Best Practices for Caring for Infants and Families Affected by Perinatal Substance Use

Perinatal Substance Exposure Task Force
of the Governor's Commission on Alcohol and Other Drugs

Presentation at Division of Children Youth and Families Conference
April 8, 2021

Franklin Pierce School of Law
Institute for Health Policy & Practice
Health Law & Policy

Perinatal Substance Exposure Task Force of the NH Governor's Commission on Alcohol and Other Drugs

NH DCYF

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Dartmouth-Hitchcock

Webinar Instructions

1. Please enter your name, role/discipline and organization in the “chat” window to introduce yourself
2. Please use the “chat” button to ask a question or make a comment

Workshop Presenters

1. Farrah A.S. Deselle, MSN, RN, IBCLC, CCBE (BFW)
2. Daisy Goodman, DNP, MPH, CNM, CARN-AP
3. Lucy Hodder, JD
4. Jennifer Ross-Ferguson, MSW

Workshop Objectives

1. Describe prevalence of prenatal opioid exposure in New Hampshire
2. Identify best practices for addressing perinatal substance exposure in New Hampshire
3. Describe how best practices relate to and are utilized by DCYF staff, and other stakeholders interacting with pregnant or new mothers.

Agenda

Welcome, Objectives and Background	11:00 - 11:05
Current Landscape of Perinatal Substance Exposure *Daisy Goodman*	11:05 - 11:25
Caring for Opioid Exposed Newborns with the ESC Model of Care *Farrah Desselle*	11:25 - 11:35
Developing Plans of Safe and Supportive Care in New Hampshire *Lucy Hodder*	11:35 - 11:50
NH DCYF Processes in Abuse and Neglect Cases and Services and Supports *Jennifer Ross Ferguson*	11:50 - 12:00
Trauma-Informed and Trauma-Responsive Care *Farrah Desselle*	12:00 - 12:15
Questions and Discussion **Facilitator:** *Farrah Desselle*	12:15 - 12:30

Perinatal Substance Exposure Task Force of the Governor's Commission on Alcohol and Other Drugs

The mission of the Perinatal Substance Exposure Task Force is to identify, clarify, and inform the Governor's Commission about issues related to perinatal substance exposure: including ways to lessen barriers pregnant women face when seeking quality healthcare; aligning state policy and activities with best medical practices for pregnant and newly parenting women and their children; and increasing public awareness about the dangers of exposure to prescription and illicit drugs, alcohol and other substances during pregnancy.

https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force

Definitions and Acronyms

- Fetal Alcohol Syndrome (FAS): Condition in a child that results from alcohol exposure during pregnancy; A more permanent condition
- Medication Assisted Treatment (MAT)
- Medication for Opioid Use Disorder (MOUD)
- Neonatal Abstinence Syndrome (NAS): The group of symptoms/conditions experienced by an infant that is caused by exposure to substances in utero (nicotine, SSRIs, opioids etc), Generally thought to be temporary.
- Neonatal Opioid Withdrawal Syndrome (NOWS): Specifically referring to withdrawal/abstinence from opioids (heroine, methadone, illicit or prescribed)
- Opioid Exposed Newborn (OEN)
- Opioid Use Disorder (OUD)
- Perinatal Substance Exposure (PSE): Exposure to substances in the perinatal period to pregnant person or fetus
- Post Traumatic Stress Syndrome (PTSD): A psychiatric disorder that may occur in people who have witnessed/experienced a traumatic event
- Substance Use Disorder (SUD)

Definitions - Addiction

- The American Society of Addiction Medicine (ASAM) defines Addiction as a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- Complex interaction between genetics, epigenetics, brain chemistry, environment, behavior
- Treatable
- 10% of the population – CDC, SAMHSA

DSM V Diagnostic Criteria: Substance Use Disorder *SEVERITY: 2-3: mild 4-5: moderate 6 or more: severe*
1. Taking the substance in larger amounts or for longer than you meant to.
2. Wanting to cut down or stop using the substance but not managing to do so.
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at home, work, or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational, or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even if you have a physical or psychological problem that could have been caused or made worse by the substance
*10. Needing more of the substance to get the effect you want (tolerance)
*11. Development of withdrawal symptoms, which can be relieved by taking more of the substance
*Criteria not met if taking prescribed drugs under supervision

Polling Question

Please choose the option that best describes your reason for attending today's session.

a. I want to help the families I work with in a trauma-informed way
b. I want to understand the scope of prenatal substance use disorder in NH
c. I want to help clients with referrals using their Plan of Safe Care (POSC)
d. I would like to know what services are available in NH to support families
e. Other (tell us in the chat)

Current Landscape of Perinatal Substance Exposure

Daisy Goodman, DNP, MPH, CNM, CARN-AP

Assistant Professor of Obstetrics & Gynecology
Geisel School of Medicine
Director of Women's Health Services
Moms in Recovery Program, DHMC
Daisy.J.Goodman@hitchcock.org

Prenatal Substance Exposure in New Hampshire

- **7.0%** of infants born in NH hospitals between May 1 and December 31, 2020 were **monitored after birth** due to prenatal substance exposure
  - Cannabis was the most common exposure, followed by opioids

- **3.5%** of infants were identified as being **affected by substance misuse or withdrawal symptoms** resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder

- The **leading cause** of pregnancy-associated deaths in NH is **accidental drug overdose, the overwhelming majority occurring postpartum**

New Hampshire vital statistics data (D. LaFlamme, PhD, NH DHHS)

Engagement in Behavioral Health: Pregnancy and Postpartum

- Pregnancy is strongly associated with substance use treatment initiation
  - Rates of SUD treatment participation > 90% [pre-COVID]
- Less than 40% of postpartum people with OUD/SUD participate in postpartum care
- 80% of pregnant people with OUD/SUD have at least one additional mental health diagnosis
- High rates of treatment discontinuation postpartum
- Loss of child custody is associated with treatment initiation, and also with treatment discontinuation

Mistrust is a Barrier to Accessing Care

For women who use substances, concern about being reported to child protective services is a significant barrier to engaging in care

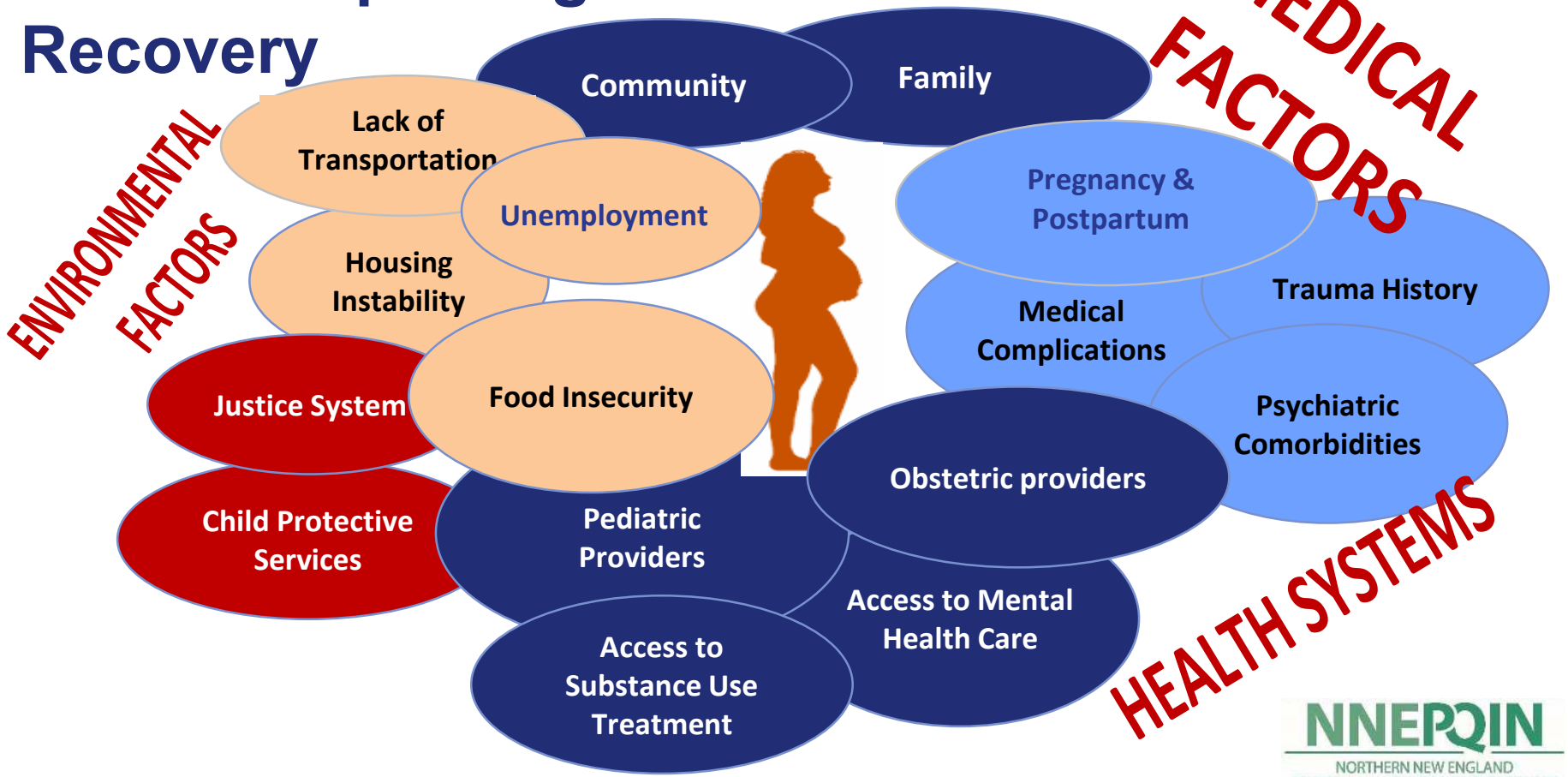
2017 Survey Results

Perinatal Provider Practices	**78%** identified "concerns about being reported to child protective services" as a serious or moderate barrier
Substance Use Treatment Provider	**92%** cited "concerns about being reported to child protective services" as a top barrier to accessing care
Continuum of Care Facilitators	**91%** cited "concerns about being reported to child protective services" as a serious or moderate barrier

Frequently Asked Questions

- Will my baby be taken away if I admit to using drugs?
- When does DCYF get called and who calls?
- Are the things I tell my providers confidential?
- Is there a way to anonymously ask a doctor/midwife questions?
- What criminal ramifications might someone face if they are found to be using substances while pregnant?

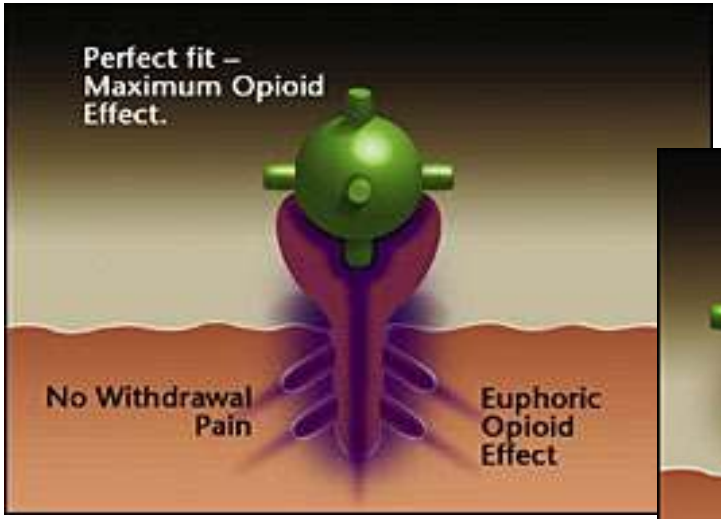
Factors Impacting Recovery



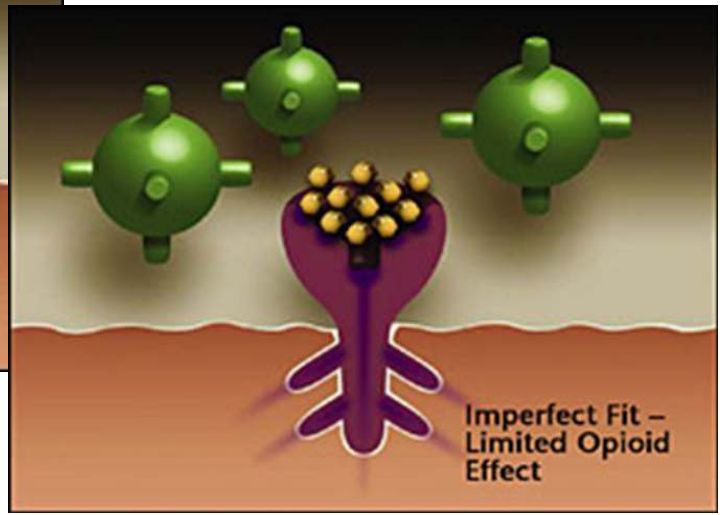
NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

Medications for OUD (MOUD)

Methadone



Buprenorphine



(Images: National Institute on Drug Abuse)

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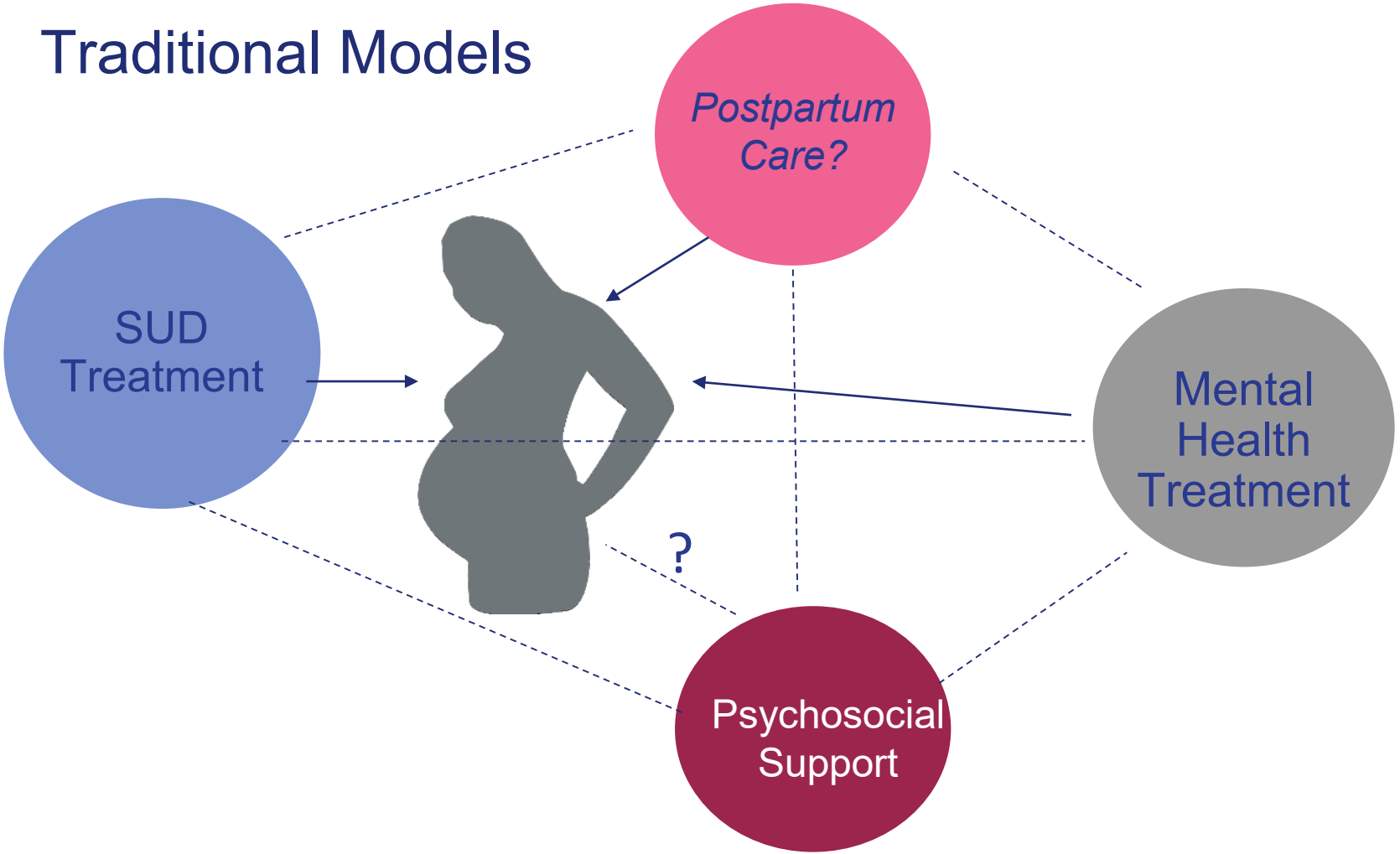
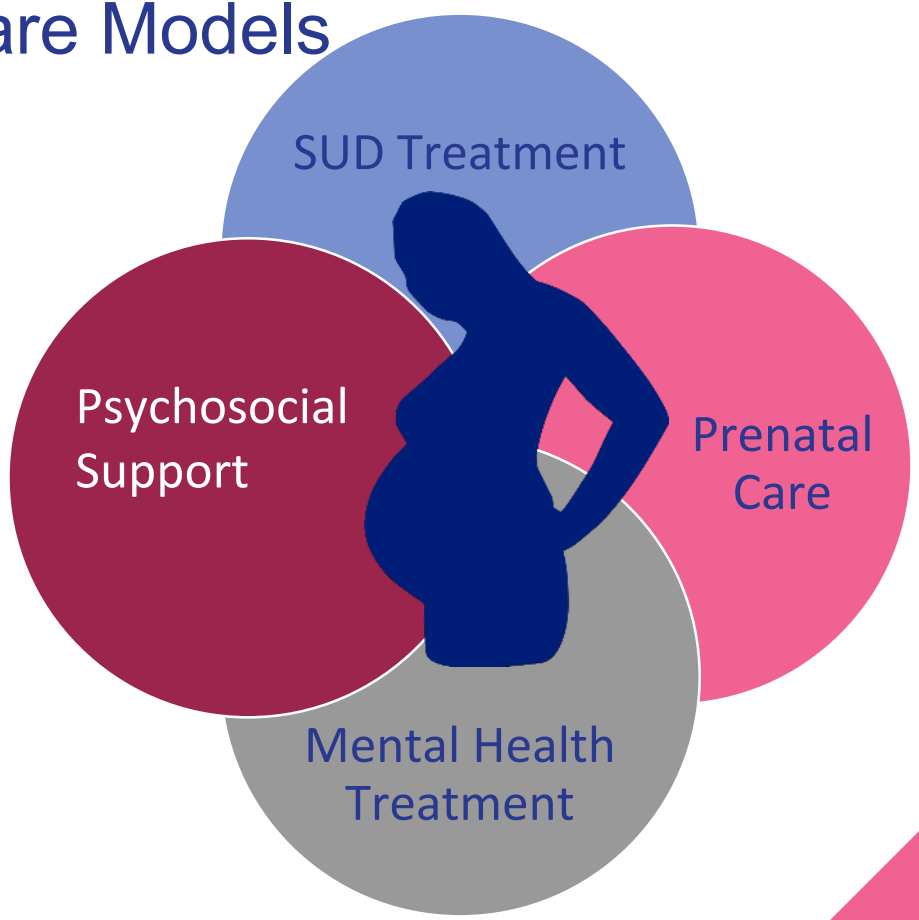
PERINATAL QUALITY IMPROVEMENT NETWORK

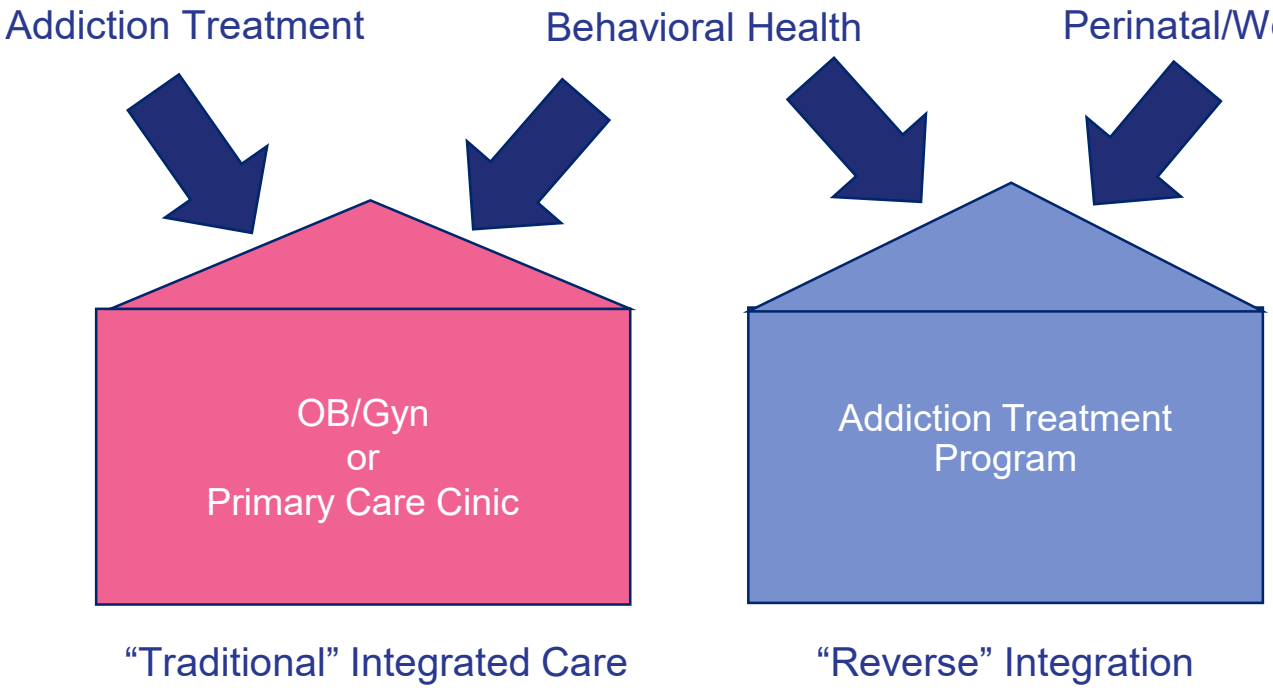
Traditional Models



Integrated Care Models



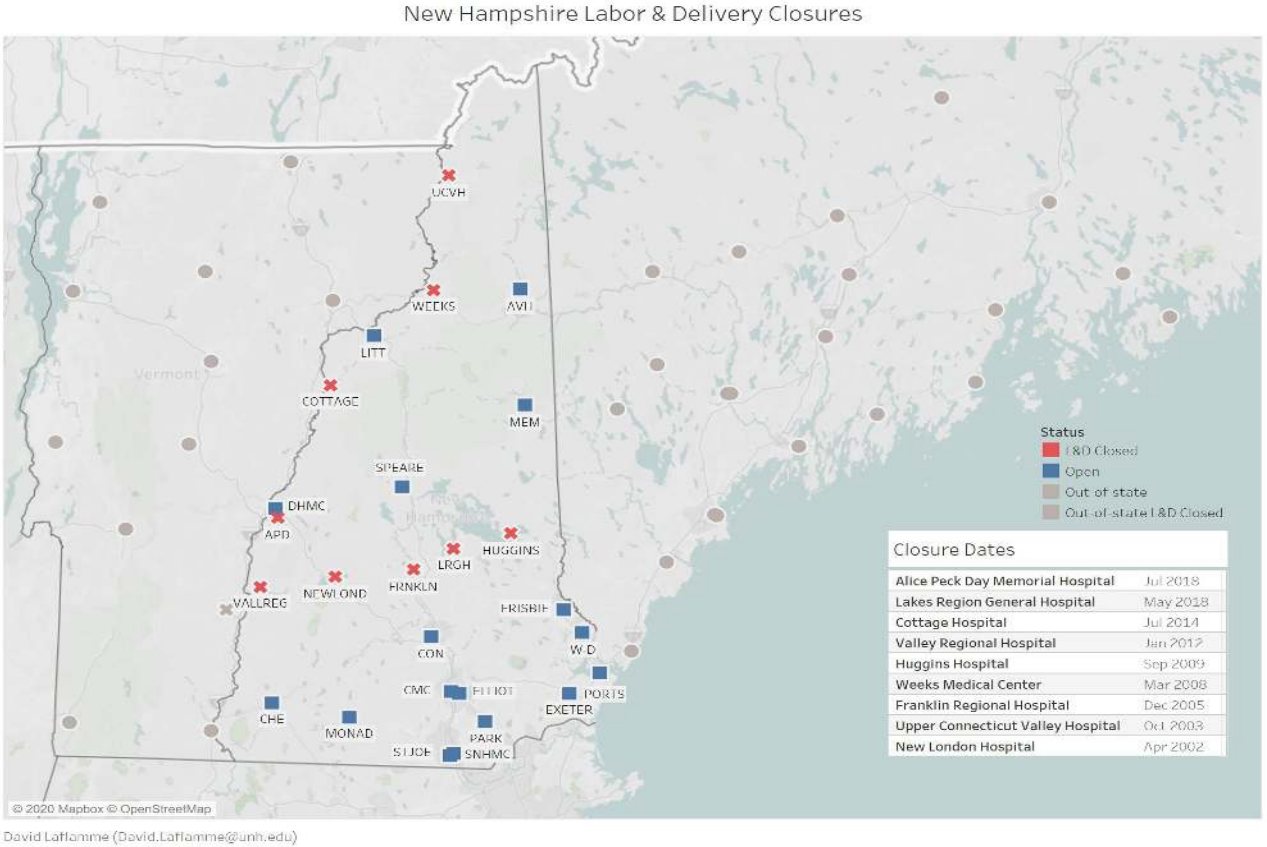
Integrated Models Deliver MOUD Co-Located With Prenatal And Postpartum Care



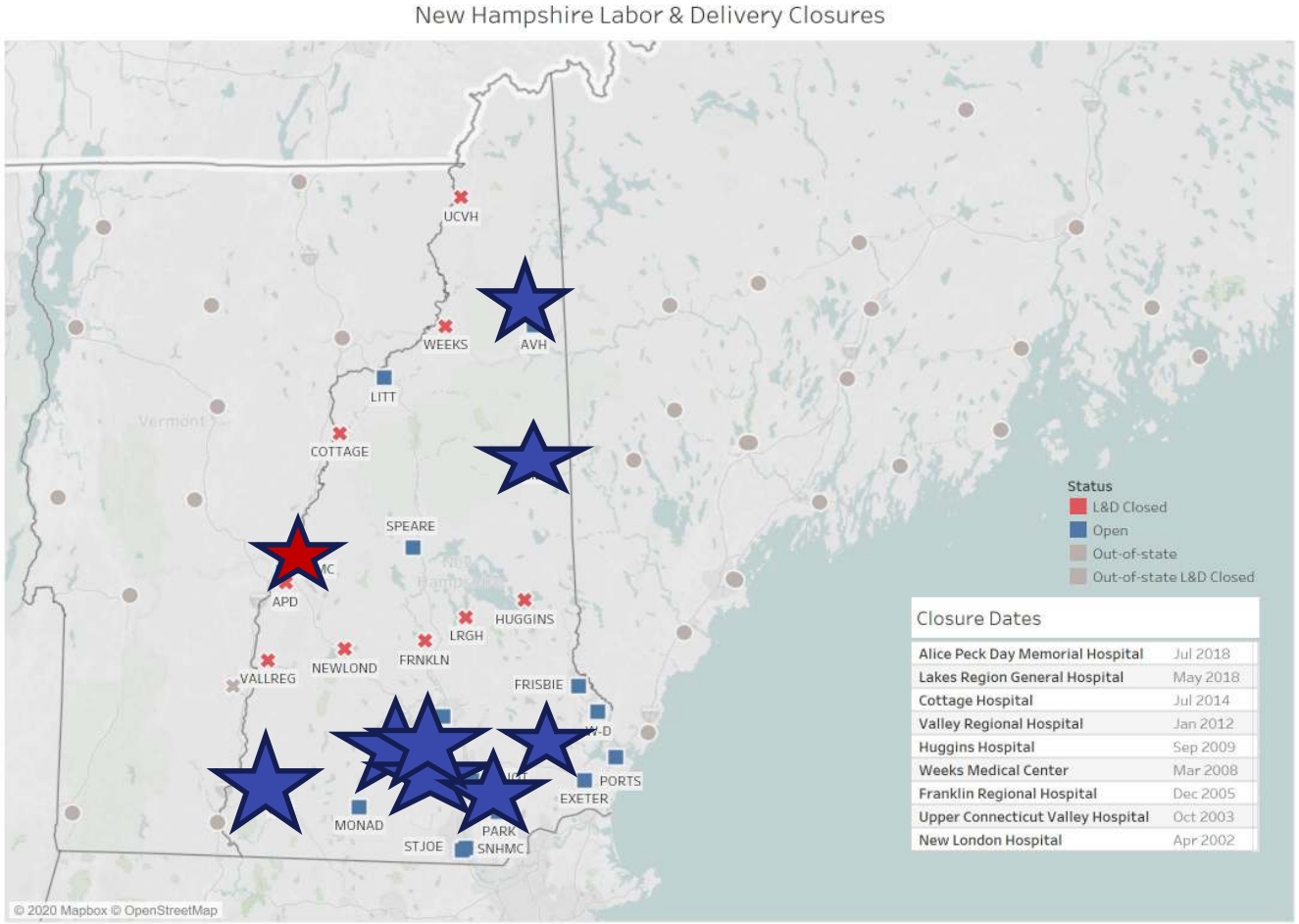
Key elements of Integrated Models

- Team-based care
- MOUD
- Mental health care
- Medical care
- Case management
- Recovery support

Maternity Care Deserts in New Hampshire



Slide courtesy of D. LaFlamme, NH DHHS



David Laflamme (David.Laflamme@unh.edu)

Integrated Perinatal Programs in New Hampshire

Caring for Opioid Exposed Newborns with the ESC Model of Care

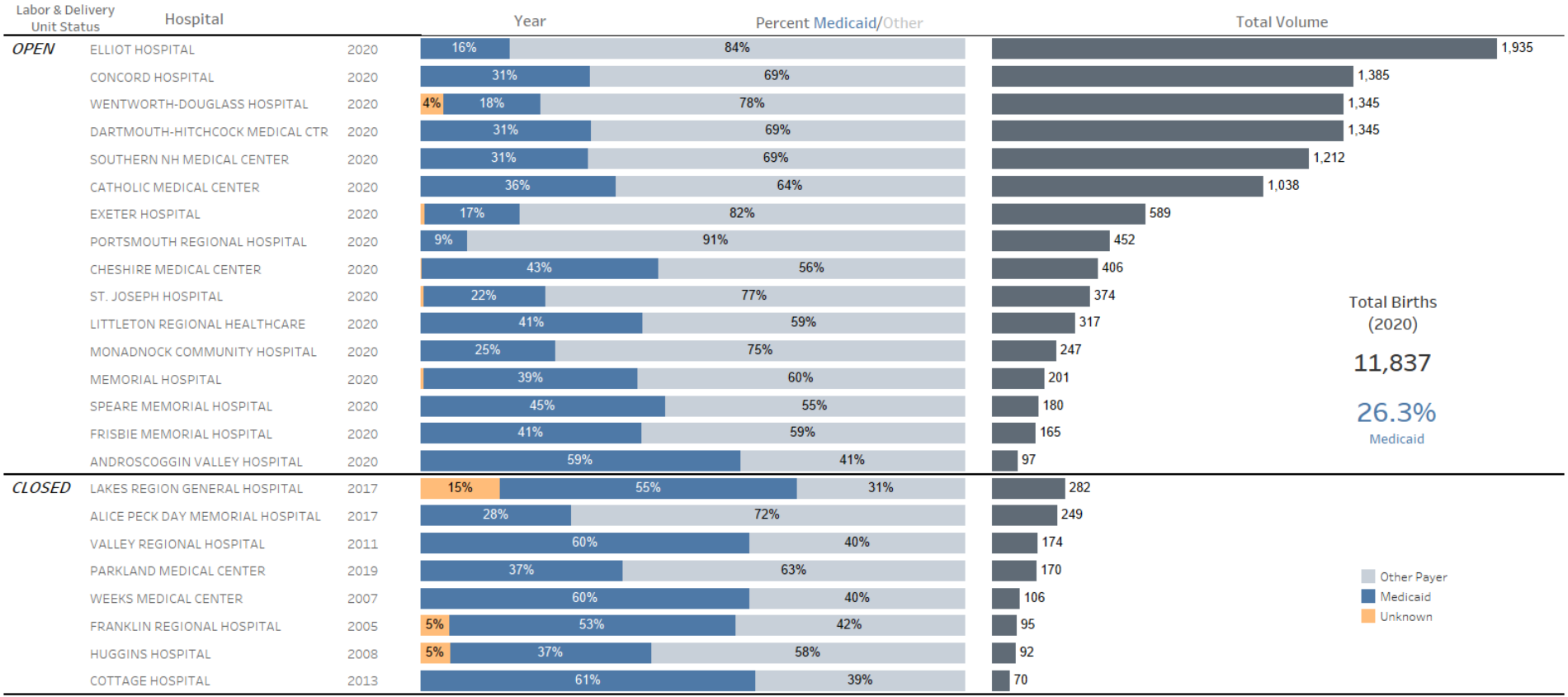
Farrah Sheehan Deselle, MSN, RN, IBCLC

Perinatal Nurse Educator and Consultant
Eat Sleep Console and Trauma-Informed Care
Farrah.A.S.Deselle@hitchcock.org

Slide courtesy of D. LaFlamme, NH DHHS

Births in NH Hospitals by Status, Payer and Volume

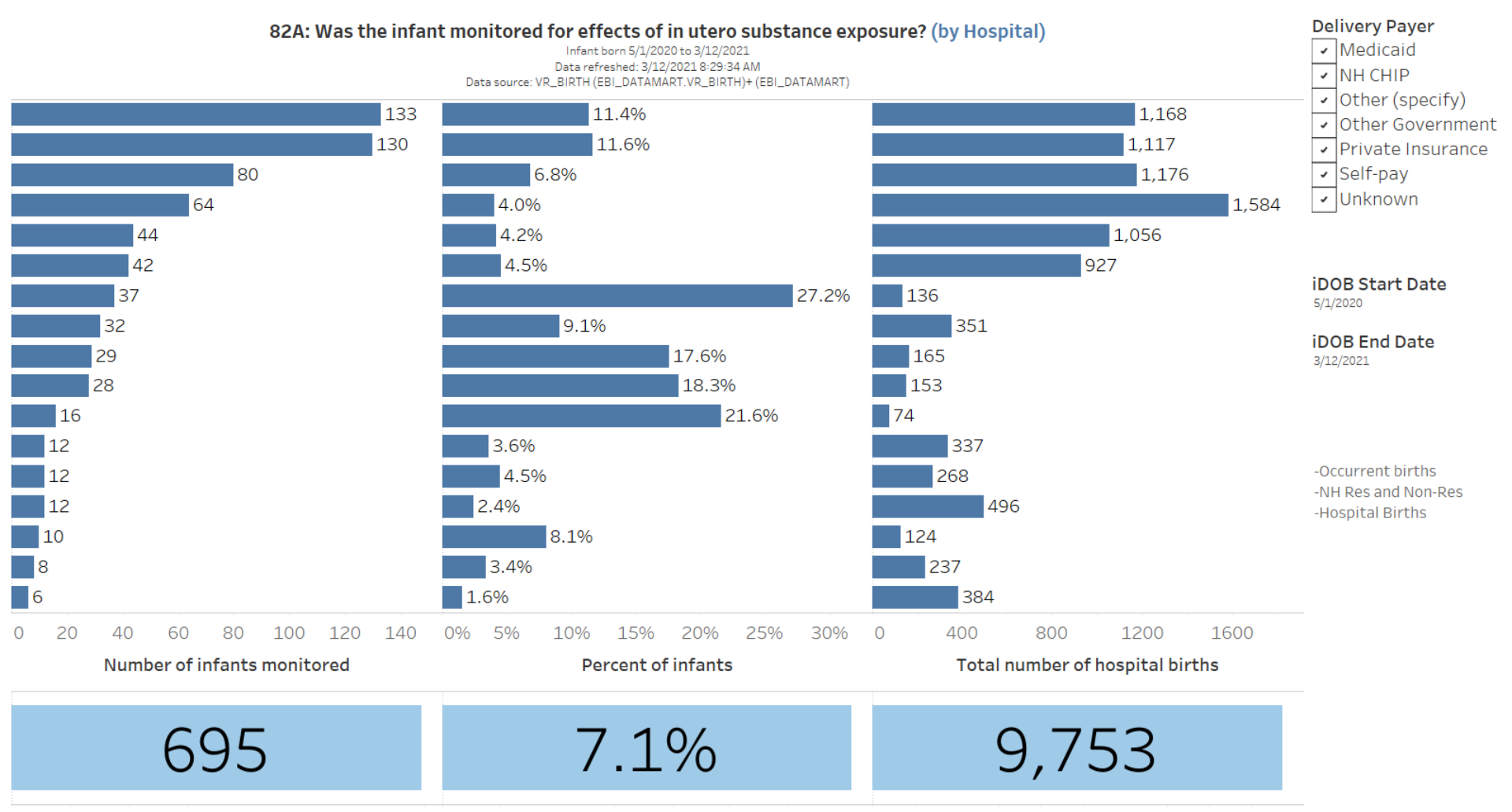
Several lower volume hospitals with (mostly) higher proportions of **Medicaid-paid** births have closed their Labor & Delivery Units.



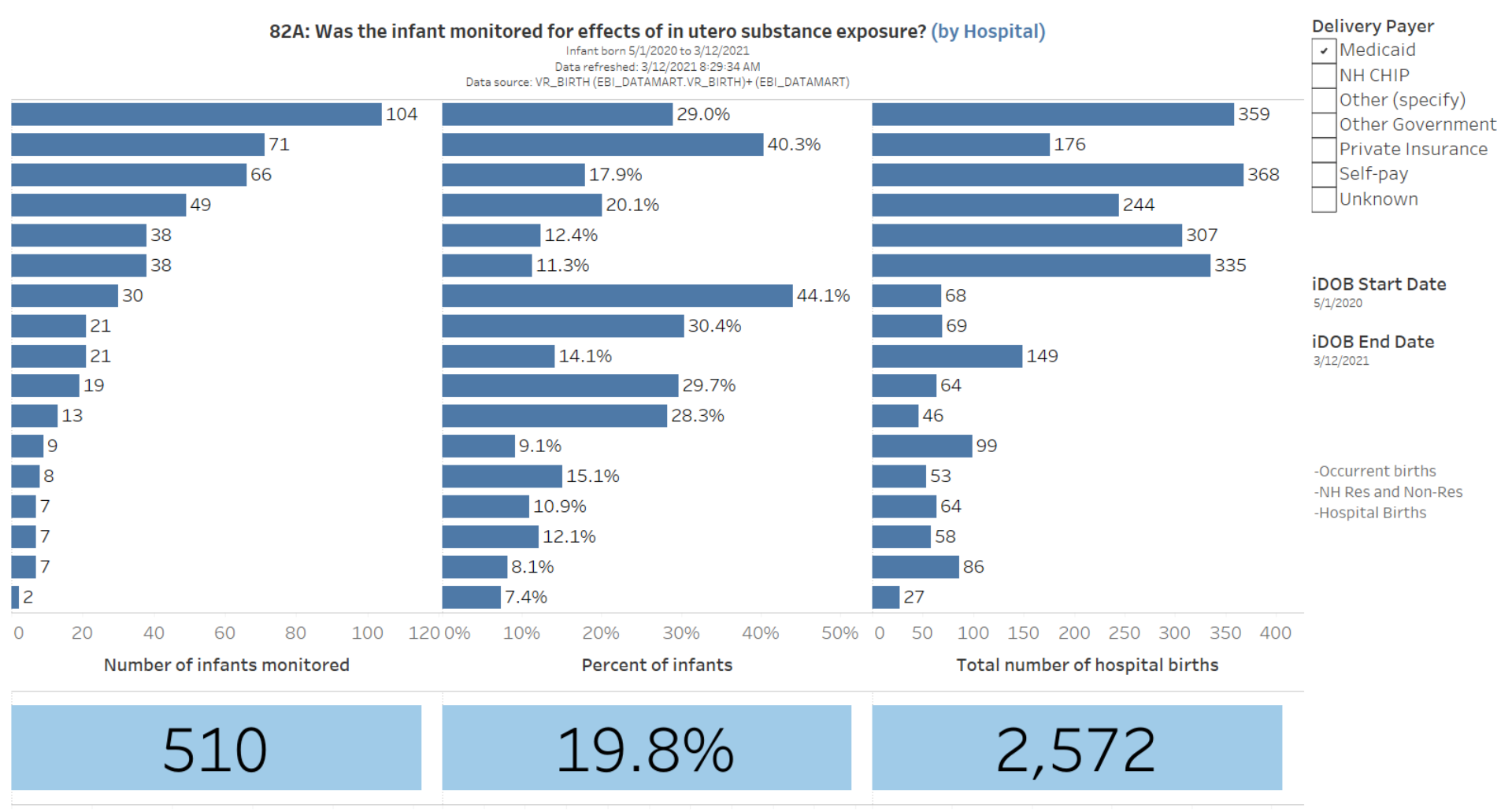
Analysis of NH Vital Records by David J. Laflamme, PhD, MPH | NH DPHS Maternal & Child Health Section

Notes: All births occurring in NH are included (residents/non-res). | Total Births includes out-of-hospital births. | Medicaid includes out-of-state plans for non-residents.

Data Refreshed: 3/12/2021 12:57:16 PM | Data Source: NH DHHS EBI Vital Records Births



Slide courtesy of D. LaFlamme, NH DHHS



Slide courtesy of D. LaFlamme, NH DHHS

NAS vs. Addiction

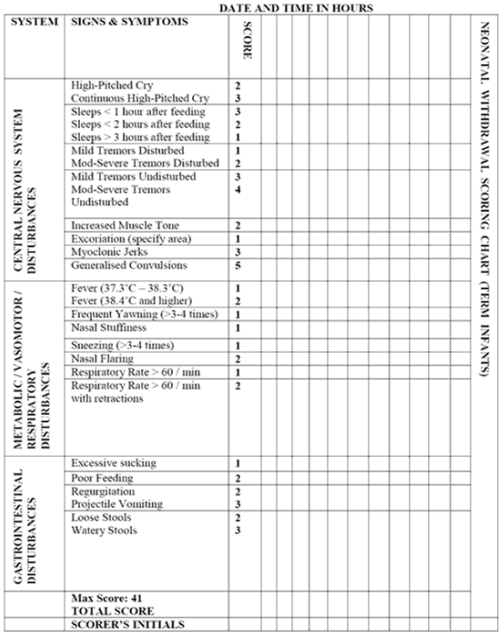
- The baby was born addicted
- The baby may experience NAS or NOWS

NAS/NOWS Symptoms

- High-pitched cry
- Jittery
- Difficulty sleeping/Irritability
- Hypertonic arms and legs
- Uncoordinated feeds
- Vomiting/spit-up
- Loose/frequent stools = severe diaper rash
- Sneezing/Yawning
- Significant weight loss (>10%)
- Sweating/febrile
- Tachypnea (>60)

Finnegan NAS Tool (FNAST)

Most Commonly Used Assessment Tool



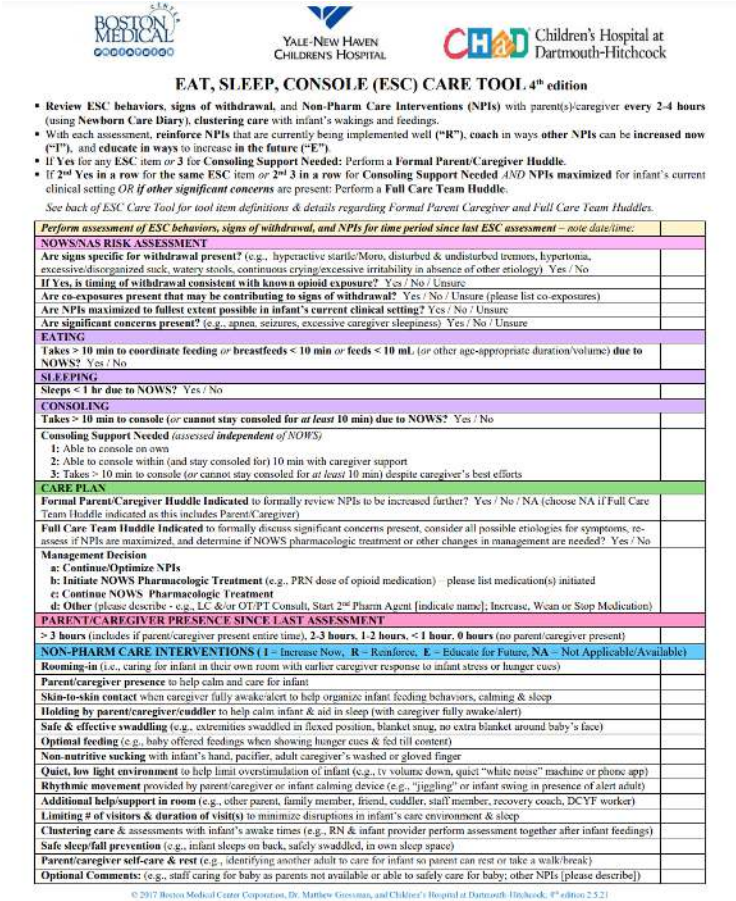
DATE AND TIME IN HOURS

SYSTEM	SIGNS & SYMPTOMS	SCORE
CENTRAL NERVOUS SYSTEM DISTURBANCES	High-Pitched Cry	2
	Continuous High-Pitched Cry	3
	Sleeps < 1 hour after feeding	3
	Sleeps < 2 hours after feeding	2
	Sleeps > 3 hours after feeding	1
	Mild Tremors Disturbed	1
	Mod-Severe Tremors Disturbed	2
	Mild Tremors Undisturbed	3
	Mod-Severe Tremors Undisturbed	4
	Increased Muscle Tone	2
	Excoriation (specify area)	1
	Myoclonic Jerks	3
	Generalised Convulsions	5
METABOLIC / VASOMOTOR / RESPIRATORY DISTURBANCES	Fever (37.3°C – 38.3°C)	1
	Fever (38.4°C and higher)	2
	Frequent Yawning (>3-4 times)	1
	Nasal Stuffiness	1
	Sneezing (>3-4 times)	1
	Nasal Flaring	2
	Respiratory Rate > 60 / min	1
	Respiratory Rate > 60 / min with retractions	2
GASTROINTESTINAL DISTURBANCES	Excessive sucking	1
	Poor Feeding	2
	Regurgitation	2
	Projectile Vomiting	3
	Loose Stools	2
	Watery Stools	3
	Max Score: 41	
	TOTAL SCORE	
	SCORER'S INITIALS	

NEONATAL WITHDRAWAL SCORING CHART (TERM INFANTS)

Eat, Sleep, Console (ESC) Model

- History of model and use of ESC Care Tool
  - Matt Grossman, MD, Yale New Haven
  - Bonny Whalen, MD, Dartmouth-Hitchcock
  - Kate McMillan, MD, Dartmouth-Hitchcock
  - Alicia Wachman, MD, Boston Medical Center
- Baby friendly, family centered approach
- Functional assessment
  - Eat / Sleep / Console
- Families First



BOSTON MEDICAL | YALE-NEW HAVEN CHILDREN'S HOSPITAL | CHaD Children's Hospital at Dartmouth-Hitchcock

EAT, SLEEP, CONSOLE (ESC) CARE TOOL 4th edition

- **Review ESC behaviors, signs of withdrawal**, and **Non-Pharm Care Interventions (NPIs)** with parent(s)/caregiver **every 2-4 hours** (using **Newborn Care Diary**), **clustering care** with infant's wakings and feedings.
- With each assessment, **reinforce NPIs** that are currently being implemented well (**"R"**), **coach** in ways **other NPIs** can be **increased now** (**"I"**), and **educate in ways** to increase **in the future** (**"E"**).
- If **Yes** for any **ESC** item *or* **3** for **Consoling Support Needed:** Perform a **Formal Parent/Caregiver Huddle**.
- If **2nd Yes in a row for the same ESC** item *or* **2nd 3 in a row** for **Consoling Support Needed** *AND* **NPIs maximized** for infant's current clinical setting *OR* ***if other significant concerns*** are present: Perform a **Full Care Team Huddle**.

See back of ESC Care Tool for tool item definitions & details regarding Formal Parent Caregiver and Full Care Team Huddles.

Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment – note date/time:	
NOWS/NAS RISK ASSESSMENT	
Are signs specific for withdrawal present? (e.g., hyperactive startle/Moro, disturbed & undisturbed tremors, hypertonia, excessive/disorganized suck, watery stools, continuous crying/excessive irritability in absence of other etiology) Yes / No	
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	
Are NPIs maximized to fullest extent possible in infant's current clinical setting? Yes / No / Unsure	
Are significant concerns present? (e.g., apnea, seizures, excessive caregiver sleepiness) Yes / No / Unsure	
EATING	
Takes > 10 min to coordinate feeding *or* **breastfeeds < 10 min** *or* **feeds < 10 mL** (*or* other age-appropriate duration/volume) **due to NOWS?** Yes / No	
SLEEPING	
Sleeps < 1 hr due to NOWS? Yes / No	
CONSOLING	
Takes > 10 min to console (*or* **cannot stay consoled for** *at least* **10 min) due to NOWS?** Yes / No	
Consoling Support Needed (*assessed* ***independent*** *of NOWS)* **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	
CARE PLAN	
Formal Parent/Caregiver Huddle Indicated to formally review NPIs to be increased further? Yes / No / NA (choose NA if Full Care Team Huddle indicated as this includes Parent/Caregiver)	
Full Care Team Huddle Indicated to formally discuss significant concerns present, consider all possible etiologies for symptoms, re-assess if NPIs are maximized, and determine if NOWS pharmacologic treatment or other changes in management are needed? Yes / No	
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS Pharmacologic Treatment** (e.g., PRN dose of opioid medication) – please list medication(s) initiated **c: Continue NOWS Pharmacologic Treatment** **d: Other** (please describe - e.g., LC &/or OT/PT Consult, Start 2nd Pharm Agent [indicate name]; Increase, Wean or Stop Medication)	
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT	
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	
NON-PHARM CARE INTERVENTIONS (I – Increase Now, **R** – Reinforce, **E** – Educate for Future, **NA** – Not Applicable/Available)	
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	
Parent/caregiver presence to help calm and care for infant	
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger	
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member, recovery coach, DCYF worker)	
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	
Optional Comments: (e.g., staff caring for baby as parents not available or able to safely care for baby; other NPIs [please describe])	

Non-Pharmacologic Treatment/Interventions

- Rooming in
- Parent/caregiver presence
- Soothing measures , 5 S's from Happiest Baby on the Block
- Safe swaddling and holding
- Skin to skin contact
- Optimal feeding at early hunger cues
- Quiet, low light environment/white noise
- Non-nutritive sucking (pacifier)
- Limited numbers of visitors
- Clustering care around feedings
- Safe sleep / fall prevention teaching
- Ensuring Parent/caregiver self care and rest needs are addressed
- Use of Cuddler program
- Aromatherapy
- Live music / reiki

What happens if my baby needs medicine to treat NAS?

Every baby is different; some may need only one dose of medicine while others might need to be treated for 10 – 14 days or longer. It is important for you to be with your baby the entire time, so you need to plan ahead:

- Pack clothing and personal items for at least a week.
- Have at least one friend/family member with you to help care for your baby while in the hospital.
- Find someone to care for your other children and pets while you are away.
- Ask your nurse or doctor for help talking with your loved ones about why your baby might need to stay longer in the hospital.

When can I bring home my baby?

Your baby's healthcare team will decide when it is safe to bring home your baby. Your baby can go home after all the medication or drug is out of their body and most of the symptoms are gone – or at least 4 – 5 days. Your baby can go home when they:

- Are feeding and sleeping well
- Are easy to console
- Are gaining weight or not losing too much weight
- Are maintaining a healthy temperature, heart rate and breathing
- Have completed all newborn screening
- Have received hepatitis B vaccine
- No longer need medicine for NAS, if it was started

What should I do to help my baby when we get home?

- Make an appointment to have a visiting nurse or primary care provider see your baby within a few days to check weight and NAS symptoms.
- Make an appointment with Early Intervention Services to help monitor your baby's growth and development.

Caring for Your Baby:
Making the Most of Your Time in the Hospital

NNEPQIN

CHaD Children's Hospital at Dartmouth-Hitchcock

Improving Care of Opioid-exposed Newborns and Their Families Using the Eat, Sleep, Console (ESC) Care Tool:

- NNEPQIN quality improvement efforts 2016 to current
- New Hampshire Charitable Foundation (NHCF) grant funding 2019:

  The overall goal is to implement the ESC model of care, utilizing the ESC Care Tool, in all 17 NH birth hospitals, with implementation support that includes training, tools, technical assistance, and coaching so that, no matter where a woman with opioid use disorder delivers, she and her baby and their family can have the best care to support them through delivery, in the immediate postpartum period, and into the transition to home and parenting.

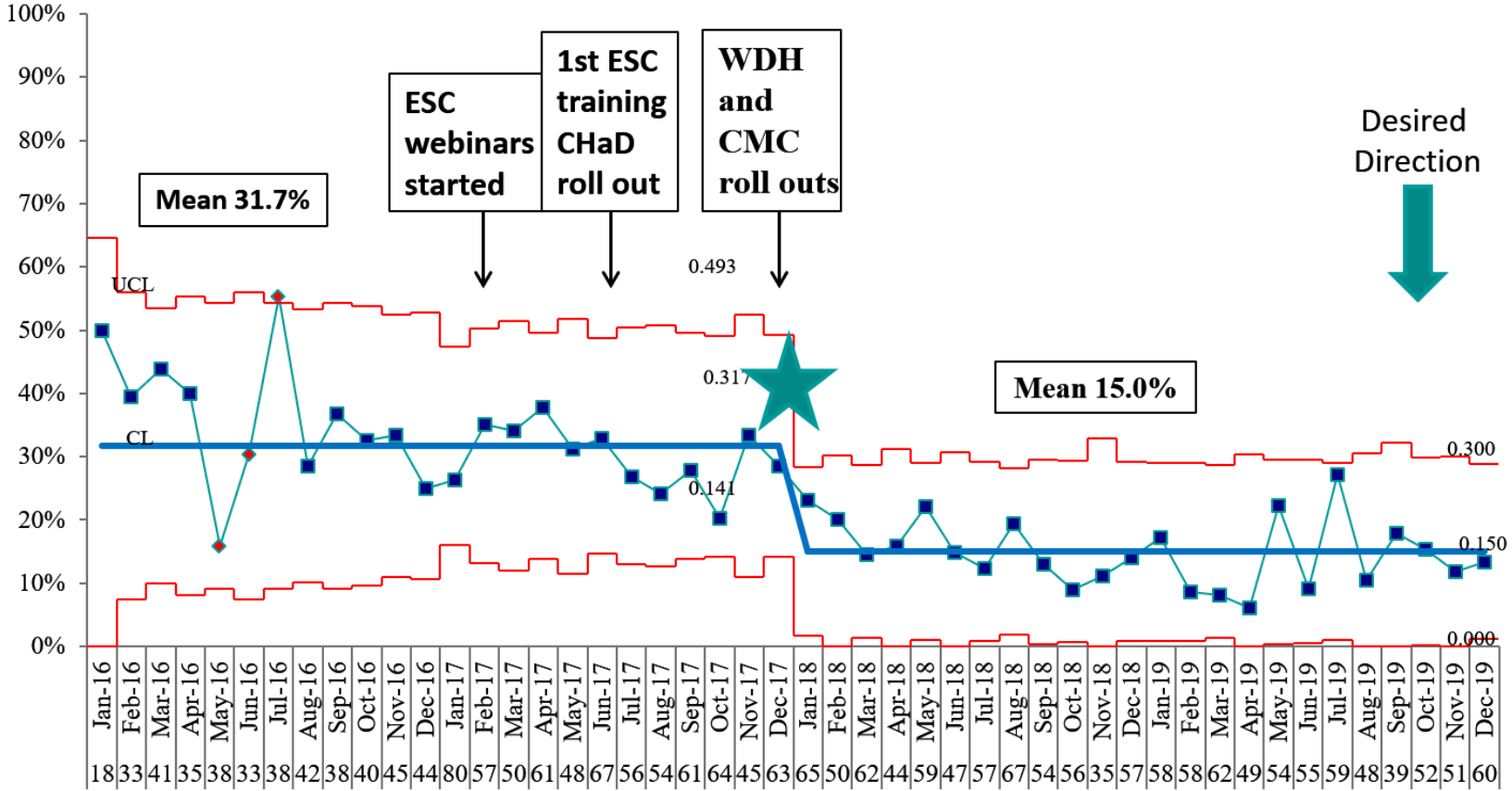
- ESC Care Tool currently implemented in 46 NNEPQIN hospitals (16/16 NH, 8/10 VT, 22/28 ME)

Slide courtesy of Alan Picarillo, MD

Statistical Process Control Chart:

Percent of Opioid-Exposed Newborns ≥ 35 weeks Receiving Pharmacologic Treatment

Jan 2016 to Dec 2019 (n = 2481 newborns)

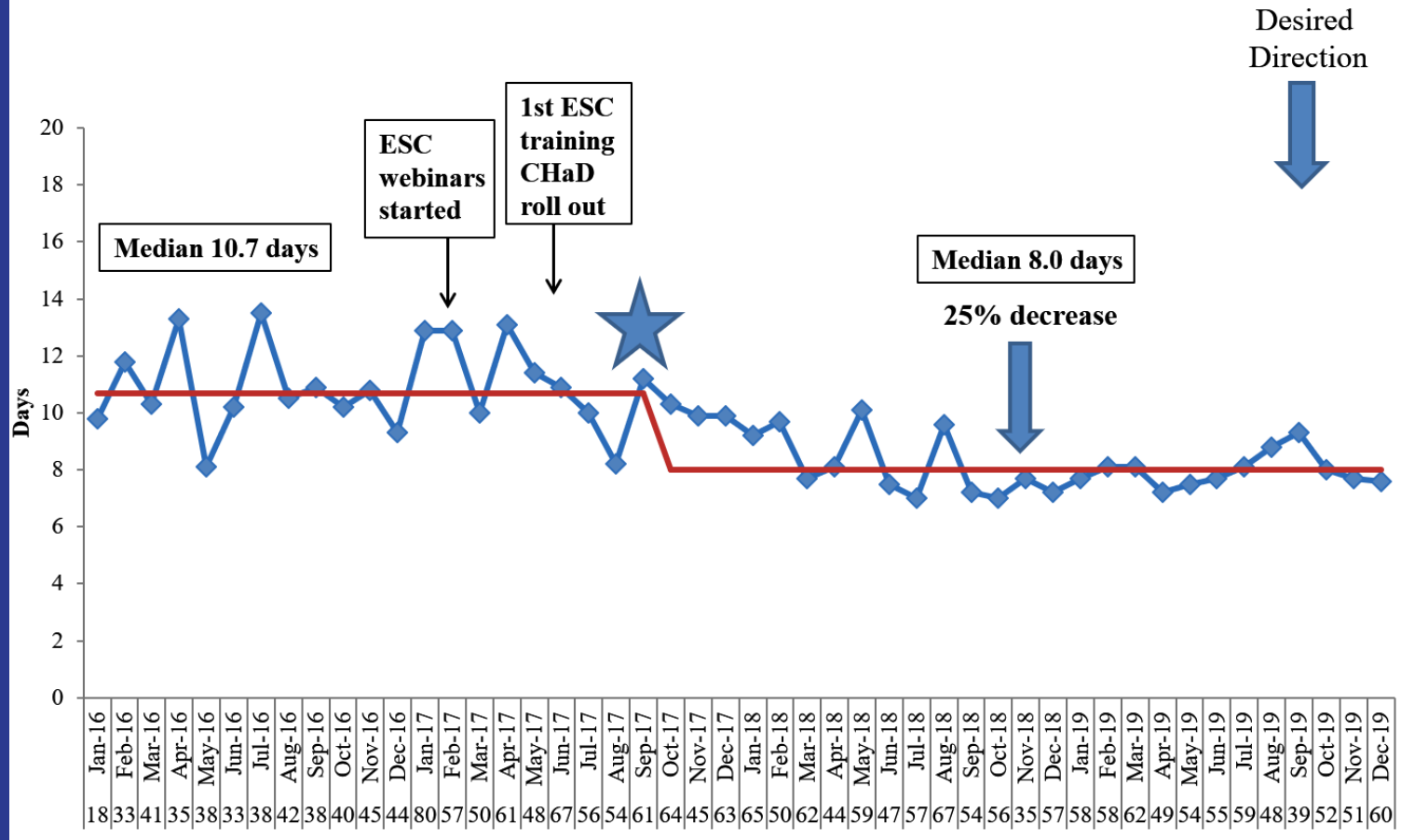


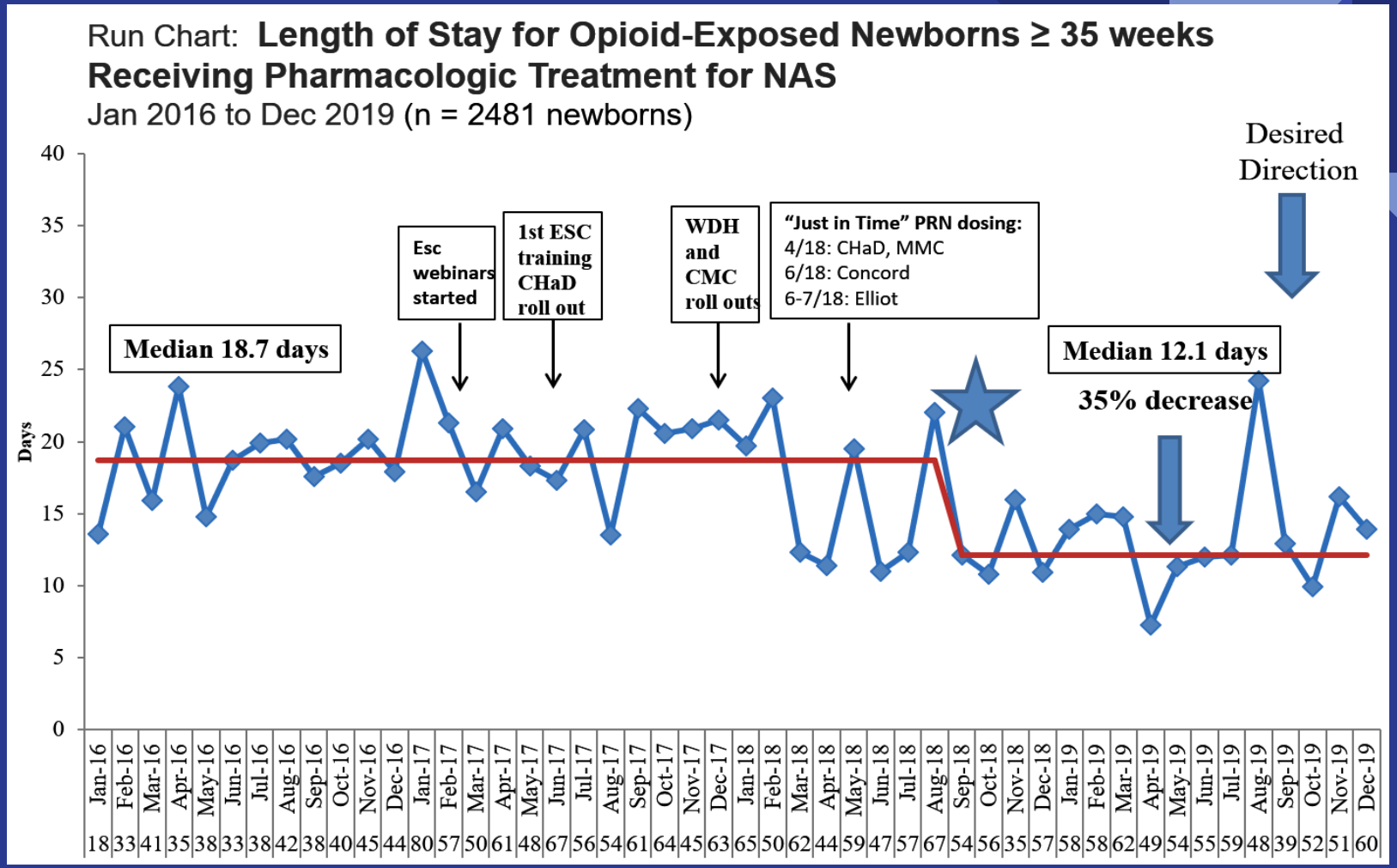
Run Chart:

Slide courtesy of Alan Picarillo, MD

Length of Hospital Stay for all Opioid-Exposed Newborns ≥ 35 weeks

Jan 2016 to Dec 2019 (n = 2481 newborns)





Slide courtesy of Alan Picarillo, MD

Family Experience

Education, Preparation & Support

- Early access to prenatal care
  - Barriers, fear
- Consistent messaging
- Building trust & transparency
- Prep for hospital stay
  - Policies, visitation, COVID-19 etc.
- Prep for home
- POSC

Understanding Family Perspectives:

A Follow-Up Qualitative Study of Family Experience with Hospitalization for Neonatal Abstinence Syndrome

Kathryn Dee L. MacMillan MD, Bonny L. Whalen MD, Victoria Flanagan RN MS, Sarah L. Chen, Katherine R. Harris, Erin Swasey MSW, Alison V. Holmes MD MPH

Manuscript in preparation

Dartmouth GEISEL SCHOOL OF MEDICINE

Children's Hospital at Dartmouth-Hitchcock

The Dartmouth Institute for Health Policy & Clinical Practice

Perceptions of Parents Regarding Neonatal Withdrawal

"He's very consolable…if you're holding him and trying to breastfeed, which makes sense because **when I went through withdrawal, I felt icky, I just wanted to be held and cuddled.**"

"It was very upsetting when I found out he was going to go through withdrawals and **it was my fault**… He's just mild right now but **still has shakes like I do and it reminds me of myself.**"

"He's losing weight, which is part of the withdrawal.. But it is kinda, like, **part of me feels like I'm a bad mother** because I don't know how to feed him."

Role of DCYF in Providing Supportive, Equitable Care

"Equity provides equality of opportunity. Everyone has a fair and just opportunity to be as healthy as possible"

Role of DCYF – Prenatally

- Consistent messaging on SUD, NAS, ESC, MOUD
- Reinforce NPIs
- Prepare for in hospital support
  - care for infant while parent sleeps, meets other needs
  - access MOUD - transportation
  - connection to recovery coach, recovery group
  - Other?
- Prepare for home
  - POSC
  - Supplies
  - Home visiting and resources (WIC, Early Intervention)
  - Transportation
  - Health care appointments
  - Other?

Role of DCYF – Postpartum/Parenting

- Story listening
  - Birth story, how things are going/went with hospital stay
  - Validation of experience, struggle, success
  - Access to share concerns, complaints or kudos
- Implementation of POSC
- Social Determinants of Health

Developing Plans of Safe and Supportive Care in New Hampshire

Lucy Hodder, JD

Director of Health Law and Policy
Professor of Law
UNH Franklin Pierce School of Law
Institute for Health Policy and Practice
Lucy.Hodder@unh.edu

Polling Question:

Have you engaged a client in reviewing a Plan of Supportive Care (POSC)?

Goals

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- Explain New Hampshire's Plans of Safe/Supportive Care process when an infant is born exposed to substances
- Explain New Hampshire law and how it can be used as a resource for those representing mothers, parents, caregivers and their children
- Highlight where and when the POSC process connects with child and family services

Why does a POSC matter to your client or patient?

ENGAGE

SUPPORT

AFFIRM

CONTINUE CARE AND TREATMENT

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Health Law & Policy

2016 Comprehensive Addiction and Recovery Act, amending the Child Abuse Prevention and Treatment Act

Plan of Safe and Supportive Care Project

- We know: A Plan of Safe Care must be developed for all infants affected by prenatal drug or fetal alcohol exposure in order to support mothers, infants and their families per federal and state requirements.
- We hope: A Plan of Safe Care is a critical tool – not only for every infant born exposed to prenatal substance exposure but for all mothers and their infants.

CAPTA's Amendments (Child Abuse Prevention and Treatment Act)

1974

Enacted to provide **federal funding** for prevention, assessment, investigation, prosecution, and treatment **activities related to child abuse and neglect**.

2003

Amended to require governors assure policies and procedures exist 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**."

2010

Amended to clarify the **definition** of substance exposed infant includes **Fetal Alcohol Spectrum Disorder**.

2016

Amended to **remove** the word "illegal" and require a Plan of Safe Care for all infants **"born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder."**

CARA's Changes to CAPTA
(Comprehensive Addiction and Recovery Act)

Healthcare providers caring for affected infants must "notify" child protective services

Notification 1

A POSC must be developed for affected infants

Affected Infants 2

- Affected infants born
- Infants for whom a POSC was developed
- Infants for whom a referral was made for appropriate services

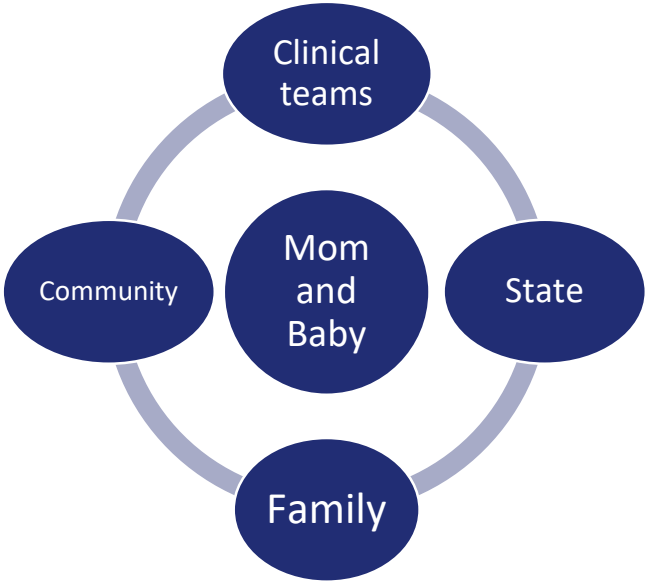
Annual Reporting to Children's Bureau 3

New Hampshire's Plan of Supportive Care Process

Caring Goals

Engage	Coordinate	Help
Engage mothers in a collaborative process to plan for healthy outcomes	Work with existing supports and coordinate new services for mother, infant and family	Help POSC support mothers and infants during pregnancy, delivery, safe transition home and in parenting

Engaging Mother and Baby



NH's Statutory Plan of Safe Care Requirements
July 1, 2018

SB 549: RSA 132:10-e and f

Infant Born…	Health Provider Shall..
"When an infant is born identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder…"	"… the health provider shall develop a Plan of Safe Care in cooperation with the infant's parents or guardians and NH DHHS, Division of Public Health Services, as appropriate."

New Hampshire Law - RSA 132:10-e and f

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Health Law & Policy

To Ensure the Safety and Wellbeing	Supporting Treatment
"to ensure the **safety and well-being** of the infant, to address the **health and substance use treatment needs** of the infant and affected family members or caregivers, and to ensure that **appropriate referrals** are made and services are delivered to the infant and affected family members or caregivers."	"The plan shall take into account whether the infant's prenatal drug exposure occurred as the **result of medication assisted treatment, or medication prescribed for the mother by a health care provider**, and whether the infant's mother **is or will be actively engaged in ongoing substance use disorder treatment following discharge** that would mitigate the future risk of harm to the infant."

New Hampshire Law - RSA 132:10-e

Provide the POSC upon discharge	Include "in the instructions for the infant"
	"A copy of the plan of safe care shall be included in the **instructions for the infant upon discharge from the hospital or from the health care provider** involved in the development of the plan of safe care. The plan of safe care **shall not be submitted to the department of health and human services unless** it is pursuant to **RSA 132:10-f** or the department makes an **official request** for a copy of the plan in compliance with confidentiality requirements."

DHHH- DPH Reminded healthcare providers about the need for POSCs in July 2019

Jeffrey A. Meyers
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-4501 1-800-852-3345 Ext. 4501
Fax: 603-271-4827 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

July 15, 2019

Dear Healthcare Provider;

The New Hampshire Department of Health and Human Services, Division for Children, Youth, and Families (DCYF) and Division of Public Health Services (DPHS) seeks to inform healthcare providers that federal[1] and state[2] law now require the development of a Plan of Safe Care (POSC) for all infants born "affected by" substance exposure, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder. The purpose of a POSC is to reinforce existing supports and coordinate referrals to new services to help infants and families stay safe and connected when they leave the hospital.

What is the "Notification" Requirement?

Notification is NOT the same as Reporting

New Hampshire has a federal data reporting requirement, which is referred to as "notification".

The state reports annually to the federal Children's Bureau the aggregate number of infants born affected by prenatal drug and/or alcohol exposure for whom a POSC was created and for whom services were referred.

Notification – Birth Questions

Added to the birth certificate April 29, 2020

Prenatal Substance Exposure

82A. Was the infant monitored for effects of in utero substance exposure?

☐ Yes ☐ No

If YES, Type of substance(s): (check all that apply)

- ❑ opioids
- ❑ stimulants (amphetamines, methamphetamines, other)
- ❑ cocaine
- ❑ cannabis
- ❑ benzodiazepines
- ❑ barbiturates
- ❑ alcohol
- ❑ nicotine
- ❑ bath salts
- ❑ Kratom
- ❑ Other (Specify) _____

Revised “Notification” Questions

Added to the birth certificate April 29, 2020

82B. Was the infant identified as being affected by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder?

☐ Yes ☐ No

Plan of Safe/Supportive Care

83. Was a Plan of Safe/Supportive Care (POSC) created?

☐ Yes ☐ No

Item 82B uses the exact language of CAPTA (other than using “*misuse*” instead of “*abuse*”) to meet the federal requirement.

While there are limitations to asking the question this way, it will serve the intended purpose.

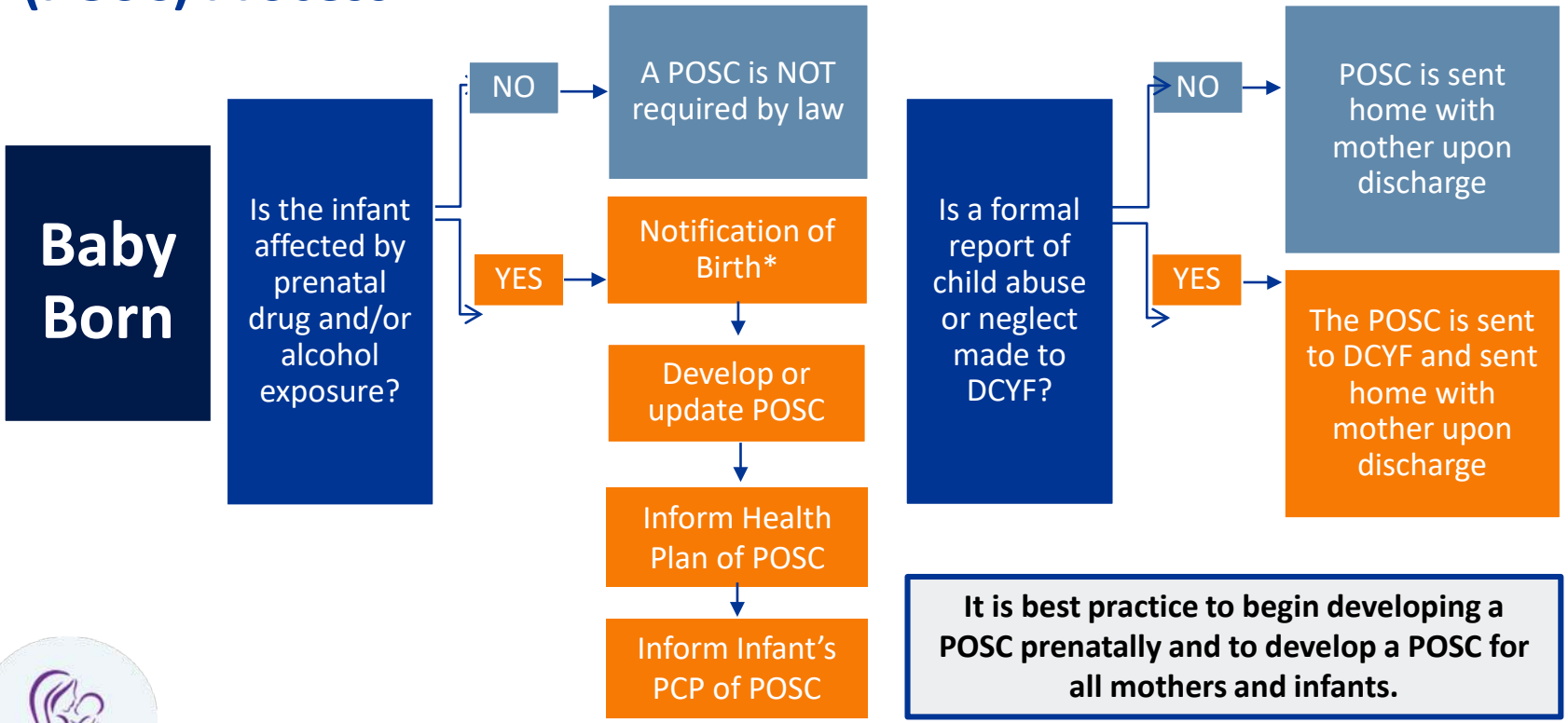
Overview – Plans of Safe Supportive Care

- POSCs are required to be developed for mothers and infants born exposed to substances under federal and state law
- Federal law requires states to have policies to address the needs of infants affected by prenatal substance use (CAPTA/CARA)
- State law requires a health provider develop a POSC when a child is born affected by substance use (RSA 132:10-e,f)

  (The law **does not** require a report of abuse and neglect when a POSC is developed).

New Hampshire's Plan of Safe/Supportive Care (POSC) Process

Perinatal Substance Exposure Task Force of the NH Governor's Commission on Alcohol and Other Drugs



It is best practice to begin developing a POSC prenatally and to develop a POSC for all mothers and infants.

***Notification is captured through answering "Prenatal Substance Exposure" questions on the birth worksheet.**

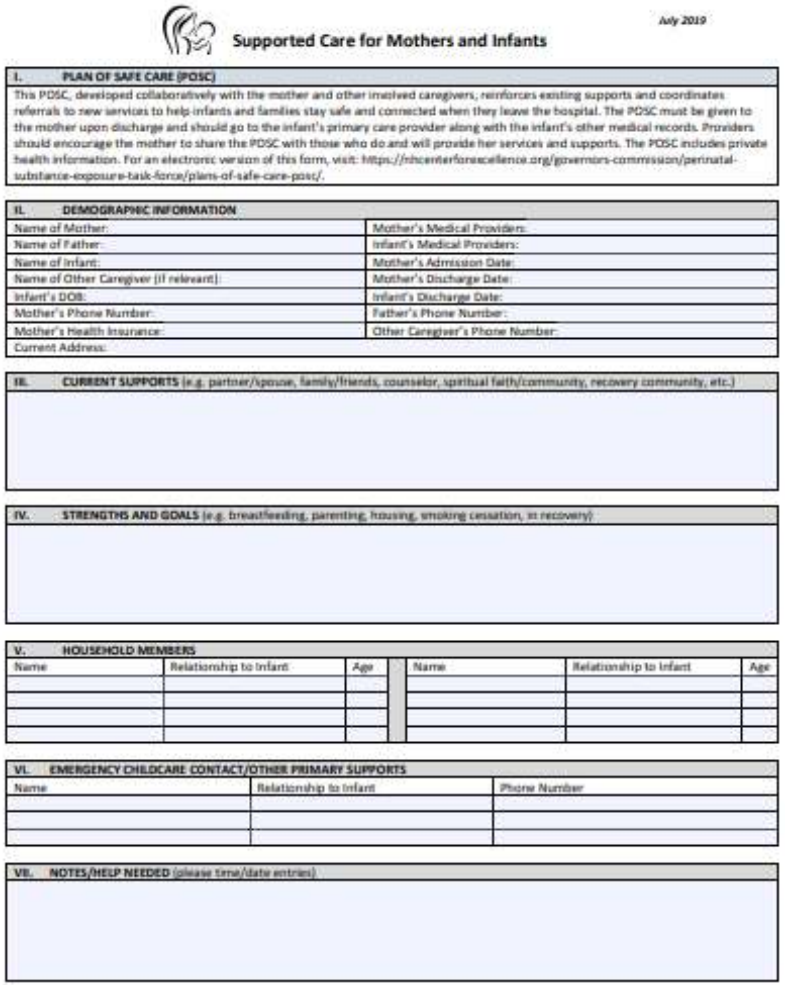
New Hampshire Medicaid Care Management

Health Insurance companies often have maternal health care management coordinator and access to other supports – your client can call the number on the back of their insurance card.

AmeriHealth Caritas New Hampshire: 1-833-704-1177 1-855-534-6730 (TTY) AmeriHealth Caritas New Hampshire	NH Healthy Families: 1-866-769-3085 nh healthy families	Well Sense Health Plan*: 1-877-957-1300 WELL SENSE HEALTH PLAN

NH's POSC Template

https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/



Supported Care for Mothers and Infants

July 2019

I. PLAN OF SAFE CARE (POSC)

This POSC, developed collaboratively with the mother and other involved caregivers, reinforces existing supports and coordinates referrals to new services to help infants and families stay safe and connected when they leave the hospital. The POSC must be given to the mother upon discharge and should go to the infant's primary care provider along with the infant's other medical records. Providers should encourage the mother to share the POSC with those who do and will provide her services and supports. The POSC includes private health information. For an electronic version of this form, visit: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/.

II. DEMOGRAPHIC INFORMATION

Name of Mother:	Mother's Medical Providers:
Name of Father:	Infant's Medical Providers:
Name of Infant:	Mother's Admission Date:
Name of Other Caregiver (if relevant):	Mother's Discharge Date:
Infant's DOB:	Infant's Discharge Date:
Mother's Phone Number:	Father's Phone Number:
Mother's Health Insurance:	Other Caregiver's Phone Number:
Current Address:	

III. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

IV. STRENGTHS AND GOALS (e.g. breastfeeding, parenting, housing, smoking cessation, in recovery)

V. HOUSEHOLD MEMBERS

Name	Relationship to Infant	Age		Name	Relationship to Infant	Age

VI. EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS

Name	Relationship to Infant	Phone Number

VII. NOTES/HELP NEEDED (please time/date entries)

NH's POSC Template

https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

July 2019

VIII. SERVICES, SUPPORTS and NEW REFERRALS

	Discussed	Active	Referred	Contact Name	Organization/Phone Number
Visiting Nurse Association (VNA)	☐	☐	☐		
Women, Infants, and Children Program (WIC)	☐	☐	☐		
health insurance enrollment	☐	☐	☐		
Family Resource Center (FRC)	☐	☐	☐		
parenting classes	☐	☐	☐		
safe sleep education/plan	☐	☐	☐		
childcare	☐	☐	☐		
other home visiting	☐	☐	☐		
Early Supports and Services	☐	☐	☐		
voluntary child welfare services	☐	☐	☐		
family planning	☐	☐	☐		
mental health	☐	☐	☐		
smoking cessation/no smoke exposure	☐	☐	☐		
housing assistance	☐	☐	☐		
Temporary Assistance for Needy Families (TANF)	☐	☐	☐		
financial assistance	☐	☐	☐		
transportation	☐	☐	☐		
legal assistance	☐	☐	☐		
personal security/Domestic Violence	☐	☐	☐		
substance use	☐	☐	☐		
Medication Assisted Treatment	☐	☐	☐		
recovery support services (e.g. recovery coaching, meetings)	☐	☐	☐		
Drug Court participation	☐	☐	☐		
Other ( )	☐	☐	☐		
Other ( )	☐	☐	☐		

IX. PRENATAL EXPOSURE

	Y/N	Notes
Does the infant have prenatal substance exposure?		
Is the prenatal substance exposure a result of prescribed medication?		
Is there prenatal substance exposure in addition to prescribed medication?		

X. IS THE INFANT DISCHARGED IN THE CARE OF SOMEONE OTHER THAN THE MOTHER?

Name:	Relationship to Infant:	Court Involvement (Y/N):
Phone Number/Address:		

XI. PARENT/CAREGIVER SIGNATURE

I acknowledge I have participated in the development of this Plan of Safe Care, I have a copy of the Plan of Safe Care, I will share the Plan of Safe Care with my baby's primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

Signature: _____ **Date:** _____

XII. STAFF SIGNATURE

I, _____ provided _____ with the Plan of Safe Care upon discharge.

Signature: _____ **Date:** _____

This form complies with NH RSA 132:10-e and NH RSA 132:10-f.

Does the POSC contain confidential information? YES!

The POSC is developed with the mother. She is encouraged to share the plan with others who can support her.

Use best practices to avoid stigma and encourage access to supports and services.

The POSC includes patient information and can be shared consistently with your privacy practices.

If a report of child abuse and/or neglect is made, the POSC must be shared with DCYF.

The POSC contains identifying information about the mother and infant that is private and is protected from disclosure by health privacy laws, and even substance use disorder record confidentiality laws if the developing provider is a SUD program (42 CFR Part 2)

What about Abuse and Neglect? 132-10-f

"When a health care provider suspects that an infant has been **abused or neglected pursuant** to RSA 169-C:3, the provider **shall report** to the department of health and human services in accordance with RSA 169-C:29. If the infant has a plan of safe care developed under RSA 132:10-e, **a copy of the plan shall accompany the report**."

What is Reporting?

Reporting	Guidance
• A provider may determine circumstances warrant a mandatory report to DCYF. • A report must be made when a provider 'has a reason to suspect' an infant has been abused or neglected pursuant to RSA 169-C:3. • If a report is made to DCYF, a copy of the POSC must accompany the report.	Mandatory reporting is required under NH RSA 169-C:29 whenever anyone has a reason to suspect child abuse and/or neglect. **The fact an infant is born with prenatal exposure to drugs and/or alcohol does not itself require a mandatory report.**

Considerations: Abuse and Neglect

NH does not have a bright line rule

Has the child's health suffered or is it likely to suffer serious impairment?

Are the parents unable to discharge responsibilities to or for the child because of hospitalization or mental incapacity?

What is the infant's contact with other persons involved in the illegal use or sale of controlled substances or the abuse of alcohol?

What Are Best Practices?

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Health Law & Policy

Develop	Develop a POSC for all mothers and babies, especially those in need of special supports and services
Begin	Begin the POSC engagement prenatally
Engage	Engage the mother and family in the POSC before, during and after the birth of the infant.

NH DCYF Processes in Abuse and Neglect Cases and Services and Supports

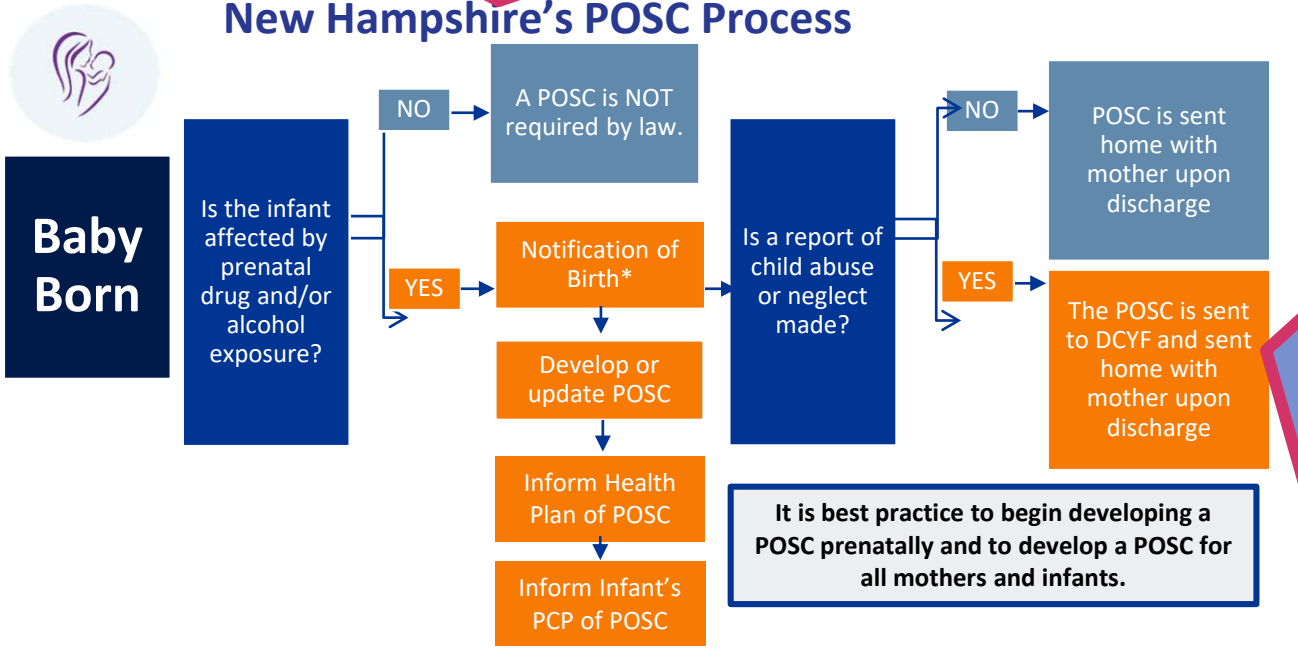
Jennifer Ross-Ferguson, MSW

Child Protection Field Administrator
NH Division of Children, Youth and Families
Jennifer.J.Ross-Ferguson@dhhs.nh.gov

If a family is referred to DCYF, then DCYF *should* receive the POSC alongside the report.

Medical Providers are responsible for creating a POSC with the parent and sending it to DCYF *when* a report is made

New Hampshire's POSC Process



*Notification is captured through answering "Prenatal Substance Exposure" question 82B on the birth worksheet.

How DCYF receives POSC

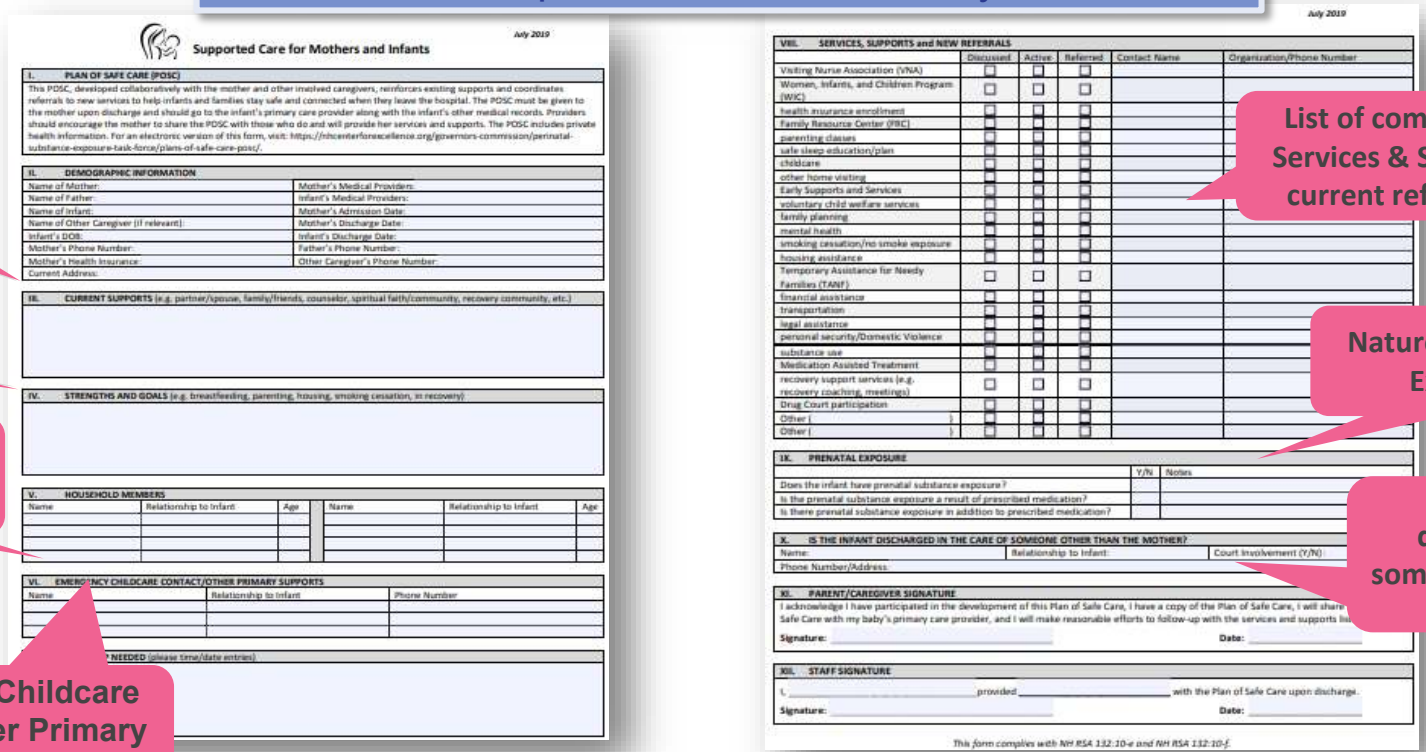
- **NH Statute** directs medical professionals to send POSC to DCYF when they make an A/N report
- BUT in practice POSC often isn't made until after DCYF is involved
- **DCYF Enhanced Assessment policy** directs CPSWs to remind medical provider of their POSC obligation if one isn't created
- ★ **Assessment workers should** request POSC as soon as it is created + remind medical providers it's a requirement

Source: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

How can CPSWs use the POSC to inform practice?

Share ideas in the chat!

NH's POSC Template includes below key elements



Supported Care for Mothers and Infants

July 2019

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Name of Father:	Infant's Medical Providers:
Name of Infant:	Mother's Admission Date:
Name of Other Caregiver (if relevant):	Mother's Discharge Date:
Infant's DOB:	Infant's Discharge Date:
Mother's Phone Number:	Father's Phone Number:
Mother's Health Insurance:	Other Caregiver's Phone Number:
Current Address:	

III. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

IV. STRENGTHS AND GOALS (e.g. breastfeeding, parenting, housing, smoking cessation, in recovery)

V. HOUSEHOLD MEMBERS

Name	Relationship to Infant	Age	Name	Relationship to Infant	Age

VI. EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS

Name	Relationship to Infant	Phone Number

NEEDED (please time/date entries)

July 2019

VIII. SERVICES, SUPPORTS and NEW REFERRALS

	Discussed	Active	Referred	Contact Name	Organization/Phone Number
Visiting Nurse Association (VNA)	☐	☐	☐		
Women, Infants, and Children Program (WIC)	☐	☐	☐		
health insurance enrollment	☐	☐	☐		
Family Resource Center (FRC)	☐	☐	☐		
parenting classes	☐	☐	☐		
safe sleep education/plan	☐	☐	☐		
childcare	☐	☐	☐		
other home visiting	☐	☐	☐		
Early Supports and Services	☐	☐	☐		
voluntary child welfare services	☐	☐	☐		
family planning	☐	☐	☐		
mental health	☐	☐	☐		
smoking cessation/no smoke exposure	☐	☐	☐		
housing assistance	☐	☐	☐		
Temporary Assistance for Needy Families (TANF)	☐	☐	☐		
financial assistance	☐	☐	☐		
transportation	☐	☐	☐		
legal assistance	☐	☐	☐		
personal security/Domestic Violence	☐	☐	☐		
substance use	☐	☐	☐		
Medication Assisted Treatment	☐	☐	☐		
recovery support services (e.g. recovery coaching, meetings)	☐	☐	☐		
Drug Court participation	☐	☐	☐		
Other ( )	☐	☐	☐		
Other ( )	☐	☐	☐		

IX. PRENATAL EXPOSURE

	Y/N	Notes
Does the infant have prenatal substance exposure?		
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Is there prenatal substance exposure in addition to prescribed medication?		

X. IS THE INFANT DISCHARGED IN THE CARE OF SOMEONE OTHER THAN THE MOTHER?

Name: | Relationship to Infant: | Court Involvement (Y/N):

Phone Number/Address:

XI. PARENT/CAREGIVER SIGNATURE

I acknowledge I have participated in the development of this Plan of Safe Care, I have a copy of the Plan of Safe Care, I will share Safe Care with my baby's primary care provider, and I will make reasonable efforts to follow-up with the services and supports li

Signature: Date:

XII. STAFF SIGNATURE

I, _____ provided _____ with the Plan of Safe Care upon discharge.

Signature: Date:

This form complies with NH RSA 132:10-e and NH RSA 132:10-f.

Current supports

Strengths & Goals

Household Members

Emergency Childcare Contact/Other Primary Supports

List of commonly used Services & Supports and current referral status

Nature of Prenatal Exposure

Was infant discharged to someone other than mother?

Source: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

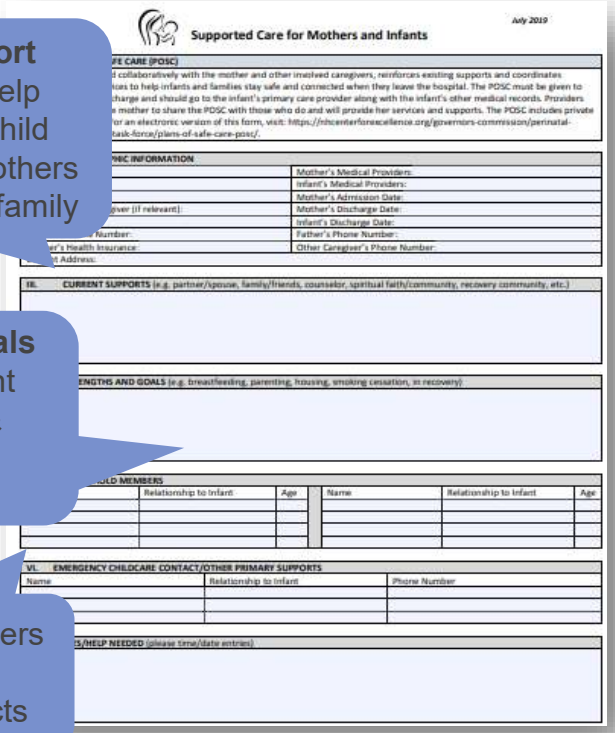
Plans of Safe Care can help DCYF with. . . .

Collateral Calls | Safety Plans | Action Plans | **Referrals** | Strengths-based client engagement & more. . . .

Current support network can help DCYF assess child safety & engage others in supporting the family

Strengths & goals can inform client engagement & **referrals discussions**

Household Members & Emergency Childcare contacts



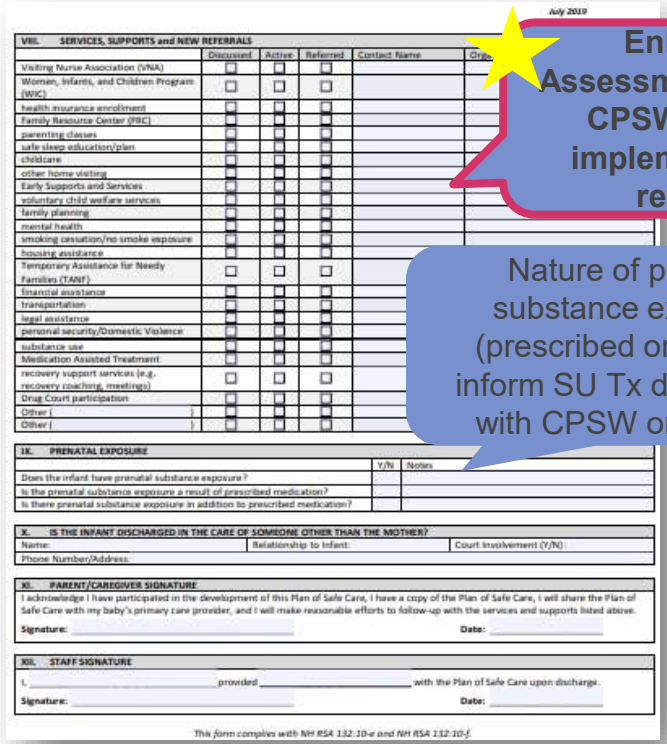
Supported Care for Mothers and Infants

July 2019

III. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

VI. EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS

Name	Relationship to Infant	Phone Number



July 2019

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childcare	☐	☐	☐	
other home visiting	☐	☐	☐	
Early Supports and Services	☐	☐	☐	
voluntary child welfare services	☐	☐	☐	
family planning	☐	☐	☐	
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housing assistance	☐	☐	☐	
Temporary Assistance for Needy Families (TANF)	☐	☐	☐	
financial assistance	☐	☐	☐	
transportation	☐	☐	☐	
legal assistance	☐	☐	☐	
personal security/Domestic Violence	☐	☐	☐	
substance use	☐	☐	☐	
Medication Assisted Treatment	☐	☐	☐	
recovery support services (e.g. recovery coaching, meetings)	☐	☐	☐	
Drug Court participation	☐	☐	☐	
Other ( )	☐	☐	☐	
Other ( )	☐	☐	☐	

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Is there prenatal substance exposure in addition to prescribed medication?		

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Phone Number/Address:

XI. PARENT/CAREGIVER SIGNATURE

I acknowledge I have participated in the development of this Plan of Safe Care, I have a copy of the Plan of Safe Care, I will share the Plan of Safe Care with my baby's primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

Signature: _____ Date: _____

XII. STAFF SIGNATURE

I, _____ provided _____ with the Plan of Safe Care upon discharge.

Signature: _____ Date: _____

This form complies with NH RSA 132:10-e and NH RSA 132:10-f.

Enhanced Assessment requires CPSWs to help implement POSC referrals

Nature of prenatal substance exposure (prescribed or not) can inform SU Tx discussions with CPSW or MLADC

Source: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

Plan of Safe Care vs. DCYF Safety Plan

Plan of Safe Care	DCYF Safety Plan
Required For: All new parents of substance exposed infants **Purpose:** • Support safety and wellbeing of family • Address health and substance use TX needs • Make appropriate referrals + deliver appropriate interdisciplinary health & social services • Account for whether the infant's prenatal exposure is due to prescribed medication and/or if the mother will be actively engaged in treatment upon discharge	**Required For:** Any family involved with DCYF for whom danger has been identified **Purpose:** • Address a serious and imminent safety concern for the child, while preserving the family unit • Ensure the parent has a concrete plan and consistent support to assure the child's safety ◦ Often includes 24 hr. secondary caregiver

Source: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

Tips: How to use the POSC to inform referrals during the Enhanced Assessment

- **Follow up on listed referrals:** CPSWs can play an important role helping "close-the-loop" on referrals families haven't yet connected with
  - Always ask the hospital referral source what referrals are in-progress or have been discussed with family

***Practice Tip**:* Often families aren't sure what referrals hospital offered them or may be in-progress. You can always re-refer a family or ask them to sign a Release of Info to inquire about their enrollment status

- **Use POSC to engage the family and start a conversation about referrals**
  - Use POSC information to start a conversation about families' strengths, goals, needs
  - Ask caregiver about the status of in-progress referrals and how you can help
- **Encourage caregiver to update their copy of the POSC with new referrals and to share it with other service providers (e.g. infant's Primary Care Physician)**
  - If a family hasn't received their POSC from hospital, you can assist them in requesting it

Why this matters

- Families with Substance Exposed Infants (SEI) are at a heightened risk of experiencing adverse outcomes (sometimes immediately, sometimes longer-term)

1 in 5 DCYF Critical Incidents involved a substance exposed infant (2020)*

430 children removed by DCYF from 2015-2019 had a history of prenatal substance exposure**

- Helping families connect to supportive resources in Assessment can help guard against future tragedies and ensure families don't need to come back to DCYF for additional support
- Navigating to services can be difficult for all families. Families with SEI face additional challenges during the postpartum period, which may include accessing recovery support and associated stigma
- Facilitated referrals and warm handoffs are the most effective way to connect families to services

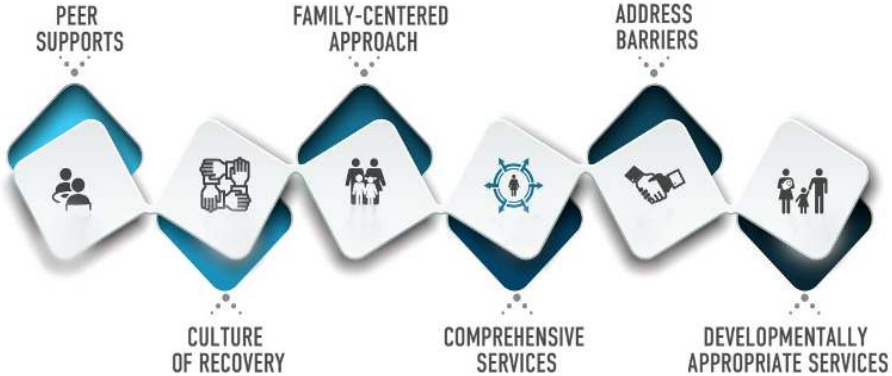
Only 3-6% Of NH families with SEI connected to key prevention service, Family Home Visiting***

Sources: *Internal analysis of DCYF CY18 Critical Incidents Tracker; **NH Office of the Child Advocate System Review 2018-01 *** Internal 2019 baseline analysis of DHHS -Contracted Family Home Visiting programs, often provided by Family Resource Centers

What we've heard from Moms with Lived Experience:

- Many families with SEI have needs or goals that can be met by community supports, but have struggled to connect because of reasons including
  - No one offered support (or didn't frame the support in a way that felt meaningful or useful)
  - Fear of judgment and system involvement, especially that children will be taken away
  - Confusion over what community supports are available or how to navigate to them
  - Feeling overwhelmed amid responsibilities of new parenthood, system-involvement, and navigating Recovery
- Families with substance exposed infants can benefit from many of the same supports all families can – parenting education and groups, housing, resource connection, etc. (don't just focus on SU Tx)
- Caregivers want to be listened to and be a part of the planning for what supports they need.
- CPSWs (and service providers) are most helpful when they're honest about not understanding all a caregiver experiencing Substance Use Disorder is going through, but do offer support and referrals as part of the process of recovery

Best Practices for Engaging Families with substance exposed infants in Referrals align with general referral best practices



Source: Children Family Futures: www.cffutures.org/files/rpgbriefs/RPG_Brief_ReferralAndEngagement.pdf

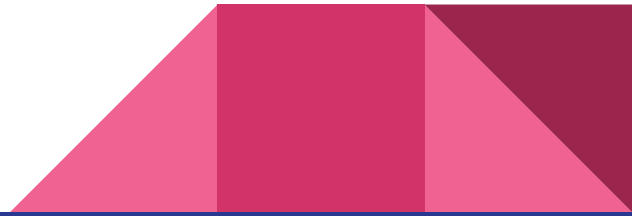
Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR). DHHS Pub. No. 0000. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

- **Engage the family** – suggest referrals based on their goals + needs & explain why in clear language
- **Customize the referral offer** to the family and where the caregiver is "at"
- **Be strengths-based and recovery-friendly** – Avoid judgment or stigmatizing language
- **Coordinate with providers** to help family overcome barriers and confirm their enrollment
- Focus on how the referral can **help the whole family**

Practice Tip: Collaborate with someone the family trusts, e.g. Hospital Social Worker or Peer Recovery Worker to offer the resource

Trauma-Informed and Trauma-Responsive Care

Farrah A.S. Deselle, MSN, RN, CCE (BFW), CLC



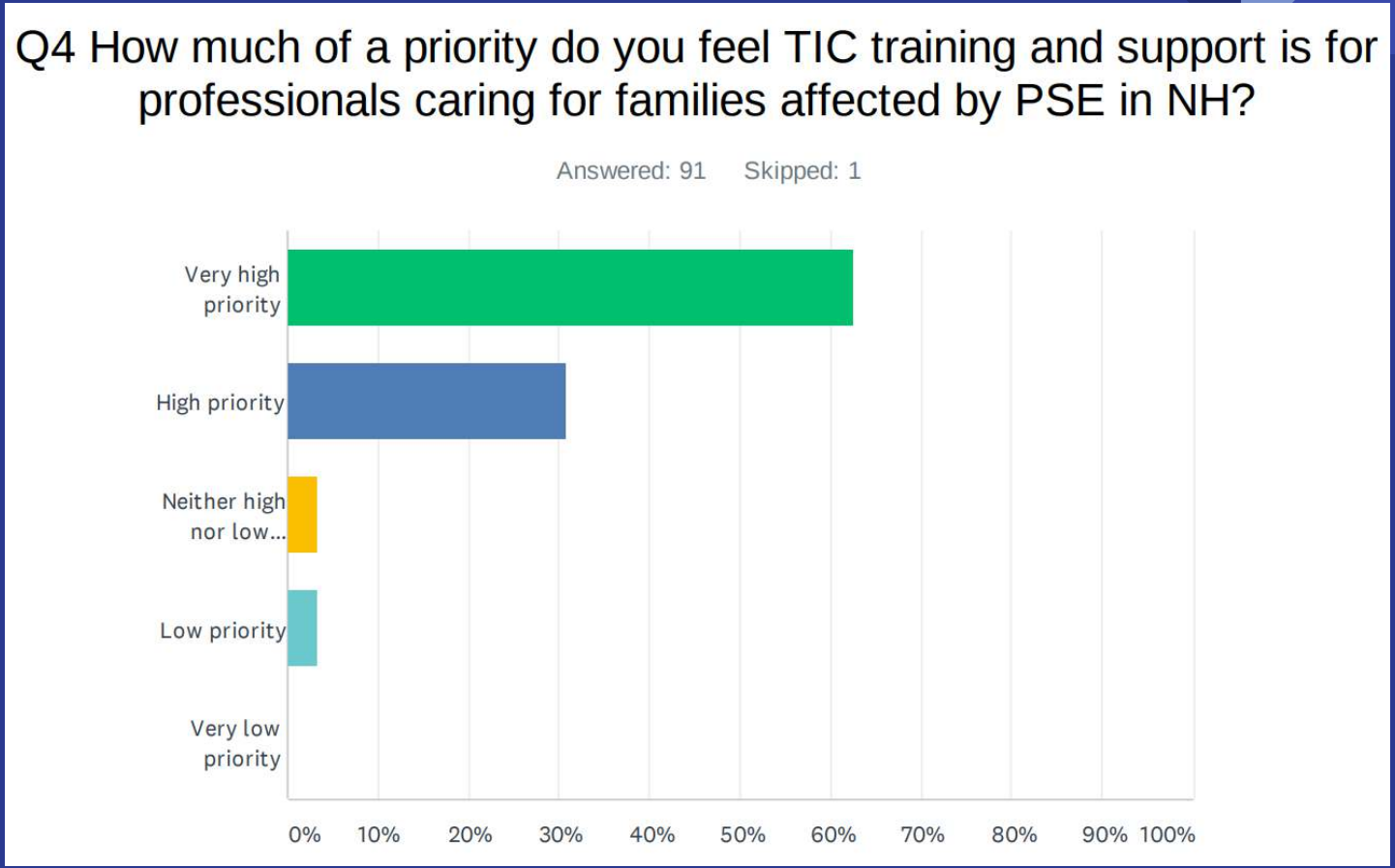
Polling Question

Please rate your level of confidence in providing trauma-informed and trauma-responsive care to the population you serve.

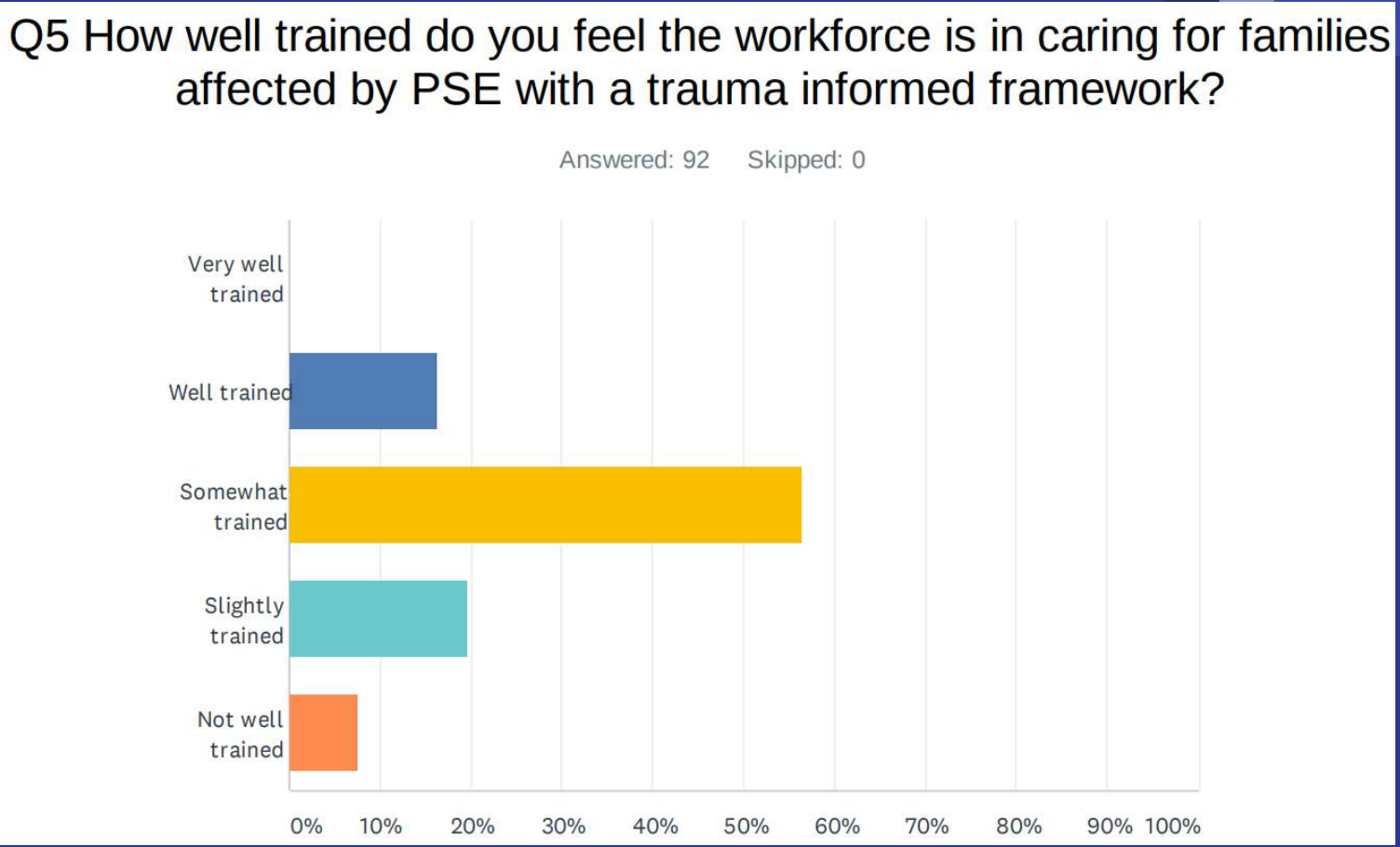
Indicators for the need for Trauma-Informed and Trauma-Responsive Care

- **Maternal Morbidity and Mortality Data – recommendations of MMM review board**
- **ESC Trainings – what is needed next?**
- **TIC Survey of NH's workforce caring for families affected by PSE**
- **AIM Safety Bundle**
- **Obstetric Care for Women with Opioid Use Disorder**
- **Building a Compassionate and Collaborative Workforce to Improve Care of Mothers, Infants, and Families Affected by Perinatal Substance Exposure:** The overall goal is to support multidisciplinary professionals to improve their quality of and collaboration in providing trauma-informed, evidence-based, and compassionate care for substance-exposed newborns and their families through increased skill building, confidence, and competence achieved through trainings, webinars, and outreach technical assistance (TA).

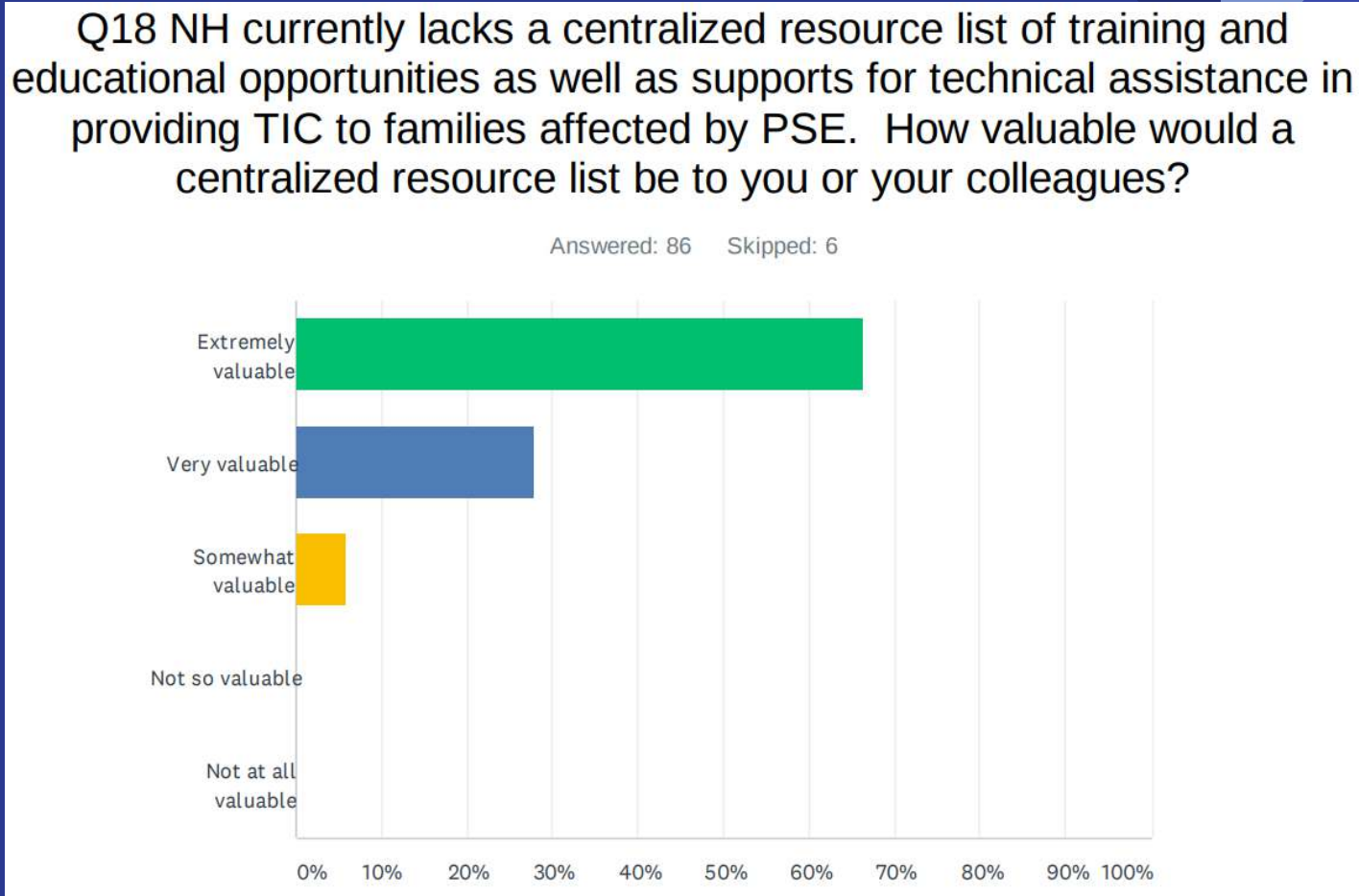
Trauma Informed Care Training and Education Survey



Trauma Informed Care Training and Education Survey

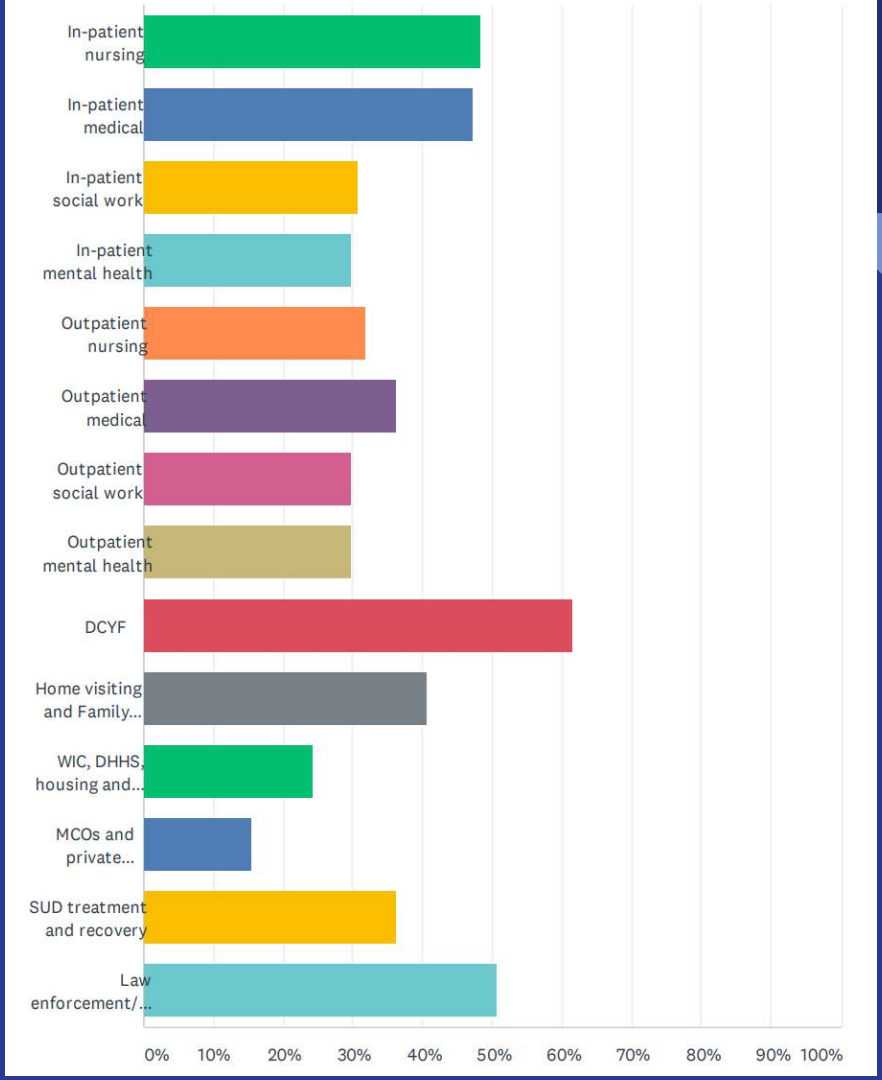


Trauma Informed Care Training and Education Survey



Q10 To help us target training, please check the top five disciplines that could most benefit from TIC training and education in NH

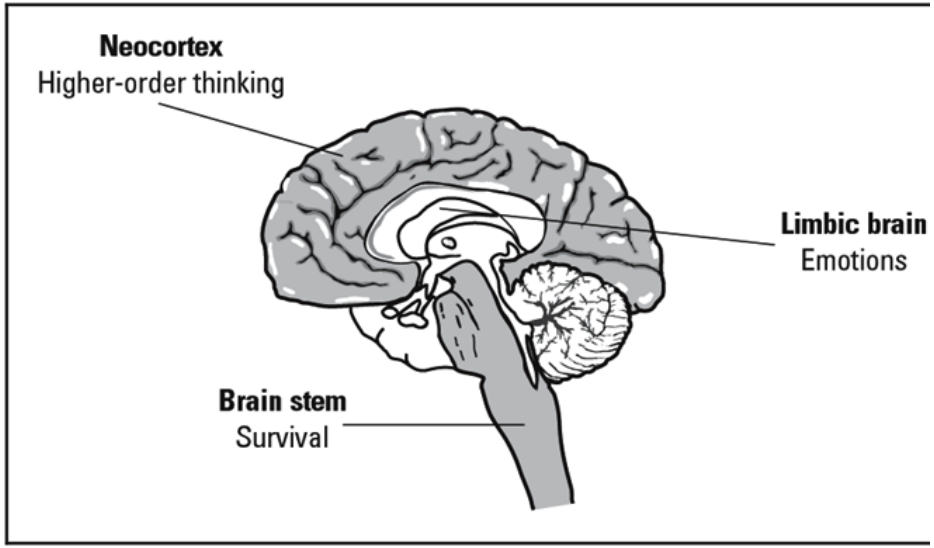
Answered: 92, Skipped: 1



Trauma Definitions

- Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (Substance Abuse and Mental Health Services Administration, SAMHSA)
- A disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury (Websters)
- Trauma is not an event, it is the response to an event

Trauma Response - What is happening?



- Perception of threat leads to protective, habitual response
- Fight-Flight-Freeze
- Limbic brain - activated
- Frontal Lobe's higher-order thinking - offline

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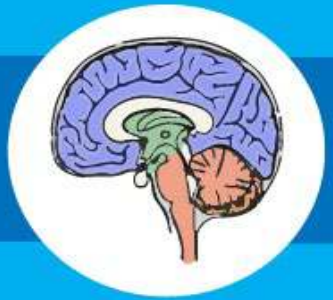
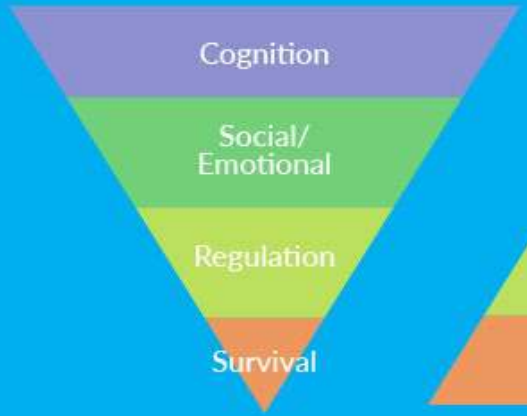
Trauma & Brain Development



- Reptilian Brain
- Limbic System
- Neocortex

Typical Development



Developmental Trauma

Adapted from Holt & Jordan, Ohio Dept. of Education

Common Triggers of a Trauma Response

TRANSITION

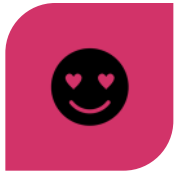
LOSS OF CONTROL

UNPREDICTABILITY OR SUDDEN CHANGE

LONELINESS

FEELING VULNERABLE OR REJECTED

CONFRONTATION

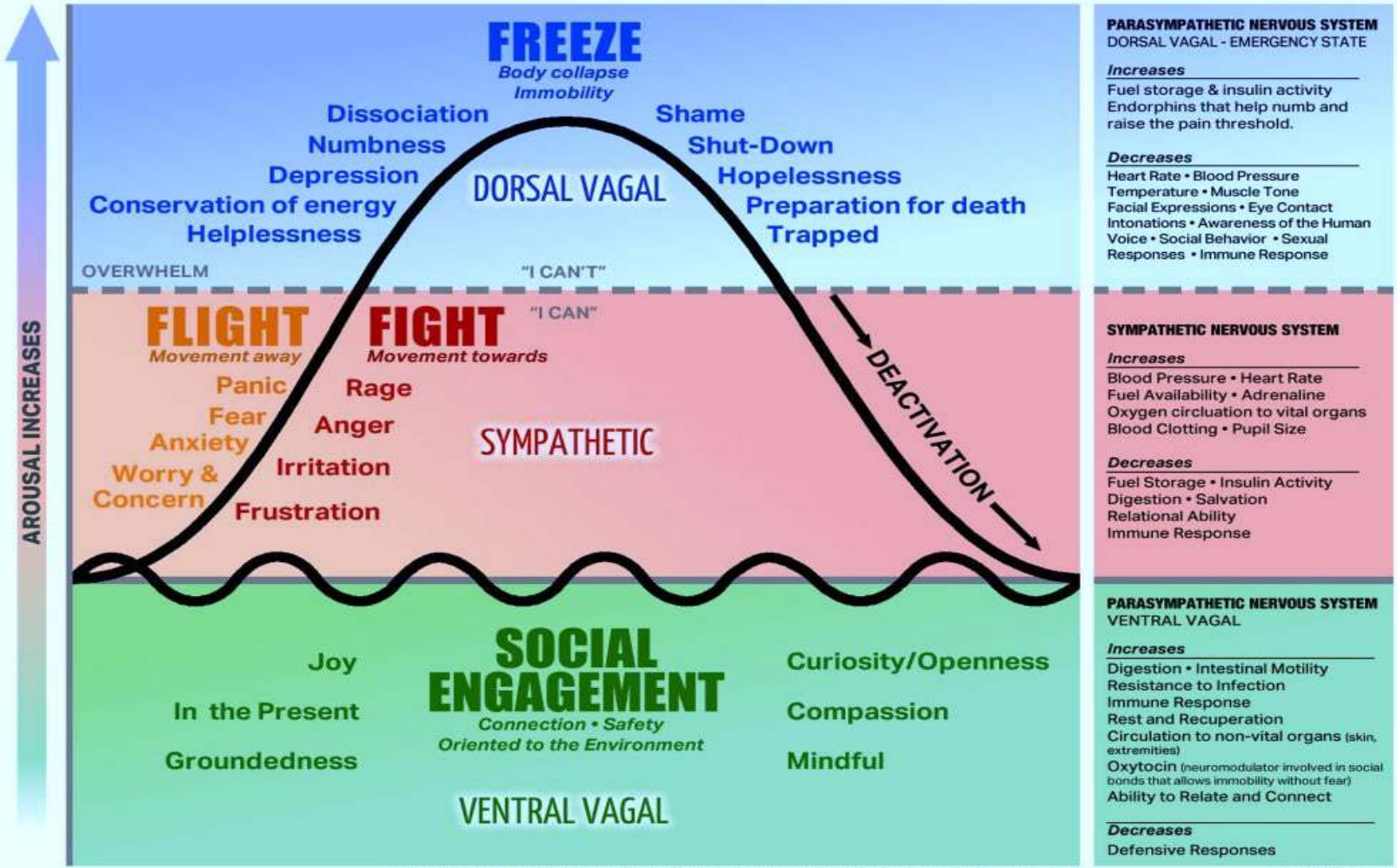


PRAISE, INTIMACY, AND POSITIVE ATTENTION

SENSORY OVERLOAD

(Adapted from ARC, Kinniburgh & Blaustein, 2010)

Why TIC?


AROUSAL INCREASES
FREEZE
Body collapse
Immobility
Dissociation
Numbness
Depression
Conservation of energy
Helplessness
DORSAL VAGAL
Shame
Shut-Down
Hopelessness
Preparation for death
Trapped
OVERWHELM
"I CAN'T"
"I CAN"
FLIGHT
Movement away
Panic
Fear
Anxiety
Worry & Concern
FIGHT
Movement towards
Rage
Anger
Irritation
Frustration
SYMPATHETIC
DEACTIVATION
Joy
In the Present
Groundedness
SOCIAL ENGAGEMENT
Connection • Safety
Oriented to the Environment
Curiosity/Openness
Compassion
Mindful
VENTRAL VAGAL
PARASYMPATHETIC NERVOUS SYSTEM
DORSAL VAGAL - EMERGENCY STATE
Increases
Fuel storage & insulin activity
Endorphins that help numb and raise the pain threshold.
Decreases
Heart Rate • Blood Pressure
Temperature • Muscle Tone
Facial Expressions • Eye Contact
Intonations • Awareness of the Human Voice • Social Behavior • Sexual Responses • Immune Response
SYMPATHETIC NERVOUS SYSTEM
Increases
Blood Pressure • Heart Rate
Fuel Availability • Adrenaline
Oxygen circulation to vital organs
Blood Clotting • Pupil Size
Decreases
Fuel Storage • Insulin Activity
Digestion • Salvation
Relational Ability
Immune Response
PARASYMPATHETIC NERVOUS SYSTEM
VENTRAL VAGAL
Increases
Digestion • Intestinal Motility
Resistance to Infection
Immune Response
Rest and Recuperation
Circulation to non-vital organs (skin, extremities)
Oxytocin (neuromodulator involved in social bonds that allows immobility without fear)
Ability to Relate and Connect
Decreases
Defensive Responses
Adapted by Ruby Jo Walker from: Cheryl Sanders, Steve Hoskinson, Steven Porges and Peter Levine
rubyjowalker.com

Trauma-Informed Care

- Understanding of trauma in **all aspects of service delivery** and place priority on the individual's **safety, trust, choice, and control**.
- **Does not require disclosure of trauma**.
- **Overall essence of the approach/relationship** vs. specific treatment strategy or method

Harris & Fallot, 2001

Trauma-Informed Care

“is an approach to engaging people with histories of trauma that recognizes the presence of traumatic symptoms and acknowledges the role that trauma has played in their lives.”

(SAMHSA)

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

4 Rs of Trauma-Informed Care (SAMHSA)

Realize – widespread impact of trauma, including on yourself, and the opportunities for healing and recovery

Recognize – signs and symptoms in individuals and communities, our own biases, traumas, triggers and judgments

Respond – integrate knowledge into individual and system response

Resist Re-Traumatization

6 Key Principles of Trauma-Informed Care – SAMHSA

1. **Safety:** Includes creating spaces where people feel culturally, emotionally, and physically safe as well as an awareness of an individual's comfort or unease.

2. **Transparency and Trustworthiness:** Includes maintaining boundaries and providing full and accurate information about what is happening and what is likely to happen next.

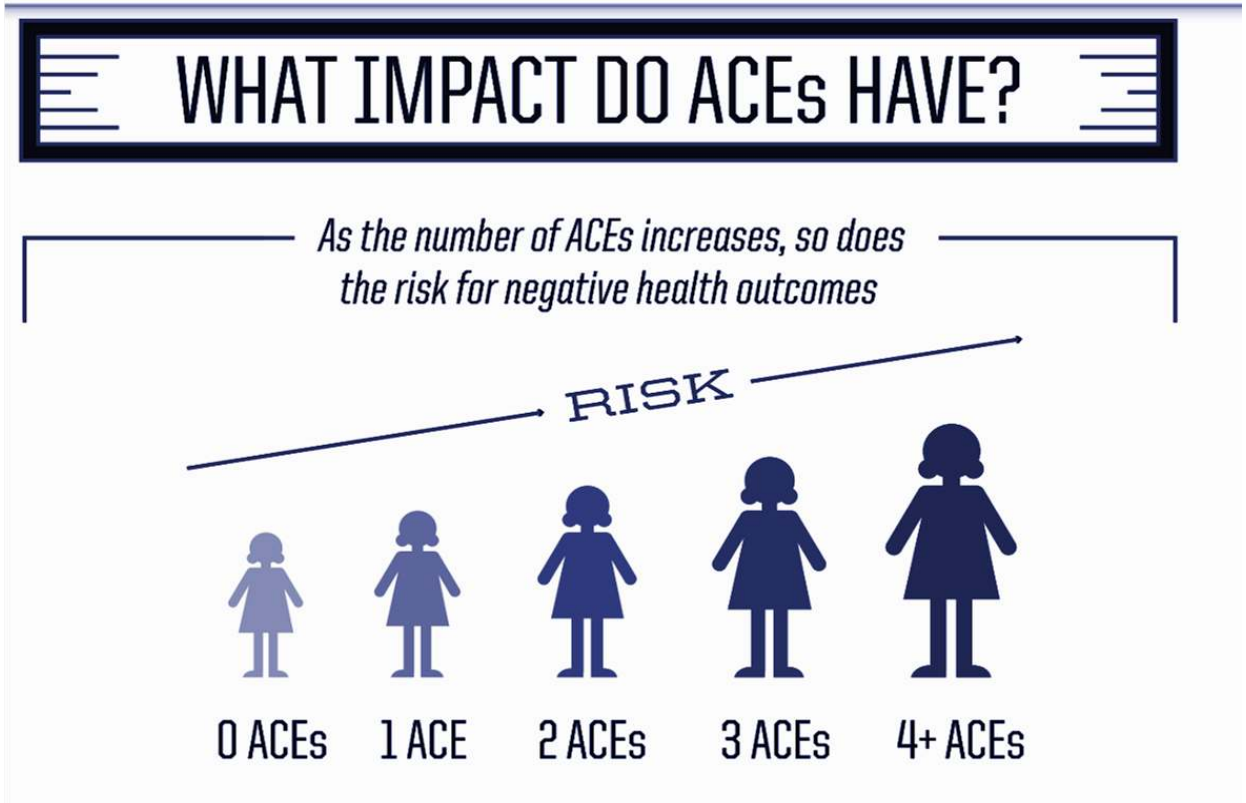
3. **Peer Support:** Includes support and self-help services, recognition of the importance of peers in healing and recover.

4. **Collaboration and Mutuality:** Includes the recognition that healing happens in relationships and partnerships with shared decision making. It is a conscious leveling of the power among consumer and provider.

5. **Empowerment, Voice, and Choice:** Includes the recognition of the need for an approach that honors the individual's dignity and strengths. These strengths are built on and validated by the interaction with the health care professional. It includes the use of shared decision making, promotion of self-advocacy, and the consumer's unique concept of recovery.

6. **Cultural, Historical, or Gender Issues:** Provide care that considers an individual's cultural background and family history, including generational trauma and experiences as a family or within a cultural group. It considers oppression and discrimination based on race, ethnicity, religion, gender, or sexual orientation and offers services that are sensitive to all issues.

Adverse Childhood Events - ACEs



rwjf.org/ACES

The three types of ACEs include

ABUSE

Physical

Emotional

Sexual

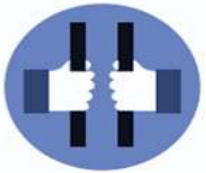
NEGLECT

Physical

Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness



Incarcerated Relative

Mother treated violently

Substance Abuse

Divorce

Polling Question

Of the families you work with, what percentage have 4 or greater ACES? (your best guess)

a. 0 – 24%
b. 25 – 49%
c. 50 – 74%
d. 75 – 100%

Individuals with 4 or more ACES have higher risk of poor health outcomes:

- Anxiety – 3.7 x more likely (than those with less than 4 ACES)
- Depression – 4.4 x more likely
- **Illicit drug use – 5.6 x more likely**
- **Problematic alcohol use – 5.8 x more likely**
- Experience violence victimization in adulthood – 7.5 x more likely
- **Problematic drug use – 10.2 x more likely**
- Attempt suicide – 30 x more likely

Huges et.al (2017)

Realize the Widespread Impact of Trauma –
Perinatal, Neonatal Experiences and Early Family Experiences

- **Birth** – a potentially traumatic event
  - Birth-related PTSD – 15.7% of women in at risk populations at 6 weeks postpartum (Cirino & Knapp, 2019)
- **Hospital environment** – unknown, unexpected, loss of control, fear of outcome, mistrust of healthcare providers/system
- **NICU family experience** – separation from infant or family, unfamiliar and high-tech environment, extended stay adding stress on family relationships etc.
- **NICU/hospital experience on infant** – separation from mother/parent, overstimulation, exposure to infection (Csaszar-Nagy & Bokkon, 2018)
- **NICU staff experience** – secondary trauma in staff
- **Family** experiencing complex social issues
- **Parent-child separation** – temporary, short term, long term, permanent

Mother's/Parent's experiences with infant with NAS

- Experience shame and guilt as they watch their babies withdraw
- Health care providers do not have current understanding of addiction
- Feel judged and stigmatized
- Find it difficult to trust
- Worried about having their baby taken away
- Negatively affected by lack of provider sensitivity to parental substance use disorder and maternal guilt

Atwood et. al, 2016; Buczkowski, et. al 2020; Cleveland & Bonugli, 2014

Transitions to Home Study

Take a “universal precautions” approach

Assume

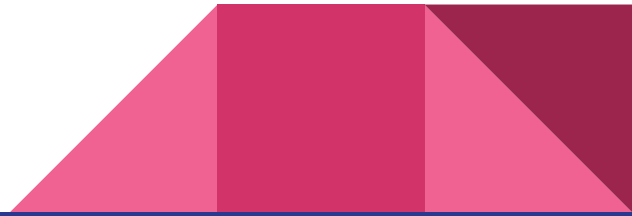
- All people have had some trauma that affects them to varying degrees and is affected by different settings and experiences (triggers)
- All people are doing the best they can with the resources they have in any moment
- Your interactions have an effect on another person – seen or unseen

Be Mindful of Language

Avoid	Instead
• Addict	• Person with SUD
• Our baby/babies • My baby/babies/kids	• Betty's baby or baby's name, or the 4 year old
• Refused	• Declined, chose not to, opted out
• Not allowed (sometimes needed, but sometimes overused)	• Not recommended or, here are the concerns about

If you can't be compassionate, can you be curious?

Questions and Discussion



For More Information

- NNEPQIN
  - NNEPQIN – Toolkit for Care of the Opioid Exposed Newborn
  - NNEPQIN – Toolkit for Care for the Women with SUD
- AIM/ERASE
- Center for Excellence on Addiction
  - POSC Website
    - Guidance Document
    - Q and A
    - Trainings
    - POSC template
    - DHHS Letter informing Medical providers of their responsibilities to create POSC
    - Questions about POSC, email: 2019POSC@gmail.com
  - Trauma-Informed Care

Resources

- Pregnant & Parenting Services and Supports – List & Map
https://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/PregnantParentingServicesList_6-20-19.pdf
- Resource Guide for Consumers: How to Access Mental Health and Substance Use Disorder Benefits
https://chhs.unh.edu/institute-health-policy-practice/focal-areas/health-law-policy#collapse_2911
- Perinatal Substance Exposure Task Force: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force
- Harm Reduction Coalition - https://harmreduction.org/
- National Council for Behavioral Health - https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/
- Peter Levine - https://www.somaticexperiencing.com/home
- RWJF - https://www.rwjf.org/en/library/collections/aces.html
- ***SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf
- Substance Abuse and Mental Health Services Administration (SAMHSA), Clinical Guidance for Treating Pregnant and Parenting Women with Substance Use Disorder - https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf
- Stephanie Covington, Helping Women Recover -https://www.stephaniecovington.com/
- Trauma Informed Care Project - http://traumainformedcareproject.org/
- ***Trauma Informed Care Implementation Resource Center - https://www.traumainformedcare.chcs.org/