HELPING OUR MOST VULNERABLE POPULATIONS IMPACTED BY THE OPIOID CRISIS:
PREGNANT WOMEN, THEIR INFANTS, AND THOSE RECEIVING CHILD WELFARE SERVICES
Learning Objectives

• Identify approaches for transforming the Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants* guide into tools for patients, providers, and researchers

• Illustrate methodology for assessing community needs and developing individualized micro-training modules for child welfare and family court

• Highlight decision support tool created for family court judges to aid in dependency cases

*The Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants guide was prepared for the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), under contract numbers HHSS283200700003I/HHSS23842007T and HHSS283201200002I/HHSS28342009T.
Presentation Overview

Part I: Opioid Use Disorder Among Pregnant and Parenting Women
• Describe the current landscape of women in the United States
• Highlight uses of the clinical guide
• Explore how the guidance can be transformed to reach women and children and the community providers that support them

Part II: Training Child Welfare and Family Court Systems to Address Opioid Use in Florida
• Illustrate methodology for assessing community needs and developing individualized micro-training modules for child welfare and family court
• Demonstrate a model of intervention with child welfare and family court staff to mitigate escalation
• Demonstrate a tool created for family court judges

Summary Points
Calls to Action
Questions
PART I: OPIOID USE DISORDER AMONG PREGNANT AND PARENTING WOMEN
Current Landscape

- In 2015, more than 27 million people in the US reported current use of an illicit drug or misuse of prescription drugs in the past 30 days (SAMHSA, 2015)

- The prevalence of opioid use disorder (OUD) during pregnancy more than doubled between 1998 and 2011 to 4 per 1,000 deliveries (Maeda et al, 2014).

- Neonatal abstinence syndrome (NAS) increased from 3.4 to 5.8 per 1,000 hospital births from 2009 to 2012 with more than 20,000 infants diagnosed with NAS in 2012 (Patrick et al, 2015).

- Women with OUD and their infants face critical barriers to optimal care such as shame, misinformation, and even legal consequence in some states.
The Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants guide can be found at https://store.samhsa.gov/product/SMA18-5054.
Factsheets in Clinical Guidance

Exhibit A.5: Factsheets in Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants

Section I: Prenatal Care
- Factsheet #1: Prenatal Screenings and Assessments
- Factsheet #2: Initiating Pharmacotherapy for Opioid Use Disorder
- Factsheet #3: Changing Pharmacotherapy During Pregnancy
- Factsheet #4: Managing Pharmacotherapy Over the Course of Pregnancy
- Factsheet #5: Pregnant Women With Opioid Use Disorder And Comorbid Behavioral Health Disorders
- Factsheet #6: Addressing Polysubstance Use During Pregnancy
- Factsheet #7: Planning Prior to Labor and Delivery
- Factsheet #8: Peripartum Pain Relief

Section II: Infant Care
- Factsheet #9: Screening and Assessment for Neonatal Abstinence Syndrome
- Factsheet #10: Management of Neonatal Abstinence Syndrome
- Factsheet #11: Breastfeeding Considerations for Infants at Risk for Neonatal Abstinence Syndrome
- Factsheet #12: Infant Discharge Planning
- Factsheet #13: Early Interventions Strategies and Developmental Assessments

Section III: Maternal Postnatal Care
- Factsheet #14: Adjusting Pharmacotherapy Dose Postpartum
- Factsheet #15: Maternal Discharge Planning
- Factsheet #16: Maternal Return to Substance Use
Factsheet Elements

I. Clinical Scenario
   Presents a brief statement to orient the healthcare professional to the situation under consideration.

II. Clinical Action Steps
   Present recommendations that are derived directly from the rated clinical decisions in the RAM report and describe what can, might, or should not be done when caring for women and their infants.

III. Supporting Evidence and Clinical Considerations
   Present strengths and weaknesses of the evidence supporting the clinical action steps. This section describes how to address or tailor recommended actions to unique patient variables and preferences, the necessary clinical experience of the provider, and available community resources. Guidance is based on expert panel and FSC discussions and additional information on treatment recommendations. For the most part, the topics in this section lack sufficient evidence to recommend a clear course of action. Instead, they detail elements that must be taken into consideration when making a decision with the pregnant woman or new mother about the best course of action.

IV. Web Resources
   Provide links to additional online information.
Healthcare providers are presented with clear action steps.

INITIATING PHARMACOTHERAPY FOR OPIOID USE DISORDER

CLINICAL SCENARIO
A pregnant woman with opioid use disorder (OUD) requests treatment.

CLINICAL ACTION STEPS

Medication-Assisted Treatment (MAT)
A pregnant woman with OUD should be offered MAT consisting of pharmacotherapy with methadone or buprenorphine and evidence-based behavioral interventions.

There is insufficient information about the safety of extended-release injectable naltrexone during pregnancy and the effects of intrauterine exposure to this medication. The expert panel did not agree on whether women on naltrexone should continue to use it during pregnancy. Women stable on naltrexone can be offered treatment with buprenorphine or methadone to prevent return to substance use if they choose to discontinue naltrexone injections. However, this transition must be carefully managed because patients on long-acting naltrexone are no longer opioid tolerant and the falling naltrexone level will result in increasing agonist activity over time during cross-titration.

Patient Education
As soon as a pregnant woman is diagnosed with OUD, healthcare professionals should review and discuss the risks and benefits of each antagonist and agonist treatment option with her. Healthcare professional should inform her that pharmacotherapy is strongly recommended and that treatment without any pharmacotherapy is complicated by poor fetal health, high rates of return to substance use, and the consequences such as risk of overdose.

Healthcare professionals should inform the pregnant woman of the possibility of neonatal abstinence syndrome (NAS) and counsel her on its diagnosis, management, and consequences. The woman should also receive education on ways to optimize the well-being of the fetus such as tobacco cessation and early pediatric care after delivery and hospital discharge. Healthcare professionals should ensure that she is aware of nonpharmacological interventions that should be provided to her infant to reduce NAS symptoms, including rooming-in.

Healthcare providers should inform the pregnant woman of the potential medical and social consequences of each form of therapy, specifically of the consequences that relate to NAS and unmonitored prenatal withdrawal.

No Known Risk of Increased Birth Defects With Pharmacotherapy for OUD
The woman should be informed that experts do not agree on whether intrauterine exposure to buprenorphine, buprenorphine/naloxone, or methadone results in lasting developmental or other problems for the infant. A woman receiving either buprenorphine or methadone should be informed that the benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD. Healthcare professionals may want to reassure women that, to date, research has not shown that buprenorphine and methadone can cause an increase in birth defects and has minimal long-term neurodevelopmental impact.

She should be informed that tobacco and alcohol exposure are known to be harmful to her and the fetus and should be provided with support to limit or preferably discontinue exposure to these substances.
Healthcare providers are presented supporting evidence, resources to review, and pointed to related factsheets in the guidance.
Healthcare providers are linked to samples to support care.

**Treatment plans need to be individualized.**
Each pregnant woman with OUD who is in treatment needs her own individualized plan that is developed in collaboration with her healthcare team. The plan needs to include elements such as which medications are being used and why; referrals and coordination of care such as scheduling help and follow-up appointments with other healthcare professionals; family involvement and whether family therapy is indicated; and a plan to treat co-occurring medical or behavioral health disorders that addresses her goals and motivations to engage in treatment (Jones et al., 2016; SAMHSA, 2014, 2015; World Health Organization [WHO], 2014). The plan should be based on shared decision-making, in which pregnant women seeking treatment and recovery can weigh that information against their personal preferences and values (SAMHSA, 2016b). The plan should also seek to optimize treatment issues that are relevant to the developing fetus and infant, particularly protocols for addressing an infant’s possible NAS and healthy early development.

**Healthcare professionals should educate women and their family members about potential legal, social, and medical consequences of each treatment option, specifically the risks of NAS.**
NAS is a medical condition that can be diagnosed and effectively treated with available interventions. Avoidance of NAS should not be the deciding factor in the initiation or dose of pharmacotherapy for OUD during pregnancy. The dose of medication does not appear to impact the risk or severity of NAS (Jones, Jansson, O’Grady, & Kaltenbach, 2013b; Jones et al., 2014; Lund et al., 2013; Patrick et al., 2015). Consequently the dose of medication should be titrated to control withdrawal, limit cravings and prevent return to opioid use.

Women who are pregnant and have OUD or another SUD may be fearful of the legal consequences they may face if they seek SUD treatment. Policies on whether and when to assume custody of a newborn or older child whose mother has untreated OUD vary by state, county, and even hospital (American Academy of Addiction Psychiatry, 2015; Guttmacher Institute, 2017; House, Coker, & Stowe, 2016). Healthcare professionals and office staff need to be aware of the regulations in their region (SAMHSA, 2016a).
Initiating pharmacotherapy needs to be individualized to each patient's medical condition. Protocols can provide a useful starting point, but healthcare professionals should evaluate the patient and review results of the initial screening with her to determine whether she has other medical conditions or polysubstance use and individualize the initiation of pharmacotherapy. Withdrawal from one or multiple substances may require inpatient care (ASAM, 2015; Commonwealth of Pennsylvania, 2016; Jones et al., 2008, 2016; McCarthy, Leaman, Willits, & Salo, 2015; Meyer & Phillips, 2015).

Individuals who select buprenorphine for pharmacotherapy need to be aware of the potential for spontaneous or precipitated withdrawal during pharmacotherapy induction (ASAM, 2015) and must be exhibiting clinical withdrawal symptoms before administration of the first dose. Many clinics now offer induction to buprenorphine as an outpatient service and sometimes as partial home induction. Partial home induction for pregnant women lacks sufficient evidence at this time.

Women who select methadone for pharmacotherapy need to be aware that achieving a stable therapeutic dose can take days to weeks. Some programs will choose to admit a pregnant woman to the hospital with a diagnosis of high-risk pregnancy to titrate her dose of methadone more quickly under continuous medical supervision and minimize the chance that she may attempt to cope with unrelieved withdrawal by using illicit opioids.

No Known Risk of Increased Birth Defects With Pharmacotherapy Medications

• Currently, research indicates no known risk of increased birth defects associated with the use of buprenorphine or methadone. A woman receiving either buprenorphine or methadone should be informed that the benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD.

Healthcare professionals may want to reassure women that, to date, research has not shown that buprenorphine and methadone can cause an increase in birth defects (Committee on Healthcare for Underserved Women, ASAM, & American College of Obstetricians and Gynecologists, 2017; Holbrook & Rayburn, 2014) and has minimal long-term neurodevelopmental impact (ASAM, 2015).

RESOURCE TO REVIEW

American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use to obtain more information on evidence-based treatment of OUD

FACTSHEET TO REVIEW

Tobacco use cessation is critical to the health of the dyad and must be addressed with specific interventions. Buprenorphine or methadone pharmacotherapy does not reduce cigarette smoking rates in pregnant women (Chisolm et al., 2012). See Factsheet #6: Addressing Polysubstance Use During Pregnancy for more information on tobacco cessation programs in pregnant women.

RESOURCE TO REVIEW

Treatment for pregnant women with OUD should promote and facilitate family, community, and social support as well as social inclusion by cultivating strong links with available childcare, economic supports, education, housing, and other relevant services as reviewed in: A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers (SAMHSA, 2016a).
<table>
<thead>
<tr>
<th>Considerations</th>
<th>Buprenorphine</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Selection</td>
<td>May be preferable for patients who are new to treatment because it is easier to transfer from buprenorphine to methadone (it can be very difficult to transfer from methadone to buprenorphine), who do not like or want methadone, or who have requested this medication.</td>
<td>May be preferable for patients who do not like or want buprenorphine treatment or who have requested this medication.</td>
</tr>
<tr>
<td>Care</td>
<td>Includes a prenatal healthcare professional, parenting classes, and SUD treatment.</td>
<td>Includes a prenatal healthcare professional, parenting classes, and SUD treatment.</td>
</tr>
<tr>
<td>Dispensing</td>
<td>May be prescribed in an office setting with weekly or biweekly prescribing/dispensing or provided in an opioid treatment program.</td>
<td>Requires daily visits to a federally certified opioid treatment program; take-home medication is provided for patients meeting specific requirements.</td>
</tr>
<tr>
<td>Treatment Retention</td>
<td>Some studies show treatment dropout is higher than that for methadone.</td>
<td>Some studies show treatment retention is higher than that for buprenorphine.</td>
</tr>
<tr>
<td>Risk of Medication Interaction</td>
<td>Few known interactions with other medications; risk of interaction is greatest with central nervous system (CNS) depressants and CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, ketoconazole, azithromycin). If these medications must be used, the clinic should monitor the patient daily for increased effect of buprenorphine; healthcare professionals should be aware that the development of sign and symptom varies and depends on a variety of factors. Other agonist/antagonist medications (e.g., butorphanol, dezocine, nalbuphine, pentazocine) and full agonists will result in precipitated withdrawal.</td>
<td>Medications that use CYP450 enzymes are commonly involved in a methadone–medication interaction. Methadone is metabolized primarily by CYP3A4 and CYP2B6. There is evidence that other CYP450 enzymes are also involved including CYP2D6. Known interactions with other medications in pregnant women are detailed in McCance-Katz (2011). If these medications must be used, the clinic should monitor the patient daily for increased or decreased effect of methadone; healthcare professionals should be aware that the development of sign and symptom varies and depends on a variety of factors. Other agonist/antagonist medications (e.g., butorphanol, dezocine, nalbuphine, pentazocine) and full agonists will result in precipitated withdrawal.</td>
</tr>
<tr>
<td>Starting Dose</td>
<td>2-4 mg</td>
<td>20–30 mg</td>
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<tr>
<td>Target Dose</td>
<td>Daily, 16 mg or product equivalent to 16 mg, is the most common dosage. The optimal dose will be determined by regular assessment of the individual and her response to treatment.</td>
<td>Daily, 80–120 mg. The optimal dose will be determined by regular assessment of the individual and her response to treatment.</td>
</tr>
<tr>
<td>Interval at Which Dose May Be Increased</td>
<td>Daily, but dose changes should not be made without patient assessment.</td>
<td>3 days is a common interval in a clinical practice, but dose changes should not be made without patient assessment.</td>
</tr>
<tr>
<td>Considerations</td>
<td>Buprenorphine</td>
<td>Methadone</td>
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<tr>
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<tr>
<td>Risk of Overdose and Death</td>
<td>Generally lower risk compared with full opioid agonists; overdose is possible when combined with other CNS depressants. Continued buprenorphine treatment reduces mortality after release from incarceration (Degenhardt et al., 2014). Buprenorphine treatment reduces the risk of death in people dependent on opioids (Gibson et al., 2008) and drug-related mortality in the first 4 weeks of treatment, a high-risk period (Kimber, Lamey, Hickman, Randall &amp; Degenhardt, 2015).</td>
<td>Generally greater risk of overdose compared with mixed agonist/antagonist opioids; overdose is possible when combined with other CNS depressants. Continued methadone treatment reduces mortality after release from incarceration (Degenhardt et al., 2014). Methadone significantly reduces the risk of drug-related mortality compared with no treatment (Evans et al., 2015). Methadone treatment reduces the risk of death in people dependent on opioids (Gibson et al., 2008) and drug-related mortality in the first 4 weeks of treatment, a high-risk period (Kimber et al., 2015).</td>
</tr>
<tr>
<td>Risk of Sedation</td>
<td>Sedation is possible but typically milder than that with full mu opioid agonists.</td>
<td>Sedation is possible and may be greater than that with partial agonist opioids (Walsh, Preston, Bigelow, &amp; Stitzer, 1995).</td>
</tr>
<tr>
<td>Ability To Fill a Prescription at a Local Pharmacy</td>
<td>Is possible depending on pharmacy availability.</td>
<td>Can be filled in a certified pharmacy to treat pain, but methadone for the treatment of OUD cannot generally be obtained from a pharmacy in the United States. It must be administered or dispensed for treatment of OUD at a certified opioid treatment program.</td>
</tr>
<tr>
<td>Treatment in a Healthcare Professional’s Office</td>
<td>Healthcare professionals who request a waiver to prescribe buprenorphine from SAMHSA and receive a unique Drug Enforcement Administration registration number for this purpose may prescribe buprenorphine for the treatment of opioid use disorder in an office-based setting.</td>
<td>May be possible under federal regulation if specific program criteria are fulfilled and relevant state and federal permission is sought.</td>
</tr>
<tr>
<td>Risk of NAS</td>
<td>Approximately 50% of exposed neonates are treated for NAS; NAS may be milder with buprenorphine compared with full mu opioid agonists such as most opioid analgesics and methadone.</td>
<td>Approximately 50% of exposed neonates are treated for NAS.</td>
</tr>
<tr>
<td>Duration of NAS</td>
<td>Most studies show shorter NAS duration compared with methadone.</td>
<td>Most studies show longer NAS duration compared with methadone.</td>
</tr>
<tr>
<td>Breastfeeding Considerations</td>
<td>Generally safe if the mother is stable and the ABM Clinical Protocol #21 breastfeeding with SUD guidelines are met.</td>
<td>Generally safe if the mother is stable and the ABM Clinical Protocol #21 breastfeeding with SUD guidelines are met.</td>
</tr>
<tr>
<td>Neurodevelopmental Outcomes of Exposed Children</td>
<td>Available research suggests there is not a linear cause and effect relationship between prenatal buprenorphine exposure and developmental problems when compared with other opioids; the research base is limited.</td>
<td>Available research suggests there is not a linear cause and effect relationship between prenatal methadone exposure and developmental problems when compared with other opioids; the research base is limited.</td>
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Transforming the Guide

Interactive Support

• Mobile application for providers
• Tweets for healthcare providers and patients
• Healthcare provider consultation and training through virtual communities of practice

Applied Tools

• Healthcare checklists, fact sheets, and infographics for pregnant and parenting women
• Practice guides for community providers (e.g., child welfare) working with pregnant and parenting women and their children
PART II: TRAINING CHILD WELFARE AND FAMILY COURT SYSTEMS TO ADDRESS OPIOID USE IN FLORIDA
Background

• More than 4,000 babies were born dependent on opioids in Florida in 2016, an increase of over 1,000 percent from a decade ago.

• Substance abuse played a role in two-thirds of the cases where children were removed from their homes within 30 days of birth in 2016.

• There has been a 38 percent increase in the number of children under the age of 5 who have been removed from homes because of substance abuse in the past 4 years.
Opioid Prescription Rates And Child Removals: Evidence From Florida

Annual statewide rates of child removal and drug prescription in Florida, 2012-15
Strong association between parental substance use disorder and child maltreatment

Research has shown that parental substance abuse (including opioid use) predicts:

- A report to child protective services
- More likely out-of-home placement
- Longer stays in care

What’s YOUR plan to reduce these health and human service costs in your jurisdiction?
MAT … not JUST a good idea

• States/jurisdictions may be liable and/or may not meet “reasonable efforts” legal requirements if they fail to assure opioid-addicted parents receive accurate and timely information about the options for treating it, including treatment with FDA-approved medications (e.g., methadone, buprenorphine, naltrexone).

• What’s YOUR plan to limit your liability while also adhering to best practice?
Florida Conducted Rapid Cycle Needs Assessment

2. How would you rate the priority of receiving training/education materials to support:

<table>
<thead>
<tr>
<th>Understanding how opioids differ from other commonly abused substances (e.g., crack, meth, Xanax)</th>
<th>No Need</th>
<th>Low Priority</th>
<th>Moderate Priority</th>
<th>High Priority</th>
<th>Need To Be Successful</th>
<th>Response Total</th>
<th>Points</th>
<th>Avg</th>
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<td>0% (0)</td>
<td>12% (3)</td>
<td>12% (3)</td>
<td>64% (16)</td>
<td>12% (3)</td>
<td>25</td>
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<th>Understanding the differences between differing types of opioids (e.g., heroin and prescription opioids)</th>
<th>No Need</th>
<th>Low Priority</th>
<th>Moderate Priority</th>
<th>High Priority</th>
<th>Need To Be Successful</th>
<th>Response Total</th>
<th>Points</th>
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<th>Understanding how to identify signs of opioid use in the home</th>
<th>No Need</th>
<th>Low Priority</th>
<th>Moderate Priority</th>
<th>High Priority</th>
<th>Need To Be Successful</th>
<th>Response Total</th>
<th>Points</th>
<th>Avg</th>
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<td>0% (0)</td>
<td>12% (3)</td>
<td>56% (14)</td>
<td>32% (8)</td>
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<th>Recognizing the risk factors for opioid misuse</th>
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<th>Moderate Priority</th>
<th>High Priority</th>
<th>Need To Be Successful</th>
<th>Response Total</th>
<th>Points</th>
<th>Avg</th>
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<td>0% (0)</td>
<td>4% (1)</td>
<td>12% (3)</td>
<td>60% (15)</td>
<td>24% (6)</td>
<td>25</td>
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<th>Recognizing the risk factors for opioid overdose</th>
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<th>Moderate Priority</th>
<th>High Priority</th>
<th>Need To Be Successful</th>
<th>Response Total</th>
<th>Points</th>
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<th>Recognizing the signs of an opioid overdose</th>
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<th>Low Priority</th>
<th>Moderate Priority</th>
<th>High Priority</th>
<th>Need To Be Successful</th>
<th>Response Total</th>
<th>Points</th>
<th>Avg</th>
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<tr>
<td>0% (0)</td>
<td>0% (0)</td>
<td>16% (4)</td>
<td>60% (15)</td>
<td>24% (6)</td>
<td>25</td>
<td>n/a</td>
<td>n/a</td>
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- JBS created 19-item needs assessment instrument (plus one open-ended question).
- The State selected 42 “key informants” to take survey from CW, the family courts, and advocacy groups.
- One week survey period/79% response rate.
- Respondents scored 17 of the 19 items as a “high priority or need”.
- Similar assessments can be designed/implemented for other States/jurisdictions.
Needs Assessment-Informed Training Module Examples:*

- Prescription Opioid Basics
- Heroin Basics
- Connecting Parental Opioid Use to Child Maltreatment (Nexus)
- Opioid Use and Pregnancy/Neonatal Abstinence Syndrome (NAS)
- Understanding Medication Assisted Treatment and Recovery (MAT-R)
- Working Effectively with Opioid Treatment Providers

* Modules can be customized to other jurisdictions
Benefits of Micro-Learning Modules

Child welfare professionals and family court are very busy; they have little time for training.

• **Quick Learning:** As micro-courses are short, the learner can easily understand the information.

• **Easy Access:** You can access courses easily, anytime, anywhere. As the courses are ‘small’, there are no loading issues.

• **One Go:** The learner can complete the module in one go, easily, as its duration does not exceed 30 minutes.
Training content covers impact of opioids on household

- Physical and mental impairments
- Spending limited funds on drugs rather than food or other household needs
- Spending time procuring, using, recovering from opioids
Training content covers potential threat to children

➢ Direct exposure to drugs, needles, paraphernalia
➢ Accidental ingestion
➢ Child participation in procurement
Training content covers impact of opioids on parental capacity

- Disruptions in healthy parent-child attachment
- Reduced capacity to respond to a child’s cues and needs
- Difficulties regulating emotions
- Estrangement from family and other social supports
- Opioid-specific Motivational Interviewing
Training content covers need for parent/child intervention

- Persistent absence of responsive care disrupts the developing brain
- Intervention is needed to heal the infant-parent relationship
- Most parents will need an evidence-based parenting program
Family Court

- Needs of families working with the child welfare system intersect with the family court system.
- Judicial staff looking for ways to better serve the interest of the families and to ensure the safety of the children.
- Practical, applied tools break down questions about child placement and safety.
Bench Guide for Opioid-Involved Dependency Cases*

An application of the current state of knowledge about opioid use disorders to the dependency court process

* These guidelines are specific to opioid use cases and are in addition to broad judicial requirements/best practices at each stage of a dependency case. See Florida’s Dependency Benchbook for comprehensive information regarding legal and non-legal matters in dependency cases. http://www.flcourts.org/resources-and-services/family-courts/dependency/dependency-benchbook.stm

† The information in these guidelines is organized around specific hearings and for brevity sake is not repeated across hearings. However, there is considerable overlap between the hearings regarding relevant information about opioids and potential judicial inquiry. The reader should view the hearing breakdowns with some flexibility.
Summary Points

• Pregnant and parenting women and children are being dramatically impacted by the opioid epidemic.
• Pregnant women with opioid use disorders need help to receive safe and effective treatment for themselves and their babies including pharmacotherapy with methadone, buprenorphine, and buprenorphine/naloxone.
• Newborns of mothers abusing opioids and children of all ages living with parents abusing opioids need comprehensive systems including child welfare and family courts to ensure their safety and well-being.
• Professionals serving these vulnerable populations need evidence-based guidance and support tools to provide effective care and treatment.
 Calls to Action

• **Rapid Assessment of Need** – What services are available for these vulnerable populations in your area? Do you know what barriers might exist for these populations? What resources are available? How prepared are providers to deliver services? What are priority areas for training?

• **Action Plan** - What immediate steps can be taken in your communities to better serve pregnant and parenting women and their children impacted by the opioid epidemic? What are the top priorities to address? What are the most impacting barriers to remove?

• **Measuring Impact** – What is the intended impact you want to make? How will you measure the impact of your actions?
VISION SESSION

“Helping Our Most Vulnerable Populations Impacted by the Opioid Crisis: Pregnant Women, Their Infants, and Those Receiving Child Welfare Services”

8:00 am – 8:45 am
Tuesday, April 3
See agenda for location.

Stop by our booth # 604 to meet with some of our content experts and pick up materials and giveaways!

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