnant women with opiate addiction and consultation for child welfare, medical, and addiction professionals across the state of Vermont
- The collaborative serves about 200 women and their infants annually.



CHARM Goal

Improve the health and safety outcomes of babies born to women with a history of opiate dependence.

1. Engage women in prenatal care as early in the pregnancy as possible
 2. Reduce cravings and withdrawal symptoms using medication assisted treatment (MAT: methadone or buprenorphine)
 3. Engage women (and partners when possible) in substance abuse counseling
 4. Provide social support and basic needs referrals for the family
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CHARM Partners



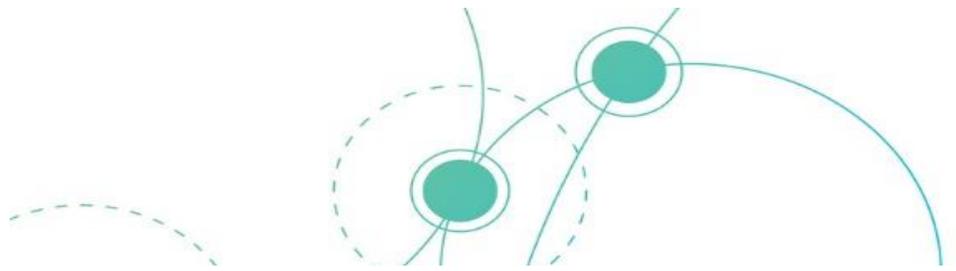
Department of Children and Families

Department of Corrections

Department of Health, Alcohol & Drug Abuse Programs

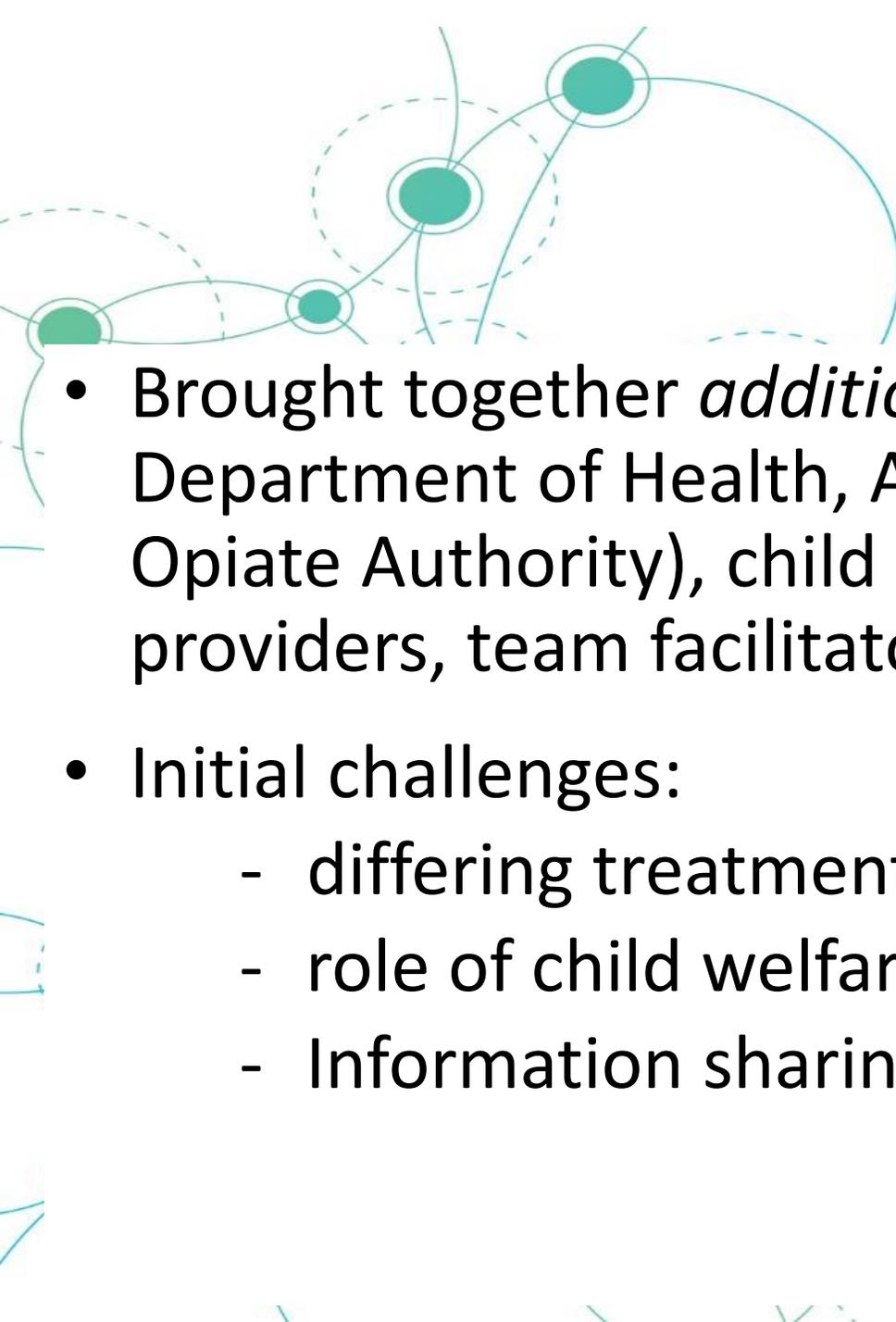
Department of Health, Maternal and Child Health

Department Healthcare Access (Medicaid)



History

- 1998
 - No methadone clinic or opiate treatment available in the State of Vermont for a heroin addicted pregnant woman
 - An Addiction Specialist Physician requested a one time waiver from the Opiate Treatment Authority.
 - Demand for medication assisted treatment continued to increase and the physician continued requesting waivers
 - 2002
 - First methadone clinic opens
 - The **addictions physician** continues working with an **obstetrician** and **neonatologist** to coordinate services for women being treated, and their infants
 - These efforts lead to the CHARM Collaborative
- 



Early Stages

- Brought together *additional key partners*, including Vermont Department of Health, Alcohol and Drug Abuse Program (State Opiate Authority), child welfare, community-based service providers, team facilitator
- Initial challenges:
 - differing treatment philosophies
 - role of child welfare
 - Information sharing / confidentiality



How it Works: Key Elements

The team meets monthly and reviews a list of current cases including:

- All new pregnant patients
- Patients due in the next month
- *Highest risk* prenatal patients
- New babies/post-partum patients
- *Highest risk* post-partum patients and their babies

A Shared Philosophy: Improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants.

Prenatal Care

Comprehensive Assessment: Confirm Pregnancy, Assess for Opioid Dependency, Assess for Additional Needs

Enhanced Prenatal Care: Urine Drug Test; Monitoring of Prenatal Visits; Monitoring for Relapse or Dose Adjustment

Assessment for Medication Assisted Treatment

Substance Abuse Counseling: Required for all Women Receiving MAT

Prenatal Neonatal Consultation: Education on Newborn Care and Neonatal Abstinence Syndrome

Our Care Notebook: Developed by CHARM women; Includes Resources, Personal Stories, and Encouragement

Collaborative Staffing: Prenatal Indicators of Strengths and Concerns

- Attendance and engagement at prenatal appointments
- Participation in substance use counseling
- Progress in Recovery
- Medication Assisted Treatment
- Partner's/Household engagement in substance use treatment
- Family Support
- Co-Occurring Issues: Domestic Violence, Mental Health, etc.
- Social services needs

Birth and Postnatal Care

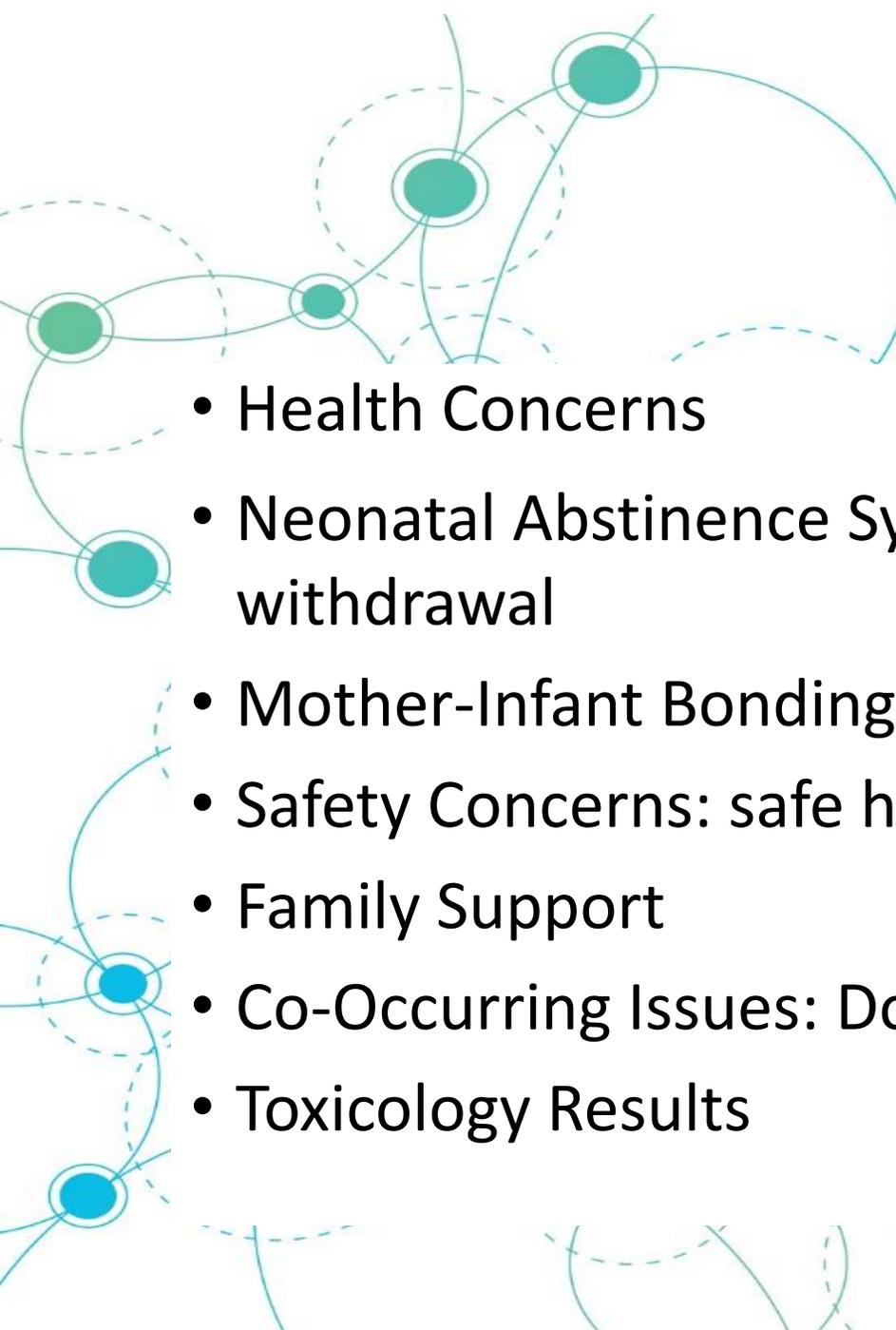
Needs and Plan of Care Developed Prior to Labor

CAPTA Plan of Safe Care Collaboratively Developed

Neonatal Abstinence Syndrome Assessment and Treatment

**Parent(s)/Caregiver(s) Trained to Administer Pharmacological Treatment to Infants
Post-Discharge, when necessary**

**Intense Level of Support Provided: Assistance and
Support Available 24 hours, 7 days**



Collaborative Staffing: Birth/Postnatal Indicators of Strengths and Concerns

- Health Concerns
- Neonatal Abstinence Syndrome Assessment and treatment for withdrawal
- Mother-Infant Bonding and Attachment
- Safety Concerns: safe home environment for baby
- Family Support
- Co-Occurring Issues: Domestic Violence, Mental Health, etc.
- Toxicology Results

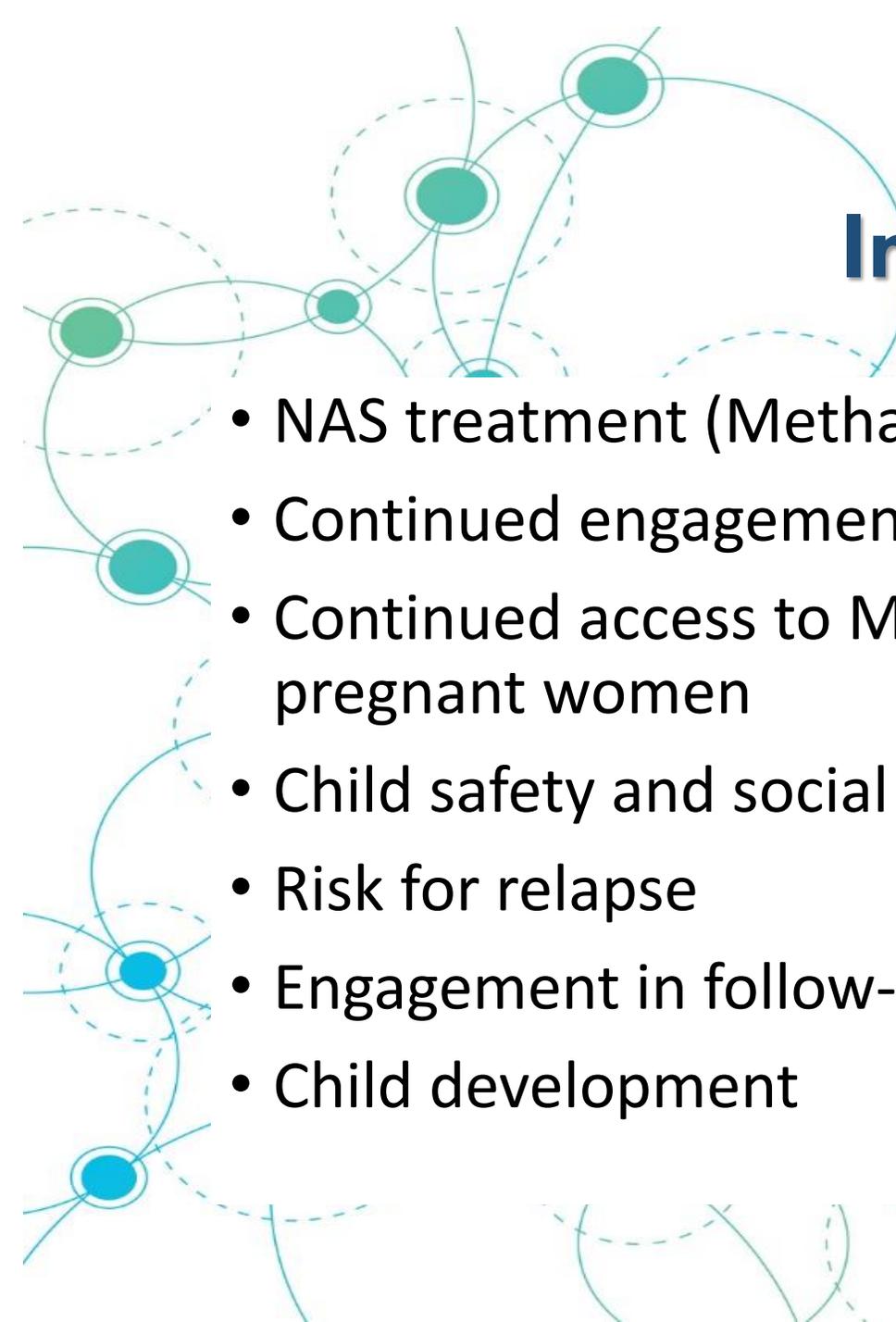
Infancy, Postpartum and Ongoing Care

Follow-up Services Continue for Both Mother and Infant

Infant Visits NeoMed Clinic Regularly Until 12-18 months

Infant Visits Include Monitoring of Growth and Development; Parent Education on Child Development ,Safe Sleep, Breastfeeding, etc.

Continued Monitoring of and Support Provided to Parent(s)/Caregiver(s) who Administer Pharmacological Treatment to Babies with NAS



Collaborative Staffing: Postpartum Indicators of Strengths and Concerns

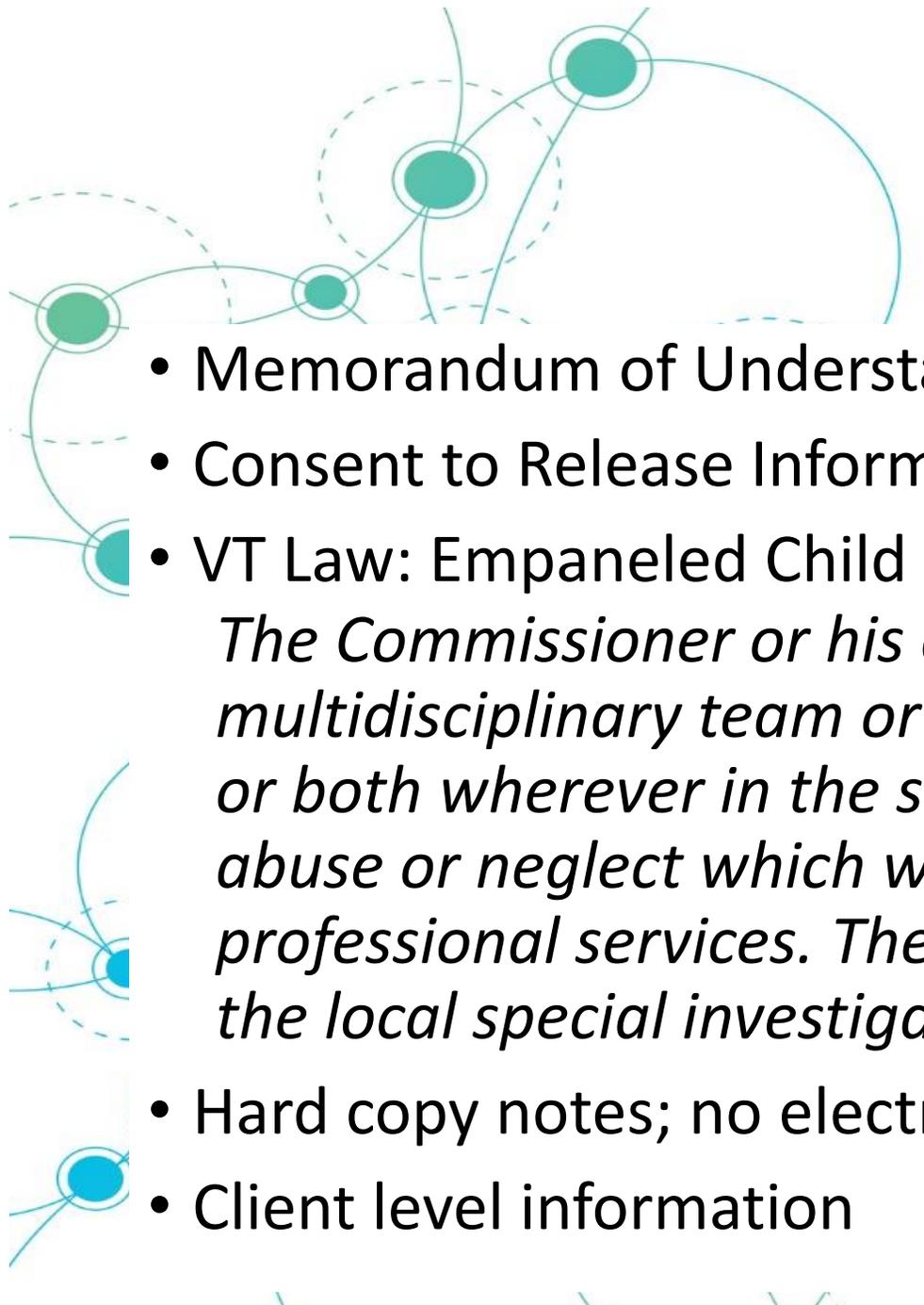
- NAS treatment (Methadone monitoring)
- Continued engagement in substance use treatment
- Continued access to MAT after delivery since priority is given to pregnant women
- Child safety and social service needs – child welfare involvement
- Risk for relapse
- Engagement in follow-up services
- Child development

What Makes it Work

- **Shared Philosophy:** Improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants.
- Value of coming together monthly to share information:
 - Time-saver
 - Develop trust
 - Minimize misunderstandings
 - Improved understanding of patients – more comprehensive view
 - Improved understanding of each other's roles and perspectives

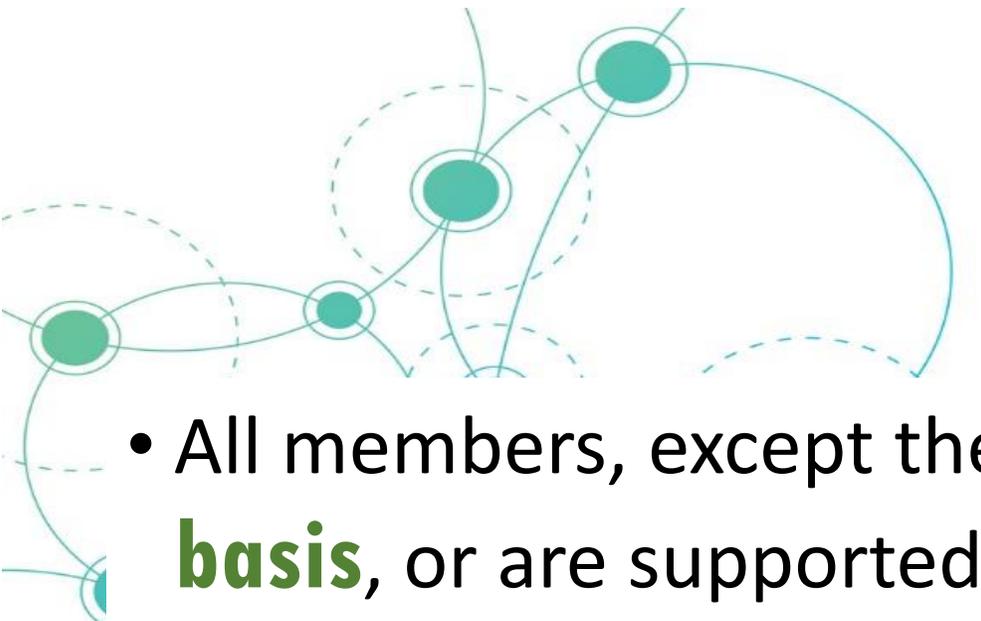
What Makes it Work

- **Sharing information** is critical to providing the best care and services to moms and babies.
- Decisions are made best with **current information**.
 - Recent example: DCF closed case after verifying at CHARM meeting that client attended treatment regularly; no CHARM members had child safety concerns.
- Outcomes evaluation and **systems improvement** through **Improving Care for Opioid-Exposed Newborns (ICON)**, a project of Vermont Child Health Improvement Program. Includes client participation and input.



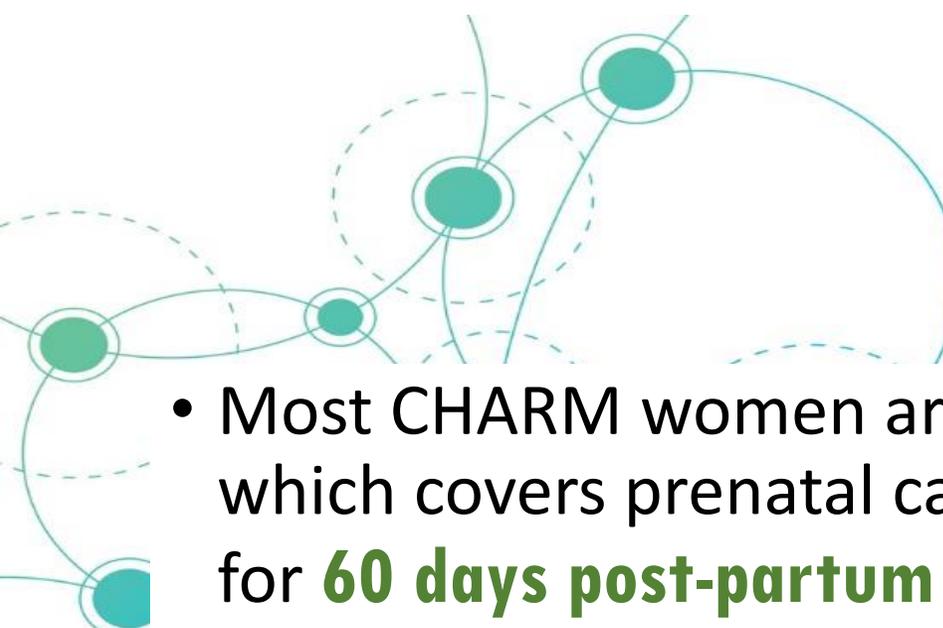
Cross-Systems Information Sharing

- Memorandum of Understanding
- Consent to Release Information
- VT Law: Empaneled Child Protection Team:
The Commissioner or his or her designee may empanel a multidisciplinary team or a special investigative multitask force team or both wherever in the state there may be a probable case of child abuse or neglect which warrant the coordinated use of several professional services. These teams shall participate and cooperate with the local special investigation unit
- Hard copy notes; no electronic information sharing
- Client level information

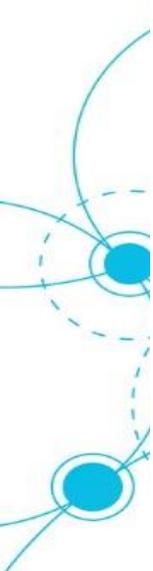


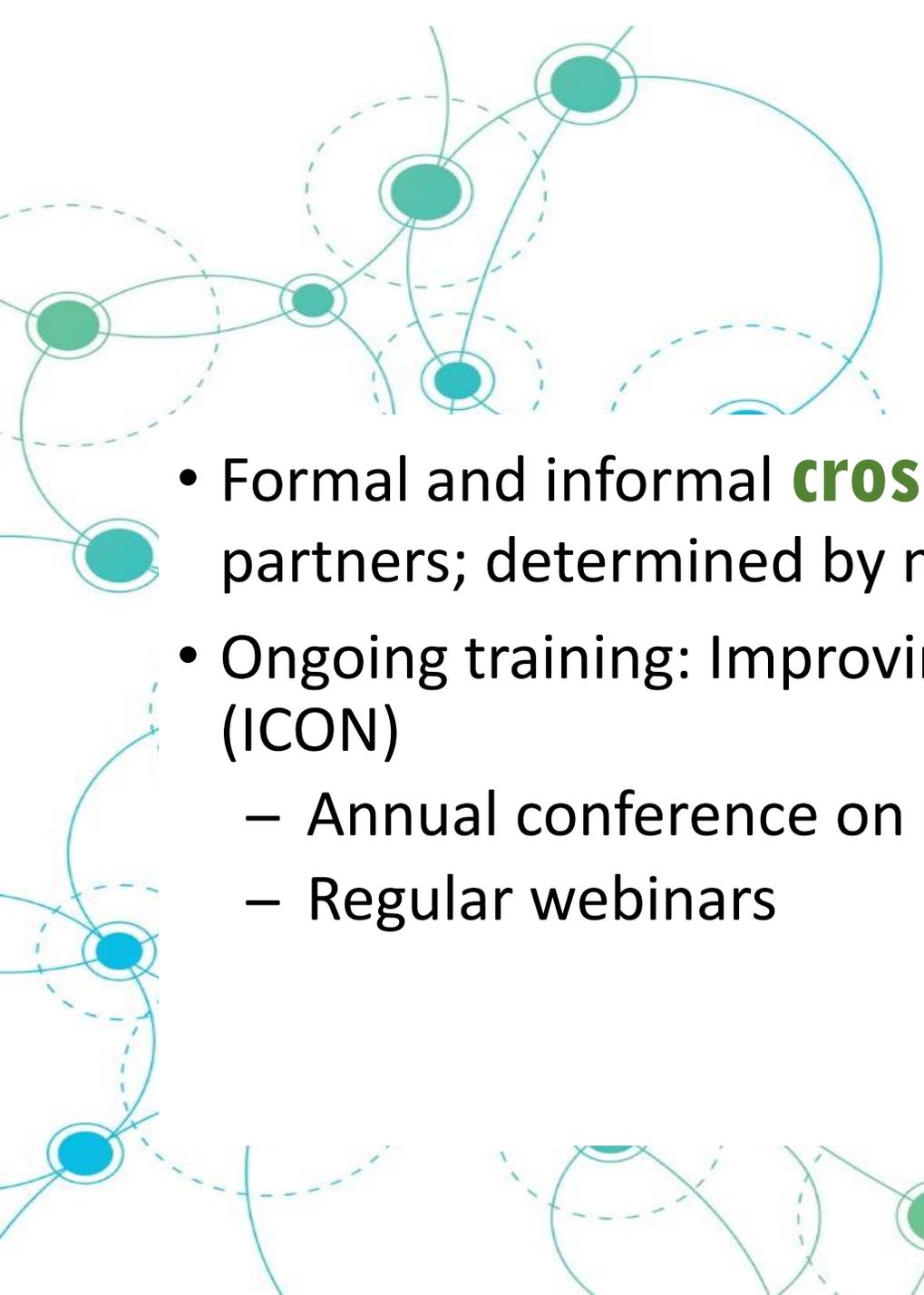
Costs: Collaborative

- All members, except the facilitator provide time on an **in-kind basis**, or are supported by their respective agencies.
 - Some agencies can bill time as **case management** or **coordination**.
 - About 15 professionals attend each meeting for a total of **30 staff hours**.
- 



Costs: Services

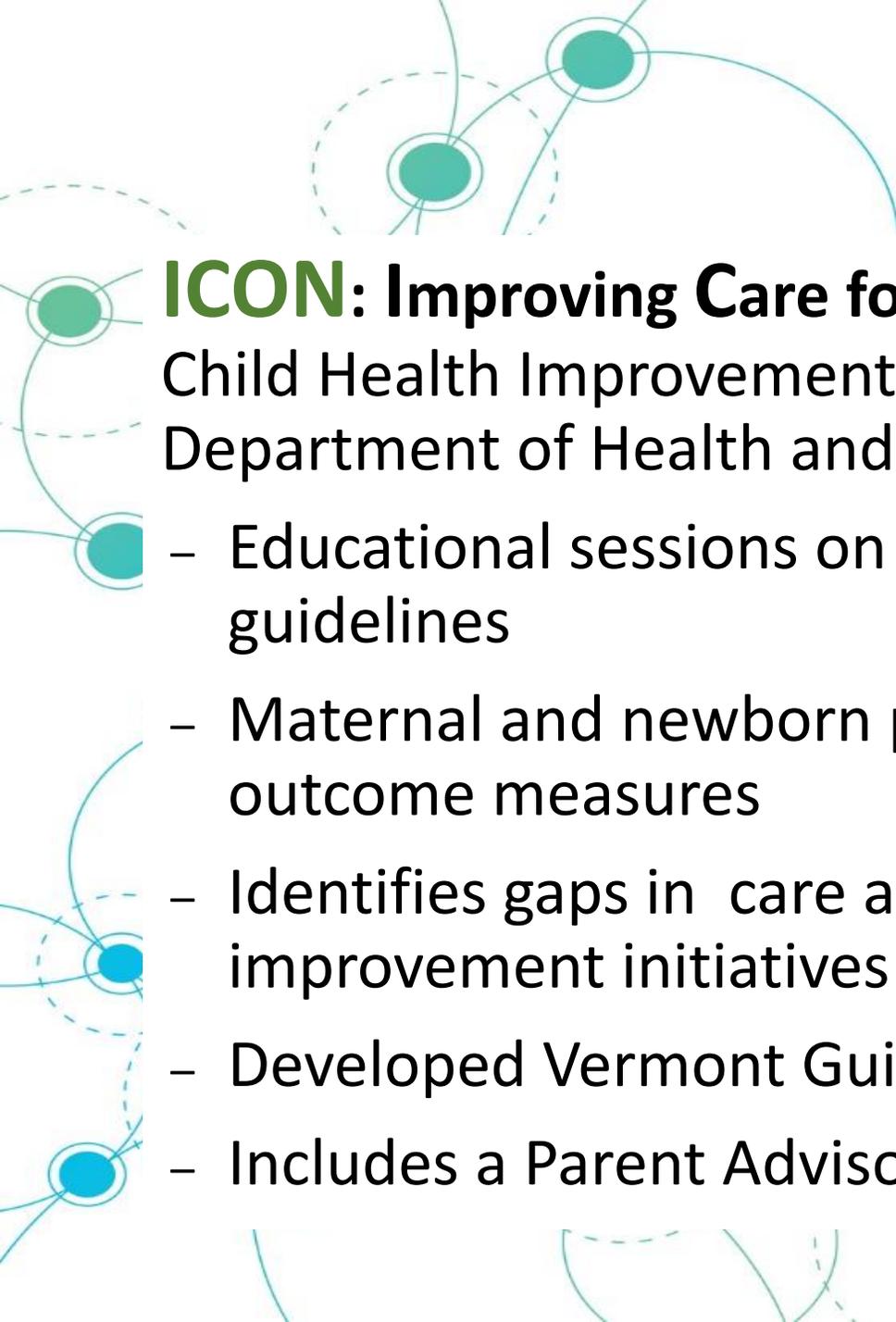
- Most CHARM women are eligible for Medicaid during pregnancy which covers prenatal care through labor and delivery and continues for **60 days post-partum**
 - Women without Medicaid can receive medical care through **Federally Qualified Health Centers** throughout Vermont
 - MAT Funding and Care Coordination: “Hubs and Spokes”
VT Alcohol and Drug Abuse Programs partnership with community-based treatment providers
- 



Training and Staff Development

- Formal and informal **cross-training** facilitated by the collaborative partners; determined by member-identified needs.
- Ongoing training: Improving Care for Opioid-exposed Newborns* (ICON)
 - Annual conference on care of infants with prenatal opioid exposure
 - Regular webinars

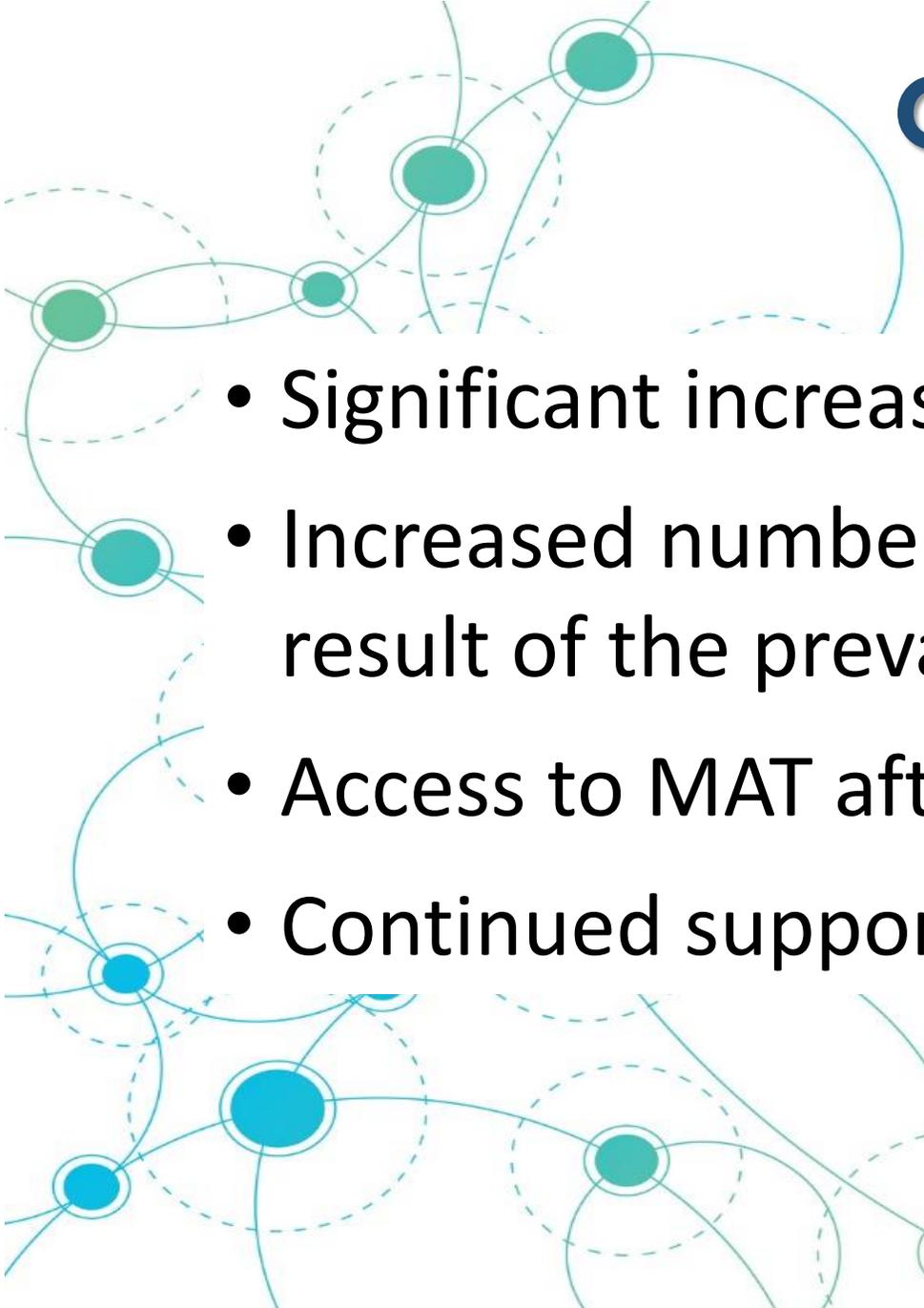
*<http://www.uvm.edu/medicine/vchip/?Page=ICON.html>



Quality Improvement

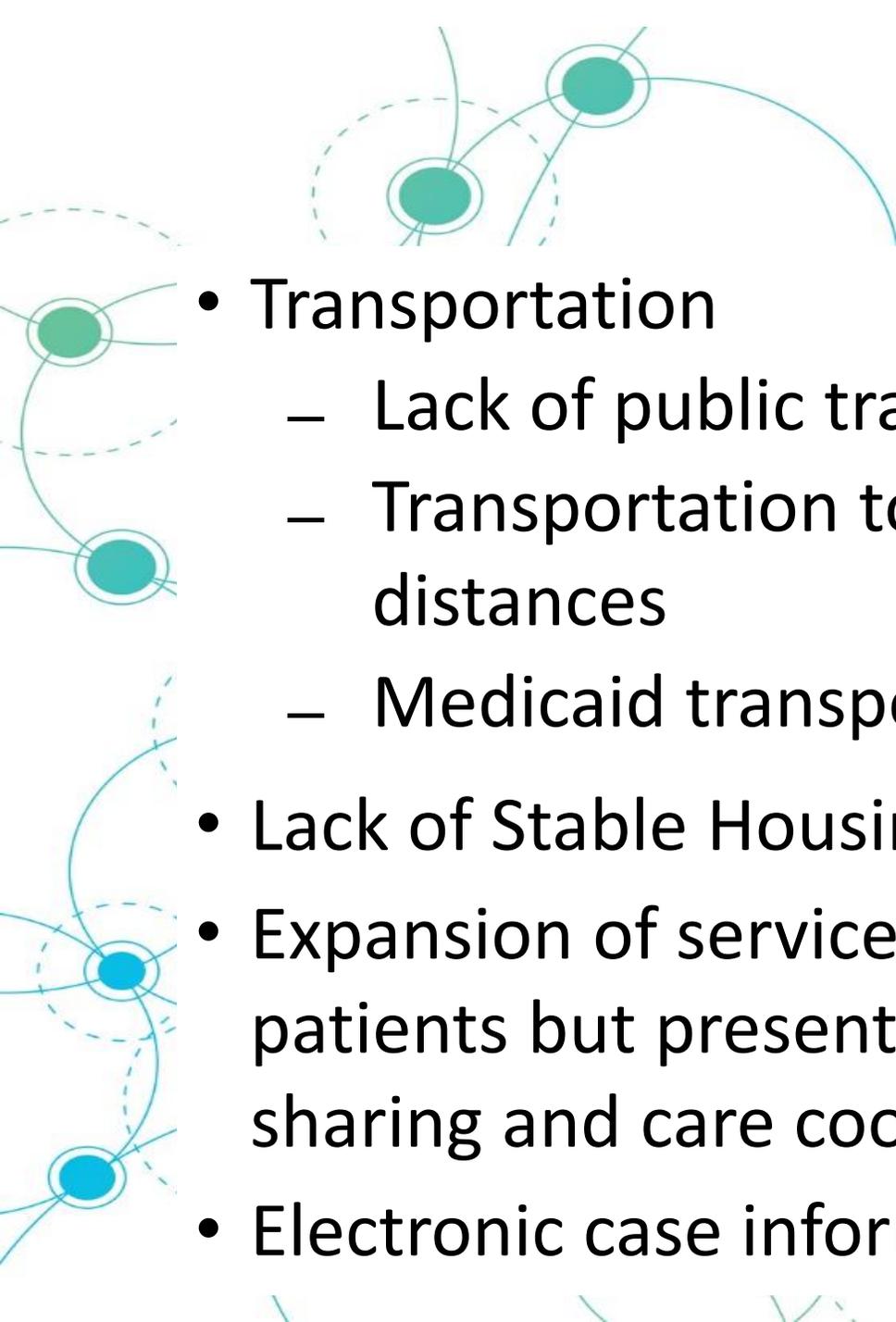
ICON: Improving Care for Opioid-exposed Newborns is Vermont's Child Health Improvement (VCHIP) partnership with the Vermont Department of Health and the Vermont Children's Hospital:

- Educational sessions on up-to-date recommendations and guidelines
- Maternal and newborn population database to track process and outcome measures
- Identifies gaps in care and systems issues; implements quality improvement initiatives
- Developed Vermont Guidelines
- Includes a Parent Advisor



Continuing Challenges

- Significant increase in opiate abuse in Vermont
- Increased number of child protection reports as a result of the prevalence of opioid abuse
- Access to MAT after delivery
- Continued support services after one year



Continuing Challenges

- Transportation
 - Lack of public transportation; rural
 - Transportation to Buprenorphine providers: long distances
 - Medicaid transportation rules re children
- Lack of Stable Housing for patients/clients
- Expansion of services statewide: Improves access for patients but presents new challenges for information-sharing and care coordination
- Electronic case information-sharing

A stylized, light-colored illustration of a plant with several leaves and a cluster of small, round buds or flowers, positioned on the left side of the slide against a dark brown background.

CHARM AND CHILD PROTECTION – TEAMING FOR SUCCESS WITH SUBSTANCE EXPOSED NEWBORNS AND THEIR FAMILIES

Karen Shea, MSW

DCF Family Services

Child Protection and Field
Operations Director

The Early Days

- DCF Family Services involvement in CHARM was not initially “easy”.
- Much time was spent trying to understand each team members role and perspective and to find “common ground” and work through concerns about each other’s “agendas”.
- Through meeting regularly, we were able to talk about our “common ground”, discuss areas of disagreement, help others know what our “agenda” was on a case by case basis so that we could build trust and so that there would be no surprises.

Informing and Being Informed

- Through case dialogue, we all learned from one another and got a cross-disciplinary view of the work being done.
- We were able to identify key areas of challenge for team members with the child welfare approach including:
 - Report Screening Practices
 - Focus of Child Welfare Intervention
 - Case Determination Practice

Policy Shifts - DCF Family Services Intake Screening Policy

- CHARM members were concerned that reports of prenatal substance use (illicit and MAT) were being treated the same way at the point of screening.
- Policy was shifted to be clear that MAT is not a “valid allegation” that would result in acceptance.

Policy Shifts - DCF Family Services Intake Screening Policy

Valid allegations if:

- 1) A physician certifies or the mother admits to use of illegal substances or non-prescribed prescription medication during the last trimester of her pregnancy.
- 2) A newborn has a positive toxicology screen for illegal substances or prescription medication not prescribed to the patient or administered by a physician
- 3) A newborn has been deemed by a medical professional to have Neonatal Abstinence Syndrome through NAS scoring as the result of maternal use of illegal substances or non-prescribed prescription medication.
- 4) A newborn has been deemed by a medical professional to have Fetal Alcohol Spectrum Disorder

Policy Shifts - DCF Family Services Intake Screening Policy

- Historically, we were opening cases for a child abuse investigation if it was found to be a “valid allegation”.
- Through dialogue, we examined this approach and the unintended implications it may have on treatment “seeking” by pregnant mothers.
- We have another option for accepting cases that does not require a case determination (substantiation or no substantiation). We decided to clarify in policy that cases of prenatal substance exposure would be assigned to receive a Family Assessment (vs. an investigations).
- Shifted the focus from “fact finding” to assessment of risk and planning for the future.

Policy Shifts - DCF Family Services Intake Screening Policy

- Charm Team members were concerned about the “when” of our involvement.
- Historically, we would not act on a report of prenatal substance exposure until after the infant was born.
- This approach felt to all of us like we were missing an opportunity to avert a crisis through encouraging earlier treatment, assessment of risk and protective factors prior the infant’s birth and engaging a larger network in planning.

DCF Family Service's Response

- DCF Family Services will conduct an assessment and determine whether there is a need for on-going involvement with the family.
- The assessment is focused on the future – Can this parent successfully and safely care for the child? Is there a need for treatment for the parent? Is there a need for referrals to services?
- The parent's use of substances while pregnant is the way we become involved but the focus of the assessment is on whether or not there are any concerns about the parents ability to meet the needs of the child into the future.

DCF Family Service's Response continued...

- DCF does not substantiate mothers for child abuse for using substances while pregnant. We do focus on whether or not the parent can safely care for the infant.
- On-going involvement with DCF Family Services after an assessment occurs if:
 - 1) The child is in need of care and supervision because of identified danger and the court becomes involved or
 - 2) DCF Family Services assesses that the risk is high or very high for future maltreatment and opens a family support case (without court involvement)

In either situation, DCF Family Services will work with the family to create a case plan to address the risks that exist.

DCF Family Service's Response continued...

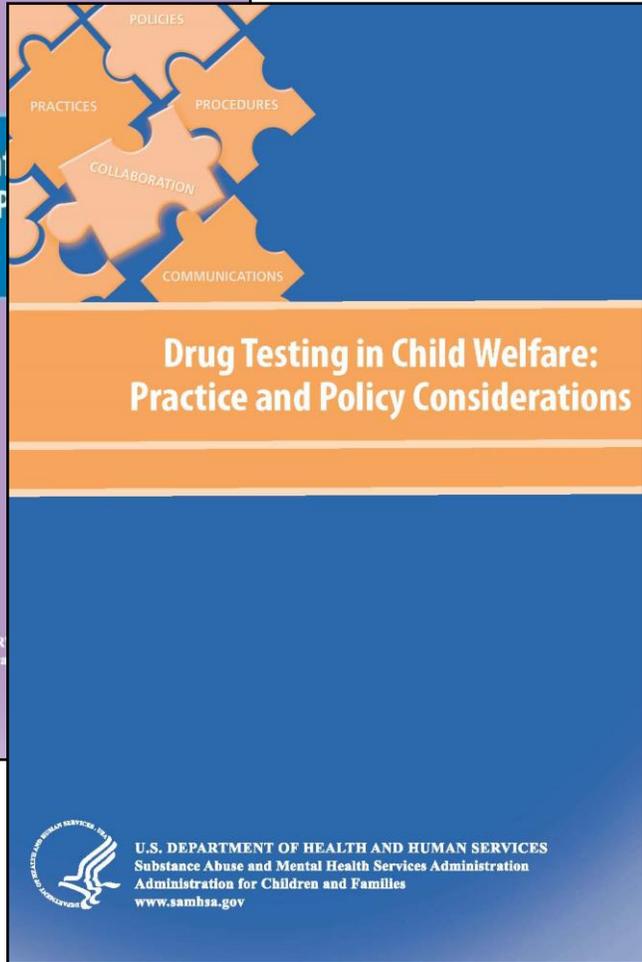
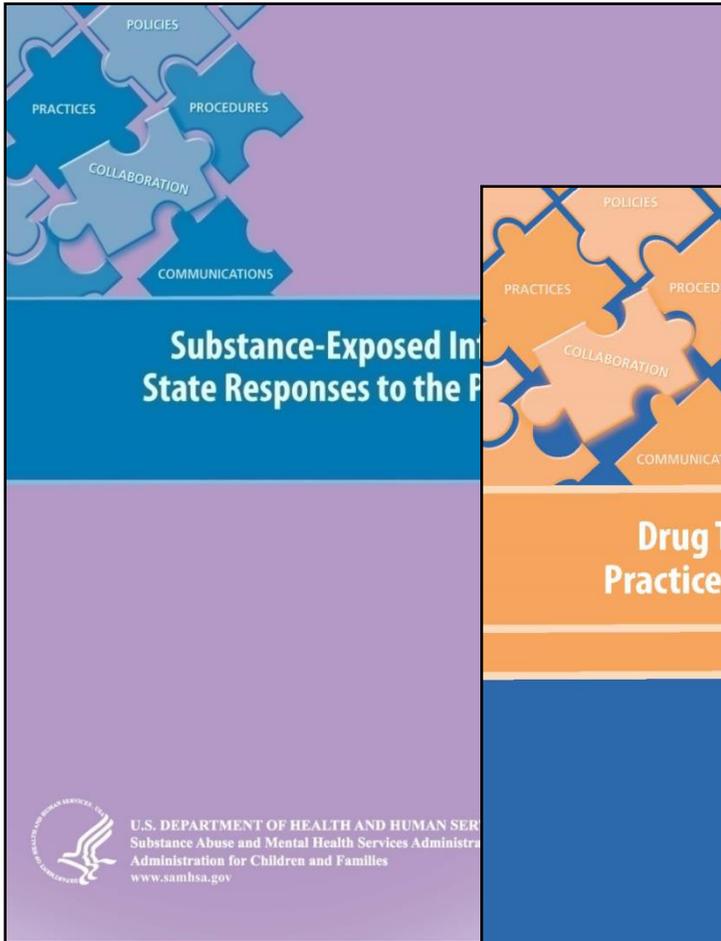
- There are many cases that come to us before CHARM has had the opportunity to be engaged or in regions of the state where we don't have a CHARM
- In some ways, cases that come to our attention through our involvement in CHARM are less concerning than other cases because they are often engaged in the treatment and services
- We have identified the need for better identification and screening of SUDs in the child welfare involved population
- RPG grant funding allowed us to try an approach that has shown great promise where we have substance abuse screeners that accompany our social workers to meet with families at the point of first contact.

Role of DCF – Our Practice Model

- Safety of children
- Work to do this by supporting families to get the treatment services that they need to safely care for their children
- Work with teams to develop plans that are appropriate to the situation
- Work to mobilize resources (formal and informal) to assist the family into the future

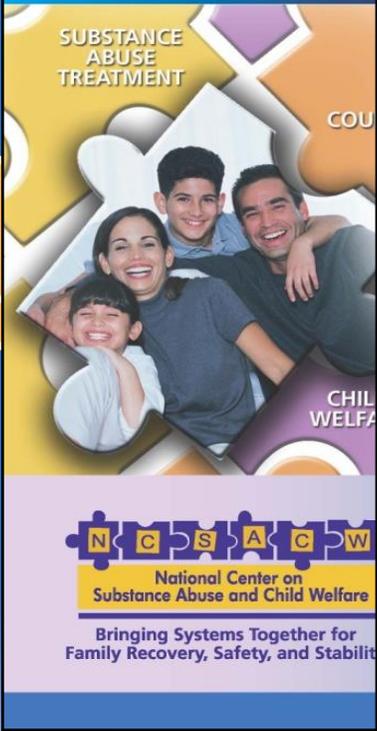
**The Children and
Recovering Mothers
(CHARM)
Collaborative
in Burlington,
Vermont
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Contact Information

Nancy K. Young, PhD

Director

National Center on Substance Abuse and Child Welfare

ncsacw@cffutures.org

1-866-493-2758



Sally Borden, MEd

Executive Director, KidSafe Collaborative

sallyb@kidsafevt.org



Karen Shea, MSW

Family Services Director

Vermont Department for Children and Families

Karen.Shea@state.vt.us



Discussion