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TESTIMONY BEFORE THE UNITED STATES SENATE

U.S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

Jennifer Donahue, Esquire, CWLS
Child Abuse Investigation Coordinator

Summary of Statement

Infants with prenatal substance exposure and their parents struggling with opioid addiction have multiple and complex needs that require a collaborative response by a multidisciplinary team. The 21st Century Cures Act and the Comprehensive Addiction and Recovery Act have helped states begin to address the damage that the opioid epidemic has caused to children and families in our nation. Plans of Safe Care for infants with prenatal substance exposure and their families should not only ensure the safety of the infant, but also provide necessary treatment services to the family for long term success. Delaware has already embarked on developing draft Plans and piloting them in several area hospitals; however, additional funding and support from our federal counterparts is critical for states' ultimate success. Additional grant opportunities under the Opioid Crisis Response Act for states to implement and monitor Plans of Safe Care, to strengthen their healthcare workforce to increase access to substance use disorder treatment, including medication assisted treatment (MAT), and access to mental health services in schools, as well as support to collect rich and informative data, is another beneficial step forward in our fight against the devastating effects of the opioid epidemic on our infants and families.

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Child Abuse Investigation Coordinator

Chairman Alexander, Ranking Member Murray and honorable members of the Committee, thank you for the opportunity to speak here today about the impact of the opioid epidemic on our nation's families and how the proposed Opioid Crisis Response Act of 2018 will further support and strengthen states' response to the problem.

My name is Jennifer Donahue and I am an attorney with the Office of the Child Advocate for the State of Delaware. In my role, I review and monitor cases involving serious physical injury and death of a child, sexual abuse of a child, and infants with prenatal substance exposure. My office facilitates a multidisciplinary team response with our child welfare partners in these cases to ensure child safety and that appropriate services are delivered to the family. My testimony today will focus on the following three sections of the proposed Opioid Crisis Response Act of 2018 as it relates to infants with prenatal substance exposure and their families:

1. Providing further grant opportunities and technical assistance support to states for the implementation of Plans of Safe Care for infants with prenatal substance exposure and their families;

2. Providing further funding and support to states to strengthen their healthcare workforce to increase access to substance use disorder treatment, including medication assisted treatment (MAT), and access to mental health services in schools; and,
3. Providing grants to states to improve data collection.

My office extends its gratitude to this Committee and Congress for the passing of the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act. These important pieces of legislation have helped states begin to address the damage that the opioid epidemic has caused to children and families in our nation. Plans of Safe Care for infants with prenatal substance exposure and their families should not only ensure the safety of the infant, but also provide necessary treatment services to the family for long term success. Delaware has already embarked on developing draft Plans and piloting them in several area hospitals; however, additional funding and support from our federal counterparts is critical for states' ultimate success. The Opioid Crisis Response Act of 2018 could be a means to that end.

SCOPE OF THE PROBLEM IN DELAWARE

The opioid epidemic has overwhelmed our entire nation and Delaware has not been spared. The problem is deep in our state and the consequences are tragic. The prevalence of pregnant women struggling with substance use disorders has increased substantially and access to treatment, particularly medication assisted treatment, is often difficult. Consequently, the number of notifications to Delaware's child welfare agency (termed "DFS") involving infants with prenatal substance exposure has also increased. In 2015, there were 294 notifications to the child welfare agency. That number jumped to approximately 450 notifications in 2017.[1] The data further shows that for infants who were prenatally exposed to 2 substances, opioids were involved in 63% of

[1] Investigation Coordinator SEI Database.

those cases. Furthermore, for infants who were prenatally exposed to 3 or more substances, opioid exposure was present in 78% of those cases. The approximate number of infants who were treated for Neonatal Abstinence Syndrome (NAS) in Delaware in 2017 was 413 and approximately 191 of those infants required pharmacological interventions.[2]

The correlation between infants with prenatal substance exposure and the risk of future abuse or neglect cannot be ignored, particularly when parents have not been successful in engaging in substance use disorder treatment. During 2015 through 2017, 14 infants with prenatal substance exposure sustained serious physical injuries and 9 died after being discharged home to their parent(s). Aiden was one of those infants. He was born in 2015 at 34 weeks gestation and was prenatally exposed to opiates. Aiden spent seventeen days in the hospital after his birth receiving morphine to assist with his withdrawal symptoms. He was subsequently released to his parents, both of whom were addicted to heroin. During the nine weeks Aiden was in the care of his parents, he sustained severe traumatic injuries to both his brain and his body. Aiden was hospitalized for four months and received extensive medical care, including life support measures. His child welfare treatment worker, Jennifer Perry, who is here with me today, spent countless hours by his side in the hospital to provide comfort and support. Aiden succumbed to his injuries in September 2015. His parents pled guilty to murder by abuse and neglect and are currently incarcerated. Aiden's passing devastated our community but it also compelled us to look deeply and objectively into our state's policies and procedures that ultimately failed him.

ADDRESSING THE PROBLEM

The Delaware Child Abuse and Neglect Panel, known as CAN Panel, reviews all child deaths and near deaths due to abuse or neglect. The review of cases between the years 2010 and 2014 resulted

[2] Delaware Perinatal Cooperative in partnership with the March of Dimes.

in approximately 17 findings of system weaknesses or policy failures involving infants with prenatal substance exposure.[3] In May, 2015, the Substance Exposed Infant Committee (SEI Committee) was formed to address the identified areas of critical concern. The SEI Committee is co-chaired by myself and Dr. Allan DeJong who is a pediatric child abuse expert at A.I. Dupont Hospital for Children. Our multidisciplinary team includes professionals from various domains including child welfare agencies, substance use disorder treatment providers, public health, medical care, mental health providers, home visiting nursing services, developmental disability agencies, education and many more. In an effort to further strengthen our response to these infants and their families, Delaware filed an application in August 2016 for In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare (NCSACW). During the past two years, IDTA change leaders have worked with our team on significant policy and practice changes. For example, the IDTA change leaders assisted our state with drafting a Plan of Safe Care and Family Assessment template (attached as Exhibit 1) which is now being utilized through our Plan of Safe Care Hospital Pilot Program. The Pilot Program was launched in 2 of our 6 birthing hospitals in October 2017 and has now expanded to 4 hospitals. There are currently 4 identified child welfare agency workers who are assigned to each of the 4 hospitals to handle the preparation, implementation and monitoring of the Plans of Safe Care. During the past 6 months, our Pilot Program teams have identified issues and concerns that need further assistance and support from our federal government. One thing is certain - no single agency has the resources or expertise to address the full spectrum of needs of infants with prenatal substance exposure and their families.

[3] Delaware Child Abuse and Neglect Panel Data 2015

OPIOID CRISIS RESPONSE ACT OF 2018

1. Grant Opportunities for the Implementation of Plans of Safe Care

Pending Delaware House Bill 140, known as Aiden's Law (attached as Exhibit 2) reinforces the requirements under CAPTA and CARA that healthcare providers notify DFS of infants born with and affected by substance abuse, withdrawal symptoms or FASD. Our non-punitive, public health oriented bill sets out the parameters of what we believe should be included in Plans of Safe Care. However, states need more guidance and financial support than CARA can provide. We are hopeful that the Opioid Crisis Response Bill will provide additional grant monies to help us not only *implement* Plans of Safe Care but to also provide us guidance on what we believe are the most important aspects of it – communication between system partners who are involved with providing services under the Plan of Safe Care and the ongoing monitoring of the family to ensure both the safety of the infant and delivery of services, particularly substance use treatment. Parents who are struggling with an opioid addiction and the stress of parenthood often do not find their way to recovery quickly. If families and infants are to be supported through this time, the "monitoring" requirements for the Plans of Safe Care are likely going to be much longer than a typical child welfare investigation. As such, child welfare workers (or some other child welfare entity) who are already struggling with caseloads that are beyond the statutory limit, will have additional cases to monitor and for longer periods of time. The child protective services workforce is already woefully underfunded and cannot assume this additional responsibility without concurrent funding. The hospital Pilot Program teams have identified practical issues for consideration as well, such as what is the appropriate duration of monitoring of the Plans and how can we create an electronic

version of a Plan of Safe Care that can be easily and confidentially shared with the plan participants.

2. Access to Substance Use Disorder Treatment, MAT and Mental Health Services in Schools

Federal resources need to be funneled towards prevention and awareness programs. Primary care physicians and obstetricians/gynecologists must routinely screen pregnant women for substance use disorders and link them to appropriate treatment prior to the birth event. Appropriate treatment should include access to medication assisted treatment and trauma-informed mental health services. Last year, our Division of Public Health issued educational materials to medical providers on how to screen pregnant patients for substance use disorders and alcohol abuse, a fact sheet on the negative effects of different drugs during pregnancy, and about www.helpisherede.com, a website that provides information about where and how to seek substance use disorder treatment in Delaware. (See Exhibit 3)[4]. Approximately 34% of Delaware mothers who gave birth to an infant with prenatal substance exposure in 2017 also had a mental health condition or diagnosis. In addition, approximately 40% of mothers had a history of trauma or DFS involvement as a child.[5] Strengthening states' healthcare workforce, specifically substance use disorder treatment providers and trauma-informed mental health services in schools, through additional funding opportunities under the Opioid Crisis Response Act, will likely reduce the number of infants born with substance exposure. Ideally, women of childbearing age will be able to access necessary treatment for their opioid addiction and seek recovery. Mental health services in schools will address the trauma that our youth have experienced and break the cycle of multigenerational trauma that may often lead to mental health concerns and substance use.

[4] Delaware Health and Social Services, Division of Public Health.
[5] Delaware Investigation Coordinator database 2017

3. Data Collection for Policy Change and Research Studies

Collecting rich and informative data will help identify system weaknesses, determine the effectiveness of services delivered to families and support research studies. Under CARA and the Opioid Crisis Response Act, states are required to collect and report out on data involving substance exposed infants and Plans of Safe Care – information that has not been routinely collected in the past and for which current databases may not have the capability to track. Funding will be necessary to update databases so that child welfare agencies may comply with the reporting requirements under CARA. In 2015, Delaware created a specific independent Excel spreadsheet for infants with prenatal substance exposure and their families to gather information about maternal and infant characteristics and specific information about the type of exposure, and many other areas. Our office and the child welfare agency have also partnered with the child abuse experts at A.I. Dupont Hospital for Children to conduct a research study on this population. We are hopeful that this study will identify maternal risk factors and infant characteristics that will help us determine which families are in need of more in-depth treatment services. Certainly, a system cannot be sustained long term on an Excel spreadsheet and would not be viable in the vast majority of states. Funding and supports for comprehensive data collection and analysis of these infants and their families is a critical component of this bill.

SUMMARY

Infants with prenatal substance exposure and their parents struggling with opioid addiction have multiple and complex needs that require a collaborative response by a multidisciplinary team. Additional grant opportunities under the Opioid Crisis Response Act for states to implement and monitor Plans of Safe Care, to strengthen their healthcare workforce to increase access to substance

use disorder treatment, including medication assisted treatment (MAT), and access to mental health services in schools, as well as support to collect rich and informative data, is another beneficial step forward in our fight against the devastating effects of the opioid epidemic on our infants and families.

Thank you very much for the opportunity to speak with you today about infants with prenatal substance exposure and I welcome any questions you may have.

STATE OF DELAWARE

PLAN OF SAFE CARE

For Infants with Prenatal Substance Exposure and their Families

INTRODUCTION: This Plan of Safe Care (POSC) is being developed to ensure that necessary services and supports are in place for the mother, infant and family. The POSC is developed by gathering information from the mother and her family, from the birthing hospital medical record and social worker notes, as well as input from community partners involved in supporting the mother and infant. The Family Assessment Form may be used as an information gathering tool to assist with the preparation of the POSC. A copy of this POSC will be shared with the identified "Plan Participants" in Section C of this document with the consent of the family.

A. FAMILY INFORMATION

DATE: _____

INFANT

Infant's Name (as it appears on birth certificate): _____ DOB: _____ Gender: _____

PARENT(S)

Mother's Full Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Contact/Cell Number: _____

Mother's Employer: _____ Employer Contact/Number: _____

Father's Full Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Contact/Cell Number: _____

Father's Employer: _____ Employer Contact/Number: _____

SECONDARY CAREGIVER(S) (If one parent is not involved):

Name	DOB	Relationship to Parent

SUPPORT PERSON(S) for Parents and/or Child

Name	DOB	Relationship to Parent(s) and/or Child

SIBLING(S) of Child

Name	DOB	Resides with? (Name/address/City/State/Zip)

B. PLAN OF SAFE CARE COORDINATOR ("POSC Coordinator")

***The primary role of the POSC Coordinator is the preparation, implementation and oversight of the POSC for the family. The POSC Coordinator will be responsible for ensuring appropriate referrals for services are made for the infant and family. The POSC Coordinator will act as the primary point of contact for the family and Plan Participants during the development and implementation period. The POSC Coordinator will share information, with informed consent, with the Plan Participants.**

POSC Coordinator's Name: _____

Phone: _____ **Email:** _____

Fax: _____

POSC Coordinator's Supervisor's Name: _____

Phone: _____ **Email:** _____

Fax: _____

POSC Coordinator's Agency Name: _____

C. PLAN PARTICIPANTS for Infant and Family Care

***The Plan Participants are the partners involved in the development and implementation of the POSC. All identified Plan Participants below will receive a copy of this POSC from the POSC Coordinator within 48 hours after the Plan of Safe Care Discharge Meeting.**

1. Birthing Hospital and Social Worker Name: _____
   Phone: _____
2. DFS/Child Welfare Worker Name: _____
   Phone: _____
3. Infant's Primary Care Doctor Name: _____
   Phone: _____ Next Appointment Date: _____
4. Infant's Specialist Physician Name: _____
   Phone: _____ Next Appointment Date: _____
5. Infant's MCO Coordinator: _____
   Phone: _____ Next Appointment Date: _____
6. Home Visiting Nurse Agency and Provider Name: _____
   Phone: _____ Next Appointment Date: _____
7. Mother's PCP/OB/GYN Name: _____
   Phone: _____ Next Appointment Date: _____
8. Mother's SUD or MAT Treatment Provider Name: _____
   Phone: _____ Next Appointment Date: _____

9. Father's SUD or MAT Treatment Provider Name: _____

Phone: _____ Next Appointment Date: _____

10. Mother's Mental Health Treatment Provider Name: _____

Phone: _____ Next Appointment Date: _____

11. Father's Mental Health Treatment Provider Name: _____

Phone: _____ Next Appointment Date: _____

12. Peer Recovery Coach Name: _____

Phone: _____ Next Appointment Date: _____

13. Other: _____

Phone: _____ Next Appointment Date: _____

D. IDENTIFIED NEEDS, RISKS AND INTERVENTIONS FOR THE FAMILY

***Based upon the information gathered by the POSC Coordinator during the family assessment phase, the following section identifies the needs of the infant, mother, father or other caregiver, and the referrals that are being made for appropriate services and treatment for the family.**

1. INFANT RISKS/NEEDS	REFERRALS MADE BY POSC COORDINATOR AT HOSPITAL DISCHARGE
a) Exposure/Withdrawal Symptoms	Reason for Referral: _____ Agency Referred to: _____ Agency Contact Person and Phone: _____ Date Referred: _____

b) Developmental Needs/Child Development Watch/Smart Start

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Other Medical Conditions

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

Special Medical Equipment needed? _____

d) Other Infant Needs/Risks

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

2. MOTHER'S NEEDS

REFERRALS MADE BY POSC COORDINATOR

a) Substance Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

b) Alcohol Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Mental/Behavioral Health

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

d) Parenting Skills/Attachment/Bonding

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

e) Family Planning Needs

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

f) Basic Needs Housing/Food/Transportation

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

g) Other

Describe: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

3. FATHER'S (or other caregiver's) NEEDS REFERRALS MADE BY POSC COORDINATOR

a) Substance Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

b) Alcohol Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Mental/Behavioral Health

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

d) Parenting Skills/Attachment/Bonding

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

e) Family Planning Needs

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

f) Basic Needs Housing/Food/Transportation

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

g) Other

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

E. OTHER SUPPORT SERVICES FOR FAMILY

TYPE OF SERVICE	REFERRALS MADE BY POSC COORDINATOR
a) Home Visiting Nursing Program	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
b) WIC	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
c) Employment/Training	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
d) Financial Assistance	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
e) Parenting Class	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____

f) Other

Date Referred: _____

Agency Referred to: _____

Agency Contact Name and #: _____

_____ Hospital Education Provided to Mother/Father or other Caregivers (check all that apply):

_____	Safe Sleeping	____	Newborn Safety
_____	SIDS	____	NAS Withdrawal Symptoms and Management
_____	Abusive Head Trauma	____	Family Planning
_____	Infant Feeding	____	Other: _____

G. DISCHARGE AND FOLLOW UP

Date of Discharge for Mother: _____

Date of Discharge for Infant: _____

Infant Discharged to whom (primary caregiver(s): _____

Discharge destination (primary caregiver(s) address): _____

Secondary/Part-time destination (name of caregiver and address): _____

Frequency that infant will reside/visit at Secondary/Part-time address: _____

DFS Child Safety Agreement in addition to POSC? _____

If yes, provide details: _____

_____

Explain Frequency of Contact by Plan of Safe Care Coordinator and Plan Participants with the Family (ie.weekly):_____

_____

_____

_____

Date of Next Multidisciplinary Meeting (in person or via teleconference) with Plan Participants to monitor POSC progress and challenges: _____

_____

Plan of Safe Care Progress/Challenges/Additional Needs: _____

_____

H. CONSENT FOR INFORMATION SHARING

By signing below, Mother, Father or other caregiver(s) acknowledge that the Plan of Safe Care has been prepared, reviewed and thoroughly discussed. It is understood that medical information will be shared/disclosed with the Plan Participants (Section C) under this written consent as provided by HIPPA (45 CFR 160, 164). It is also understood that substance use treatment information will be shared/disclosed with the Plan Participants under this written consent per 42 CFR Part 2. The Mother, Father or other caregiver(s) hereby consent to the sharing of the POSC with the Plan Participants.

The Plan Participants will regularly communicate and share information to ensure that timely referrals for services are made by the POSC Coordinator and that the appropriate services are delivered to the family. The POSC Coordinator and Plan Participants agree to ensure confidentiality of the information received through the POSC and agree to only share information with the identified Plan Participants.

The POSC Coordinator hereby confirms that the Division of Family Services has been notified of the infant's birth, this Plan of Safe Care has been prepared for the infant and family and a copy of the Plan has been provided to the Plan Participants listed in Section C of this document with mother's consent.

Plan of Safe Care Coordinator: _____ Date _____

Supervisor: _____ Date _____

Parent Signature: _____ Date _____

Parent Signature: _____ Date _____

Other Caregiver: _____ Date _____

Other Support Person: _____ Date _____

Other plan participant: _____ Date _____

Other plan participant: _____ Date _____

STATE OF DELAWARE

FAMILY ASSESSMENT FOR PLAN OF SAFE CARE

For Infants with Prenatal Substance Exposure and their Families

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***Plan of Safe Care Coordinators may choose to use this Family Assessment or their own tools to gather information about family functioning in order to prepare the Plan of Safe Care. The completed Assessment shall be included in the POSC Coordinator's records and shall not be shared with the Plan Participants.**

A. INFANT'S NEEDS

1. PRENATAL SUBSTANCE EXPOSURE: _____ YES _____ NO

Date(s) of testing: _____

Results of testing: _____

2. LABOR AND DELIVERY

Infant Urine or Meconium Drug Test: _____ YES _____ NO

If yes, result: _____ Positive _____ Negative

Type of Positive Substance(s): _____

Withdrawal symptoms? _____ YES _____ NO

If yes, describe: _____

Medication treatment needed? ____ YES ____ NO Comments: _____

Fetal Alcohol Spectrum Disorder? ____ YES ____ NO Comments: _____

Premature (less than 37 weeks): ____ YES ____ NO Comments: _____

Other Medical conditions? ____ YES ____ NO Comments: _____

Other: _____

3. ATTACHMENT AND BONDING

_____ Normal behavior/interaction with infant Comments: _____

_____ Regular visits and calls while in hospital Comments: _____

_____ Bed sharing with infant in hospital Comments: _____

_____ Infant supplies obtained Comments: _____

_____ Crib/safe sleeping arrangements Comments: _____

_____ Other strengths or concerns Comments: _____

B. MOTHER'S NEEDS

1. PRENATAL CARE: _____ YES _____ NO _____ Unknown

IF YES: OB/Gyn Provider Name: _____ Contact number: _____

Date when prenatal care began: _____ Regular visits: ____ YES _____ NO _____ Unknown

If no, explain: _____

Prenatal Drug Testing Conducted: _____ YES _____ NO _____ Unknown

Dates of Testing: _____

Results of Testing: _____

Valid Medication Prescription? : _____ YES _____ NO

If yes, please list substance, for what condition and prescribing provider name:

1. Substance: _____ Condition: _____ Provider: _____

Verified Valid: _____ YES _____ NO Comments: _____

2. Substance: _____ Condition: _____ Provider: _____

Verified Valid: _____ YES _____ NO Comments: _____

Referral made by OB/GYN for substance use treatment for mother? _____ YES _____ NO _____ Unknown

If yes, date of referral: _____ Agency name/contact #: _____

Indicate other substances of concern during pregnancy per maternal self-report: _____

2. MATERNAL SUBSTANCE USE

Maternal Urine Drug Test at Labor/Delivery: _____ YES _____ NO

If yes, result: _____ Positive _____ Negative

Name(s) and Type(s) of Positive Substances: _____

_____

Valid Prescription for Positive Substance(s)? _____

If yes, please list substance, for what condition and prescribing provider:

Substance: _____ Condition: _____ Provider: _____

Verified Valid: _____ YES _____ NO Comments: _____

Substance: _____ Condition: _____ Provider: _____

Verified Valid: _____ YES _____ NO Comments: _____

Substance: _____ Condition: _____ Provider: _____

Verified Valid: _____ YES _____ NO Comments: _____

Substance: _____ Condition: _____ Provider: _____

Verified Valid: _____ YES _____ NO Comments: _____

Maternal history of substance use disorder? ____ YES ____ NO Comments: _____

Mother actively engaged in substance use treatment? ____ YES ____ NO

If yes, what agency/clinic? _____ Counselor name/contact #: _____

Date treatment began: _____

Verified compliant with treatment (ie. regular attendance, no positive illicit drugs)? _____

Comments/Strengths/Concerns: _____

_____

Mother actively engaged in Medication Assisted Treatment? ____ YES ____ NO

If yes, what agency/clinic? _____ Counselor name/contact #: _____

Verified compliant with MAT (ie. regular attendance, no positive illicit drugs)? _____

Comments/Strengths/Concerns: _____

_____

Maternal history of *prior* substance use treatment? ____ YES _____ NO _____ Unknown

If yes, list date(s) and provider(s): _____

Successfully completed treatment or discharged non-compliant? _____

Prior Infant(s) born with prenatal substance exposure? ____ YES ____ NO

If yes, date(s) of prior SEI birth(s): _____

Substance(s): _____

3. DOMESTIC VIOLENCE/CRIMINAL ACTIVITY

Domestic violence concerns in mother's home? Explain: _____

Criminal activity concerns in mother's home? Explain: _____

What referrals to be provided? _____

Adverse Childhood Experiences (ACEs): use optional screening tool to determine mother's ACE score.

C. PATERNAL OR OTHER CAREGIVER SUBSTANCE USE

Paternal (or other caregiver) current substance use or abuse disorder? ____ YES ____ NO ____ Unknown

If yes, type of substance: _____

Paternal (or other caregiver) actively engaged in substance use treatment? ____ YES ____ NO ____ Unknown

If yes, what agency/clinic? _____ Counselor name/contact #: _____

In treatment since? _____

Verified compliant with treatment (ie. regular attendance, no positive illicit drugs)? _____

Paternal (or other caregiver) history of *prior* substance use treatment? ____ YES ____ NO ____ Unknown

If yes, list date(s) and provider(s): _____

Successfully completed treatment or discharged non-compliant? _____

Domestic violence concerns in father's home? Explain: _____

Criminal activity concerns in father's home? Explain: _____

What referrals to be provided? _____

Adverse Childhood Experiences (ACEs): use optional screening tool to determine father's ACE score.

D. PRIOR HISTORY OF DFS INVOLVMENT WITH MOTHER, FATHER OR OTHER CAREGIVERS

***The below information shall remain in the POSC Coordinator's records only and shall <u>not</u> be shared with Plan Participants.**

____	No DFS history			
____	DFS case is currently ACTIVE	____ Mother	____ Father	____ Other Caregiver
____	Prior DFS history of abuse or neglect allegations	____ Mother	____ Father	____ Other Caregiver
____	Prior DFS history of children removed from the home	____ Mother	____ Father	____ Other Caregiver
____	Prior DFS substantiation of abuse or neglect	____ Mother	____ Father	____ Other Caregiver
____	Infant's siblings currently placed out of the home	____ Mother	____ Father	____ Other Caregiver

____ Infant's siblings in DFS custody ____ Mother ____ Father ____ Other Caregiver

____ Prior termination of parental rights ____ Mother ____ Father ____ Other Caregiver

Comments for Check marks above : _____

_____

_____

_____

_____

*Name of Person who completed this form: _____

*Date form completed: _____

SPONSOR: Rep. M. Smith & Rep. Briggs King & Rep. Longhurst & Sen. Henry & Sen. Lopez & Sen. Townsend
Reps. Heffernan, Q. Johnson, Miro, Osienski, Ramone, Viola, Wilson; Sens. Hocker, Lavelle, Marshall, Sokola

HOUSE OF REPRESENTATIVES
149th GENERAL ASSEMBLY

HOUSE BILL NO. 140

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO INFANTS WITH PRENATAL SUBSTANCE EXPOSURE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by inserting a new chapter to read as follows:

Chapter 9B. Infants with Prenatal Substance Exposure.

§ 901B. Purpose.

The child welfare policy of this State shall serve to advance the best interests and secure the safety and well-being of an infant with prenatal substance exposure, while preserving the family unit whenever the safety of the infant is not jeopardized. To further this policy, this chapter:

(1) Requires that notifications of infants with prenatal substance exposure be made to the Division by the healthcare provider involved in the delivery or care of the infant.

(2) Requires a coordinated, service-integrated response by various agencies in this State's health and child welfare systems to work together to ensure the safety and well-being of infants with prenatal substance exposure by developing, implementing, and monitoring a Plan of Safe Care that addresses the health and substance use treatment needs of the infant and affected family or caregiver.

§ 902B. Definitions.

As used in this chapter:

(1) "Division" is as defined in § 902 of this title.

(2) "Family assessment and services" is as defined in § 902 of this title.

(3) "Healthcare provider" is as defined in § 714 of this title.

(4) "Infant with prenatal substance exposure" means a child not more than 1 year of age who is born with and identified as being affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder. The

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healthcare provider involved in the delivery or care of the infant shall determine whether the infant is affected by the substance exposure.

(5) "Investigation Coordinator" is as defined in § 902 of this title.

(6) "Internal information system" is as defined in § 902 of this title.

(7) "Plan of Safe Care" or "Plan" means a written or electronic plan to ensure the safety and well-being of an infant with prenatal substance exposure following the release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver, and monitoring these plans to ensure appropriate referrals are made and services are delivered to the infant and affected family or caregiver. The monitoring of these plans may be time limited based upon the circumstances of each case.

(6) "Substance abuse" means the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of this title.

(7) "Withdrawal symptoms" means a group of behavioral and physiological features in the infant that follow the abrupt discontinuation of a drug that has the capability of producing physical dependence. Withdrawal symptoms resulting exclusively from a prescription drug used by the mother or administered to the infant under the care of a prescribing medical professional, in compliance with the directions for the administration of the prescription as directed by the prescribing medical professional, its compliance and administration verified by the healthcare provider involved in the delivery or care of the infant, and no other risk factors to the infant are present, is not included in the definition and does not warrant a notification to the Division under § 903B of this title.

§ 903B. Notification to Division; immunity from liability.

(a) The healthcare provider who is involved in the delivery or care of an infant with prenatal substance exposure shall make a notification to the Division by contacting the Division report line as identified in § 905 of this title.

(b) When two or more persons who are required to make a notification have joint knowledge of an infant with prenatal substance exposure, the telephone notification may be made by one person with joint knowledge who was selected by mutual agreement of those persons involved. The notification must include all persons with joint knowledge of an infant with prenatal substance exposure at the time the notification is made. Any person who has knowledge that the individual who was originally designated to make the notification has failed to do so, shall immediately make a notification.

(c) A notification made under this section is not to be construed to constitute a report of child abuse or neglect under § 903 of this title, unless risk factors are present that would jeopardize the safety and well-being of the infant.

(d) The immunity provisions under § 908 of this title will also apply to this chapter.

§ 904B. Notification information.

(a) Upon receipt of a notification of an infant with prenatal substance exposure, the Division shall enter it into the Division's internal information system.

(b) Upon receipt of a notification of an infant with prenatal substance exposure, the Division shall notify the office of the Investigation Coordinator of the notification in sufficient detail to permit the Investigation Coordinator to undertake its duties as specified in § 906 of this title.

§ 905B. State response to notifications of infants with prenatal substance exposure.

(a) In implementing the Division's role in protecting the safety and well-being of infants with prenatal substance exposure, upon receipt of a notification under § 903B of this title, the Division shall do all of the following:

(1) Determine if the case requires an investigation or family assessment.

(2) Develop a Plan of Safe Care.

(3) Provide copies of the Plan of Safe Care to all agencies and providers involved in the care or treatment of the infant with prenatal substance exposure and affected family or caregiver.

(4) Implement and monitor the provisions of the Plan of Safe Care.

(b) For any case accepted by the Division for investigation or family assessment, the Division may contract for services to comply with § 906 of this title and § 905B of this chapter.

(c) For cases that are not accepted by the Division for investigation or family assessment, or those cases accepted for family assessment where the report does not involve a multidisciplinary case under § 906(e)(3) of this title, but that still meet the definition of an infant with prenatal substance exposure, the Division shall contract for services to do any of the following:

(1) Protect the safety and well-being of the infant with prenatal substance exposure following release from the care of healthcare providers while preserving the family unit whenever the safety of the infant is not jeopardized.

(2) Develop a Plan of Safe Care.

(3) Provide copies of the Plan of Safe Care to all agencies and providers involved in the care or treatment of the infant with prenatal substance exposure and affected family or caregiver.

(4) Implement and monitor the provisions of the Plan of Safe Care.

(5) Provide a final report to the Division to assist the Division in complying with Section 906B of this Chapter.

(d) For any case referred for contracted services under this chapter, the contractor shall immediately notify the Division if it determines that an investigation is required or is otherwise appropriate under § 906 of this title. The contracted

staff who have conducted the assessment may remain involved in the provision of services to the child and family as appropriate.

(e) In implementing the Investigation Coordinator's role in ensuring the safety and well-being of infants with prenatal substance exposure, the Investigation Coordinator, or the Investigation Coordinator's staff, shall have electronic access and the authority to track within the Department's internal information system each notification of an infant with prenatal substance exposure.

§ 906B. Data and reports.

(a) The Division shall document all of the following information in its internal information system for all notifications of infants with prenatal substance exposure under this chapter:

(1) The number of infants identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder.

(2) The number of infants for whom a Plan of Safe Care was developed, implemented and monitored.

(3) The number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.

(4) The implementation of such Plans to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

(b) The Department of Health and Social Services, the Investigation Coordinator and healthcare providers shall assist the Division in complying with this section.

(c) In addition to any required federal reporting requirements, the Division, with assistance from the Department of Health and Social Services and the Investigation Coordinator, shall provide an annual report to the Child Protection Accountability Commission and Child Death Review Commission summarizing the aggregate data gathered on infants with prenatal substance exposure.

(d) To protect the privacy of the affected family or caregivers, including the infant named in a report, this chapter is subject to the privacy and confidentiality provisions in § 906 and § 909 of this title.

Section 2. This Act shall be known and may be cited as "Aiden's Law."

SYNOPSIS

This non-punitive, public-health oriented bill seeks to codify certain sections of the federal law known as the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act (CARA), that requires states to have policies and procedures in place to address the needs of infants born with and identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder, including a requirement that healthcare providers involved in the delivery or care of such infant notify the child protection services system. This bill

formalizes a uniform, collaborative response protocol for the development of a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers.

Fact Sheet for Medical Providers:

SUBSTANCE USE DURING PREGNANCY

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware law requires that medical providers educate pregnant patients about the dangers of substance use:

DE Code, Title 24, Chapter 17, § 1769A. Required warning to pregnant women of possible effects of using alcohol, cocaine, or other narcotics.

(a) A person certified to practice medicine who treats, advises, or counsels pregnant women for matters relating to the pregnancy shall post warnings and give written and verbal warnings to all pregnant women regarding possible problems, complications, and injuries to themselves and/or to the fetus from the consumption or use of alcohol or cocaine, marijuana, heroin, and other narcotics during pregnancy.

(b) A person who treats, advises, or counsels pregnant women pursuant to subsection (a) of this section and who is certified to practice medicine may designate a licensed nurse to give the warnings required by this section.

(c) The Director of the Division of Public Health shall prescribe the form and content of the warnings required pursuant to this section.

QUICK SUMMARY OF SUBSTANCE EFFECTS

	Nicotine	Alcohol	Marijuana	Opioids	Cocaine	Methamphetamine
Short-term Effects/Birth Outcome						
Fetal Growth	Effect	Strong Effect	Effect	Effect	Effect	Effect
Anomalies	?	Strong Effect	?	No Effect	No Effect	?
Withdrawal	No Effect	Effect	Effect	Strong Effect	No Effect	Effect
Neurobehavior	Effect	Effect	Effect	Effect	Effect	Effect
Long-term Effects/Birth Outcome						
Growth	?	Strong Effect	No Effect	No Effect	?	*
Behavior	Effect	Strong Effect	Effect	Effect	Effect	*
Cognition	Effect	Strong Effect	Effect	?	Effect	Effect
Language	Effect	Effect	No Effect	Effect	Effect	*
Achievement	Effect	Strong Effect	Effect	*	?	*

? No Consensus on Effect * Limited or no data available

Updated by the Delaware Division of Public Health in 2017. Original source: Behnke, M. & Smith, V. C. (2013). Technical Report. Prenatal substance abuse: short and long-term effects on the exposed fetus. American Academy of Pediatrics, 131(3), e1009- e1024.

WHAT TO TELL YOUR PATIENTS

No amount of alcohol, marijuana, or other illegal drugs is safe for you or your baby. Prescription opioids should be taken exactly as prescribed and babies may experience neonatal abstinence syndrome (NAS) after birth, which will likely need medical intervention.

From the American College of Obstetricians and Gynecologists:

"A drug's effects on the fetus depend on many things: how much, how often, and when during pregnancy it is used. The early stage of pregnancy is the time when main body parts of the fetus form. Using drugs during this time in pregnancy can cause birth defects and miscarriage. During the remaining weeks of pregnancy, drug use can interfere with the growth of the fetus and cause preterm birth and fetal death."

(December 2013: www.acog.org/Patients/FAQs/Tobacco-Alcohol-Drugs-and-Pregnancy).

OPIOIDS: LEGAL AND ILLEGAL

what your patients need to know

Opioids are a highly addictive substance, and their use and abuse is driving the current addiction epidemic. Opioids can cause life-threatening withdrawal symptoms in babies, better known as neonatal abstinence syndrome (NAS). Symptoms include excessive crying, high-pitched cry, irritability, seizures, and gastrointestinal problems, among others. NAS requires hospitalization of the affected infant and possibly treatment with morphine or methadone to relieve symptoms. Treatment should also include non-pharmacological interventions like skin to skin contact and rooming in.

The research on the long-term impacts of opioid use during pregnancy is still evolving but there is some evidence to suggest behavorial and potential cognition effects on children whose mother used opioids.

No patient should be counseled to immediately stop using opioids, including heroin. Suddenly stopping use could send the fetus into distress, threaten the pregnancy, and even cause miscarriage. Consistent with ACOG guidelines, physicians should discuss a broad range of treatment options, including Medication Assisted Treatment (MAT). For information on treatment programs or to learn more about MAT for pregnant women, call 1-800-652-2929 in New Castle County or 1-800-345-6785 in Kent and Sussex counties.

COCAINE AND METHAMPHETAMINE (STIMULANTS)

what your patients need to know

Pregnant women who use cocaine are at higher risk for maternal migraines and seizures, premature membrane rupture, and placental abruption (separation of the placental lining from the uterus). Cocaine could exacerbate cardiac problems--sometimes leading to serious problems with high blood pressure (hypertensive crises), spontaneous miscarriage, preterm labor, and difficult delivery.

Babies born to mothers who use cocaine during pregnancy may also have low birth weight and smaller head circumferences, and are shorter in length than babies born to mothers who do not use cocaine. They also show symptoms of irritability, hyperactivity, tremors, high-pitched cry, and excessive sucking at birth.

Resources

For information on detox, recovery, intervention, and treatment resources, visit: www.helpisherede.com.

HELP is here.
PREVENT · TREAT · RECOVER

To help patients connect with home visiting and a variety of prenatal supports, call 2-1-1 for "Help Me Grow."

ALCOHOL

what your patients need to know

Alcohol is the number one cause of preventable birth defects. When a pregnant woman drinks alcohol, the alcohol reaches the baby through the placenta. While an adult liver will break down the alcohol, a baby's liver cannot and so the alcohol is significantly more toxic. Drinking alcohol during pregnancy can cause: damage to a baby's organs, physical, emotional and behavorial problems as they grow, difficulties in learning or memory, and higher incidence of Attention Deficit Hyperactivity Disorder (ADHD). The damage caused by drinking alcohol is well-documented and vastly underestimated.

MARIJUANA

what your patients need to know

Marijuana use should not be viewed as a "safe" alternative to other drugs, and, contrary to reports, marijuana can be addictive. The American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) state that marijuana cannot be used safely during pregnancy. There is research to suggest impaired neurodevelopment in fetuses, as well as low birth weight and problems in behavior and cognition in childhood. But, more research must be done. And, as ACOG suggests, the adverse effects of smoking to mother and fetus are well-documented.

TOBACCO

what your patients need to know

While this brief focuses on alcohol, illegal substances and prescription drug abuse, the negative impact of tobacco use on birth outcomes is well-documented. If a patient indicates they smoke, consider referrals to the Delaware Quitline for free cessation resources and tools at www.quitnow.net/delaware or by calling 1-866-409-1858."

Sources

ACOG Committee Opinion Number 637, July 2015, "Marijuana Use during Pregnancy and Lactation"

ACOG FAQ170, December 2013: Tobacco, Alcohol, Drugs, and Pregnancy

ACOG Committee Opinion 479, March 2011, Reaffirmed 2017, "Methamphetamine Abuse in Women of Reproductive Age

Centers for Disease Control and Prevention: Fetal Alcohol https://www.cdc.gov/ncbddd/fasd/

National Institute of Drug Abuse https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/substance-use-while-pregnant-breastfeeding

Delaware Fetal Alcohol Task Force

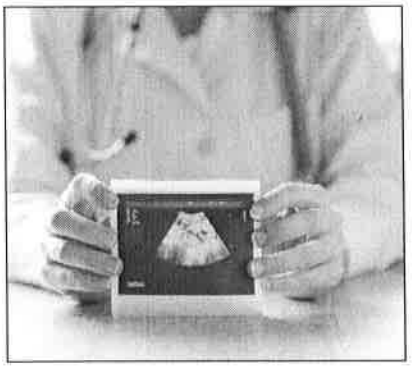
DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

DE THRIVES

Guidance for Medical Providers:

How to Screen Pregnant Patients for Substance Use Disorder and Alcohol Use

RECOMMENDATION



All pregnant women should be educated on the dangers of substance use during pregnancy and screened for substance use disorder and alcohol use, particularly during the first and third trimesters.

The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening with brief intervention and treatment referrals for cannabinoids, alcohol, club drugs, dissociative drugs, hallucinogens, opioids, stimulants, tobacco, and other compounds such as anabolic steroids and inhalants.

BACKGROUND

No amount of alcohol, marijuana, illegal drugs, or tobacco is safe for the mother or baby. Alcohol is still the number one cause of preventable birth defects, and even minimal alcohol exposure can hurt a fetus. Data shows there are short- and long-term negative impacts of alcohol, tobacco, opioids, and other drug use on the mother and baby.

For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

Legal prescription drugs, including opioids, should be closely monitored and used exactly as prescribed. For mothers who consumed opioids legally as part of a treatment plan, their infant will still likely need treatment for neonatal abstinence syndrome (NAS) following birth.

Any pregnant woman who is on legal or illegal opioids should not cease her use immediately or there may be significant risks to the fetus. Conversion to Medication Assisted Treatment (MAT) is preferred for women seeking to discontinue use of illegal or legal opioids during pregnancy (see page 4).

To learn more about MAT treatment locations for pregnant women, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent and Sussex counties.

OPIOIDS AND PAIN MANAGEMENT

Legally prescribed opioids are a proven pipeline to opioid dependence. Nearly 80 percent of heroin users report they started with prescription opioids. And, the benefits of long-term opioid therapy for chronic pain are not well supported by the evidence.

Prescribers of opioids for pain management should consider recommending alternatives to opioid medications, including non-opioid medications, exercise and physical therapy, behavioral therapy, and relaxation techniques. For patient and physician opioid fact sheets and links to new prescription regulations, visit Help is Here: www.helpisherede.com/Health-Care-Providers.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

HELP is here.
PREVENT • TREAT • RECOVER

DE THRIVES

CONSIDERATIONS

Substance use disorder is a chronic disease. Similar to diabetes and other illnesses that can harm a mother or her baby during pregnancy, a potential substance use problem should be identified and addressed early through screening using a validated screening tool.

ACOG recommends that routine screening for substance use disorder be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status.

You have an important role in educating women on the dangers of substance abuse during pregnancy, screening women for substance use disorder, and referring those with a potential substance use disorder. The goal is to help the mother and her baby. Education, screening, and referrals should be integrated seamlessly into regular prenatal visits.

Be nonjudgmental and reassuring. You are more likely to get honest responses if the patient feels comfortable and safe. When asking about substances, pregnant patients may naturally be concerned about admitting drug or alcohol use. They may fear stigma or that they will be reported to child protective services.

Pregnant women cannot be penalized for substance use during pregnancy under the law. Medical providers do not have a legal requirement or obligation to report substance use in pregnant women or to perform testing to confirm suspected use. In fact, child protective services will not take a report for behavior while pregnant as that is outside their legal authority.

Under federal law, pregnant women must receive priority substance abuse treatment. To learn more about what treatment services are available, visit www.HelpIsHereDE.com.

GENERAL SCREENING RECOMMENDATIONS

STEP ONE: START THE CONVERSATION

Following the SBIRT model (Screening, Brief Intervention and Referral to Treatment), start the conversation in a reassuring and compassionate manner. "Can I ask you about drug or alcohol use? This information is important to working with you to have a healthy pregnancy."

Be reassuring. Be clear the information will not be used against the patient or impact her ability to keep custody of the child. Emphasize the importance of your commitment to help her have a healthy pregnancy.

STEP TWO: DO THE SCREENING

Use the screening tool that works best for your practice and your population. The next page includes three validated screening tools that can be used easily in a health care setting. All seek to identify potential issues that would require further dialogue with the patient and referrals to treatment providers for further assessment.

These screening tools are in the public domain and recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA).

GENERAL SCREENING TOOLS

"Screening" means using a validated screening tool to ask questions aimed at understanding the patient's potential substance use. There are several validated screening tools for pregnant women, including 4P's, T-ACE, and CRAFFT for adolescents and young adults.

THE 4 P'S

4 P's for Substance Abuse:

1. Have you ever used drugs or alcohol during **Pregnancy**?

2. Have you had a problem with drugs or alcohol in the **Past**?

3. Does your **Partner** have a problem with drugs or alcohol?

4. Do you consider one of your **Parents** to be an addict or alcoholic?

Scoring: Any "yes" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "yes" to two or more questions should be referred for further assessment.

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.

T-ACE

ACOG recommends the T-ACE screening tool for alcohol, specifically developed for use with pregnant women. Ask patients four questions:

(T) Tolerance: How many drinks does it take to make you high?

(A) Have people annoyed you by criticizing your drinking?

(C) Have you ever felt you ought to cut down on your drinking?

(E) Eye opener: Have you ever had a drink the first thing in the morning to steady your nerves or get rid of a hangover?

Scoring: Any woman who answers more than two drinks is scored two points. Each "yes" to the additional three questions scores one point. A score of two or more is considered a positive screen, and the woman should be referred for further assessment.

Source: Sokol RJ, Martier SS, Ager JW. 1989. The T-ACE questions: Practical prenatal detection of risk drinking, American Journal of Obstetrics and Gynecology 160 (4).

CRAFFT – SUBSTANCE ABUSE SCREEN FOR ADOLESCENTS AND YOUNG ADULTS

C - Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using drugs or alcohol?

R – Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A – Do you ever use alcohol or drugs while you are by yourself, **ALONE**?

F – Do you ever **FORGET** things you did while using drugs or alcohol?

F – Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T – Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.

Source: Center for Adolescent Substance Abuse Research, Children's Hospital of Boston. The CRAFFT screening interview. Boston (MA) CeASAR; 2009.

TOBACCO

While this guidance focuses on alcohol, illegal substances, and prescription drug abuse, screening for tobacco is still recommended. The negative impact of tobacco use on birth outcomes is well documented. If a patient indicates they smoke, consider referrals to the Delaware Quitline for free cessation resources and tools at www.quitsupport.com or by calling **1-866-409-1858**.

STEP THREE: EDUCATE THE PATIENT AND PROVIDE REFERRALS

If the screening tool does not identify a potential problem:

• State law requires that all medical providers serving pregnant women counsel them on the dangers of any alcohol, marijuana, or other drug use during pregnancy. Recommend they cease use with the exception of opioids, which require special considerations and may need to involve Medication Assisted Treatment. For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

If the screening tool does identify a risk for substance use disorder:

• Be clear that you know the mother wants to be as healthy as possible for her baby and herself, and that she can reduce the health risk to them both by stopping the use of alcohol and drugs. If eligible, connect her with a Care Coordinator through her medical insurance.

• Discuss possible strategies for her to stop — individual or group counseling, 12-step program, or substance use disorder treatment. If she is struggling with opioid addiction, Medication Assisted Treatment should be discussed.

• Recommend women visit www.HelpIsHereDE.com or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent or Sussex counties to learn more about services for pregnant women.

MEDICATION ASSISTED TREATMENT

Medication Assisted Treatment (MAT) is an important part of the treatment regimen for pregnant women and is proven to improve outcomes. According to ACOG, "the rationale for Medication Assisted Treatment during pregnancy is to prevent complications from illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to the patient associated with a drug culture." *(ACOG Committee Opinion, Opioid Abuse, Dependence and Addiction in Pregnancy, Number 524, May 2012, page 2).*

The two main medications involved in MAT for pregnant women are methadone and buprenorphine (without Naloxone). The decision regarding the most appropriate medication should be made jointly with the MAT provider, the obstetrician, and the woman.

METHADONE	BUPRENORPHINE (WITHOUT NALOXONE)
• **May have better treatment retention**	• **Probably less severe NAS; works best in patients needing less monitoring**
• **No risk precipitating withdrawal**	• **Reduced risk of overdose during induction**
• **Patients with more severe opioid use disorder**	• **Reduced risk of overdose if children are exposed to medication.**

Source: Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/.

SOURCES

For a full list of sources, call the Division of Public Health at 302-744-4704.