

SELF – STUDY COURSE

DRUG ENDANGERED CHILDREN
“FROM RESEARCH TO PRACTICE, PART 1”

Kathryn Wells, MD, FAAP

This self-study course for 2.5 credit hours is based on the following sources:

- **DVD** Dr. Wells's presentation at the 2007 Prevent Child Abuse and Neglect Conference in April 2007, 1 hour 25 minutes in length
- Handouts from Dr. Kathryn Wells, 37 pages
- Post test which requires some personal reflection on how to implement the concepts in this course

The questionnaire/post test on page two of this course is a way to check your understanding and a means for your Family Resource Specialist to assess that you have processed and understood the majority of the information provided. In order to obtain credit for this course, please review the DVD (available online) and give your completed questionnaire/post test (available online or directly from your FRS) to your Family Resource Specialist at your Child and Family Services office. Your FRS will Score the post test and may credit your training record with 2.5 hours.

The Montana Department of Public Health and Human Services
Child and Family Services Division Training Unit

**Thank you to our valuable resource parents who are
dedicated to the care and protection of children.**

Post test for Drug Endangered Children "From Research to Practice, Part 1"
Self Study Course
2.5 Hours

Questions for the Resource Parent Training Module

Drug Endangered Children "From Research to Practice, Part 1"

Provide the appropriate answer to the following questions. First try to answer from your understanding of the material before referring back to the DVD and the handouts.

1. The American Academy of Pediatrics estimates that how many newborns in the United States are exposed to illicit drugs each year?

2. How much more per year are the projected costs thought to be per birth for drug exposed infants vs. "usual births?"

3. The relationship between drug exposure and gestational age is thought to result in the most severe malformations during what time period?

4. What substance is described as "universal" among drug using pregnant women?

Post Test for Drug Endangered Children "From Research to Practice, Part 1"
Self Study Course
2.5 Hours

5. List at least three fetal anomalies that occur resulting from the transfer of methamphetamine to the fetal blood?

6. Name at least three possible effects seen in newborns that have been exposed to methamphetamine?

7. According to a study done by Dr. Shaw, what age period/stage of development would one expect to be symptom free otherwise known as the "honeymoon" period?

8. Five points of suggested intervention are?

9. Why is helping parent's access treatment thought to be a better solution than criminalization?

Please note: If you have topics that you would like to see developed into a self-study course for resource parents, please contact the FRS in your local office.

**Drug Endangered Children:
From Research to Practice – Part I**

Montana 2007 Prevent Child Abuse and Neglect
Conference
Missoula, MT – May 9, 2007

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**Overview:
From Research to Practice - Part I**

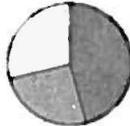
- Substance abuse and child abuse and neglect
- Drug Endangered Children defined
- Drug exposure in utero

**Overview:
From Research to Practice - Part I**

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Children in Substance-Abusing Homes

8.3 million (11% of U.S. children) live with at least one parent who is alcoholic or in need of substance abuse treatment



8.3 million -
alcohol
22.1 million -
smoking
23.4 million -
drinking

[Source: 1996 National Household Survey on Drug Abuse (NHSDA)]

Children of Parents with Substance Abuse Problems

- Have poorer developmental outcomes (physical, intellectual, social and emotional) than other children
- Are at (an eight-fold) increased risk of substance abuse themselves

Substance Abuse Affects Parenting

- Impaired judgment and priorities
- Inability to provide the consistent care, supervision and guidance children need
- Substance abuse is a critical factor in child welfare

[Source: Blending Perspectives and Building Common Ground, A Report to Congress on Substance Abuse and Child Protection, April 1999]

Child Abuse and Neglect

- In the U.S., more than 3 children die each day as a result of child abuse and neglect
- In 2000, just under 3 million reports were made for child abuse and neglect concerning 5 million children
- In 2000, 879,000 children were found by child protection agencies to have been victims of child abuse and neglect

Substance Abuse and Child Abuse and Neglect

88% of respondents named substance abuse as one of the top two problems presented by families reported for child abuse

(Source: *No Safe Haven Report*, The National Center on Addiction and Substance Abuse at Columbia University, 1998)

Substance Abuse and Child Abuse and Neglect

- Substance abuse causes or exacerbates 7 out of 10 cases of child abuse and neglect
- Children whose parents use drugs and alcohol are:
 - 3x more likely to be abused
 - More than 4x more likely to be neglected

Substance Abuse Problem in Child Protection is Multifactorial

- Prenatal exposure
- Environmental exposure
- Labs: Toxin exposure/Explosion risk
- Risk of:
 - Neglect
 - Emotional abuse
 - Sexual abuse
 - Physical abuse

**Overview:
From Research to Practice - Part I**

- Substance abuse and child abuse and neglect
- Drug Endangered Children defined
- Drug exposure in utero

Who are Drug Endangered Children?

- Children under 18 years of age
- Suffer physical harm or neglect from direct or indirect exposure to illegal drugs or alcohol
- Children who are exposed to or ingest illegal drugs in the home

Who are Drug Endangered Children?

- Live in a house where illegal drugs are used and/or manufactured
- Children exposed to the toxic chemicals of home drug labs
- Children being cared for by a caregiver under the influence of illegal drugs or intoxicated by alcohol
- Infants exposed to illegal drugs in utero

Who are Drug Endangered Children?

Most importantly:
Infants/Children who suffer abuse or neglect because of their caretaker's substance abuse

Overview:
From Research to Practice - Part I

- Substance abuse and child abuse and neglect
- Drug Endangered Children defined
- Drug exposure in utero

The Facts...

- Montana and the nation have a growing problem with methamphetamine use
- Many women of child-bearing age are using methamphetamine and other drugs

The Problem

- *Nationally, 5-20% of all infants born have detectable levels of illegal drugs in their bodies...*
- America's and Montana's children are not adequately protected from exposure to illegal drugs and their effects or the effects of exposure *in utero*
- Limited national policy exists

Who?

- Incidence Increasing
 - Chemical dependence among women of childbearing age
 - Number of maternal and perinatal complications
- Actual number of pregnant women using not known

How Prevalent?

- Survey of 36 hospitals found an estimated 375,000 infants exposed in utero to illegal drugs each year in the U.S., or 11% of all births
(Chasnoff, 1989)
- The American Academy of Pediatrics estimates that 1 in 10 newborns in the US have been exposed to an illicit drug
(AAP, 1990)

How Prevalent?

- Dallas, Denver, Oakland, Philadelphia, and Houston all reported 3x-4x increases in the number of drug-exposed infants from 1985-1988.
(Kandall, 1991)
- 1992 study at a Detroit hospital (near universal screening and meconium analysis) found prenatal drug use in 44% of 3,010 births
(Ostrea, Brady, Gause, Raymundo & Stevens, 1992)

How Prevalent?

- Universal screening UA's in women of mixed socioeconomic status on first prenatal visit showed illicit exposure rate of 13.8%
(Chasnoff, Landress, & Barrett, 1990)
- A 2002 survey of women aged 15 to 44 admitted use in the last month of:
 - Illicit drugs - 3%
 - Alcohol - 3%
 - Cigarettes - 17%
(National Survey on Drug Use and Health, 2004)

Spokane County, Washington

- 820 samples were analyzed
 - 7.8% (64) positive
 - 4.0% (33) opiates
 - 4.0% (33) marijuana
 - .06% (5) cocaine
- Not analyzed for methamphetamine

Obtaining Data Difficulties

- The unreliability of mother's self-reports
- The limitations of urine toxicology techniques
- The nature of observable clinical conditions
- Lack of uniformity in hospital policies and procedures
- Drug-affected vs. drug-exposed

Prenatal Substance Abuse

- Small proportion of the children affected by substance abuse
- Often not identified for:
 - Fear of prosecution
 - Fear of losing their children

What is the Problem?

- Attentional, self-regulatory, and cognitive difficulties
- Effects may be fetal, maternal or both
- Great variability in harm
- Risk of maltreatment and impaired attachment
- Significant financial cost

The Cost...

- The cost of newborn care of a drug-exposed infant can be in excess of 5 times that of a non-drug-exposed infant
- First-year costs to the states of births affected by maternal substance use were estimated as high as \$50,000 *each* above "usual births" – state expenditures for public assistance and foster care for each year after the first can be as high as \$20,000
- National estimates show costs that approach \$500 million
- Costs estimated at \$700 million by the time the children reach kindergarten

(The Journal of Substance Abuse Treatment, 1996)

What Drugs?

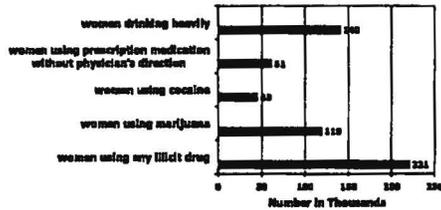
- Legal: tobacco, alcohol
- Illegal: LSD, marijuana
- Substances with recognized medical uses: cocaine, narcotics, barbiturates, and amphetamines

What Drugs?

- Alcohol – 5-10%
- Cigarettes – 20%
- Marijuana – 10%
- Cocaine – 1%
- Opiates – 0.5%

(Center on Addiction and Substance Abuse, 1996)

Women Using Illicit Drugs or Drinking Heavily During Pregnancy



[Sources: National Pregnancy and Health Survey (National Institute on Drug Abuse, 1994 for illicit drug numbers; Center for Disease Control, 1997 for numbers on heavy drinking)]

Indirect Maternal Effects

- Infections: HIV, tuberculosis, hepatitis, syphilis, endocarditis, pulmonary infections
- Toxin-Induced: nutritional deficiency (alcohol), cardiotoxins (cocaine, alcohol, amphetamines), direct pulmonary effects (marijuana, tobacco), hepatotoxic (cirrhosis, solvent), nephropathy (heroin)

Obstetrical Complications

- Abortion
- Abruptio placenta
- Amnionitis
- Breech presentation
- Previous cesarean-section
- Chorioamnionitis
- Eclampsia
- Gestational diabetes
- Intrauterine death
- Intrauterine growth retardation
- Placental Insufficiency
- Post-partum hemorrhage
- Pre-eclampsia
- Premature labor
- Premature rupture of membranes
- Septic thrombophlebitis

Fetal Effects

- Route of intake (dose) and dosage interval
- Route of administration (IV, PO, SQ, Inhalation)
- Rate of absorption
- Rate of elimination
- Lipid solubility
- Protein binding
- Concomitant maternal pathology (renal, hepatic, etc.)
- Placental well-being
- Gestational age

Relationship to Gestational Age

- First 6 weeks: most severe malformations
- Up to 12 weeks: malformations of the abdominal wall, gastrointestinal tract, reproductive system and urinary tract
- Second and third trimesters: intrauterine growth retardation and vascular disruption syndromes

Neonatal Medical Complications

- Autoimmune deficiency syndrome
- Hyperbilirubinemia
- Hypocalcemia
- Hypoglycemia
- Intracranial hemorrhage
- Intrauterine growth retardation
- Neonatal abstinence syndrome
- Meconium aspiration
- Pneumonia
- Respiratory distress syndrome
- Septicemia
- Sudden Infant death syndrome

Overview – Pregnancy and Methamphetamine

- Very little information
- Studies ongoing
- Similar to cocaine exposure
- Many challenges

Drug Use During Pregnancy

- Women who use methamphetamine/cocaine in the first trimester are more likely to use during the third trimester
 - Nicotine use is universal among drug using pregnant women
 - Marijuana and alcohol are secondary drugs, used in 60% of the group
- (Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Methamphetamine Use During Pregnancy: IDEAL Study

- Methamphetamine is the only substance of abuse whose use does NOT diminish during pregnancy
- In the IDEAL study population thus far, average use by trimester was 3, 2 and 2 days/week
- 73% of users smoked methamphetamine

Methamphetamine Use Prenatal Care History

Methamphetamine Use in Pregnancy

- Transfer of methamphetamine to fetal blood where - remains in fetal circulation longer than in maternal blood
- Fetal anomalies
 - CNS abnormalities
 - Cardiovascular abnormalities
 - Intestinal abnormalities
 - Urogenital system abnormalities
 - Malformations of extremities
- May have periods of extreme heart rate variability

Methamphetamine – Effects on Pregnancy and Delivery

- Premature rupture of membranes, early onset of labor and preterm delivery
- Common knowledge on the streets – may attempt self-induced abortions
- Birth outcomes improve if mother stops drug in the last 3 months of pregnancy
- Damage to vessels is non-reversible

Methamphetamine – Effects on the Newborn

- Intrauterine growth delay
- May have some withdrawal symptoms
- First few weeks - sleepy and lethargic (often don't wake to feed)
- After the first few weeks - behave similar to cocaine-exposed infants - jittery, cry shrilly, startle at even the slightest stimulation

Methamphetamine – Effects on the Newborn

- Abnormal sleep, poor feeding, tremors and increased muscle tone
- Poor ability to habituate or self-regulate, especially under stressful conditions

Increased Infant Mortality

- Associated increased risk of SIDS (?)
- Associated risk of positional overlay
- Associated risk of very premature birth and severe complications

Symptoms of Meth Exposed Infants and Children

Newborn to 4 Weeks (I)

(Dopamine Depletion Syndrome)

- Lethargic – Excessive sleep period
- Poor suck and swallow coordination
- Sleep apnea
- Poor habituation

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Symptoms of Meth Exposed Infants and Children

4 weeks to 4 months (II)

- Symptoms of CNS immaturity – effects on motor development
- Sensory integration problems – tactile, defensive, texture issues
- Neurobehavioral symptoms – interaction social development

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Symptoms of Meth Exposed Infants and Children

6 months to 18 months (III)

- The Honeymoon Phase
- Symptom-free period

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Symptoms of Meth Exposed Infants and Children

18 months to 5 years (IV)

- Sensory integration deficit (same as II)
- Less focused attention
- Easily distracted
- Poor anger management
- Aggressive outbursts

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Methamphetamine – Effects on the Growing Child

- Too early to know
- Behavior problems
- Small changes in IQ and language abilities
- Later on may have aggressive behavior and poor school performance by 7-8 years of age

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SPECIAL REPORT

FERTILE MINDS

FROM BIRTH, A BABY'S BRAIN CELLS PROLIFERATE WILDLY, MAKING CONNECTIONS THAT MAY SHAPE A LIFETIME OF EXPERIENCE. THE FIRST THREE YEARS ARE CRITICAL.

BY J. MADOLENE HARR

The Facts...

Infants born to women with addictions are at risk for **birth defects, premature birth, and complications** after birth such as withdrawal. In addition, these infants display a **higher incidence of child abuse and neglect.**

What We Don't Know

- Effect of other factors
 - Other exposures
 - Environment
 - Brain effects
 - Labs
- Long-term outcomes
- Most effective approach

What Happens Next?

- Most go home – 75-90% of substance-exposed infants are undetected and go home
- Why?
 - Many hospitals don't test or don't systematically refer to CPS
 - State law may not require report or referral
 - Test only detect very recent use

Source: Department of Health and Human Services, 2003

Emerging Issues

- Increasing number of pregnant women and children affected by maternal use of methamphetamine
- Advancing research on fetal alcohol spectrum disorders and alcohol-related neurodevelopmental disorders
- Renewed proposals of State legislation aimed at both fetal alcohol exposure and maternal abuse of illegal drugs
- Child Abuse Prevention and Treatment Act (CAPTA) amendments of 2003

Source: Department of Health and Human Services, 2003

Child Abuse Prevention and Treatment Act (CAPTA)

- Reauthorized in 2003
- Established new legislative responsibilities regarding prenatally exposed infants

Child Abuse Prevention and Treatment Act (CAPTA)

- Stated that states must have in place:
 - 106(b)(2)(A)(ii) "Policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure,"

Child Abuse Prevention and Treatment Act (CAPTA)

- (ii) "including a requirement that health care providers involved in the delivery or care of such infants notify the child protection services system of the occurrence of such condition in such infants,"

Child Abuse Prevention and Treatment Act (CAPTA)

- (ii) "except that such notification shall not be construed to:
 - (I) Establish a definition under Federal law that constitutes child abuse; or
 - (II) Require prosecution for any illegal action"

Child Abuse Prevention and Treatment Act (CAPTA)

(III) "The development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms"

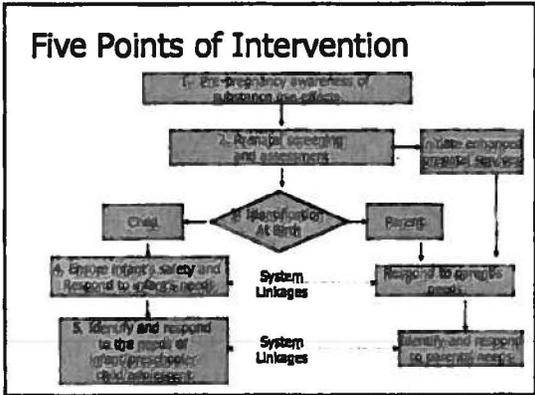
C-SIMI Grant

- Colorado Systems Integration Model for Infants (C-SIMI)
- Model Development or Replication to Implement the CAPTA Requirement to Identify and Serve Substance-Exposed Infants
- Funded by the Department of Health and Human Services, Children's Bureau
- 60 month project with five 12-month budget periods

Five Points of Intervention

1. Pre-Pregnancy
2. Prenatal Screening and Services
3. Screening and Testing at Birth
4. Post-Natal Services to Infants and Children
5. Post-Natal Services to Parents

Colorado Department of Health and Human Services, Children's Bureau



- ### 1. Pre-Pregnancy
- Public education campaigns
 - Warning signs at points of sale
 - Warning signs at other venues
 - Work with institutions of higher education to disseminate the message
 - Studies suggest that message is not getting to critical group of pregnant women

- ### Five Points of Intervention
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2. Prenatal Screening and Services

- Prenatal screening - standardize
- Give pregnant women priority status in entering treatment, in accord with Federal requirements
- No states require prenatal screening for substance abuse
- State and local prevention efforts

Identification – Screening



- Prepregnancy visits
- Prenatal visits
- Medical history
 - Significant for cirrhosis, hepatitis, GI hemorrhage, endocarditis, pneumonia, pancreatitis, nutritional deficiencies, obvious IV "Track" marks, edema of the extremities
 - Usually history not positive for substance abuse
- Social history
 - Association with criminal behavior such as prostitution and drug-related crimes

Identification – Screening (cont.)

- History of pregnancy complications
 - Intrauterine growth retardation, protracted intensive care nursery stays, abruptio placentae, meconium-stained amniotic fluid, premature rupture of membranes, and fetal deaths
 - Vertebral, neurologic, cardiac, urogenital, and skeletal fetal abnormalities
 - Recurrent fetal loss, SIDS, and premature labor

Prenatal History

- Increase in lability of affect
borderline functioning/depression
- Low maternal attachment
- Poor Impulse control
- Marital dysfunction
- Spouse who perceives fetus a threat
- Family history of child abuse

Maternal Depression

- Presence relatively high (up to 16%)
- Fatigue, change in appetite,
sleeplessness, loss of energy
- Difficult to diagnosis
- Strongly associated with Increased life
stresses, decreased social support,
poor weight gain, and use of
substances

2. Prenatal Screening and Services

- Referrals of pregnant women to treatment and
progress in treatment are not monitored on a
Statewide basis
- Extensive wait lists in some states, especially for
residential care
- Admissions of pregnant women are a very small
percentage of total admissions

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Five Points of Intervention

1. Pre-Pregnancy
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5. Post-Natal Services to Parents

3. Screening and Testing at Birth

- Policies on screening at birth are not at State level – local hospital policy
- Hospital policies vary widely with few standardized protocols that are consistently implemented
- Reporting requirements – recent legislation
- Defining substance exposure as evidence of abuse or neglect

3. Screening and Testing at Birth

- States do not monitor screening and referrals
- Detection of and response to FAS and FASD is inconsistent with policy and practice

Screening

- Infants vs. mothers
- Screen for tobacco and alcohol as well as illicit drugs
- Great potential for preventing negative outcomes if identified early
- Need to follow an objective protocol
- Universal vs. targeted testing
 - Reliability and fairness
 - Cost from financial or civil rights perspective
 - Don't miss the "big picture"

Indications for Screening

- Placental abruption
- Adolescent pregnancy (?)
- "Drop-in" delivery
- History of drug use
- Preterm birth
- Late/no prenatal care
- Cigarette smoking

Duration of Positive Tests (Urine)

Amphetamines	48 hours
Alcohol	12 hours
Barbiturates	10 – 30 days
Valium	4 – 5 days
Cocaine	24 – 72 hours
Heroin	24 hours
Marijuana	3 – 30 days
Methadone	3 days

(USDHHS, SAMHSA, CSAT TIP #5, 1993)

Meconium Testing

- High sensitivity
- Easy collection
- Detects illicit drug use from 24 weeks gestation until birth

Controversies

- *State of Florida v. Johnson*
 - First criminal conviction of a woman for health endangering behavior during pregnancy
 - Criminally charged with child abuse for delivering illegal substances to a minor under age 18
 - Sentenced to one year of community control in drug treatment program, 14 years of probation and 200 hours of community service
 - Ruling included that if she ever conceived again, she must advise probation officer of the pregnancy and enter a prenatal care program approved by the court
 - Has been overturned

Controversies (cont.)

- *Roe v. Wade*
 - Unresolved issues of fetal rights and legal intervention in the lives of pregnant women
 - To force a pregnant woman to abstain from certain deleterious behavior is unlawful under *Roe v. Wade* as an infringement on the woman's constitutionally protected right to autonomy and bodily integrity during pregnancy

Controversies (cont.)

- *Whitner v. South Carolina*
 - Criminal prosecution of women positive for illegal drug use
 - Only state Supreme Court that has upheld the prosecution of a mother who used drugs while pregnant (1992)
 - Overturned by U.S. Supreme Court

What Happens Next?

- Referral for services/report to DSS
- Care plan established
- Support services
- Monitoring of progress

Five Points of Intervention

1. Pre-Pregnancy
2. Prenatal Screening and Services
3. Screening and Testing at Birth
4. Post-Natal Services to Infants and Children
5. Post-Natal Services to Parents

4. Post-Natal Services to Infants and Children

- Early Intervention policies and process for referrals
- Child welfare developmental assessments of substance-exposed Infants or older children just entering the system

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Treatment of Drug Exposed Infants and Children

- Symptoms may vary
- Diagnosis based on a detailed evaluation including a detailed history of drug/alcohol use during pregnancy
- Treatment based on symptoms that the Infant/child is exhibiting, not solely on the history of drug/alcohol exposure
- Not all drug/alcohol exposed infants and children will have problems

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

5. Post-Natal Services to Parents

- Consider setting aside supplemental federal funding for treatment for pregnant and parenting women
- Family-centered services
- Significant gaps
- Capacity of programs not sufficient to serve all those in need of treatment

(Source: Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, IA)

Pregnancy Is Only A Part....

**Factors in the
postnatal
environment
mediate prenatal
factors in
predicting
developmental
outcomes**

The Solution?

- **Treatment is needed for mothers who choose to use drugs during pregnancy**
- **Criminalizing prenatal use will not solve the problem and will likely result in avoiding prenatal care**
- **Helping these parents access treatment is a better solution than criminalization**

Treatment is Critical!

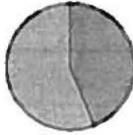
- **The United States Supreme Court and the health care community - drug addiction is an illness**
- **The American Medical Association has unequivocally stated that "it is clear that addiction is not simply the product of the failure of individual willpower. Instead, dependency is the product of complex hereditary and environmental factors. It is properly viewed as a disease, and one that physicians can help many individuals control and overcome."**

Treatment Can Be Effective

- One-third of substance abuse treatment clients achieve sustained abstinence from their first attempt at recovery
- One-third of clients have a period of relapse episodes but eventually achieve long-term abstinence
- One-third of clients have chronic relapses that result in eventual death from complications of their addiction

Treatment and Child Custody

Child Custody is an Important Reason For Substance Abuse Treatment Entry Among Women With Children, 1994



44% of female drug treatment clients who have children report they entered substance abuse treatment in order to retain or regain custody of their

[Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration. *National Treatment Improvement Evaluation Study* (retabulations from 1996 study data by CSTAT's National Evaluation Data Services)]

Successful Treatment Programs for Women

- Removed barriers to attendance
 - allowing children
 - transportation
- Addressed children's emotional and behavioral problems
 - therapeutic child care
 - children's social skills training
 - substance abuse education for the children
- Provide parent support services
 - Parenting classes
 - Home visitation
 - Job skills training

Women's Treatment

- Addressing more than substance abuse alone:
 - mental illness
 - domestic violence
 - HIV/AIDS
 - low incomes
 - inadequate or unsafe housing
- Must remove all barriers to successful treatment and recovery
- Recovery will only be successful to the extent that the issues which precipitate it are also ameliorated

Family Drug Courts?

- Offers the client the opportunity to contract with the court to seek treatment instead of potentially losing their child
- Referred through the county's regular judicial system, the department of health or other governmental agency
- One- to two-year process of outpatient treatment and aftercare, culminating with educational, job-training or work programs
- Report to case manager and judge on a regular basis
- Drug tested at least once a week

Motherhood as Incentive

- Motherhood is often the only legitimate social role valued by drug dependent women
- Most women in treatment are very concerned about how their substance abuse had affected their children
- Pregnancy and motherhood are times of increased motivation for treatment

Drug Treatment

- Treatment for methamphetamine addiction is effective
- Important component in order to break the cycle
- You can influence a parent's desire to participate in treatment
- Addiction is not a moral failing but rather a brain disease
- Every child deserves a parent whose abilities are not hampered by substance abuse or addiction

Recovery

Recovery is
a lifetime
journey,
not an
event

Colorado Systems Integration Model for Infants (C-SIMI) Grant

Timeline

- 60 month project with five 12-month budget periods (non-competitive renewal):
 - Year 1 – planning year
 - Years 2-3 – Denver model
 - Years 4-5 – program replication

C-SIMI Primary Objective

To develop and test a new model that integrates best practice approaches from the child welfare, drug treatment, legal and health care systems involved with substance-exposed infants and their families.

C-SIMI Core Components

- Increased identification of substance affected newborns through comprehensive assessment

- Services to substance affected newborns and their families

C-SIMI Outcomes

- Improved birth outcomes as evidenced by full term, healthy neonates and infants

- Assurance of the safety of infants deemed at risk secondary to familial substance use

- Enhanced parent-child relationship

Primary Partners

- Denver Department of Human Services
- Denver Health and Hospital Authority
- Colorado Department of Human Services
 - Child Welfare Division
 - Alcohol and Drug Abuse Division (ADAD)
- Kempe Children's Center
- JFK Partners

Additional Partners

- Colorado Department of Public Health and Environment (CDPHE)
- Colorado Department of Education
- Denver Children's Advocacy Center
- Denver District Attorney's Office
- Denver Police Department
- Courts
- Many others...

Structure

- **Systems Integration Group**
 - Work Groups
 - Identification
 - Assessment
 - Treatment
 - Legal/Public Policy
- **Advisory Board**

C-SIMI Model Program

- **DDHS-based Program**
- **Started April 2007**
- **Family eligibility for C-SIMI Model Program**
 - Newborns thought to be exposed to illegal substances or alcohol in utero
 - Pregnant, substance-using women

C-SIMI Model Program

- **Frequency of C-SIMI Team meetings: weekly**
- **C-SIMI Team**
 - DDHS Intake Supervisor (part-time)
 - C-SIMI hired Intake Worker (full-time)
 - DDHS contributed Intake Worker (full-time)
 - DDHS contributed Ongoing Child Protection Worker (part-time/consultation)
 - Nacshon Zohari - DDHS Substance Abuse Coordinator (consultation)
 - Christina Little - C-SIMI Program Director (consultation)
 - Kathryn Wells - C-SIMI PI and medical consultation

Barriers to Collaboration

- Fear of "flooding": "there are no treatment programs", "we'll get inappropriate referrals"
- Concern about punitive responses: "if we report, removal of child will result"
- Basic lack of information about other agencies' services and policies
- Different missions: child safety, parents' services needs, family stability

Source: Berman, G. (1997). *Child Welfare and the Family: A Handbook of Child Welfare Practice*. New York: Guilford Press.

No One Agency

Issue Demands:

- Comprehensive services
- Provided along a continuum of prevention, intervention and treatment
- At different developmental stages in the life of the child and family

- NO single agency can deliver all of these

Source: Berman, G. (1997). *Child Welfare and the Family: A Handbook of Child Welfare Practice*. New York: Guilford Press.

Needed Partners

- Hospitals
- Private physicians
- Health care management plans
- Maternal and child health
- Children's and adult mental health
- Domestic violence agencies
- Child welfare
- Drug and alcohol prevention, treatment, and aftercare
- Developmental disabilities agencies
- Schools and special education
- Family/dependency courts
- Child care and development
- Employment and family support agencies
- And more...

Source: Berman, G. (1997). *Child Welfare and the Family: A Handbook of Child Welfare Practice*. New York: Guilford Press.

Building a Stronger Continuum of Interventions

- Strengthened partnerships between multiple agencies are key to many of these innovations
- Possible with little or no additional expenditures
- Compromise on a unified plan

**Success is a Journey,
Not a Destination**

Questions?

Thank you!
