Supporting Families Affected by Opioid and Other Substance Use Disorders

Nancy K. Young, Ph.D., M.S.W., Executive Director, Center for Children and Family Futures
OBJECTIVES

Understand the data on the effects of parental substance use on children and families, child welfare services, and courts.

Know the changes in the Child Abuse Prevention and Treatment Act in the Comprehensive Addiction and Recovery Act of 2016.

Identify strategies to address prenatal substance exposure and the current knowledge on effects of prenatal exposure on infants and families.

Learn how collaborative teams can develop an approach to implement comprehensive and effective CAPTA Plans of Safe Care.
RELATED QIC GOALS

IMPLEMENTATION

Enhance the capacity of CCCTs to appropriately implement the provisions of the Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse and Prevention Treatment Act (CAPTA)

CAPACITY

Enhance and expand CCCTs’ capacity to effectively collaborate to address the needs of infants, young children, and their families/caregivers affected by substance use disorders (SUDs) and prenatal substance exposure

To Improve Outcomes for Children and their Families
The Data

- Parental Substance Use in Child Welfare Services
- Treatment for Substance Use Disorders
Number of Children in Out of Home Care at End of Fiscal Year in the United States, 2000 to 2016

Note: Estimates based on children in foster care as of September 30

Source: AFCARS Data, 2000-2016
88% of states (N=45) had an increased rate of children placed in OOHC from 2012 to 2016

Note: Estimates based on children who entered out of home care during Fiscal Year (AFCARS, 2012-2016)
Number of Children who Entered Foster Care, by Age at Removal in the United States, 2016

N = 273,506

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

Source: AFCARS Data, 2016
Children under age one are a growing percentage of children who enter out of home care each year.

Of all Children who Entered Out of Home Care, Percent who were Under Age One, 2000 to 2016

Source: AFCARS Data, 2000-2016
88% of states (N=45) had an increased rate of infants placed in OOHC from 2012 to 2016. 67% of states (N=34) had an increased rate of children aged 1 or older placed in OOHC from 2012 to 2016.

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

Source: AFCARS Data, 2012-2016
Percentage Change from 2012 to 2016 of Children Under and Over Age One who were Placed in Out of Home Care by State

88% of states (N=45) had an increased rate of *infants* placed in OOHC from 2012 to 2016. 67% of states (N=34) had an increased rate of *children aged 1 or older* placed in OOHC from 2012 to 2016.

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

Source: AFCARS Data, 2012-2016
Prevalence of Parental Alcohol or Other Drug Use Reported as a Contributing Factor for Reason for Removal in the United States, 2000 to 2016

Number of Children in Out of Home Care in 2016 = 687,721

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2000-2016
Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal by State, 2016

Efforts in data collection have improved in recent years, but significant undercount remains in some states.

Note: Estimates based on all children in out-of-home care at some point during Fiscal Year

Source: AFCARS Data, 2016
Gender and Age at Substance Abuse Treatment Admission in the United States, 2014

Total treatment admissions in US: 1,581,445

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>65.5%</td>
</tr>
<tr>
<td>Female</td>
<td>34.5%</td>
</tr>
<tr>
<td>Under 20 Years</td>
<td>8.5%</td>
</tr>
<tr>
<td>21 to 30 Years</td>
<td>32.2%</td>
</tr>
<tr>
<td>31 to 40 Years</td>
<td>25.7%</td>
</tr>
<tr>
<td>41 to 50 Years</td>
<td>18.4%</td>
</tr>
<tr>
<td>51 Years or Older</td>
<td>15.2%</td>
</tr>
</tbody>
</table>

Source: TEDS Data, 2014
Substance Abuse Treatment Admissions by Primary Substance and Gender in the United States, 2015

* This category includes admissions for non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects.
** This category includes tranquilizers, other stimulants, inhalants, sedatives, PCP, and hallucinogens.

Source: TEDS Data, 2016

National Average:
Number of Women (15-44) who Entered Treatment: 398,475
Number of Women Pregnant at Entry: 20,665 (5.2% of Treatment Admissions of Women of Child-Bearing Age)

*2014 TEDS Data was not available for South Carolina.
Estimated Number of Infants Affected by Prenatal Exposure, by Type of Substance and Infant Disorder, 2016

- **Tobacco**: 488,000 (12.2%)
- **Alcohol**: 352,000 (8.7%)
- **Illicit Drugs**: 220,000 (5.4%)
- **Binge Drinking**: 176,000 (4.4%)
- **Heavy Drinking**: 34,000 (.8%)
- **Withdrawal Syndrome (NAS)**: 79,000 (20 per 1,000 births)
- **FASD**: 28,000 (.2-7 per 1,000 births)

(National Vital Statistics Report, 2017; NSDUH, 2017; Patrick et al., 2015; Milliren et al., 2017; May & Gossage, 2001)
THE OPIOID CRISIS AND ECONOMIC OPPORTUNITY: GEOGRAPHIC AND ECONOMIC TRENDS

Study Released July 9, 2018

• Examined the relationships between indicators of economic opportunity and the prevalence of prescription opioids and substance use.

• Overall, areas with lower economic opportunity are disproportionately affected by the opioid crisis.

• However, the extent of that relationship varies regionally.

Ghertner, R. & Groves, L (2018)
1. The prevalence of drug overdose deaths and opioid prescriptions has risen unevenly across the county, with rural areas more heavily affected. Specific geographic areas, such as Appalachia, parts of the West and the Midwest, and New England, have seen higher prevalence than other areas.

2. Poverty, unemployment rates, and the employment-to-population ratio are highly correlated with the prevalence of prescription opioids and with substance use measures. On average, counties with worse economic prospects are more likely to have higher rates of opioid prescriptions, opioid-related hospitalizations, and drug overdose deaths.

3. Some high-poverty regions of the country were relatively isolated from the opioid epidemic, as shown by our substance use measures, as of 2016.
Assistant Secretary on Planning and Evaluation (ASPE)
Study on Substance Misuse and Child Welfare

Quantitative

- Identify the effect of substance use prevalence and drug death rates on child welfare caseloads, including:
  - Total reports of child maltreatment
  - Substantiated reports of child maltreatment
  - Foster care entries

Qualitative

- Interviews with over 170 professionals to understand barriers and practice challenges

ASPE, 2018
Quantitative Study Findings

Study Findings: Relationship of Substance Use and Child Welfare Indicators

10% increase in the overdose death rate

- Drug deaths: 10%
- Reports of maltreatment: 2.3%
- Substantiated Reports: 2.6%
- Foster Care Placements: 4.5%

Counties where Rates of Drug Overdose Deaths and Foster Care Entries were both above the National Median in 2015

Sources: ASPE Study Findings; CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.
Factors that undermine the effectiveness of agencies’ responses to families

- Lack of treatment specific to pregnant women
- Clients received repeated detoxification without engagement in on-going treatment
- Mistrust of Medication Assisted Treatment (MAT)
- Family-friendly treatment options were limited
- Haphazard substance use assessment practices
- Barriers to collaboration
- Shortages of trained staff

(Radel et al., 2018)
Addressing Prenatal Exposure

Multiple Intervention Points
Family-Centered Approach
Policy and Practice Framework: 5 Points of Intervention

1. **Pre-Pregnancy**
   - Awareness of substance use effects
   - Initiate enhanced prenatal services

2. **Prenatal**
   - Screening and Assessment
   - Identification at Birth

3. **Child**
   - Identification at Birth
   - Parent
   - Respond to parents’ needs

4. **Post-Partum**
   - Ensure infant’s safety and respond to infant’s needs

5. **Infancy & Beyond**
   - Identify and respond to the needs of the infant, toddler, preschooler, child and adolescent

Young, Gardner, et al., 2009

Substance Exposed Infants: State Responses to the Problem. [https://ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf](https://ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf)
Public awareness campaigns on the risk of substance use while pregnant, the impact of opioid use and the disease model of substance use disorder are implemented.

Physicians screen all women of childbearing age for substance use disorders?
Prenatal Period

- Universal prenatal screening using an evidence-based tool

- Cross-system providers acknowledge Medication Assisted Treatment (MAT) as effective treatment of opioid use disorders for pregnant women

- MAT providers educate pregnant women on the risks of Neonatal Opioid Withdrawal Syndrome (NOWS)

- MAT and OB/GYN providers join the treatment team and share information on progress, concerns
Comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorders and their infants.

The Clinical Guide helps healthcare professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

• Hospitals universally screen mothers at delivery

• Infants are tested based on identified criteria and policies

• Hospitals understand and follow notification criteria

• Pediatricians are identified before hospital discharge and participate in the POSC

• Non-pharmacological treatments for NAS are used, including breastfeeding and rooming in where not contraindicated
Promising Practice:

A Revised Approach to NAS Treatment from a Multi-Year Improvement Effort at Yale New Haven Children’s Hospital

(Grossman et al., 2017)
Interventions for infant treatment focused on simplified approach to assessment, nonpharmacological therapies, care outside of the NICU and empowering messages to parents led to…

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

(Grossman et al., 2017)
What was different?

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

(Grossman et al., 2017)
Changes from this program affected hospital culture including…

- Additional bonding time
- Increased breastfeeding
- More time for observation of parenting capacity
- Opportunities for real-time parenting support

(Grossman et al., 2017)
Benefits of the Approach in this Study Site

• Length of hospital stay for infants
  22.4 to 5.9 days

• Infants receiving pharmacological treatment
  98% to 14%

• Hospital costs per family
  $44,824 to $10,289

No infants were readmitted for treatment of NAS and no adverse events were reported

(Grossman et al., 2017)
Promising Practice:

Many hospitals across the country are implementing these practice changes for non-pharmacological approaches.

There remains a critical need for additional research to understand:

- Implementation challenges and lessons
- Operational definitions of assessment of eat, sleep, console
- Criteria for the use of medications
- Longer-term outcomes for infants and families beyond length of stays in hospitals

(Graham, D.L., 2015)
• Mothers and caregivers are informed on what to expect after delivery and how to support the infant

• All providers receive training on non-pharmacological interventions

• Infants receive a referral to early intervention services

• Discharge plans are completed for both mother and infant and shared with all providers
Infancy & Beyond

• Regular screenings are occurring through childhood and adolescence
• Early Intervention referrals are consistent
• Providers coordinate services to address the needs of the family
We Know What Works

• Evidence-based treatment and enhanced recovery support
• Services to support the parent-child relationship and family recovery
• Cross-system collaboration
Treatment that Supports Families

- Encourages retention in treatment
- Increases parenting skills and capacity
- Enhances child well-being

A Randomized Control Trial of Recovery Coaches in Child Welfare Cook County, IL (n=3440)

Comprehensive Screening & Assessment + Early Access to Treatment = Consistently High Reunification Rate

(Ryan et al., 2017)
Peer Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment + Early Access to Treatment + Recovery Coach = 31% increase in reunification

(Ryan et al., 2017)
Medication Assisted Treatment

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

- Increase retention in treatment
- Decrease illicit opioid use
- Decrease criminal activities, re-arrest and re-incarceration
- Decrease drug-related HIV risk behavior
- Decrease pregnancy related complications
- Reduce maternal craving and fetal exposure to illicit drugs

(Fullerton et al., 2014; The American College of Obstetricians and Gynecologists, 2012; Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008)
PSYCHOLOGICAL EFFECTS
Counseling targets the cortex

PHYSICAL EFFECTS
Medication effects the limbic region
Stability for pregnant woman and fetus, prevent relapse
Medications used to Treat Opioid Use Disorders

- Methadone (50 year research base)
- Buprenorphine (Subutex; 2010- MOTHER Study)
- Buprenorphine-Naloxone Combination (Suboxone®; Zubsolv)
- Naltrexone Extended-Release (Vivitrol®) – Once per Month injection
- Naloxone (Narcan®) – Reverses overdose

“...opiate dependence is a medical disorder and ... pharmacologic agents are effective in its treatment.”

(NIH, 2017; Jones et al., 2012)
Overview

Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Prevention and Treatment Act (CAPTA)
Most states ignore 2003 federal law

“A lot of officials – nurses, social workers – say, ‘We don’t report when the mother is trying to get better.’ I always come back and say, ‘Well, it’s not about the mother. What about the baby?’”

“There’s no doubt this baby was at risk, and the mother had already been on drugs. I don’t know what transpired at the hospital.”

Duff Wilson & John Shiffman
Helpless and Hooked, December 2015, Reuters
Primary Changes in CAPTA Related to Infants with Prenatal Substance Exposure

Important to note that Tribes don’t participate in the CAPTA grant thus do not make assurances regarding programs and policies.

- **1974**: Child Abuse Prevention and Treatment Act (CAPTA)
- **2003**: The Keeping Children and Families Safe Act
- **2010**: The CAPTA Reauthorization Act
- **2016**: Comprehensive Addiction and Recovery Act (CARA)
• Further clarified population requiring a Plan of Safe Care:

  “Born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” specifically removing “illegal”

• Required the Plan of Safe Care to include needs of both the infant and family/caregiver:

  “the development of a Plan of Safe Care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –
  (I) addressing the health and substance use disorder treatment needs of the infant and affected family/caregiver”
• Specified data reported by States, to the extent practicable, through National Child Abuse and Neglect Data System (NCANDS)
  • The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
  • The number of infants for whom a Plan of Safe Care was developed
  • The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver

• Specified increased monitoring and oversight
  • Children’s Bureau through the annual CAPTA report in the State plan
  • States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services
PLANS OF SAFE CARE

Lessons from the National Center on Substance Abuse and Child Welfare (NCSACW)
Who are Plans of Safe Care for?
“… infant born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder”
Three Potential Populations

1. Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and **does not have a substance use disorder**

2. Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is **actively engaged in treatment** for a substance use disorder

3. **Misusing** prescription drugs, or is using legal or illegal drugs, **meets criteria for a substance use disorder**, not actively engaged in a treatment program
Who could do Plans of Safe Care?

- Multi-agency
- Well-trained
- Shared trust and knowledge
- Supportive hand-offs

(Sloper, 2004)
A Plan of Safe Care for an infant and their parents or caregivers is developed reducing the number of crises at birth for women, babies, and systems!

Women with substance use disorders are identified during pregnancy...

engaged into prenatal care, medical care, substance use treatment, and other needed services...
Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and **does not have a substance use disorder**

### Lead Agency/Provider

<table>
<thead>
<tr>
<th>Prenatal Period</th>
<th>Identification at Birth &amp; Infant Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prenatal Care Provider</strong> in concert with pain specialist or other physician</td>
<td><strong>Maternal and Child Health Service Provider</strong> (i.e. home visiting, early childhood intervention, etc.)</td>
</tr>
</tbody>
</table>
Who Could Do This?

Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is **actively engaged in treatment** for a substance use disorder

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<tbody>
<tr>
<td><strong>Prenatal Care Provider</strong> in concert with Opioid Treatment Provider or waivered prescriber and/or therapeutic treatment provider</td>
<td>Therapeutic Substance Use or Opioid Use Disorder Treatment Provider with support from Maternal and Child Health Provider OR Child Welfare Services</td>
<td></td>
</tr>
</tbody>
</table>
Who Could Do This?

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</tr>
</thead>
<tbody>
<tr>
<td>Identification at Birth &amp; Infant Affected</td>
<td></td>
</tr>
<tr>
<td>Prenatal Care Provider or High Risk Pregnancy Clinic in concert with substance use disorder treatment agency and Child Welfare Services, if available prenatally</td>
<td></td>
</tr>
<tr>
<td>Child Welfare Services</td>
<td></td>
</tr>
</tbody>
</table>

**Misusing** prescription drugs, or is using legal or illegal drugs, **meets criteria for a substance use disorder**, not actively engaged in a treatment program.
What is a Plan of Safe Care?

- Key Components
How is **Plan of Safe Care** Different?
Domains that might be in a Plan of Safe Care

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

No one template fits the needs of all communities, settings or families
Preparing for baby’s safe arrival and beyond

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

Plans of Safe Care benefit from being...
When could Plans of Safe Care be developed?
New Beginnings

• Motivation to make health related changes is enhanced during pregnancy

• Prenatal care is a touch point to services

(Edvardsson et al., 2011; Crittenden et al., 1994)
Child Welfare will generally not be involved with a family in the prenatal period unless there is another child with an open case.

Partners are important for early engagement of pregnant women in treatment and prenatal care to improve the health and well-being outcomes for mother and the infant.
PLAN OF SAFE CARE PLANNING GUIDE TA TOOL (2018)

Designed as a planning guide that NCSACW can assist with to further your communities’ efforts in developing a comprehensive approach to implementing Plans of Safe Care

ncsacw@cffutures.org
Working Better Together

Plans of Safe Care are an unique opportunity for cross-system collaboration

No single agency can do it alone
The Necessity of Collaboration

- **Multi-generational problems** can only be addressed through a coordinated approach across multiple systems.
- Collaboration across systems that includes agreement on **common values**, enhanced communication and information sharing, **blended and braided funding** and **data collection** for **shared outcomes**...
- ...results in improved outcomes for families:
  - Increased treatment engagement and retention
  - Fewer children removed
  - Increased family reunification
  - Fewer children reentering to the system

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2010)
Demonstration sites must include intensive collaboration among the following agencies:

<table>
<thead>
<tr>
<th>State/Tribal Government Oversight Level</th>
<th>Local Court Team Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Court Improvement Program</td>
<td>• Child Welfare</td>
</tr>
<tr>
<td>• Child Welfare</td>
<td>• Substance use disorder treatment and mental health providers</td>
</tr>
<tr>
<td>• Substance Use Disorder Treatment</td>
<td>• Maternal and infant health care providers</td>
</tr>
<tr>
<td>• Public Health: Maternal and Child Health</td>
<td>• Hospitals</td>
</tr>
<tr>
<td>• Tribal Government, Consortia</td>
<td>• Attorneys</td>
</tr>
</tbody>
</table>
• **Engage** with state/tribal agencies to develop/implement/monitor the state/tribal plan
• **Support MAT** as standard of care for pregnant women with opioid use disorders and allow them to receive MAT while participating in court program
• **Establish protocols** for reliance on clinical decisions regarding health care and treatment for substance use disorders and mental health concerns
• Ensure **coordination of care** for infants across service systems
• Facilitate **information sharing** across agencies and the court
• Ensure **appropriate time** for parenting (visitation) skill development
• **Support best practices** for mother-infant attachment
• Partner with the POSC Coordinator or entity overseeing the POSC
• **Provide oversight** of POSC implementation
THERE IS NO STANDARDIZED TEMPLATE – EVERY COMMUNITY MAY LOOK DIFFERENT – STATES AND TRIBES HAVE A GREAT DEAL OF DISCRETION IN THEIR PLAN BUT...
Taking Next Steps

What will you do?
Identify and agree on initial action steps during site team breakout sessions

Network with colleagues

Engage with the QIC Change Team, including subject matter experts

Plan for your site visit, including a systems walk through
Download the Cross-Systems Guide

- Use these system specific guides to help establish a baseline understanding of the practices and policies used across systems.

Download [https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)
View and Discuss Related Webinars

A Collaborative Approach
Addressing the needs of pregnant women with opioid use disorders, their infants and families.

Partnering to Treat Pregnant Women
Lessons Learned from a Six Site Initiative will provide an overview and share lessons from the SAMHSA-funded initiative, Substance Exposed Infants In-Depth Technical Assistance program.

A Framework for Intervention for Infants with Prenatal Exposure and Their Families
Identifies points of intervention for comprehensive reform to prevent prenatal exposure and respond to the needs of pregnant women, mothers, their families and infants.

Visit www.cffutures.org
Purpose: Support the efforts of States, Tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

Audience
- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

National Workgroup
- 40 professionals across disciplines
- Provided promising and best practices; input and feedback over 24 months

This fact sheet serves as a guide for individuals seeking substance use disorder treatment. It provides three steps to complete prior to using a treatment center and the five signs of a quality treatment center.

Available for download here: https://store.samhsa.gov/product/Finding-Quality-Treatment-for-Substance-Use-Disorders/PEP18-TREATMENT-LOC
NCSACW Resources

- Publications
- Online Resource Inventory
- Webinars
- Online Tutorials
- Toolkits
- Video

Please visit:

http://www.ncsacw.samhsa.gov/
NCSACW Online Tutorials Cross-Systems Learning

FREE CEUs!

www.ncsacw.samhsa.gov/.../org

Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals

In-Depth Technical Assistance

- 18 months of technical assistance to strengthen collaboration and linkages across systems focused on infants with prenatal substance exposure
- 11 sites: Connecticut, Delaware, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, North Carolina, Virginia, West Virginia

Web-based Resource Directory

- Includes research, training materials, webinars and videos, site examples and other resources
- Topics include medication-assisted treatment, neonatal abstinence syndrome, infants with prenatal substance exposure, and supporting families with opioid use disorders

Technical Assistance: Developing a Comprehensive Approach to Plans of Safe Care

- Identifying planning steps for developing a comprehensive approach to Plans of Safe Care
- Questions to engage partners in considering a communities Plan of Safe Care approach
- Examples of state and local legislation, policies and templates

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Please visit: www.cffutures.org
References


• Center for Behavioral Health Statistics and Quality. (2017). 2016 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.


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