TTAC

Perinatal and Early Childhood Mental Health Network

Training and Technical Assistance Center

Supporting Families with Substance Use Disorders During the Perinatal Period: Synthesizing Clinical, Research & Policy Perspectives

June 11, 2025

NYC Health

Photostream

- Share photos taken throughout the day!
- Use our step-and-repeat backdrop in the meal room
- Upload photos using the QR code by the display, on your tables, or projected during breaks

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Logistics

- Speaker Bios & Conference Resources
- Venue details
- Re-entry Protocol
- Recording
- Index Cards
- Meals
- CEs
- Photostream
- Resources
- Surveys

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Welcome Remarks

Evelyn Blanck , LCSW |

Director

P+ECMH Training and Technical Assistance Center

Marnie Davidoff, MPA |

Assistant Commissioner, Bureau of Children, Youth and Families

NYC Department of Health and Mental Hygiene

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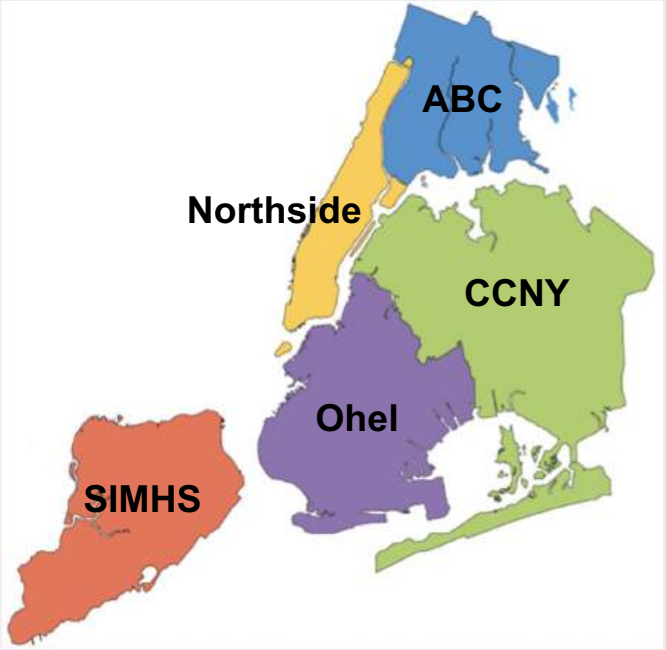
NYC Perinatal and Early Childhood Mental Health Network

Funded by the NYC Department of Health and Mental Hygiene since 2016.

- Specialized clinics offer mental health treatment and family peer support for families with children under 5, and for pregnant and postpartum people. Mental health consultants offer guidance to staff in early childhood and perinatal settings.
- TTAC equips clinicians and professionals across disciplines with knowledge and skills to respond to mental health needs of families they serve.



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TTAC: Who We Are

The New York City Perinatal and Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Department of Health and Mental Hygiene (DOHMH).

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute for Poverty Policy and Research

- **New York Center for Child Development** is a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice

- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

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Goals of TTAC

- Building capacity and competencies of mental health professionals and early childhood professionals in family serving systems to identify and address the social-emotional needs of young children and their families.
    - Healthy social emotional development for infants and toddlers is dependent on the quality and consistency of their relationships with parents and caregivers.
    - To address the mental health needs of infants and young children we need to support the health and mental health of the caregivers

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Training for Perinatal and Early Childhood Professionals across Child Serving Systems

- Have trained over 16,800 individuals as of April 2025
- TTAC offers Evidence Based Training and other intensive training to the 5 Early Childhood Treatment Centers located in each of the 5 Boroughs
- TTAC offers webinars both on foundational perinatal and early childhood mental health as well as cutting edge trainings on key topics in the field
- All our webinars are offered both live virtually with CEUs offered and the webinar and power points are posted on our website

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Visit the TTAC Website

A Variety of Features:

- View upcoming and archived content, trainings, and resources on the **Trainings page.**
- Access videos, slides, and presenter information
- Contact the TTAC team by clicking on **Ask TTAC** and filling out our **Contact Us form**

Explore all the provider resources at ttacny.org

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Today's Objectives

To bring together two essential but often disconnected fields: perinatal and infant mental health and substance use disorder (SUD) treatment. Integrating these areas is critical to effectively supporting families during and after pregnancy.

Designed for perinatal and SUD practitioners, as well as infant and early childhood mental health clinicians, we will explore:

- Types of SUDs and their impact on perinatal care
- Research on the intersection of trauma, parenting, and substance use
- Policies and practices that effectively support families during pregnancy and postpartum

Today's conference will highlight three national experts

Leah Habersham
MD, MBA, MLIS, MSCR, FACOG, FASAM

Amanda Lowell
PhD

Andra Wilkinson
PhD, MSPH

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We will also feature parents with lived experience and a representative from ACS

- **Heather** and **Jalynda** - The Lived Experience: Substance Use Disorders During the Perinatal Period

- **Katherine Haver & Jill Krauss, NYC ACS -** The Evolving Focus of Child Welfare: Supporting Families with Substance Use Disorder in the Perinatal Period

The day will end with a multidisciplinary panel facilitated by TTAC's Clinical Co-Directors **Dr. Gil Foley** and **Dr. Susan Chinitz**.

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The Lived Experience: Substance Use Disorders During the Perinatal Period

Speakers: Heather and Jalynda

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Substance Use and Use Disorders in Pregnancy & Postpartum Periods: Clinical, Ethical, and Systems-Level Approaches for All Providers

Leah L. Habersham MD MBA MS FACOG FASAM
Icahn School of Medicine at Mount Sinai

Director, The Bridge Program

Assistant Professor
Department of Obstetrics, Gynecology, & Reproductive Sciences
Department of Psychiatry

Icahn School of Medicine at Mount Sinai

No disclosures

Icahn School of Medicine at Mount Sinai

Objectives

Identify	Identify current epidemiological trends and disparities in substance use and overdose-related deaths.
Explain	Explain how to screen for and distinguish between substance use and substance use disorders.
Describe	Describe best practices for treatment, care coordination, and the application of trauma-informed and ethically sound care during pregnancy and postpartum.

Personal Motivation

Early experiences

Medical School & Residency

Practice as General OBGYN in rural community settings

Addiction Medicine Fellowship from the perspective of an OBGYN

Habersham, L. L. (2022). An unexpected path to addiction medicine. *American Journal of Obstetrics & Gynecology MFM*, *5*(3).

Epidemiology

General Population

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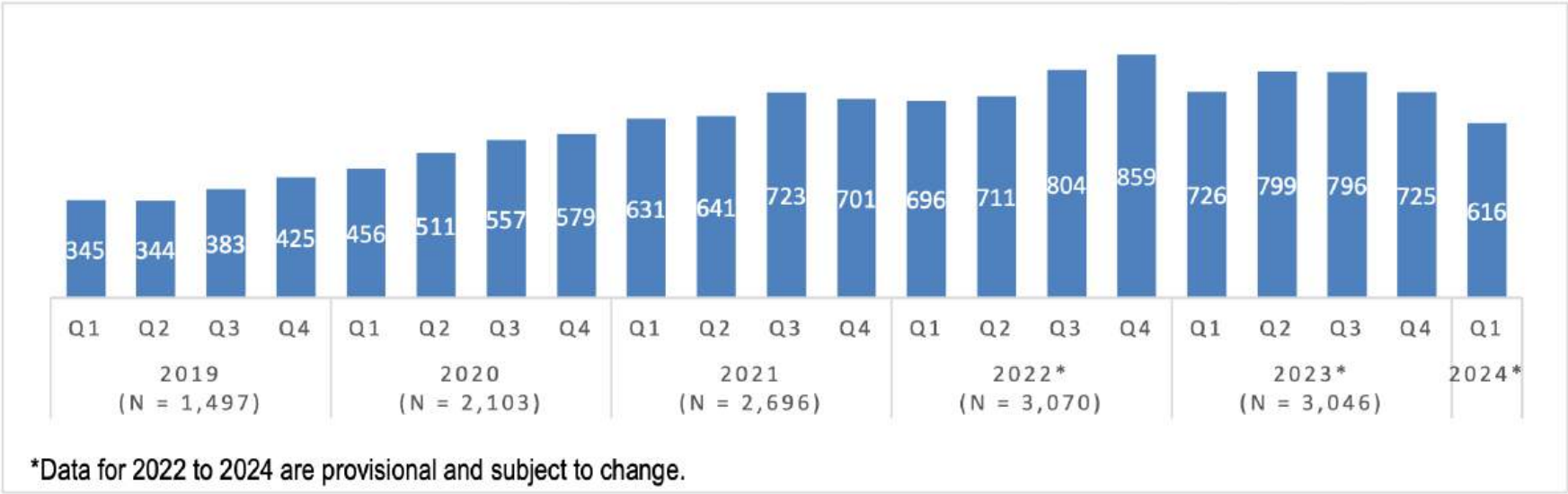
Trends in Overdose in NYC

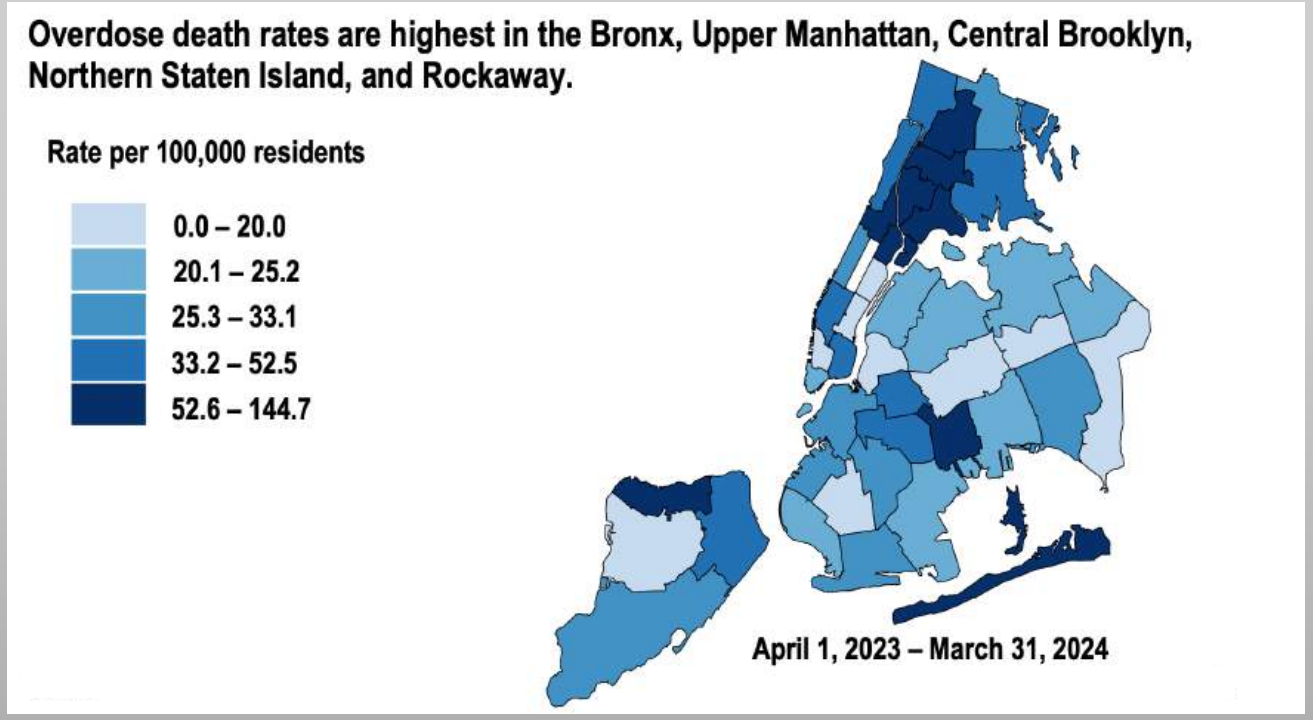
Number of confirmed overdose deaths by quarter, NYC, 2019-2024

Deaths from 2022 to 2024 are still pending final determinations; more recent quarters are subject to larger increases.



*Data for 2022 to 2024 are provisional and subject to change.

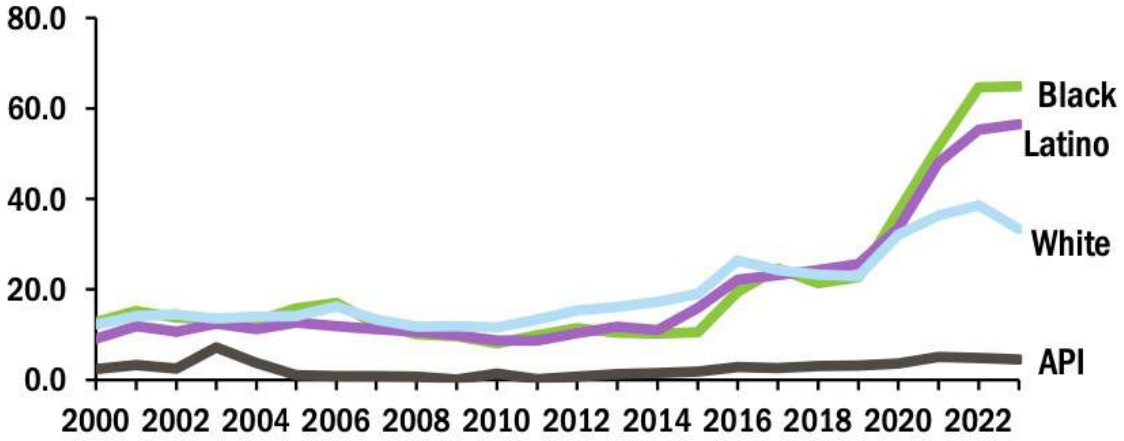
NYC Locations Most Impacted



Rising Racial Disparities in Overdose

In New York City, disparities in overdose death continue to widen among race-ethnicity groups^

Age-adjusted rate per 100,000 residents of unintentional drug poisoning (overdose) deaths, New York City, 2000-2023



^Asian/Pacific Islander (API), Black, and white race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Sources: NYC Office of Chief Medical Examiner and NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2000-2023. 2022 and 2023 data are provisional and subject to change.

Maternal Population

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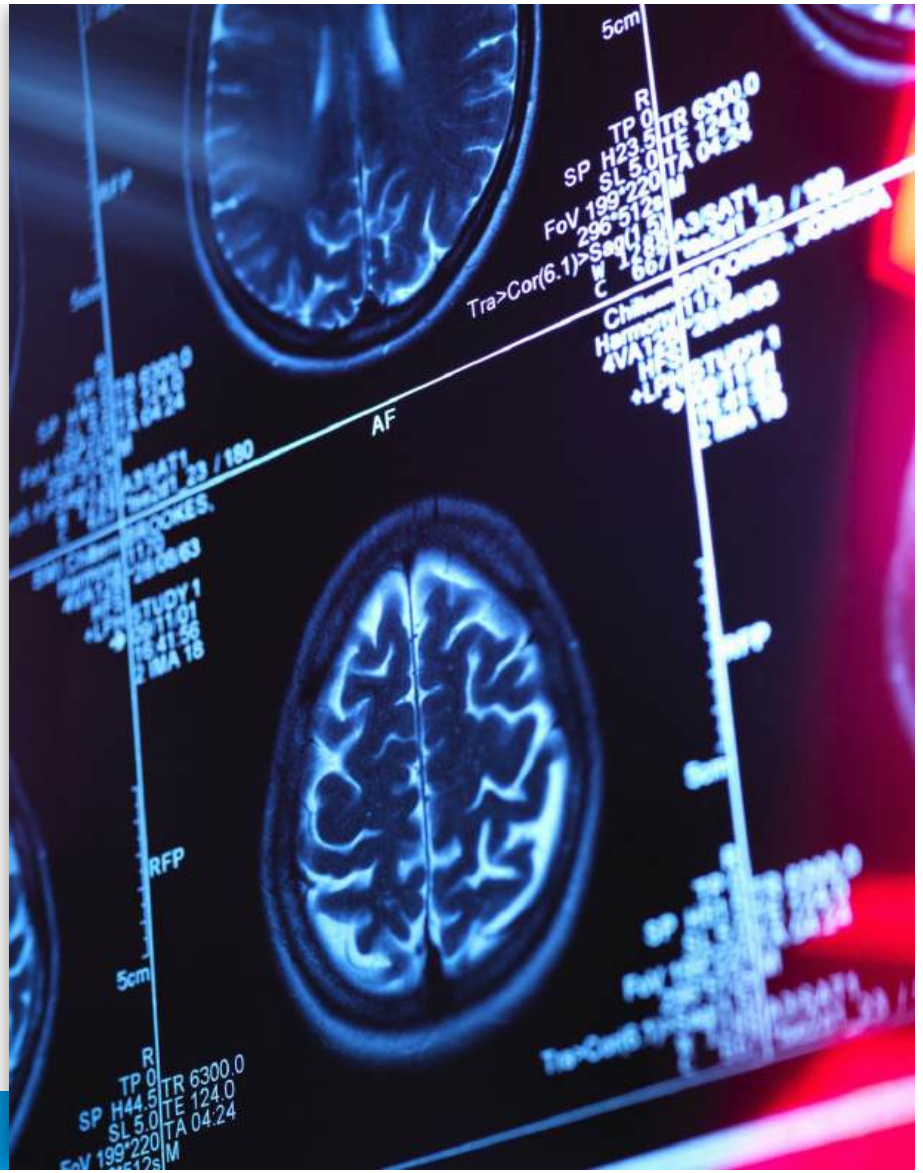
Leading Causes of Pregnancy-Related Death

The leading underlying causes of pregnancy-related death include:

- **Mental health conditions (suicide & overdose) (23%)**
- Excessive bleeding (hemorrhage) (14%)
- Cardiac and coronary conditions (heart) (13%)
- Infection (9%)
- Thrombotic embolism (9%)
- Cardiomyopathy (heart) (9%)
- Hypertensive disorders of pregnancy (high blood pressure) (7%)



https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

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Commissioner

Pregnancy-Associated Mortality in New York City, 2021

September 2024

Table 1. Causes, Timing, Location and Pregnancy Outcomes of Deaths, NYC, 2021

	Pregnancy-associated deaths n (%)	Pregnancy-related deaths n (%)
Total	58 (100.0)	30 (100.0)
Causes of death[a]		
Mental health conditions[b]	21 (36.2)	12 (40.0)
Infection	5 (8.6)	3 (10.0)
COVID-19	5	3
Cancer[c]	5 (8.6)	-
Hemorrhage	4 (6.9)	4 (13.3)
Seizure disorders	3 (5.2)	1 (3.3)
Cardiovascular conditions[d]	2 (3.5)	1 (3.3)
Embolism	2 (3.5)	2 (6.7)
Homicide[e]	2 (3.5)	1 (3.3)
Amniotic fluid embolism	2 (3.5)	2 (6.7)
Blood disorders	2 (3.5)	1 (3.3)
Metabolic or endocrine conditions	2 (3.5)	-
Other[f]	8 (13.8)	3 (10.0)

[b] Among the 21 pregnancy-associated deaths due to mental health conditions, 20 were due to overdose. Sixteen of the 20 overdose deaths involved an opioid.

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Pregnancy-Associated Mortality in New York City, 2021

September 2024

Table 1. Causes, Timing, Location and Pregnancy Outcomes of Deaths, NYC, 2021

	Pregnancy-associated deaths n (%)	Pregnancy-related deaths n (%)
Total	58 (100.0)	30 (100.0)
During pregnancy	12 (20.7)	5 (16.7)
0-1 day after end of pregnancy	7 (12.1)	6 (20.0)
2-6 days after end of pregnancy	2 (3.5)	2 (6.7)
7-42 days after end of pregnancy	8 (13.8)	4 (13.3)
43 days-1 year after end of pregnancy	29 (50.0)	13 (43.3)

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PREGNANCY-ASSOCIATED MORTALITY IN NEW YORK CITY, 2019

January 2023

Leading cause of death among **Black and Latina women is mental health conditions**

Table 2. Characteristics of pregnancy-associated deaths, New York City, 2019

Characteristic	Pregnancy-associated deaths n (%)	Pregnancy-related deaths n (%)
Total	**57 (100.0)**	**28 (100.0)**
Race/ethnicity[8]		
Black non-Latina	26 (45.6)	13 (46.4)
White non-Latina	11 (19.3)	6 (21.4)
Latina	20 (35.1)	9 (32.1)
Borough of residence		
Brooklyn	20 (35.1)	9 (32.1)
Bronx	12 (21.1)	7 (25.0)
Queens	12 (21.1)	6 (21.4)
Manhattan	6 (10.5)	4 (14.3)
Staten Island	4 (7.0)	1 (3.6)
Rest of State	3 (5.3)	1 (3.6)

National Overdose Deaths: During Pregnancy and Postpartum

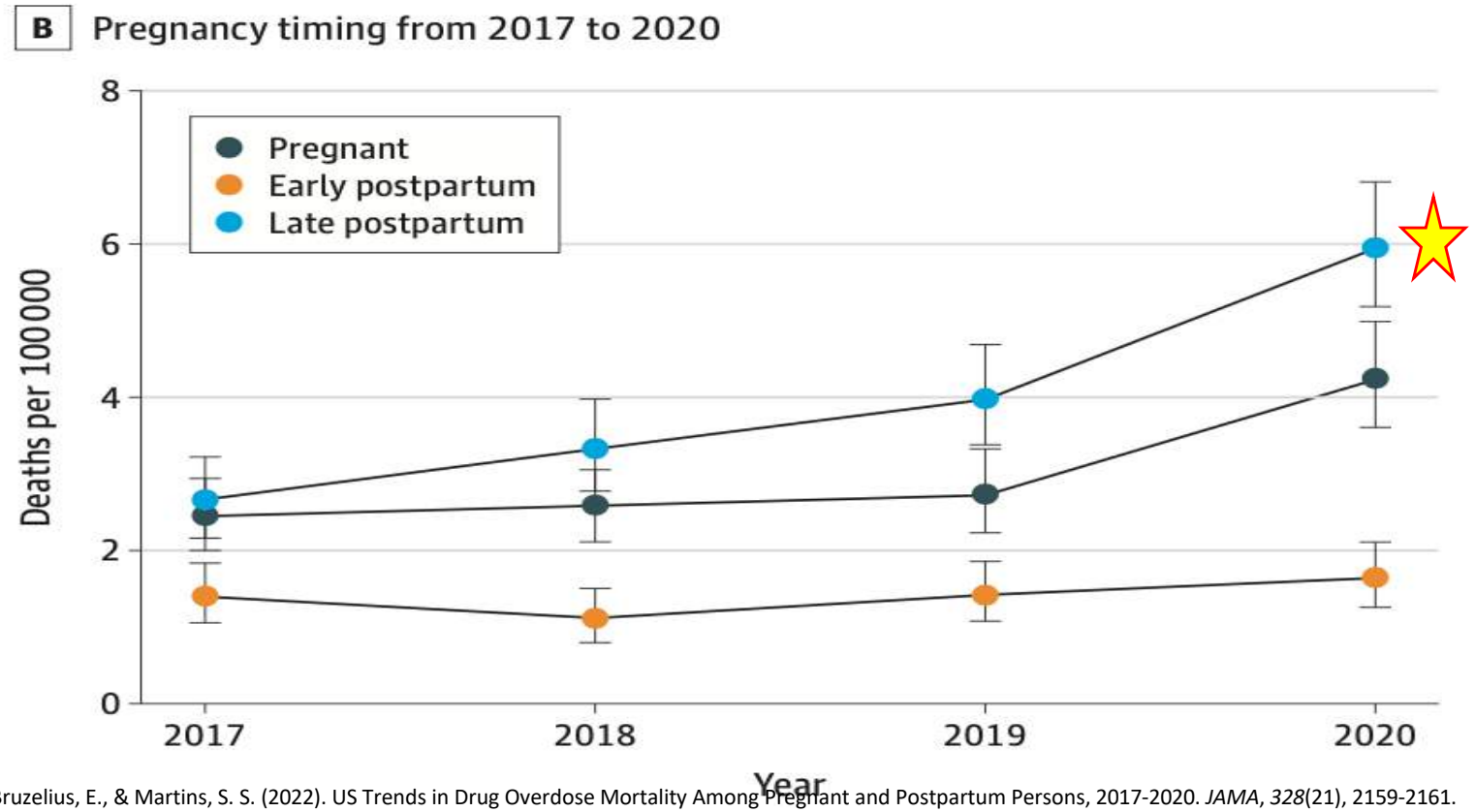
Han, Beth, et al. "Pregnancy and Postpartum Drug Overdose Deaths in the US Before and During the COVID-19 Pandemic." *JAMA psychiatry* (2023).

Table 1. Pregnancy-Associated Mortality Ratios and Average Semiannual Percentage Changes (ASPC) Among Women Aged 10 to 44 Years Who Died From a Drug Overdose, 2018-2021

	Mortality ratio per 100 000 mothers with a live birth (95% CI)									
	2018		2019		2020		2021			
Characteristic	January-June	July-December	January-June	July-December	January-June	July-December	January-June	July-December	ASPC (95% CI)	*P* value
35-44	4.9 (3.0-8.0)	7.8 (5.4-11.4)	8.9 (6.2-12.8)	12.5 (9.3-16.8)	14.2 (10.7-18.9)	12.9 (9.6-17.3)	14.2 (10.7-18.8)	15.8 (12.3-20.4)	15.9 (8.7-23.6)	<.001
Race and ethnicity[d]										
Non-Hispanic American Indian or Alaska Native	31.7 (20.1-50.1)				49.8 (34.0-73.0)				18.1 (−6.0 to 42.2)[a]	.14
Non-Hispanic Black	4.6 (2.6-8.0)	4.0 (2.2-7.1)	4.3 (2.4-7.7)	10.7 (7.5-15.3)	13.8 (9.9-19.2)	17.4 (13.1-23.3)	19.5 (14.7-26.0)	10.2 (7.0-14.8)	21.6 (2.0-44.8)	.03
Hispanic	2.9 (1.6-5.0)	1.5 (0.7-3.2)	2.4 (1.3-4.4)	2.4 (1.3-4.3)	4.1 (2.6-6.6)	3.2 (1.9-5.3)	6.2 (4.2-9.1)	4.7 (3.1-7.1)	14.6 (3.0-27.6)	.02
Non-Hispanic multiple races	7.5 (5.1-11.1)								NA	NA
Non-Hispanic White	10.3 (8.4-12.6)	11.1 (9.2-13.4)	12.0 (9.9-14.4)	11.2 (9.2-13.5)	16.7 (14.2-19.6)	15.9 (13.6-18.8)	17.0 (14.5-19.9)	17.7 (15.2-20.5)	8.8 (5.0-12.8)	.001

ASPC is the rate at which the mortality ratio changes on average over a six-month period

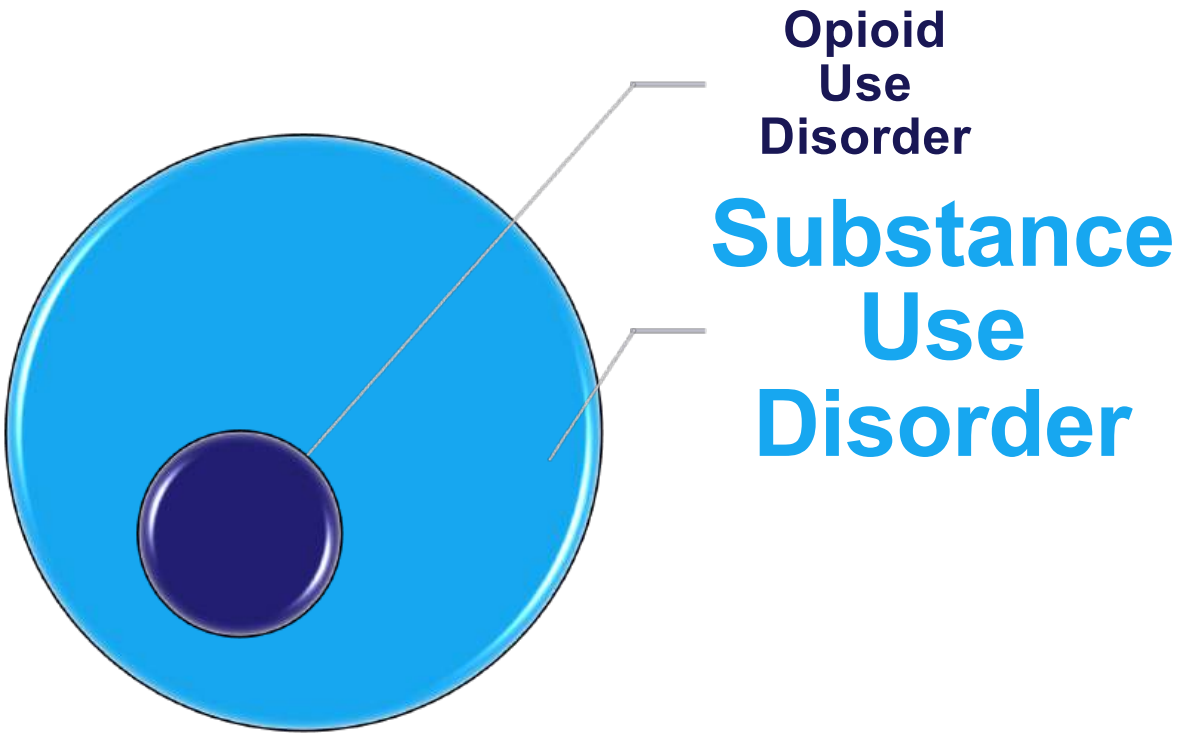
Overdose Deaths—National: During Pregnancy and Postpartum



Bruzelius, E., & Martins, S. S. (2022). US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. *JAMA*, *328*(21), 2159-2161.

Identifying Substance Use and Substance Use Disorders

SUD vs OUD



About 15% of SUDs are OUD in those 12+

Case Presentation

Case Presentation

- Ms. MD was a 28-year-old female, who initiated prenatal care in the 2nd trimester.
- No medical problems, no significant social history
- Labs all normal, including routine UTox which all our patients received.
- Pregnancy was progressing normally.

Case Presentation

- At 32 weeks GA, patient tearfully stated, “I need to tell you something”:
- Had a h/o addiction to prescribed opioids
- Detoxed herself using high doses of loperamide
  - “Poor Man’s Methadone”
- Continued with her use of loperamide, taking 300-400mg daily
- Weaned herself down to 150-200mg daily

Background

- Loperamide “poor man’s methadone” – ease of access and low cost
- FDA approved for up to 8mg daily OTC, or 16mg daily for Rx
- For those misusing – 70-200mg daily – crossing blood-brain-barrier and affect CNS opioid receptors

American Journal of Emergency Medicine 38 (2020) 693.e5–693.e6

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Case Report

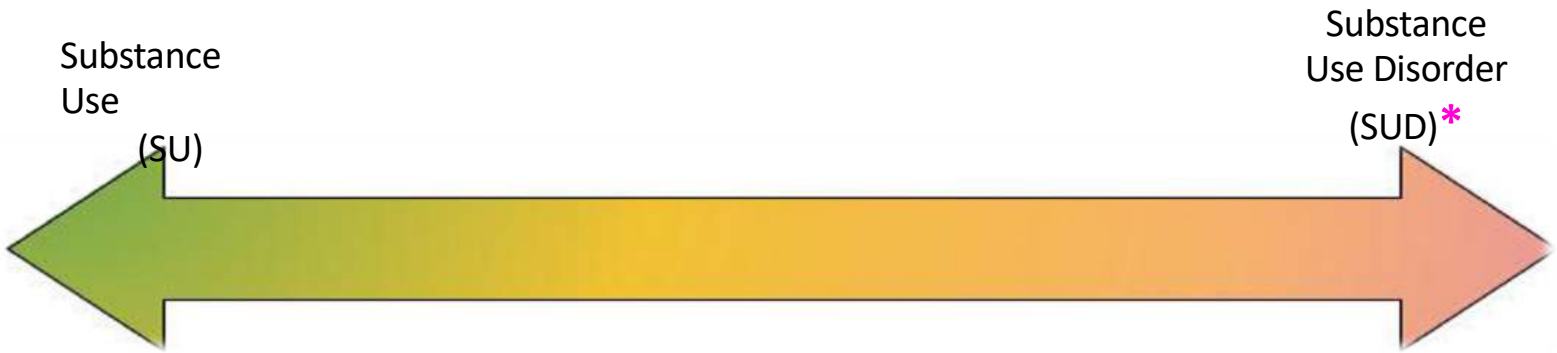
Loperamide toxicity mimicking peripartum cardiomyopathy

Anderson Wang [a,*], Michael Nguyen [a], Jesus Diaz, M.D [c], Travis Smith, D.O [a,b]

[a] Lake Erie College of Osteopathic Medicine, 5000 Lakewood Ranch Blvd, Bradenton, FL 34211, USA
[b] St. Vincent's Medical Center Southside Emergency Department, 4201 Belfort Rd, Jacksonville, FL 32216, USA
[c] St. Vincent's Medical Center Southside Critical Care Unit, 4201 Belfort Rd, Jacksonville, FL 32216, USA

Substance Use is a Part of the Human Experience

Substance Use Lies on a Continuum



Savage, C. L. (2016). Substance Use and Substance Abuse—What's in a Name?. *Journal of Addictions Nursing, 27* (1), 47-50. doi: 10.1097/JAN.0000000000000111.

How do we identify SUD?

Screen Everyone

USPTF, ACOG, and SMFM all endorse **screening** all pregnant and postpartum people for substance use (SU)/ SUD

When SU or SUD is identified we need to provide counseling/ education (**intervention**)

Depending on the level of the problem – **treatment** may be warranted

Icahn School of Medicine at Mount Sinai

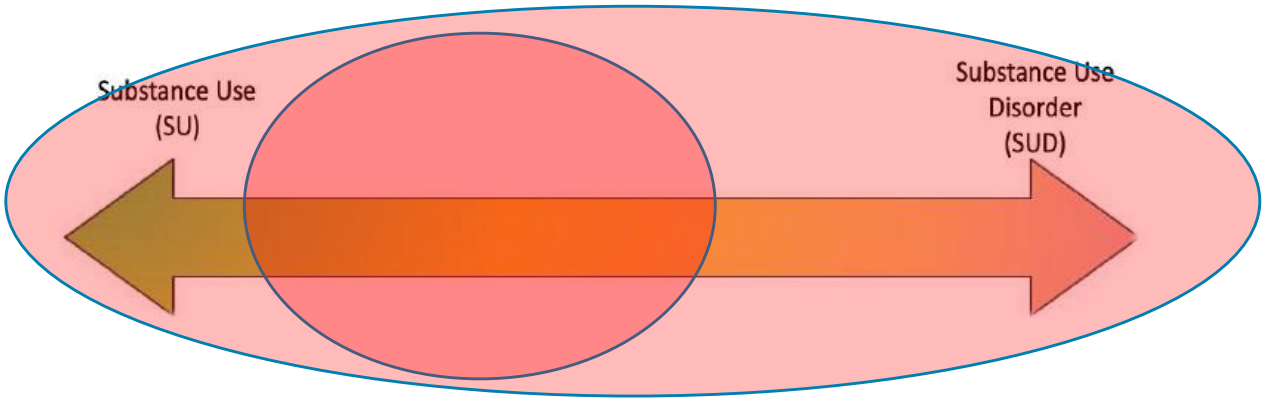
Standard of Care for SUDs

Identifying SU vs SUD

How do we distinguish substance use vs SUD?

Toxicology Test

Screening Tool



Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., ... & Yonkers, K. A. (2019). Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology*, *221*(1), B5-B28.

What is Utility of Toxicology Testing?

Utility..

Patient presents obtunded/ altered mental status

Patient used substances, needs anesthesia, and unsure of what's really in their system

- Anesthetic of choice interacts with some commonly misused substances

Toxicology Testing in Prenatal Setting

Biologic testing not recommended by ACOG/ SMFM as screening method.

While there is a place for biologic testing in certain situations, it shouldn't be the only means of identifying substance use or SUD

False-positive results are not uncommon, with potentially devastating consequences

Committee on Obstetric Practice. (2017). Committee opinion no. 711: opioid use and opioid use disorder in pregnancy. *Obstetrics and gynecology*, *130*(2), e81-e94.
Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., ... & Yonkers, K. A. (2019). Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology*, *221*(1), B5-B28.

Window of Detection by Substance

https://www.bccsu.ca/wp-content/uploads/2022/06/Detection-Time-of-Substances-Urine.pdf

Detection Time of Substances in Urine

Substance	Detection time in urine
ALCOHOL	
Methadone	≤3 days
EDDP (methadone metabolite)	≤6 days[3]
TETRAHYDROCANNABINOL	
Single use	1–3 days[1]
Chronic use	≤30 days[3]

ELSEVIER

AJOG Global Reports
Volume 4, Issue 2, May 2024, 100313

Original Research

Prolonged detection of urine norfentanyl in individuals enrolled in a medication for opioid use disorder in pregnancy and postpartum program: a case series

Miranda K. Kiefer DO [1], Jamie Cowen BA [2], Katherine A. Hinely RN [1], Kara M. Rood MD [1], Jessica R. Gray MD [1], Davida M. Schiff MD [1], Sarah N. Bernstein MD [1]

NYS Law

There is no specific NYS Public Health Law or regulation that governs toxicology testing for pregnant people and/or their newborns.

"With the exception of emergency situations, a patient would need to give informed consent (meaning the risks, benefits, etc. are explained to the patient) prior to procedures/testing and that ***consent must be documented*** *in the patient's medical record."*

Public Health Law 2805-d, as well as 10 NYCRR 405.7(b)(9)

Addressing Related Inequities


What is the Harm of Toxicology Testing?

Fear

Inequities Exist in Toxicology Testing & Child Protective Services Reporting

Equal use of substances among White and Black pregnant women: 15.4% and 14.1%

Inequities of Substance Use **Testing**

- Black and Hispanic women are 4.3 and 5.8 times more likely to undergo toxicology testing

Black women are 10x more likely than White women to be **reported** to child protective services (**CPS**).

Chasnoff, I. J., Landress, H. J., & Barrett, M. E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *The New England journal of medicine*, *322*(17), 1202–1206. https://doi.org/10.1056/NEJM199004263221706

Perlman NC, Cantonwine DE, Smith NA. Toxicology Testing in Pregnancy: Evaluating the Role of Social Profiling. Obstet Gynecol. 2020 Sep;136(3):607-609. doi: 10.1097/AOG.0000000000003986. PMID: 32769654.

Disparities of SUD Treatment in Pregnancy

There are no significant differences of race/ethnicity amongst pregnant who have SUDs

Pregnant women of color are *less likely to receive treatment for SUDs* compared with White

Black and Hispanic pregnant *less likely to complete SUD treatment* compared with White

Salameh, T. N., Hall, L. A., Crawford, T. N., Staten, R. R., & Hall, M. T. (2019). Racial/ethnic differences in mental health treatment among a national sample of pregnant women with mental health and/or substance use disorders in the United States. *Journal of psychosomatic research*, *121*, 74-80.

Suntai, Z. (2021). Substance use among women who are pregnant: Examining treatment completion by race and ethnicity. *Journal of Substance Abuse Treatment*, *131*, 108437.

Schiff, D. M., Nielsen, T., Hoeppner, B. B., Terplan, M., Hansen, H., Bernson, D., ... & Taveras, E. M. (2020). Assessment of racial and ethnic disparities in the use of medication to treat opioid use disorder among pregnant women in Massachusetts. *JAMA Network Open*, *3*(5), e205734-e205734.

Punitive approaches drive patients away

Toxicology testing tied to CPS reporting creates fear.

Fear leads to avoidance of prenatal care and silence about substance use.

Austin, A. E., Naumann, R. B., & Simmons, E. (2022). Association of state child abuse policies and mandated reporting policies with prenatal and postpartum care among women who engaged in substance use during pregnancy. *JAMA Pediatrics, 176*(11), 1123–1130. https://doi.org/10.1001/jamapediatrics.2022.3159

American Academy of Pediatrics. (2017). A public health response to opioid use in pregnancy. *Pediatrics, 139*(3), e20164070. https://doi.org/10.1542/peds.2016-4070b

Roberts, S. C. M., & Pies, C. (2011). Complex calculations: How drug use during pregnancy becomes a barrier to prenatal care. *Maternal and Child Health Journal, 15*(3), 333–341. https://doi.org/10.1007/s10995-010-0594-7

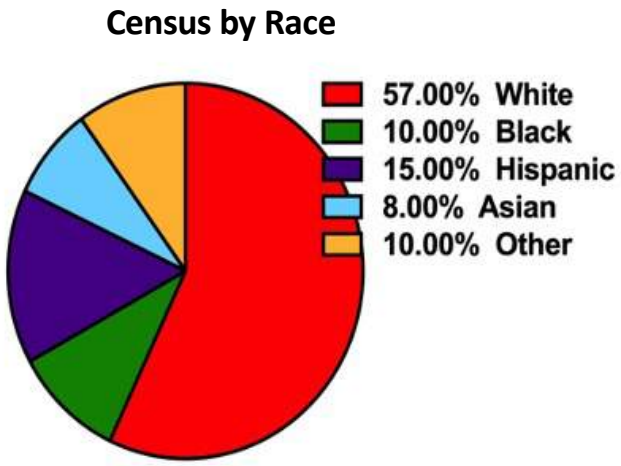
Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice, 3*, 2. https://doi.org/10.1186/s40352-015-0015-5

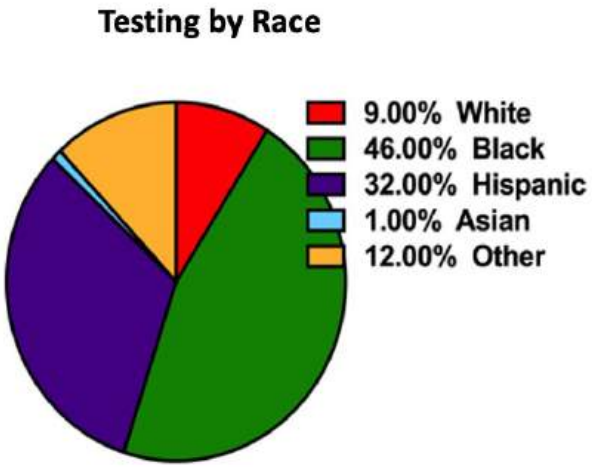
"A positive toxicology result for a parent or a newborn, by itself, does not constitute reasonable suspicion of child abuse or maltreatment, and thus does not necessitate a report to the SCR.

The mother should be screened for substance use disorder and, if a substance use disorder is identified, a Plan of Safe Care should be developed and monitored by the medical provider or healthcare team."

ACS | DOHMH Joint Guidance, issued November 12, 2020

Inequities in Toxicology Testing



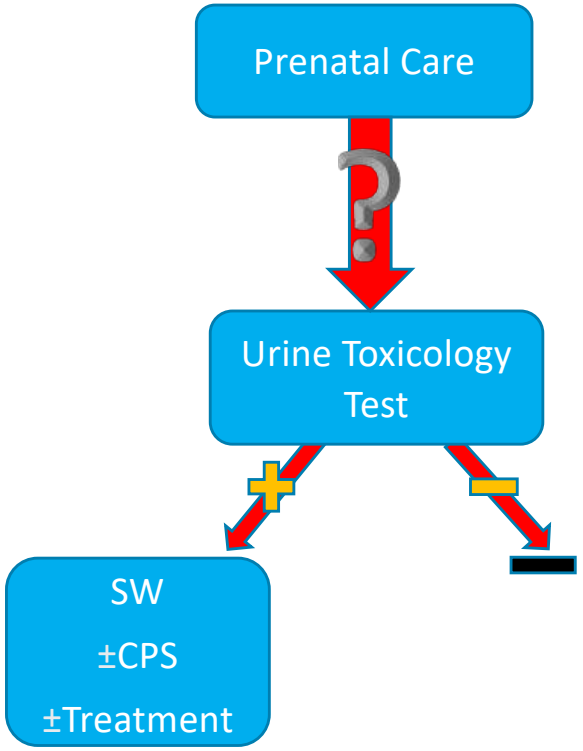


Inequities in Toxicology Testing

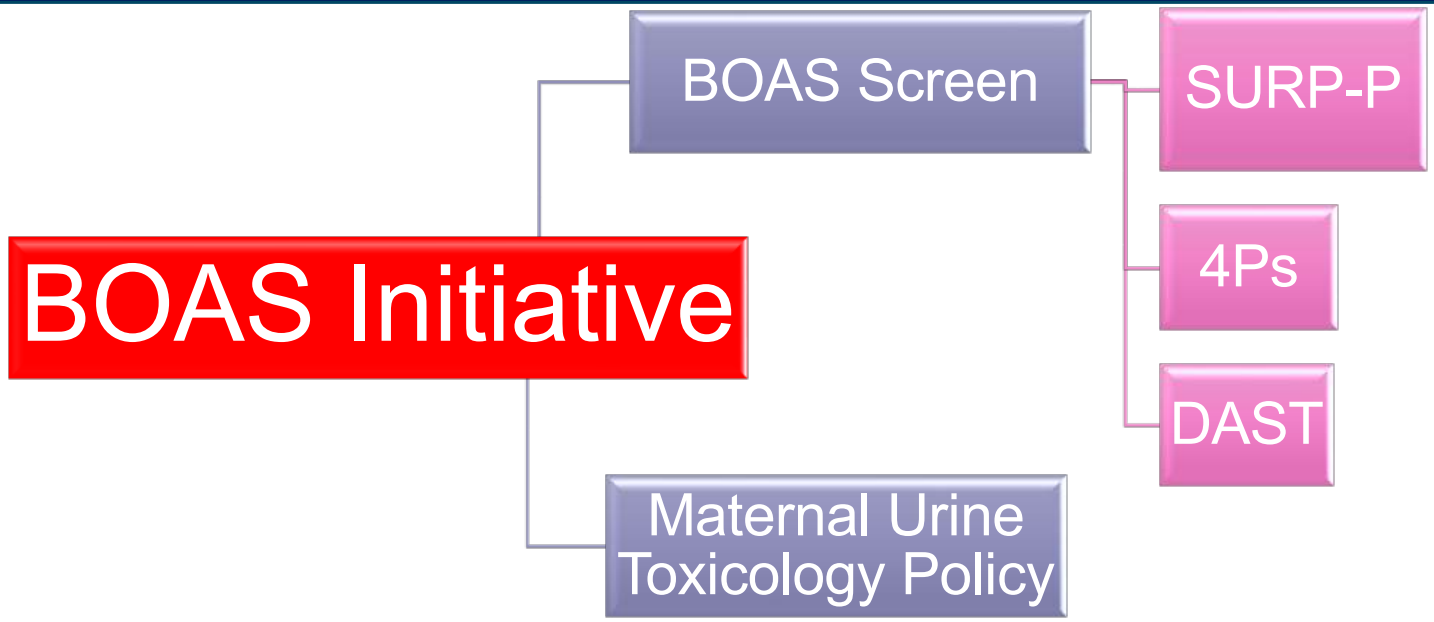
	Unadjusted Model		Adjusted Model	
	Odds Ratio (OR)	95% Confidence Interval	Odds Ratio (OR)	95% Confidence Interval
Testing Allocation				
Black	**32.72**	23.72, 45.13	**4.28**	2.91, 6.29
Hispanic	**14.68**	10.54, 20.45	**1.98**	1.34, 2.94
Other	**7.37**	5.0, 10.87	**2.38**	1.55, 3.64
White	Reference	Reference	Reference	Reference

Habersham et al. *American Journal of Obstetrics & Gynecology.*

Substance Use & Use Disorder Identification Workflow

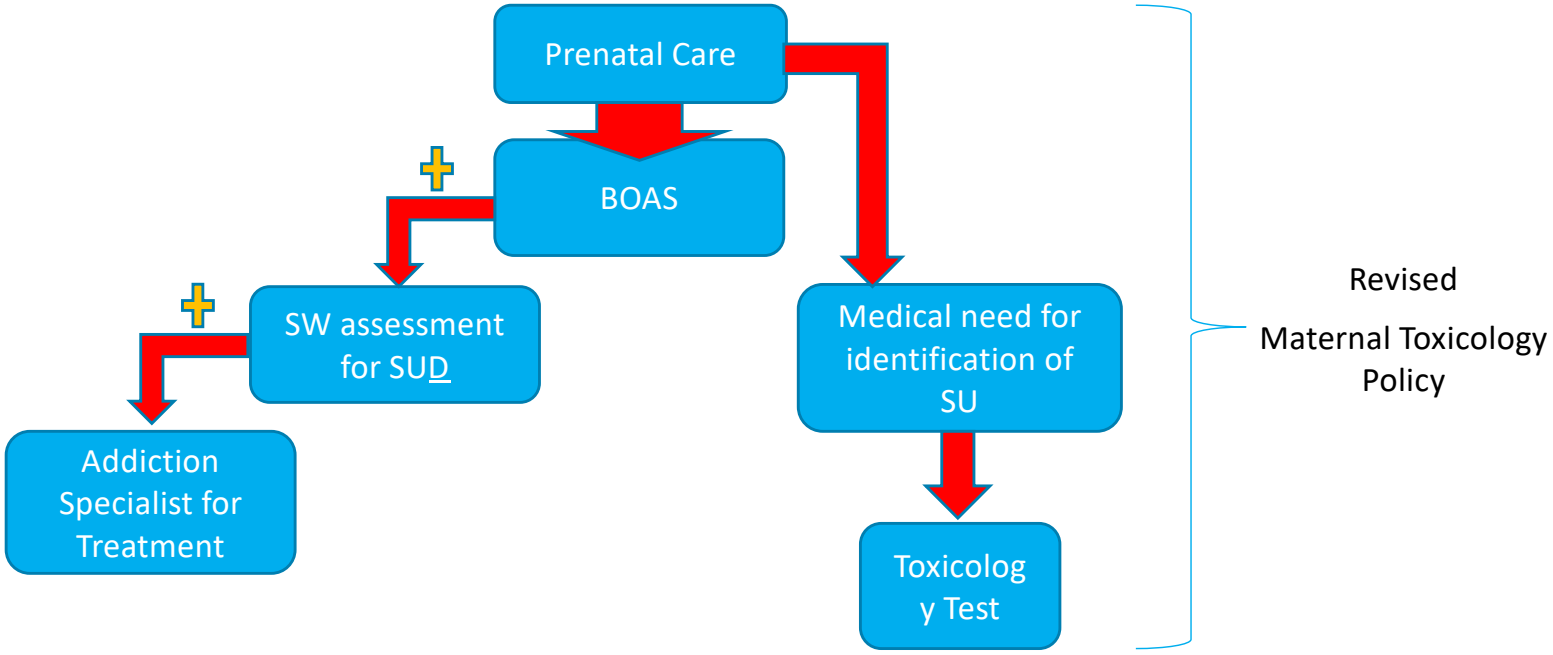


BOAS Initiative



SURP-P: Substance Use Risk Profile—Pregnancy
4Ps: *Parents, Partner, Past, Pregnancy*
DAST: Drug Abuse Screening Test

BOAS Workflow



Post-Intervention

	Unadjusted Model		Adjusted Model	
Post-Intervention				
Testing Allocation				
Black	**5.87**	3.28, 10.51	1.01	0.49, 2.08
Hispanic	**4.18**	2.37, 7.38	0.78	0.38, 1.59
Other	2.1	0.89, 4.96	0.69	0.27, 1.75
White	Reference	Reference	Reference	Reference
Positive Test Result				
Black	1.36	0.42, 4.40	1.6	0.40, 6.37
Hispanic	0.9	0.29, 2.82	1.42	0.37, 5.43
Other	0.36	0.06, 2.31	0.54	0.06, 5.33
White	Reference	Reference	Reference	Reference

Habersham LL, Bianco AT, Kudrich CJ, et al. An Institutional Intervention on Toxicology Testing Reduces Inequities During the Birthing Hospitalization. *Am J Obstet Gynecol*. Published online December 7, 2023. doi:10.1016/j.ajog.2023.11.1254

Best Practices for Managing SUDs Among Maternal Populations

Supportive, Trauma-Informed Care Builds Engagement

Replace automatic testing and reporting with:

- Universal, **nonjudgmental screening**
- Brief **intervention** rooted in empathy
- **Referral to treatment** via a warm handoff
- A **trauma-informed approach** that prioritizes safety, trust, and choice

When care feels safe, patients show up — and stay engaged in both prenatal care and substance use treatment.

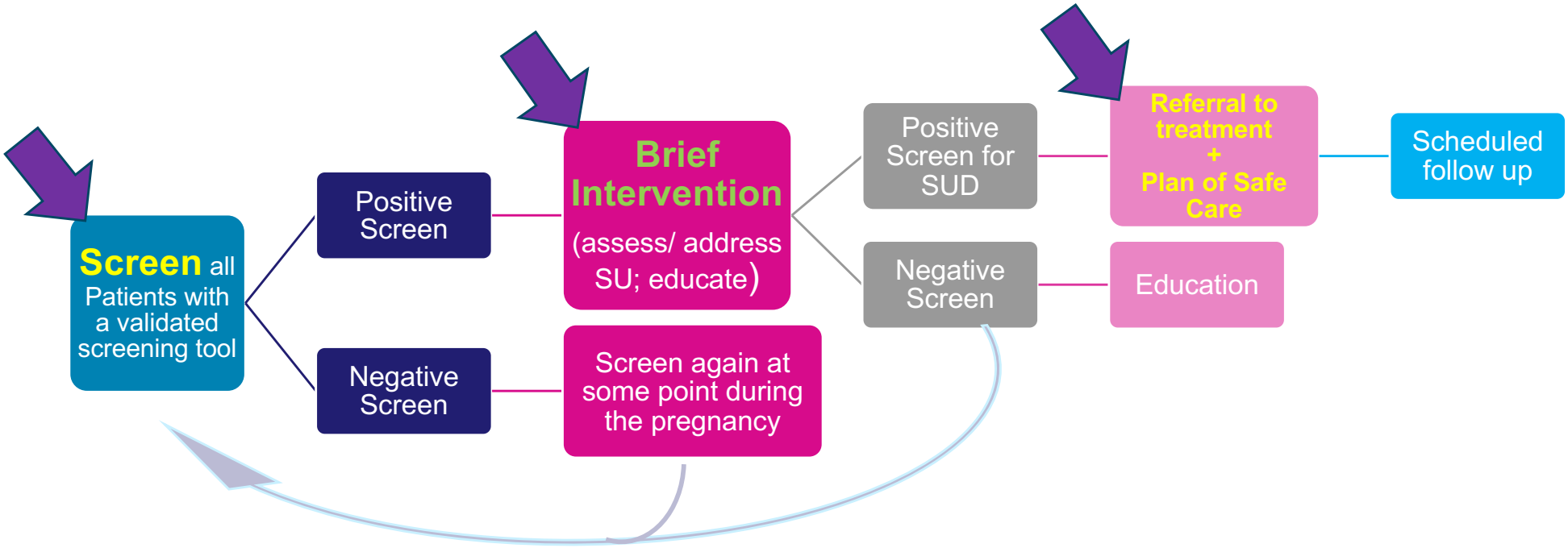
Casey Family Programs. (2023, August 3). *How can prenatal substance use be addressed more effectively through prevention?* https://www.casey.org/prenatal-substance-exposure-prevention/

Morton Ninomiya, M. E., Varcoe, C., Firestone, M., Wells, S., & Poole, N. (2023). Supporting pregnant and parenting women who use alcohol during pregnancy: A scoping review of trauma-informed approaches. *Women's Health, 19*, 1–19. https://doi.org/10.1177/17455057221147459

Center for Health Care Strategies. (2024, January). *Building healthy futures: Addressing mental health and substance use disorders during pregnancy and postpartum.* https://www.chcs.org/media/Building-Health-Futures_Addressing-Mental-Health-and-Substance-Use-Disorders-During-Pregnancy-and-Postpartum.pdf

Casey Family Programs. (2023, March 20). *What are Plans of Safe Care and how do they support infants and families?* https://www.casey.org/infant-plans-of-safe-care/

Sample Workflow



Based upon findings from: Habersham, Leah L., et al. "Content Analysis of Maternal Toxicology Testing Policies to Inform Equity in Substance Use Disorder Identification." *Maternal and Child Health Journal*(2025): 1-9.

What is SBIRT?

Process of carrying out **screening** for substance use (SU)* or substance use disorder (SUD), providing an early **intervention** through counseling on the impact of substance use, and offering **referral** to **treatment**

Screening → **B**rief **I**ntervention → **R**eferral to **T**reatment

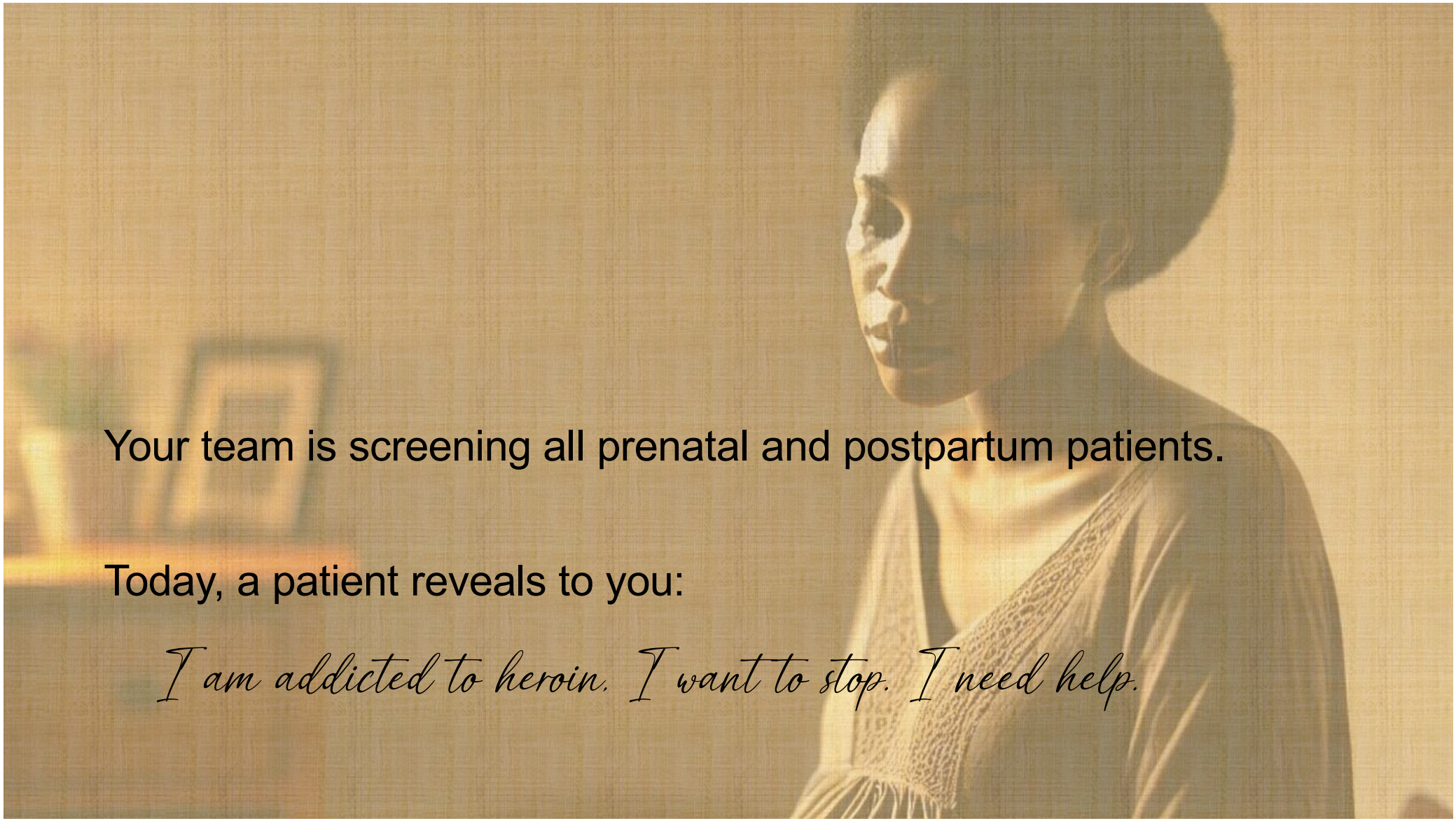
Wright, Tricia E., et al. "The role of screening, brief intervention, and referral to treatment in the perinatal period." *American journal of obstetrics and gynecology* 215.5 (2016): 539-547.

Reimbursement for SBIRT

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes	$48.00

https://www.samhsa.gov/sbirt/coding-reimbursement

Updated as of 4/17/2024


Your team is screening all prenatal and postpartum patients.
Today, a patient reveals to you:
I am addicted to heroin. I want to stop. I need help.


Now What?

Trauma-Informed Care Is…

More Than a Buzzword

A Clinical Skill, Not Just a Concept
Trauma-informed care (TIC) requires presence, practice, and precision—not just good intentions.

Why It Matters
Patients with histories of trauma—such as substance use*—often fear that honesty could lead to surveillance or punishment.

The Goal
Create a care environment where patients feel safe enough to share their truth without fear of harm.

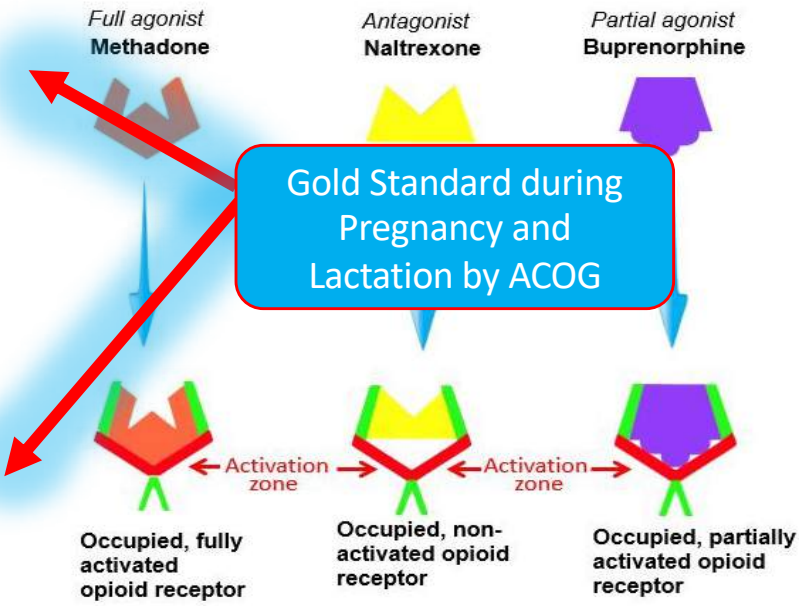
Core Principle
Trust is earned through behavior, not promised with words.

Trauma-Informed Care in Action

1. Preempt Fear with Transparency
2. Acknowledge the Lived Reality
3. Create Space for Silence
4. Ask for Permission
5. Reflect Strengths, Not Just Risks
6. Center the Patient's Priorities

Medications for OUD (MOUD)

Agonist	• **Methadone** • Full agonist of Mu, Delta, Kappa
Antagonist	• Naltrexone • Antagonist at Mu, Delta, Kappa
Partial Agonist	• **Buprenorphine** • Mu partial agonist, Kappa/ Delta antagonist



Soyka, M. (2021). Transition from full mu opioid agonists to buprenorphine in opioid dependent patients—A critical review. *Frontiers in Pharmacology*, 2901

Levels of Addiction Care

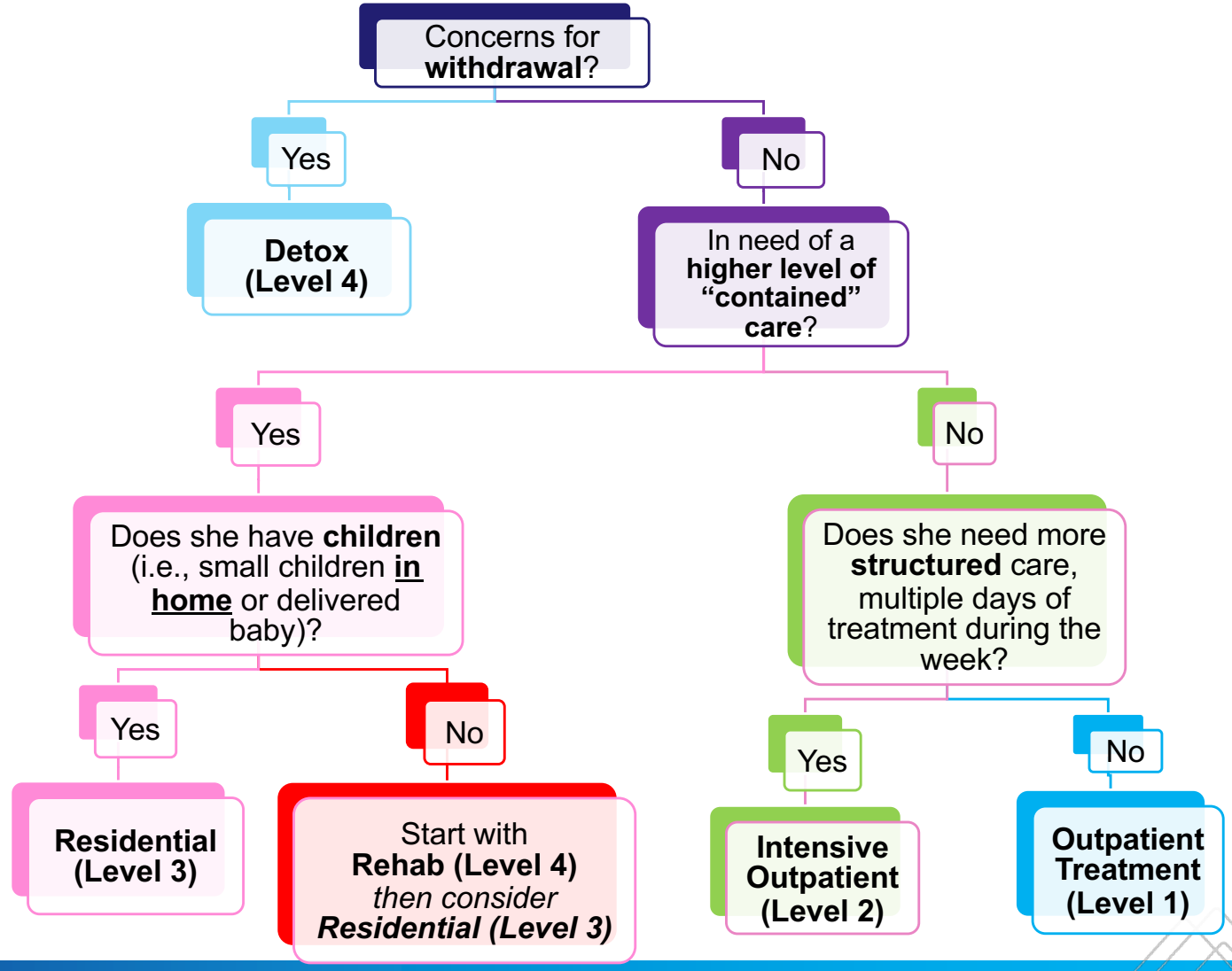
Detox/Rehab

Residential

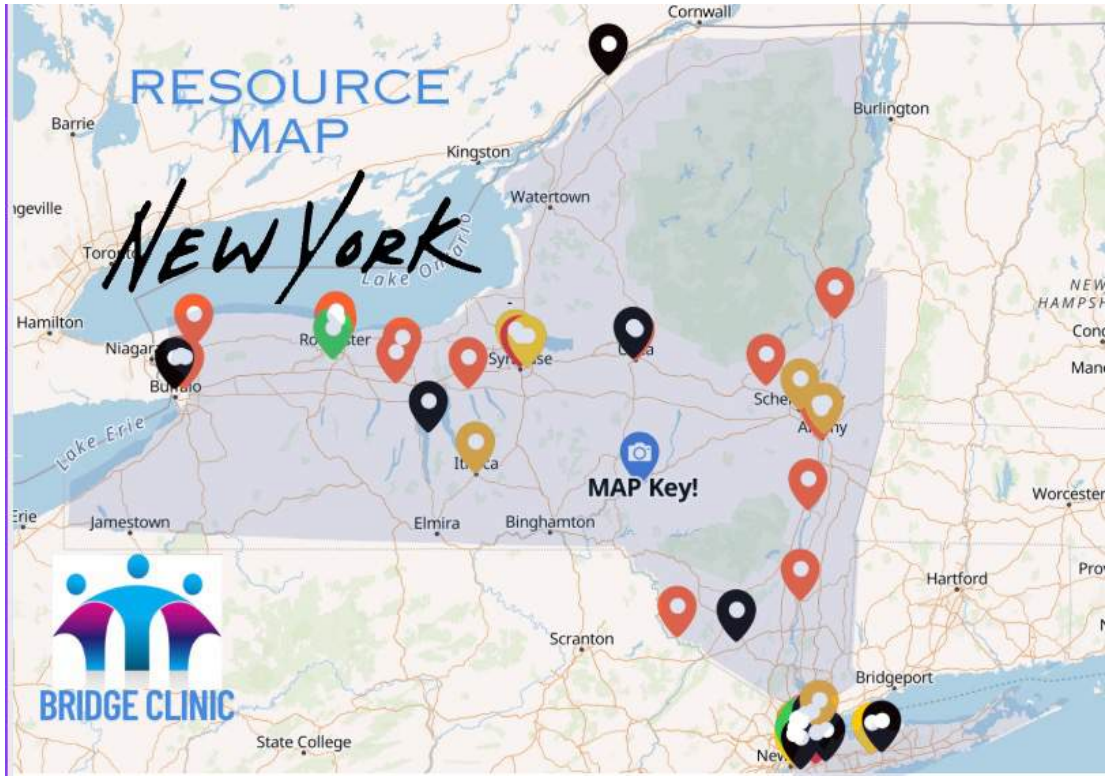
Intensive Outpatient

Outpatient

Maternal Patient With SUD: Decision Tree



NYS Resources



RESOURCE MAP

Adjuncts to Medical Treatment

Behavioral therapy (BT) in the context of addiction treatment is an important and useful adjunct to medication therapy

Group therapy

Individual therapy

Approaches: Motivational interviewing, Mindfulness, Cognitive Behavioral Therapy (CBT)

Case Management

Case management programs provide linkage to various aspects of care – culminating in more holistic care that practices are often unable to address

Assess and *Address* the social issues, medical issues, and addiction issues with ongoing follow up

Utilizing the Plan of Safe Care

Continued follow up is important – linking patients to treatment is not the end

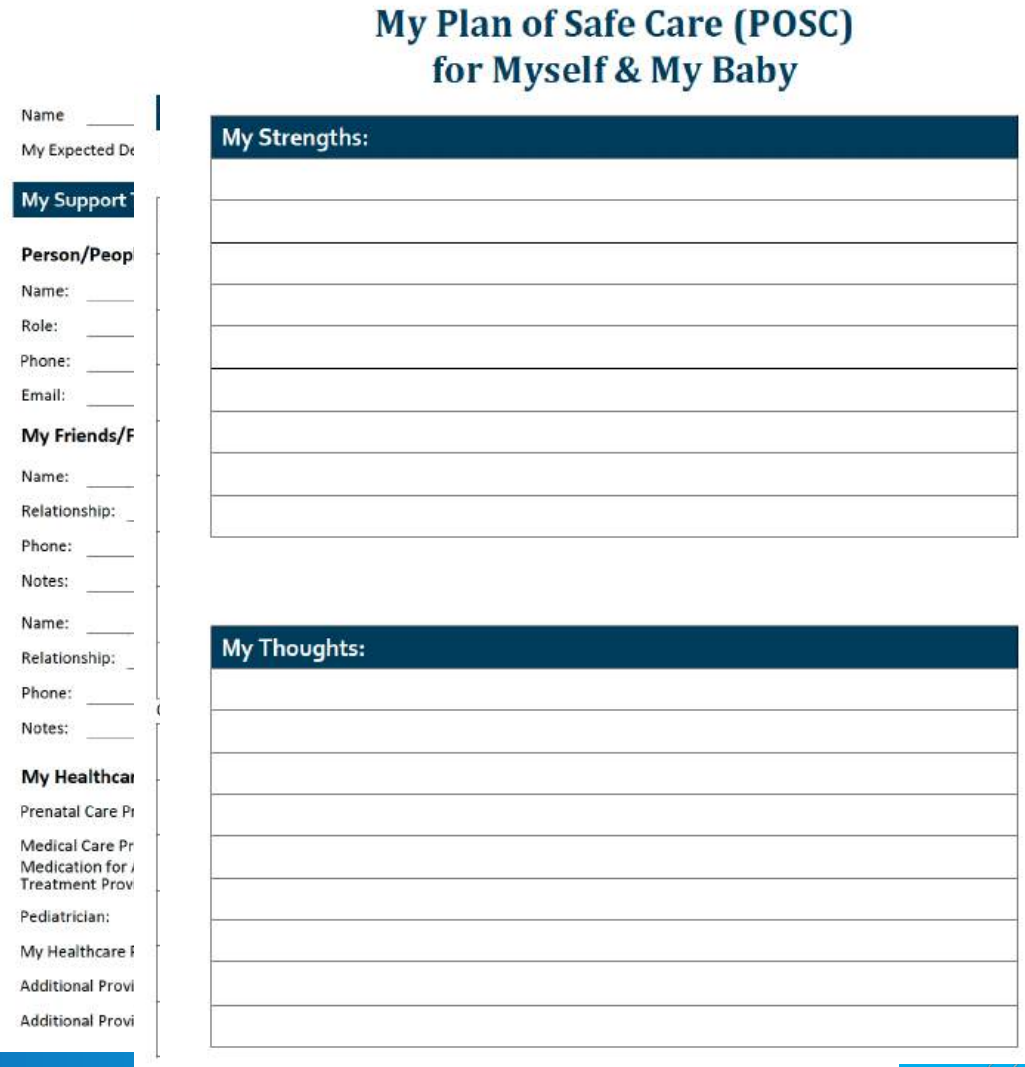
Care coordination is key to maintaining health

POSC is a great way to keep the team informed of complexities and details of each dyad's care: monitors care of both infant and mother

Federally mandated (CAPTA/**CARA**)

Should be included in care plan during prenatal/postpartum care or at least during birthing hospitalization

Plan of Safe Care



My Plan of Safe Care (POSC)
for Myself & My Baby

Name
My Expected De
My Support
Person/Peop
Name:
Role:
Phone:
Email:
My Friends/F
Name:
Relationship:
Phone:
Notes:
Name:
Relationship:
Phone:
Notes:
My Healthcar
Prenatal Care Pr
Medical Care Pr
Medication for
Treatment Prov
Pediatrician:
My Healthcare F
Additional Provi
Additional Provi

My Strengths:

My Thoughts:

NYS Guidance for POSC Initiation During Prenatal Period

Prenatal Period

Who can develop a POSC in collaboration with a pregnant person?

- Case Manager
- Community Health Worker (CHW)
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC)
- Discharge Planner
- Doula
- Family Member/Friend/Support Person
- Home Visitor
- Licensed Mental Health Provider
- Midwife
- Ob/Gyn
- Opioid Treatment Provider
- Primary Care Provider
- Social Worker
- Substance Use Provider

Who should have a POSC?

Pregnant individuals who:

- are diagnosed with a substance use disorder **OR**
- are receiving medication for addiction treatment (MAT) for a substance use disorder **OR**
- are under the care and supervision of a healthcare provider who has prescribed opioids

Consent to include a POSC in EMR or Paper Chart should be obtained from the pregnant person before sharing with other providers.

Intrapartum and Postpartum Approaches

OUD Complicating Birthing Hospitalization Management

Pain Management

Increased pain sensitivity (opioid-induced hyperalgesia) may require multimodal pain management strategies

Regional anesthesia (epidural/spinal) is preferred for labor analgesia and cesarean delivery.

Avoid opioid agonist-antagonists (e.g., nalbuphine, butorphanol) can precipitate withdrawal.

Medication for Opioid Use Disorder (MOUD)

Continue methadone or buprenorphine during labor and delivery. These medications **do not** provide adequate analgesia for labor pain.

Split dosing of methadone/ BUP (e.g., q6-8 hrs) may improve pain control.

Breastfeeding Considerations

Encouraged esp. if on stable MOUD, as it helps reduce NAS symptoms.

Contraindications: ongoing illicit drug use, HIV (in resource-rich settings), or poor maternal adherence to treatment.

American College of Obstetricians and Gynecologists. (2017). Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. *Obstetrics & Gynecology*, 130(2), e81–e94.

Multimodal Pain Management is key

	Description	Localization	Description	Etiology	Management
Nociceptive	Tactile on skin and external soft tissues; musculoskeletal	Very localized	Variable but typically sharp, stabbing	Trauma, pressure	Anti-inflammatories, centrally acting agents; opioids as last resort
Visceral	Deeper origin, e.g., gut or brain (colic, obstruction)	Poorly localized (headache, abdominal pain, chest pain)	Dull, achy, colicky, intermittent	Injury or trauma to internal organs	Centrally acting; opioids as last resort, need to pursue cause
Neuropathic	Commonly peripheral extremities (spinal cord injury, herpes zoster, DM neuropathy)	Usually well localized	Burning, piercing, tingling; constant	Chronically damaged nerves from DM, ischemia,	Nerve stabilizers, antidepressants > anti-inflammatory; opioids as last resort
Inflammatory	Soft tissues and joints	Usually well localized	Burning, aching, worse with movement	Soft tissue or joint inflammation locally	Anti-inflammatory; ice, compression; opioids as last resort

https://www.apsf.org/article/multimodal-analgesia-and-alternatives-to-opioids-for-postoperative-analgesia/

https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/ctr-17-0004-multi-model-pain-project-pdf-version-m1.pdf

Class	Drug	Dose	Important Considerations
Alpha-2-agonists	Dexmedetomidine*†	IV loading dose: 0.5–1 mcg/kg over 10 min Infusion: 0.2–1.7 mcg/kg/hr	Can cause severe bradycardia and hypotension Can cause severe hypertension during loading dose Consider dose reduction in geriatric patients
	Clonidine*†	PO‡: 0.2 mg BID Epidural: 30–40 mcg/hr	Can cause severe hypotension Can lead to withdrawal if stopped abruptly after regular use Epidural use approved only for severe cancer pain
Anti-convulsants	Gabapentin*†	PO: 300–1200 mg TID	May reduce postoperative pain if given preoperatively[14] Can cause dizziness, drowsiness, water retention Manufacturer recommends discontinuation over 1 week
	Pregabalin*†	PO: 150–600 mg per day in 2–3 divided doses	90% bioavailability vs. gabapentin[13] Starting dose: 150 mg in 2–3 divided doses
NMDA Antagonist	Ketamine[16,§]	IV bolus: 0.3–0.5 mg/kg[16] Infusion: start at 0.1–0.2 mg/kg/hr[16]	Intensive monitoring suggested for bolus doses > 0.35 mg/kg or infusion rates > 1 mg/kg/hr[16] Can cause dysphoria and excessive salivation
Local anesthetics	Lidocaine[17,†]	IV bolus: 1.5 mg/kg[17] Infusion: 1–2 mg/kg/hr[17]	Can cause conduction block, dizziness, seizures, bradycardia[17]
Acetaminophen*		PO: 325–650 mg q 4–6hr IV: 1000 mg q 6 hr IV if >50 kg; if <50 kg, 15 mg/kg q 6 hr	Do not exceed 4 gm/24 hr Reduce to 2 gm/day in chronic alcohol use Potentiates warfarin anticoagulation PO and IV dosing are equivalent
NSAIDS	Diclofenac*	PO: 100–200 mg per day in 2–3 divided doses	Dose-dependent relief Should start at lowest possible dose Prolonged use predisposes to GI, CV, and renal dysfunction For IV and PO ketorolac limit to 5 days PO ketorolac should only be used to continue therapy after IV initiation Increases lithium levels Prone to gastric ulceration with bisphosphonates
	Ibuprofen*	IV: 400 mg first dose, followed by 100–200 mg q 4–6 hr PO: 1200–3200 mg per day in 3–4 divided doses	
	Ketorolac*	IM or IV: 15–30 mg every 4–6 hr PO: 10 mg q 4–6 hr	
	Meloxicam*	PO: 7.5–15 mg daily	
	Celecoxib*	PO: 50–200 mg daily in a single dose or 2 divided doses	

Neonatal Opioid Withdrawal Syndrome & Eat, Sleep, Console (ESC)

4th Trimester Considerations

- Educate patients on **return-to-use**—risk of overdose*
- Level of care still appropriate?
- Ensure care coordination remains ongoing and by whom?

Summary

Substance use is a leading cause of maternal mortality, with rising overdose deaths during pregnancy and postpartum.

Screening, trauma-informed care, and evidence-based treatment improve maternal and neonatal outcomes.

Multimodal pain management, regional anesthesia, and continued MOUD are key to safe intrapartum and postpartum care.

Maternal health care workers play a vital role in reducing stigma, expanding access to care, and advocating for policy change.

Thank you!

Leah.Habersham@mountsinai.org

Psychotherapy and beyond:

Tapping into reflective functioning when working with families impacted by parental substance use

Amanda Lowell, PhD
Assistant Professor, Department of Psychiatry, University of Massachusetts Chan Medical School
Adjunct Assistant Professor, Child Study Center, Yale School of Medicine

NY TTAC Annual Spring Conference
June 11, 2025

Disclosures

Agenda

01.

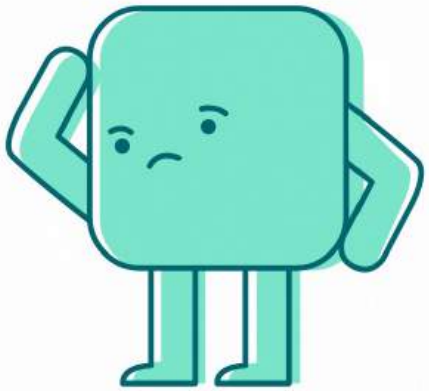
Links among addiction, adversity, & attachment

02.

Psychotherapeutic techniques & common elements

03.

Systems-level interventions



>21m

children live with a parent who misuses substances

Ghertner, 2022

>2m

children live with a parent diagnosed with an SUD

Ghertner, 2022

>70%

people who use opioids have children

Scheidell et al., 2022

>14,000

treatment admissions per year for pregnant people

Treatment Episode Data Set: Admissions (TEDS)-A Data, 2020

83%

increase in Neonatal Opioid Withdrawal Syndrome (NOWS) from 2010-2017

Hirai, Ko , & Owens, 2021

1 baby every 24 minutes

diagnosed with NOWS

Healthcare Cost and Utilization Project (HCUP), 2020

>45,000

notifications to CPS due to prenatal exposure

US Department of Health & Human Services, 2024

79.2%

were screened in for CPS investigation or alternative response

US Department of Health & Human Services, 2024

2-4x

Black newborns more likely to be reported to CPS following identification of prenatal exposure...

...compared to White & Latine/Hispanic newborns

Roberts & Nuru-Jeter, 2012;
Sieger et al., 2024

Risks to children…

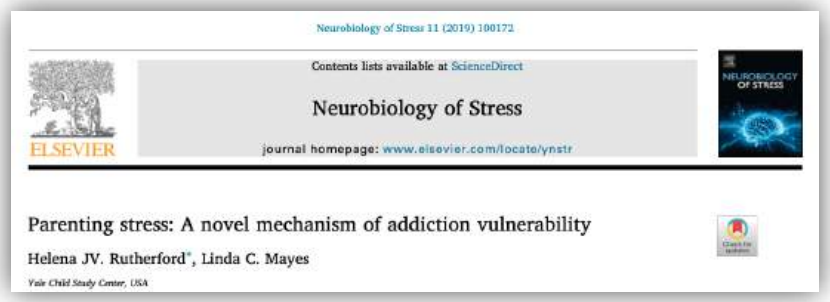
Prenatal exposure:

- Neonatal Abstinence Syndrome (NAS) → Neonatal Opioid Withdrawal Syndrome (NOWS)
- Neurobiological differences
  - Sensorimotor
  - Arousal/motivation/reward
  - Executive functioning & emotion regulation

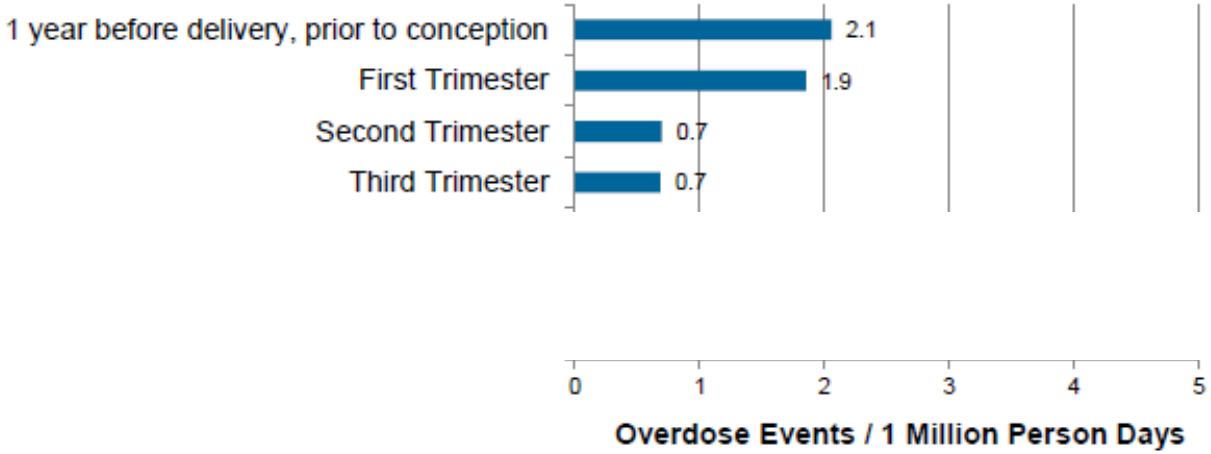
Early childhood exposure:

- Co-occurring contextual factors
  - Cumulative risk
- Stress & trauma
  - Neglect
  - Violence
  - Grief
- Caregiving
  - Neurobiology
  - Psychology
  - Behavior

...risks to parents...



Pregnancy and Postpartum Risks



...risks to dyads...

Sensitivity

Attunement

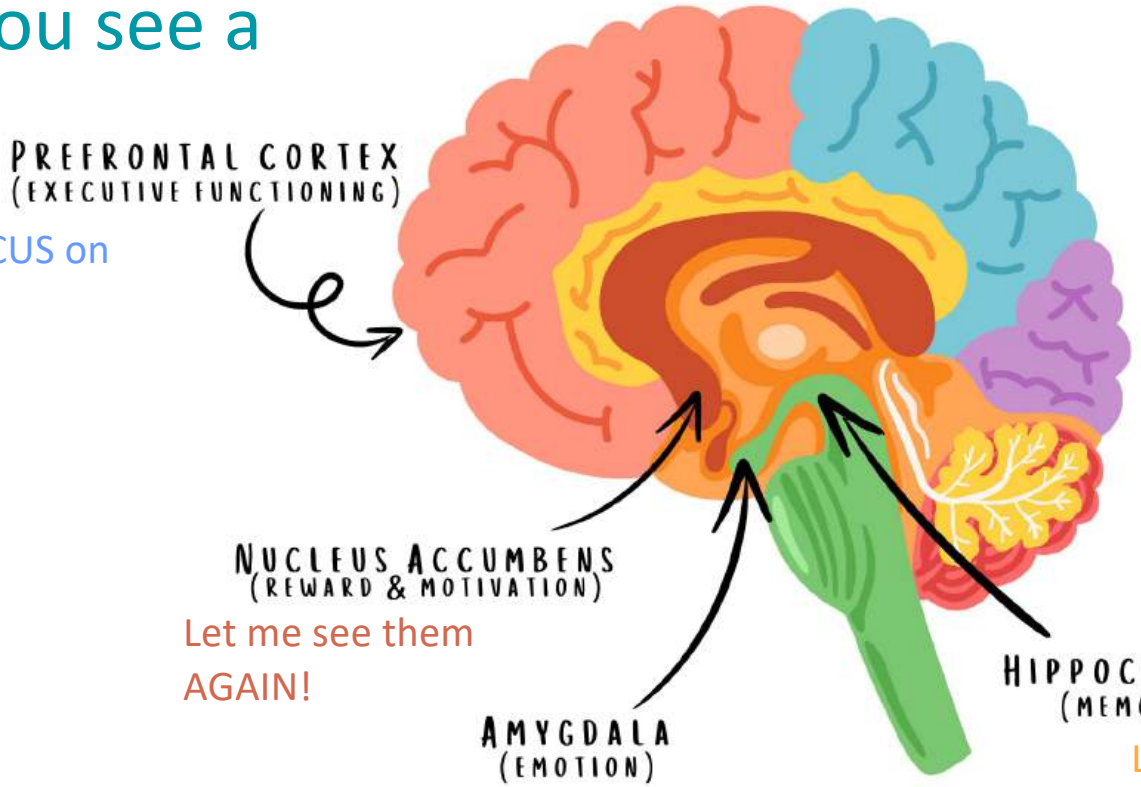
Reflective functioning

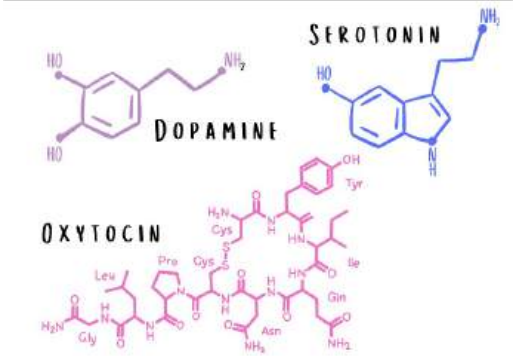
Attachment

Links among addiction, adversity & attachment

Parental neurobiology

When you see a child.....





Let me FOCUS on them!

Let me see them AGAIN!

That FELT great!

Let me REMEMBER where, when, and how this happened!


Stress
Reward

Prefrontal Cortex → Parental reflective functioning

- **Prefrontal Cortex**
  - Connectivity associated with…
    - Empathy
    - Understanding others
    - Perspective-taking
    - Self-other distinction

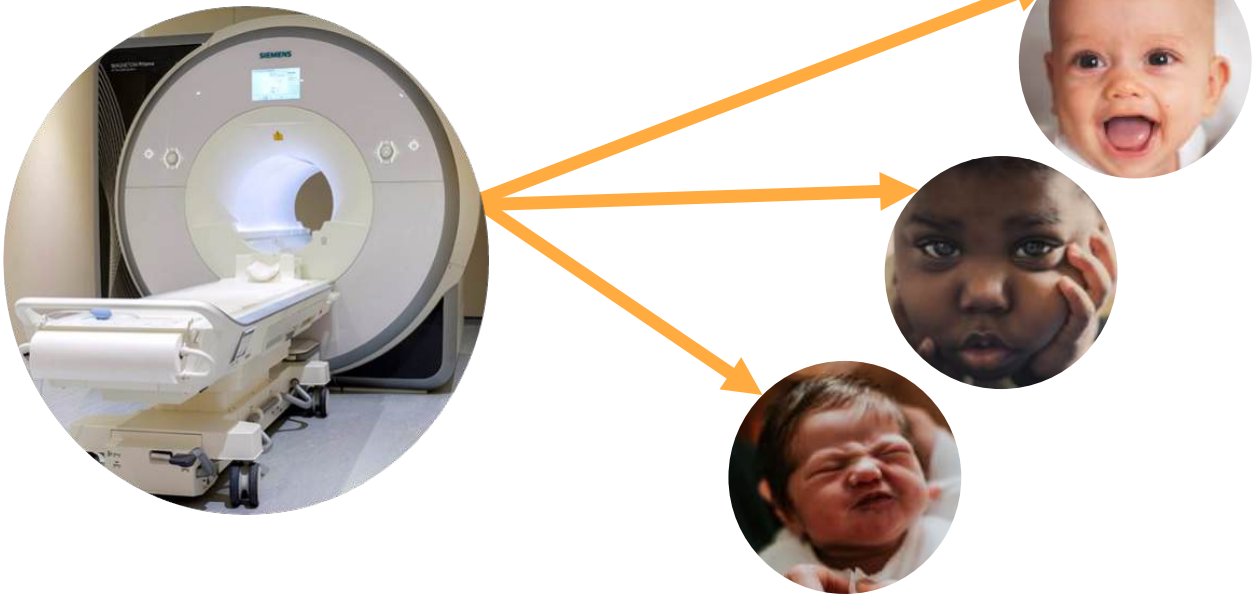
- **Necessary ingredients for <u>parental reflective functioning</u>**
  - Parents' ability to meaningfully and accurately recognize and make sense of their own and their child's behavior in terms of underlying mental states

confidence that distress will be met with comfort

Parental Reflective Functioning

"I feel that you feel that I feel"

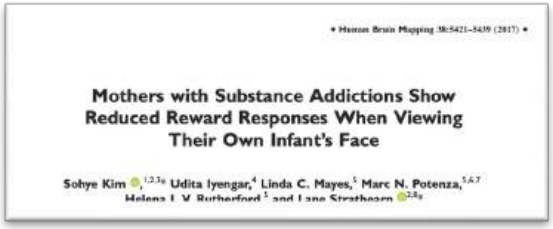
Addiction & attachment trauma associated with dampened neural activation



frontiers in PSYCHIATRY

ORIGINAL RESEARCH ARTICLE

Maternal neural responses to infant cries and faces: relationships with substance use



Mothers with Substance Addictions Show Reduced Reward Responses When Viewing Their Own Infant's Face

Sohye Kim, Udita Iyengar, Linda C. Mayes, Marc N. Potenza

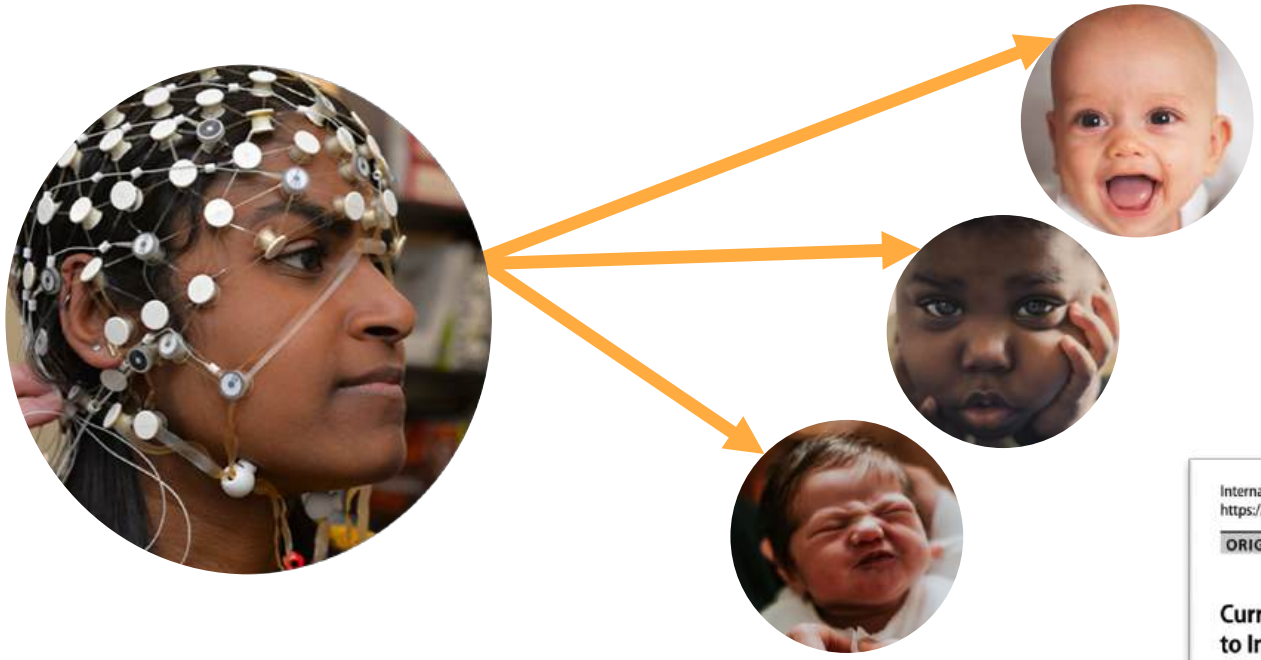
Drug and Alcohol Dependence

Full length article

Differential responses to infant faces in relation to maternal substance use: An exploratory study

Helena J.V. Rutherford, Sarah W. Yip, Patrick D. Worhunsky, Sohye Kim, Lane Strathearn, Marc N. Potenza, Linda C. Mayes

Addiction associated with slower neural responses; and heightened activation to low distress cries



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DOI: 10.1080/15295192.2017.1262176

Routledge
Taylor & Francis Group

Current Tobacco-Smoking and Neural Responses to Infant Cues in Mothers

Helena J. V. Rutherford, Angela N. Maupin, Nicole Landi, Marc N. Potenza, and Linda C. Mayes

ARTICLE

WILEY

Substance use and mothers' neural responses to infant cues

Amanda F. Lowell[1,2] | Angela N. Maupin[3] | Nicole Landi[1,3,4,5] | Marc N. Potenza[1,3,6,7,8] | Linda C. Mayes[2] | Helena J. V. Rutherford[3]

International Journal of Mental Health and Addiction
https://doi.org/10.1007/s11469-022-00947-2

ORIGINAL ARTICLE

Check for updates

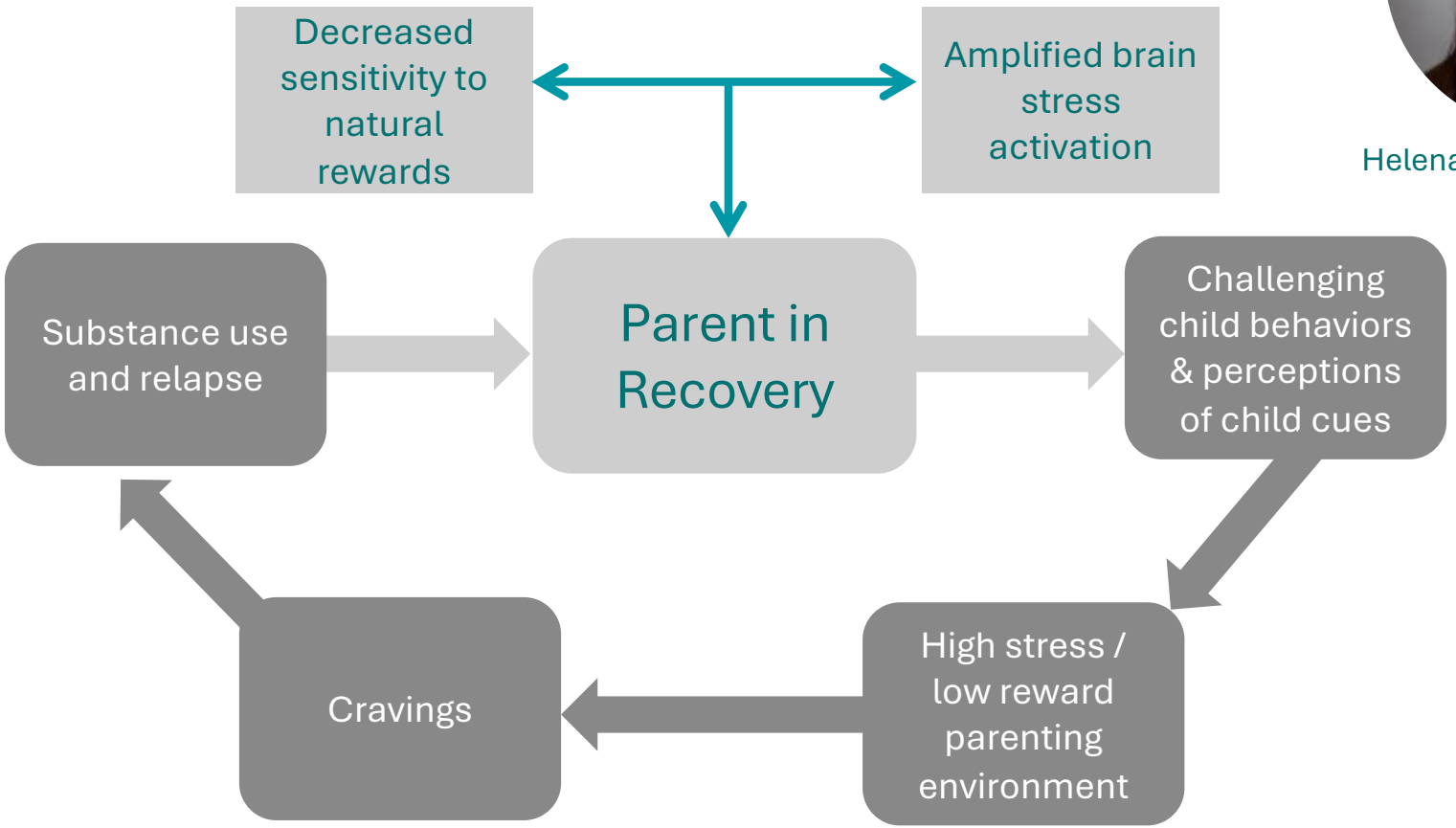
Current Substance Use and Maternal Neural Responses to Infant Faces and Cries

Kathryn M. Wall[1,2] · Jaclyn Dell[3] · Amanda Lowell[1] · Marc N. Potenza[1,4,5,6,7,8] · Linda C. Mayes[1] · Helena J. V. Rutherford[1]


Stress
Reward

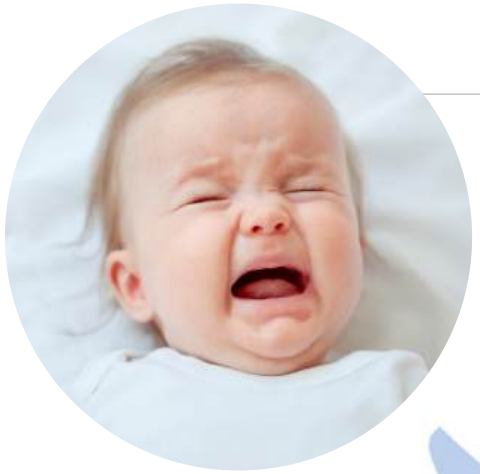
Reward-Stress Dysregulation Model of Parenting and Addiction

Helena Rutherford, PhD



adapted from Rutherford, 2011

...risks to dyads...



Fight

Flight

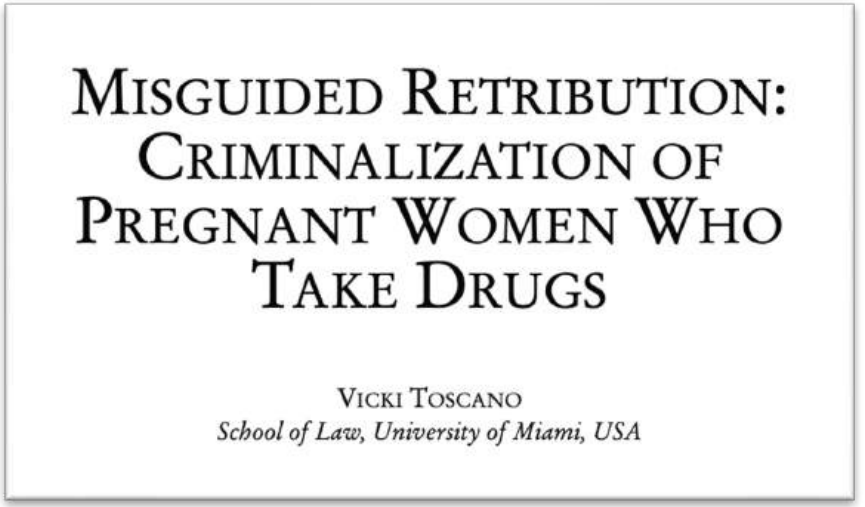
Fawn

Freeze

Attachment trauma

...and risks to families

- Criminalization of pregnancy
  - Punishment of pregnant people for actions that would not be criminal were they to be undertaken while not pregnant
    - "status offense"
  - Systemic discrimination
  - Increased baseline surveillance



MISGUIDED RETRIBUTION: CRIMINALIZATION OF PREGNANT WOMEN WHO TAKE DRUGS

VICKI TOSCANO
School of Law, University of Miami, USA

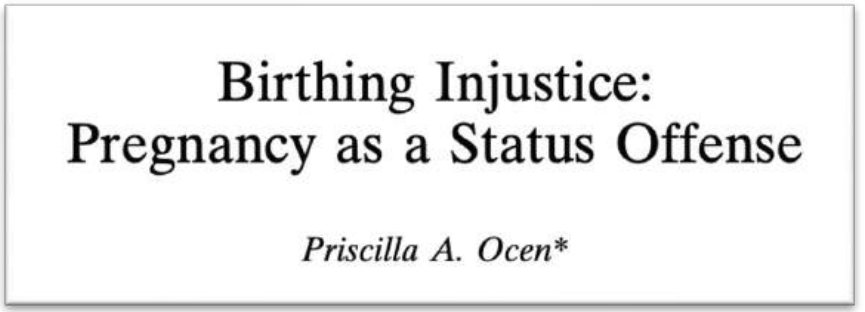
Journal of Health and Social Behavior
Volume 63, Issue 2, June 2022, Pages 162-176

https://doi.org/10.1177/00221465211058152

SAGE journals

Criminalization of Care: Drug Testing Pregnant Patients

Katharine McCabe



Birthing Injustice: Pregnancy as a Status Offense

*Priscilla A. Ocen**

...and risks to families

- Child Abuse & Prevention Treatment Act (CAPTA)
- Some states consider parental substance use a form of child abuse...
  - ...even though parental substance use is not an unequivocal or perfect predictor of child maltreatment (Kepple, 2018)
- Child removal associated with increased
  - substance use (Wall-Wieler et al., 2018)
  - overdose events (Thumath et al., 2021)

Stigma

Cognitive and cultural models activated by the topic of parental SUD (Lowell, Van Scoyoc, & Mayes, 2021)

- Lack of knowledge
- Selfishness
- External stressors
- Addiction as a disease

"They're not educated to understand that this is not like 'Oh well, oops I messed up on a test.'"

"I think everyone growing up in America knows that you are supposed to stay away from drugs and alcohol while pregnant. But you may choose to anyway because if you are not as mentally sound or feeling like you have things together you are less likely to care about the life that is developing in you."

Child Abuse & Neglect 79 (2018) 31–41

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Domestic violence, parental substance misuse and the decision to substantiate child maltreatment

Bryan G. Victor*, Andrew Grogan-Kaylor, Joseph P. Ryan, Brian E. Perron, Terri Ticknor Gilbert

Predicted probability of substantiation

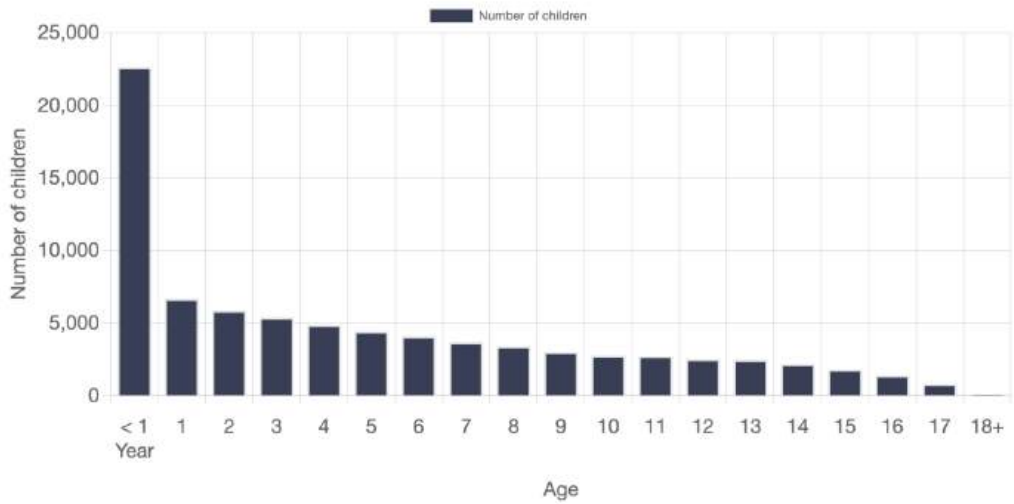
BY TYPE OF RISK FACTOR(S) IDENTIFIED

National Center on Substance Abuse and Child Welfare

Number of Children who Entered Out of Home Care with Parental Alcohol or Drug Abuse as a Condition Associated with Removal, by Age in the United States, 2021

Source: AFCARS Data, 2021, as of 3/21/23

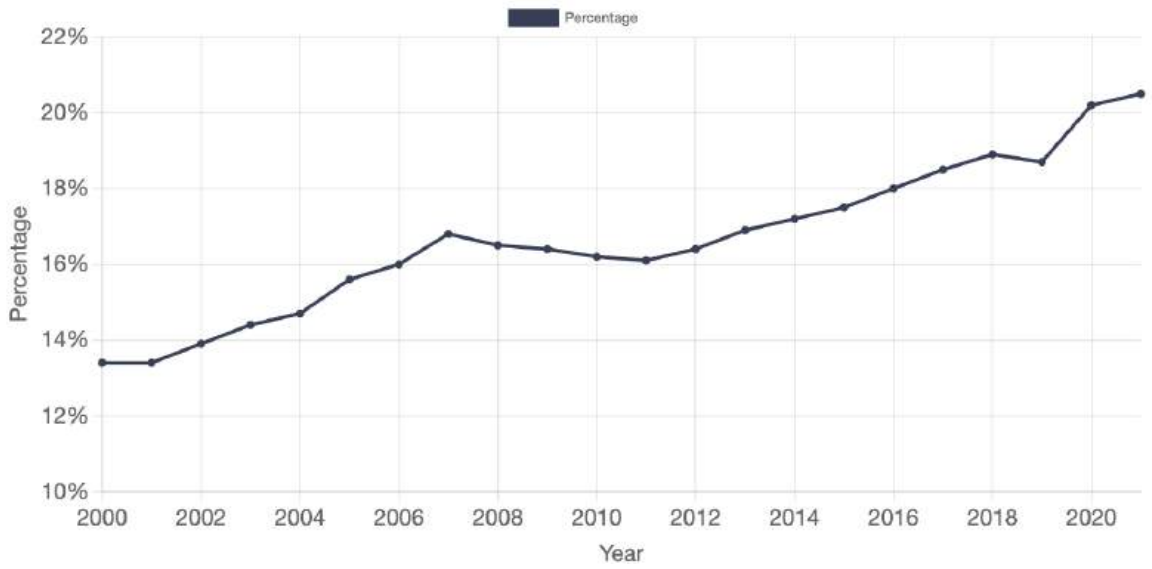
N = 80,877

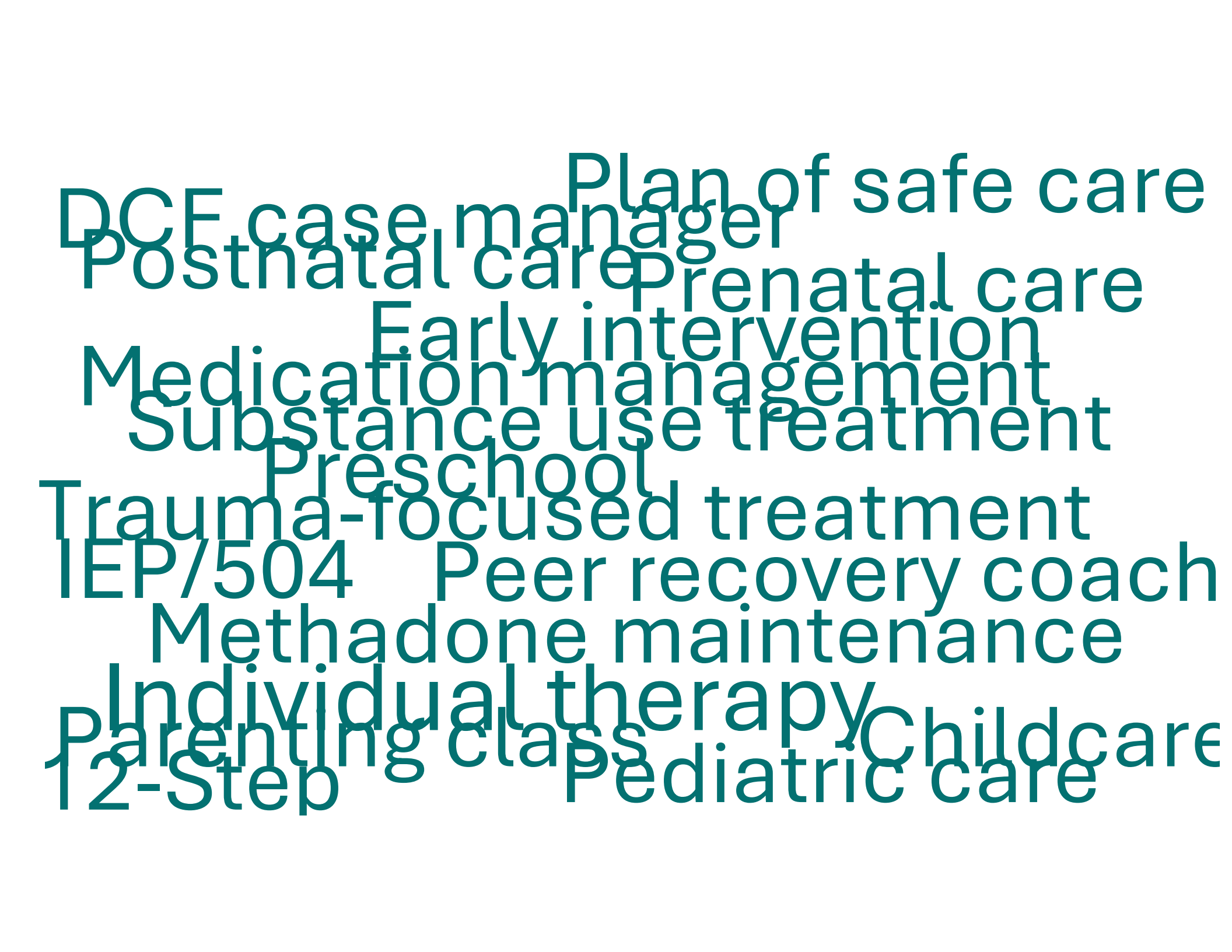


National Center on Substance Abuse and Child Welfare

Percent of Children who Entered Out of Home Care who were Under Age 1 in the United States, 2000 to 2021

Source: AFCARS Data, 2000-2021, as of 3/21/23




Plan of safe care
DCF case manager
Postnatal care
Prenatal care
Early intervention
Medication management
Substance use treatment
Preschool
Trauma-focused treatment
IEP/504
Peer recovery coach
Methadone maintenance
Individual therapy
Parenting class
Childcare
12-Step
Pediatric care

A double bind for parents

- **To engage…**
  - Ideally, will experience benefit, but…
  - Can be overwhelming
  - Make self & family vulnerable
- **Or not to engage…**
  - May be able to avoid identification by child welfare and legal systems, but…
  - Don’t receive support that would have been helpful
  - If pregnant, identification at hospital at time of birth

A double bind for systems

- **To report…**
  - Reduce some risk of trauma for children
  - Attachment disruption and related mental health sequelae
  - Increased risk for parental substance use & overdose, mental health problems, trauma symptoms, criminal involvement
- **Or to support…**
  - Children potentially exposed to stress & trauma
  - Children potentially exposed to inconsistent or non-attuned caregiving
  - Caregivers potentially motivated to remain hopeful & engage in recovery supports

The support that is accessible isn't always great

- **Support for people with SUD**
  - **Vary widely…**
    - Peer-led
    - 12-step
    - Cognitive-behavioral
    - Disease-centric
    - Medication-assisted
    - Developed/researched on males
    - Parenting is not kept in mind
- **Support for parents**
  - **Many scaled up, widely available, evidence-based supports are…**
    - behavioral, skills-based, focused on child (mis)behavior
    - OR focused on processing child trauma
    - miss the parent's needs
    - For parents with SUD…
      - associated with premature exit
      - minimally effective

Suchman et al., 2004; Suchman et al., 2006


Park ROW
BROADWAY
ONE WAY
DEPT OF TRANSPORTATION

Support often fails to recognize intersecting identities

Attending to the identity of <u>parent</u>:

"Her [pediatrician]... was like, 'Well, is he okay?... How's he responding to this or that?' She never really asked how I was."

Attending to the identity of <u>person with SUD</u>:

"Like, if we were in a group and our kids started crying or needed a change, they wouldn't let us leave to go do it and if we did, we would lose our credit for the group."

Elizabeth Peacock-Chambers, MD

SUBSTANCE ABUSE
https://doi.org/10.1080/08897077.2021.1904091

Taylor & Francis
Taylor & Francis Group

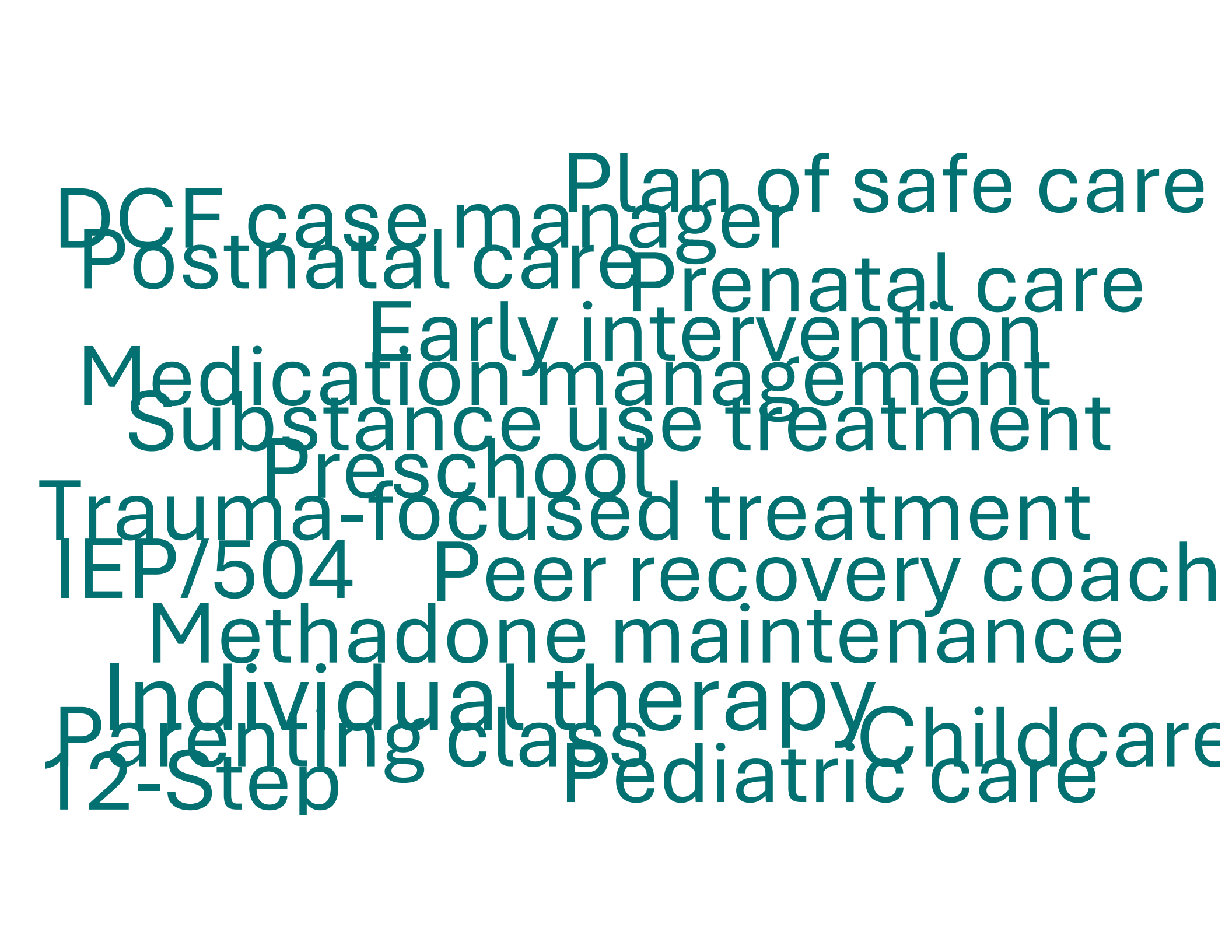
ORIGINAL RESEARCH

Check for updates

Engagement in perinatal outpatient services among women in recovery from opioid use disorders

Elizabeth Peacock-Chambers, MD, MS[a,b], Mary T. Paterno, PhD, CNM[c], Daniel Kiely, BS, RN[d], Tinamarie Fioroni, LMHC[e], Nancy Byatt, DO, MS, MBA[f], and Peter D. Friedmann, MD, MPH[g]

Psychotherapeutic techniques & common elements


Plan of safe care
DCF case manager
Postnatal care
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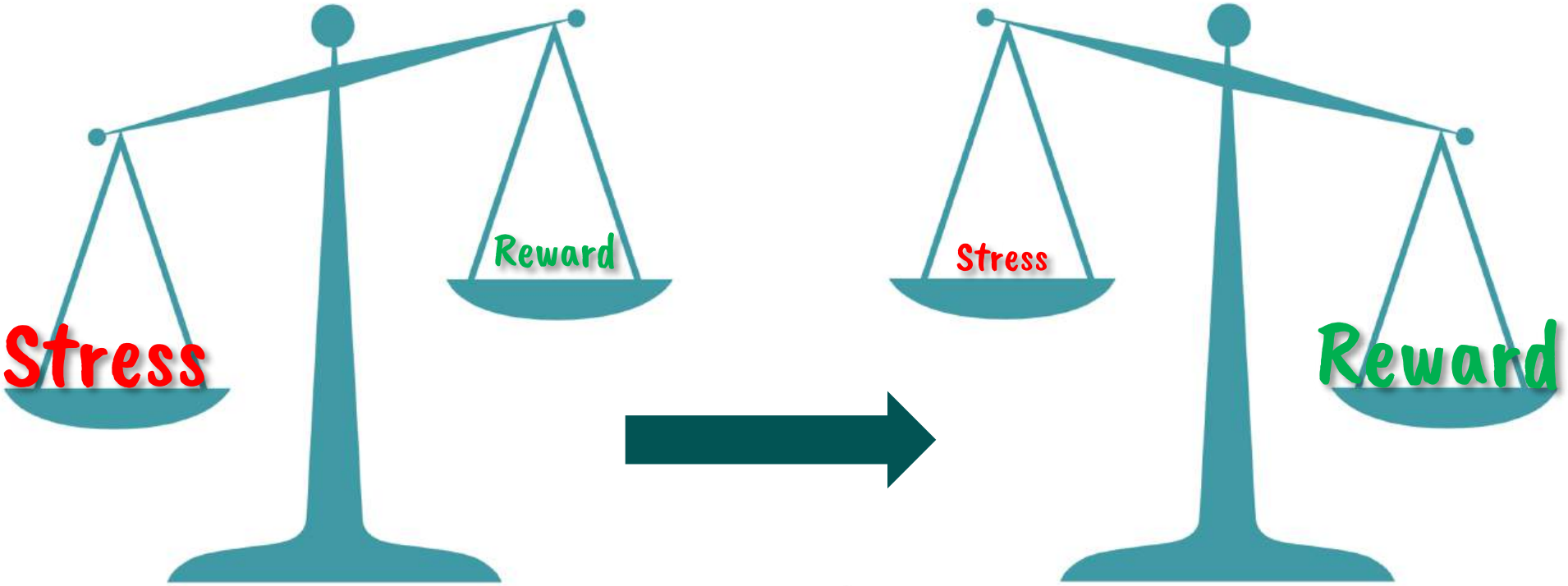
Medication management
Substance use treatment
Preschool
Trauma-focused treatment
IEP/504
Peer recovery coach
Methadone maintenance
Individual therapy
Parenting class
Childcare
12-Step
Pediatric care

Guiding principle:



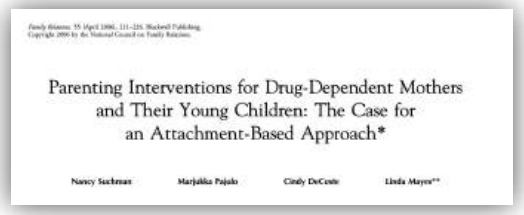
ELSEVIER

Journal of Substance Abuse Treatment

Regular article

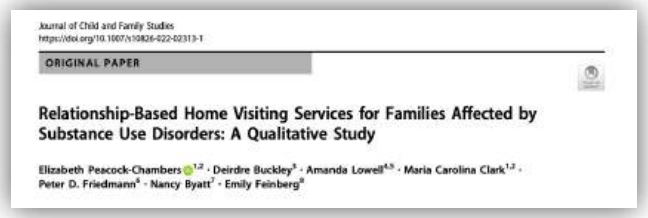
Rethinking parenting interventions for drug-dependent mothers: From behavior management to fostering emotional bonds

Nancy Suchman, (Ph.D.)[a,*], Linda Mayes, (M.D.)[b], Joanne Conti, (M.A.)[c], Arietta Slade, (Ph.D.)[b], Bruce Rounsaville, (M.D.)[a]



Parenting Interventions for Drug-Dependent Mothers and Their Young Children: The Case for an Attachment-Based Approach*

Nancy Suchman · Marjukka Pajulo · Cindy DeCoste · Linda Mayes**



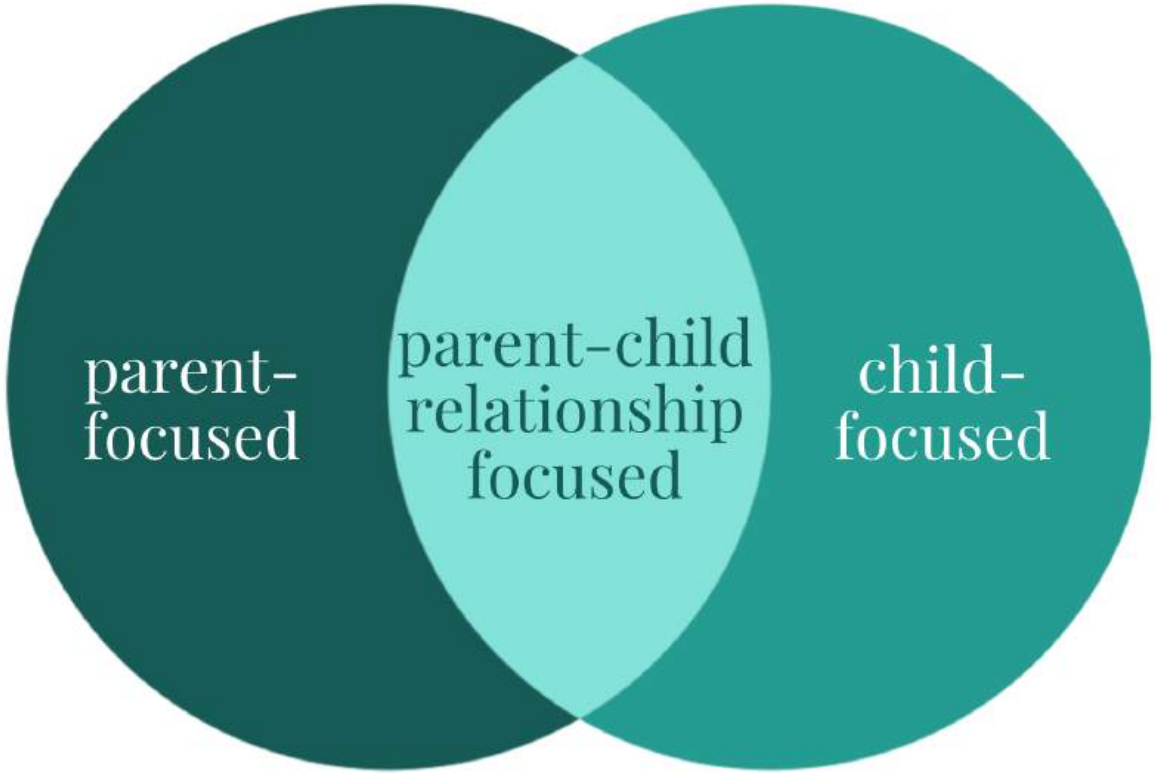
Journal of Child and Family Studies

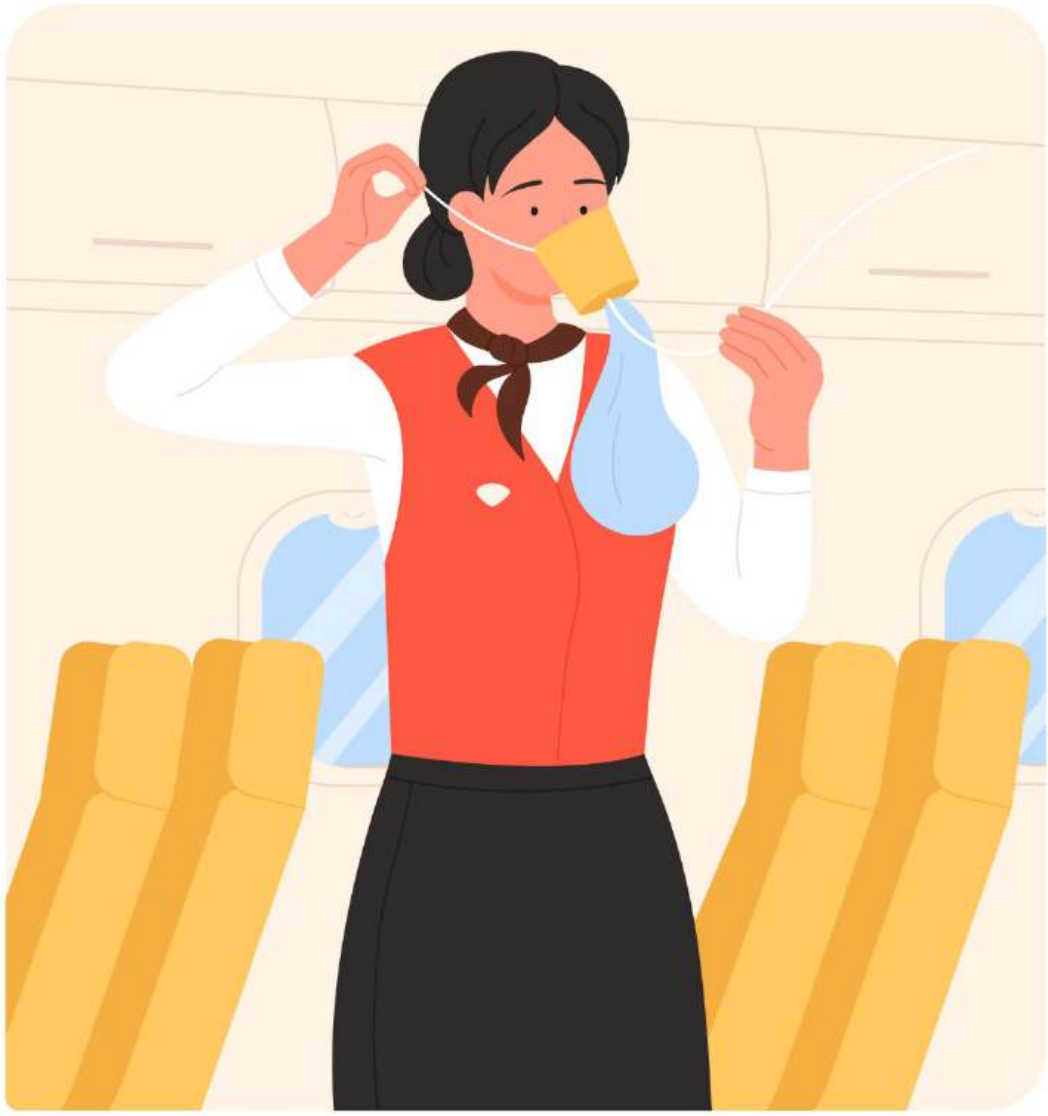
ORIGINAL PAPER

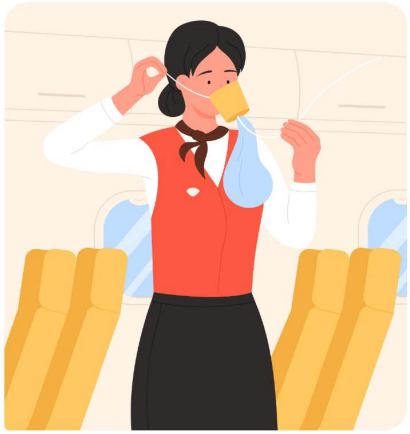
Relationship-Based Home Visiting Services for Families Affected by Substance Use Disorders: A Qualitative Study

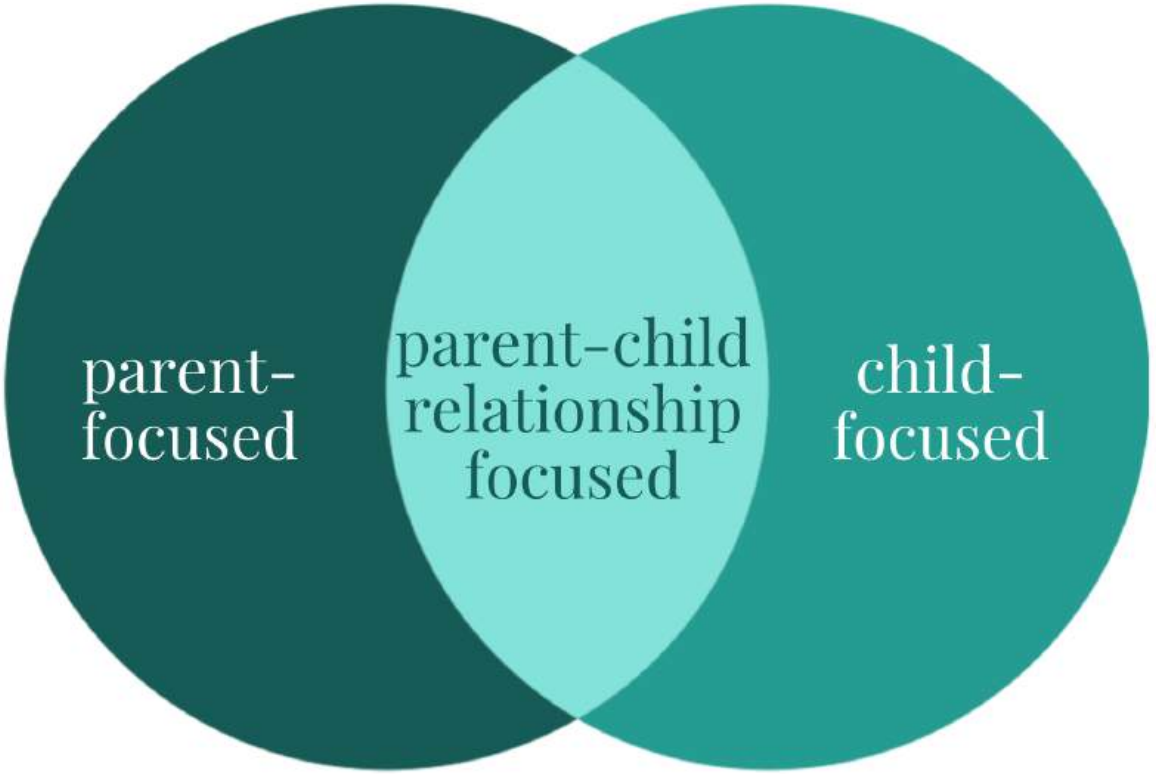
Elizabeth Peacock-Chambers[1,2] · Deirdre Buckley[3] · Amanda Lowell[4,5] · Maria Carolina Clark[1,2] · Peter D. Friedmann[4] · Nancy Byatt[7] · Emily Feinberg[8]

Nancy Suchman, PhD








parent-focused
parent-child relationship focused
child-focused

Case example:

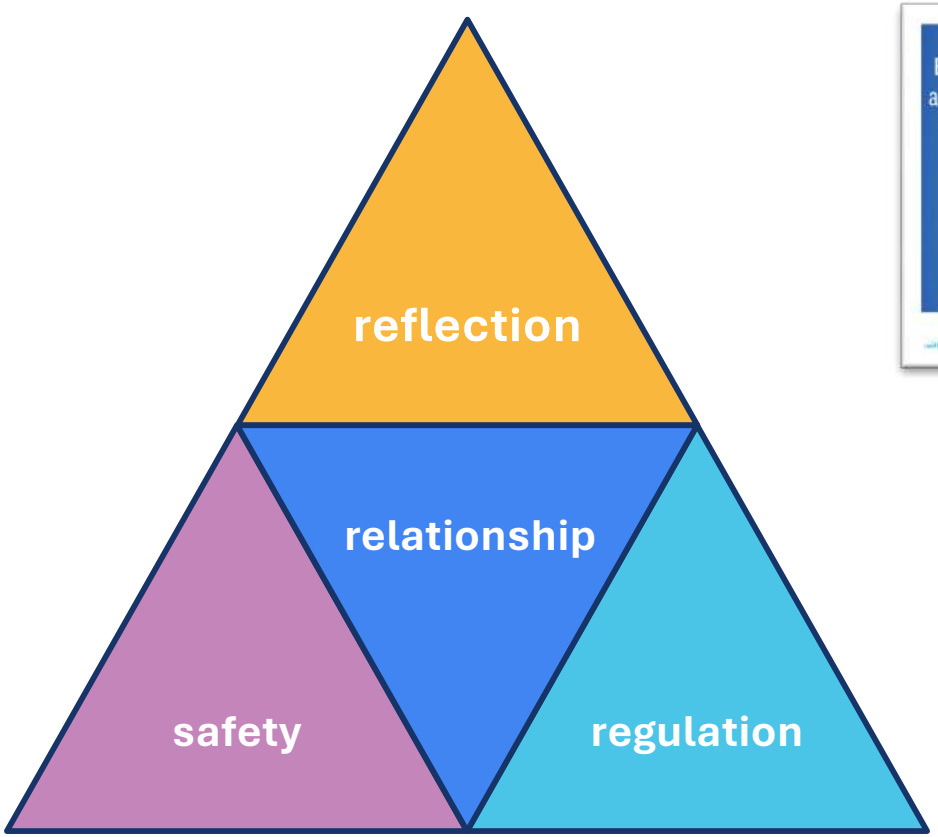
- **Vanessa**
  - 33-year-old Puerto Rican mother of 3
    1. **4-year-old daughter**
       - Headstrong & “attitude problems” at home
       - Hyperactive, impulsive, aggressive at daycare
       - Generally “whiny,” “clingy,” lacking independence
       - Shy & anxious around new people
    2. **14-month-old son**
       - “a good baby”
       - “knows right from wrong”
    3. **Currently pregnant with baby girl**
       - Worries around who is going to help around the house
  - Married (father of all 3 children)
    - History of intimate partner violence
  - 4.5-years of recovery; prescribed methadone

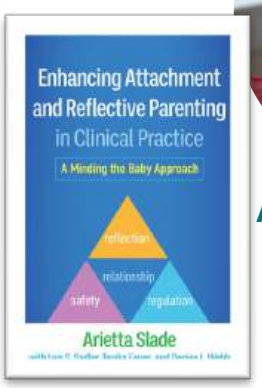
Presenting complaint

- **Brought 4-year-old daughter to clinic due to concerns for ADHD**
  - Difficulty concentrating
  - Hyperactive, impulsive
  - Lack of independence, needs support with “everything”
  - “Doesn’t listen”
  - Seeking medication management

- **Became evident to 4-year-old’s psychiatrist that trauma perhaps played a role**
  - Prenatal substance exposure
  - Witnessed IPV between parents
  - Witnessed Vanessa’s substance use and active addiction
  - Witnessed Vanessa’s incarceration


reflection

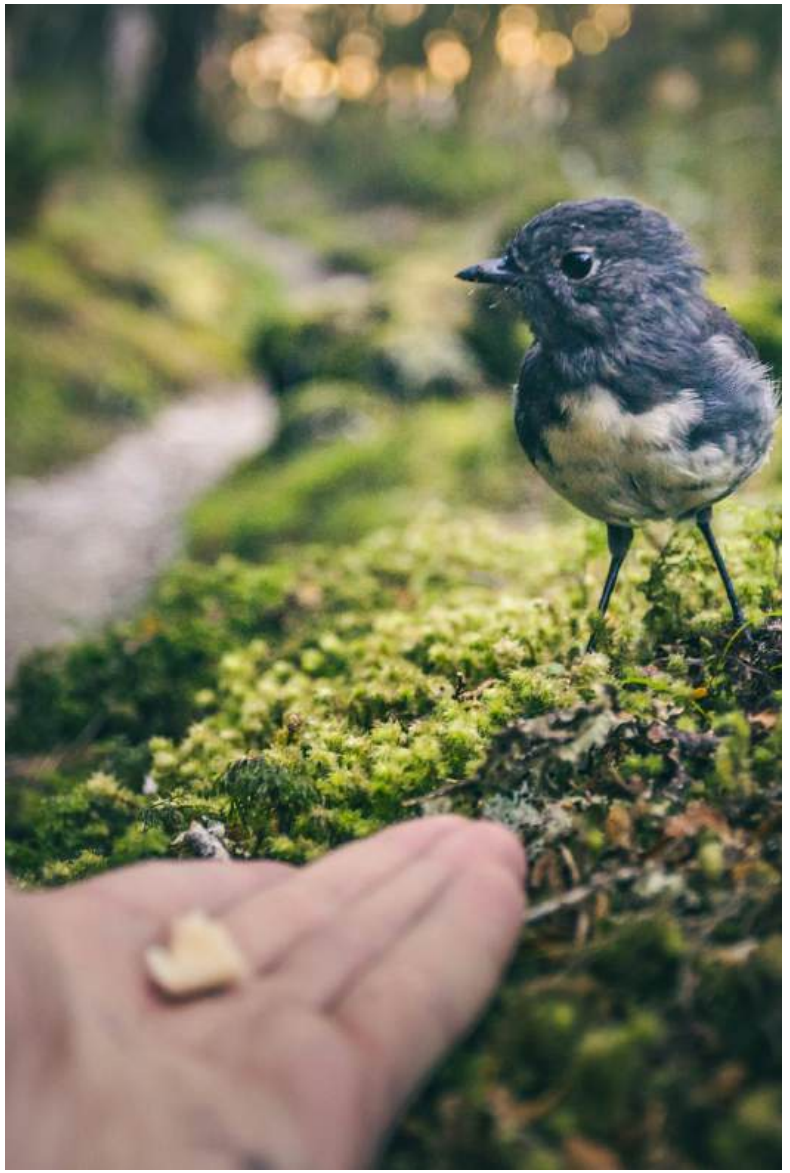




Arietta Slade, PhD

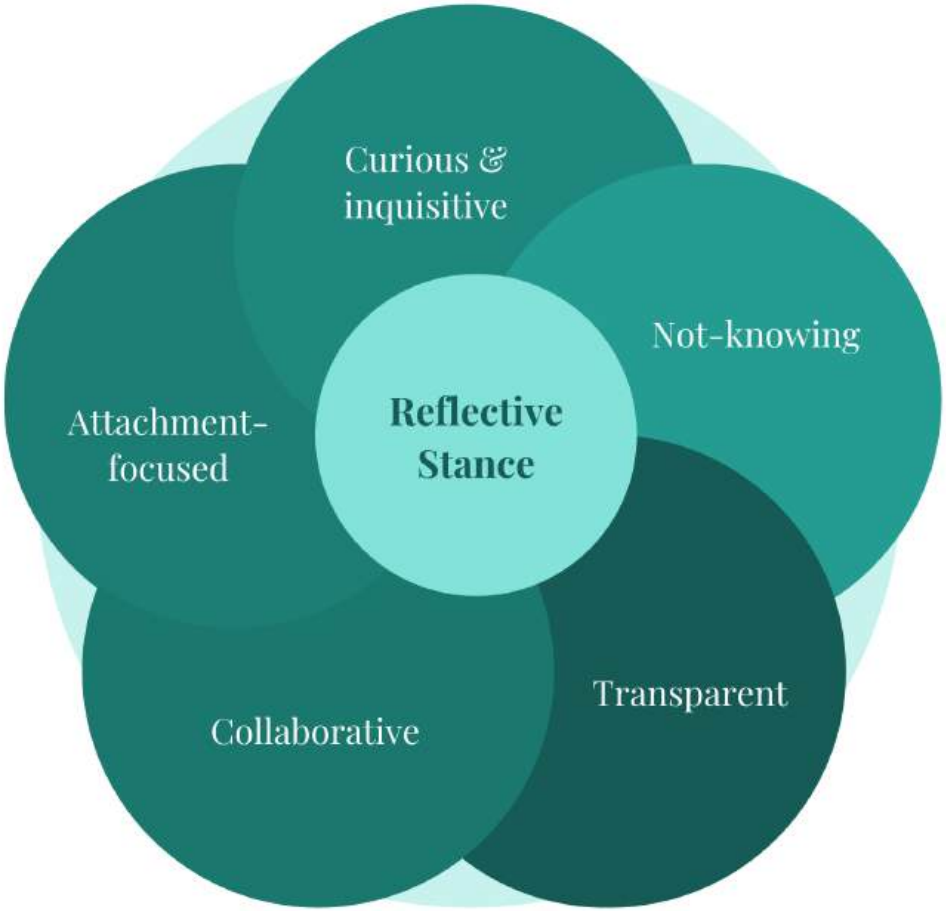
Building the "Relational Foundations of Reflection"

- **Vanessa was referred to a specialized in-home program for perinatal mothers in recovery**
  - Peer-recovery support specialists
    - Case management
    - On-call support
    - Connection to community
    - Building **safety**, **regulation**, trust in **relationships** & the help being offered
  - Clinicians
    - Foster parental **reflective functioning**
    - Provide attachment-based developmental guidance
    - e.g., *Mothering from the Inside Out*



Holding a reflective stance

Nancy Suchman, PhD



"we-ness"

Tapping into mom's mind first

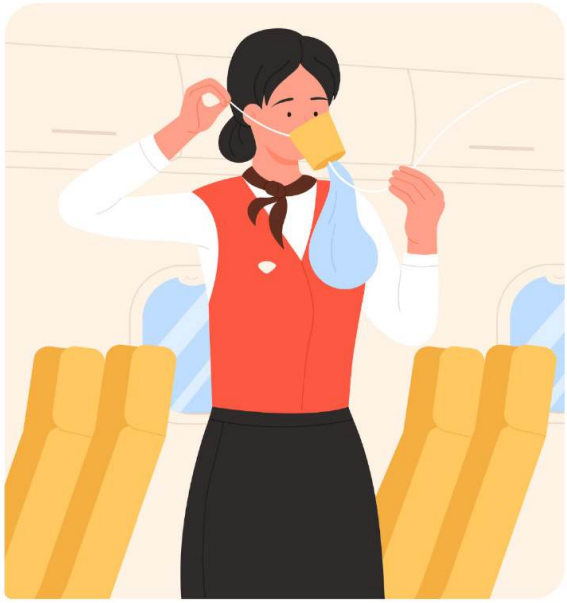
- **Vanessa's history**
  - Parents' substance use & mental illness
  - Parents' gang involvement, drug trafficking
  - Physical abuse
  - Sexual abuse
  - Kinship, foster care, many moves
  - Human trafficking

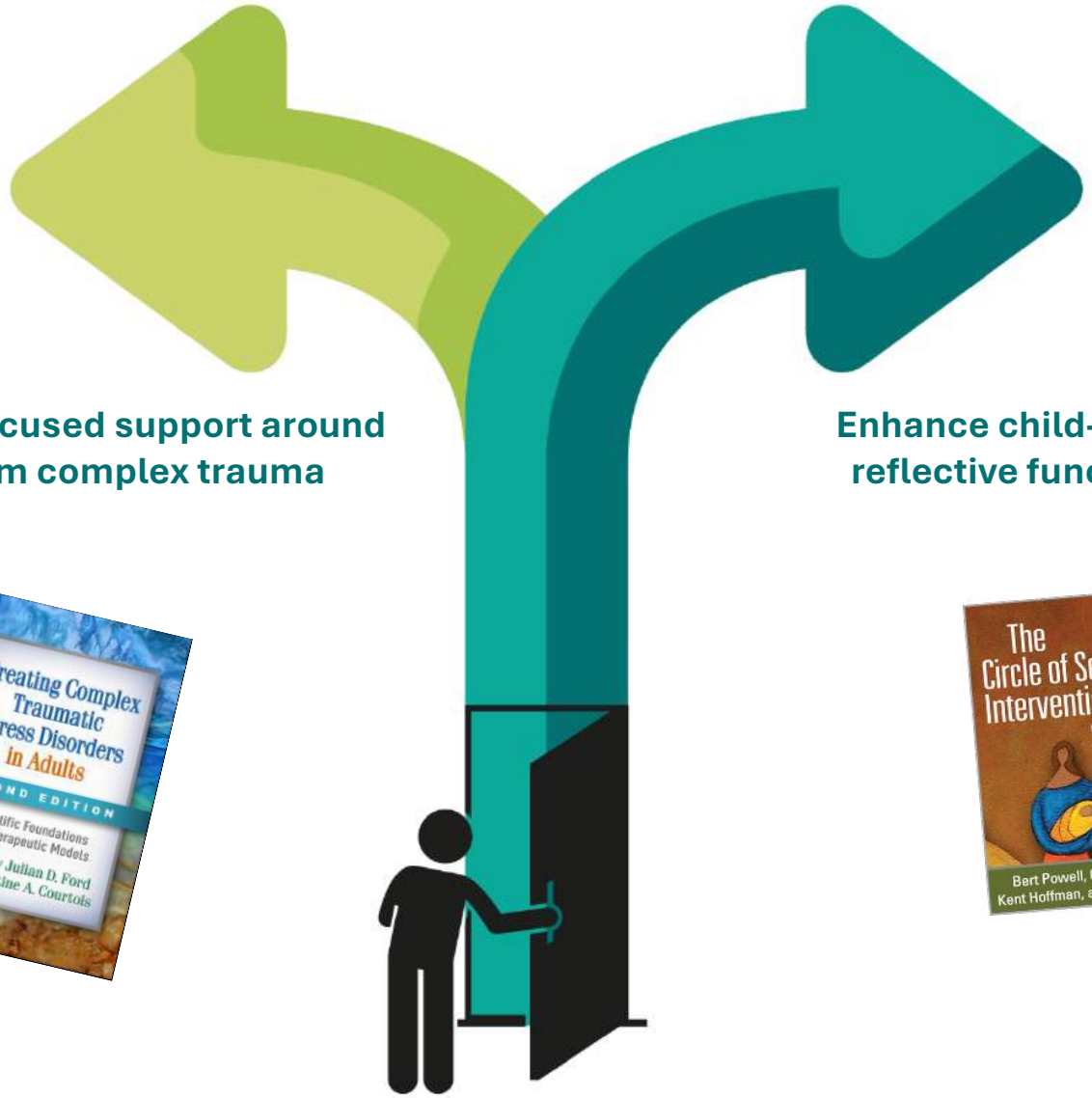
- **"Understanding of minds is hard without the experience of having been understood as a person with a mind"**
  - (Fonagy & Target, 2005)

Tapping into mom's mind first

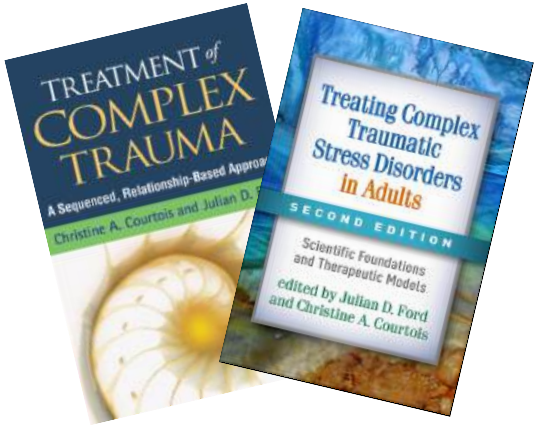
- **Fostered Vanessa's <u>self-focused</u> reflective functioning**
  - What are Vanessa's thoughts, emotions, wishes, intentions…
    - …as a mom?
    - …as a person?
  - What runs through Vanessa's mind…
    - …when she needs help?
    - …when her children need help?
  - What feels rewarding vs. stressful…
    - …as a person?
    - …as a mom?
  - How does Vanessa make sense of her own mind?
  - Where do Vanessa's mental states come from?

  - Ghosts & Angels in the Nursery

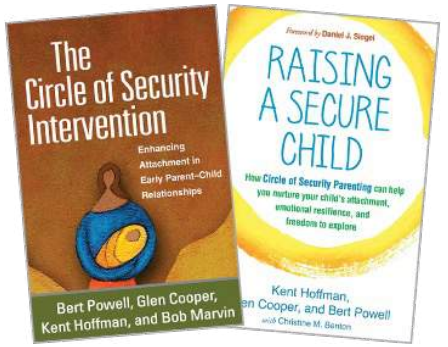




Further self-focused support around healing from complex trauma



Enhance child-focused reflective functioning



Making room for the child's mind

- **Fostered Vanessa's child-focused reflective functioning**
  - How is Vanessa making sense of her children's behavior?
  - Held a stance of playful curiosity
  - Scaffolded thinking about minds
  - Offered multiple options from a not-knowing stance
  - Expressed curiosity about what reflecting for her daughter was like
  - Transparently acknowledged that it might be painful to enter the mind of her daughter
  - Made room for considering the minds of her 14-month-old son & new baby on the way

- **Provided attachment-based developmental guidance**
  - Discussed the basics about attachment needs & behavior
  - Gently helped Vanessa make sense of her daughter behavior as adaptations to stress early in their relationships with her

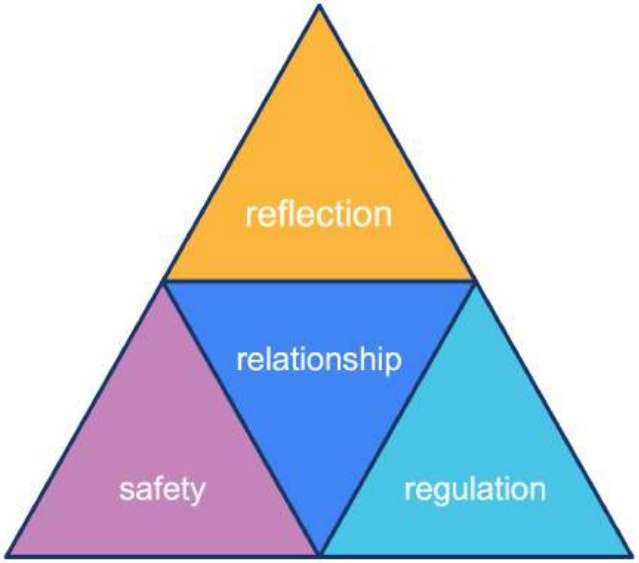
Often, only possible when...

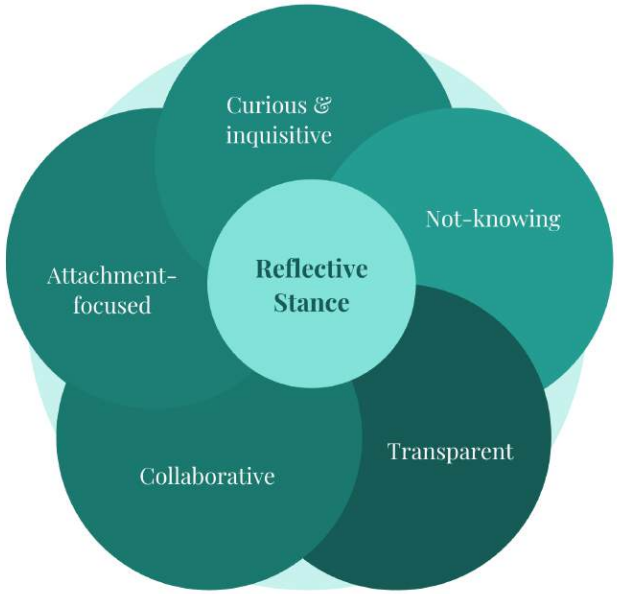
"I feel that you feel that I feel"

Unlocking relational insight & connection

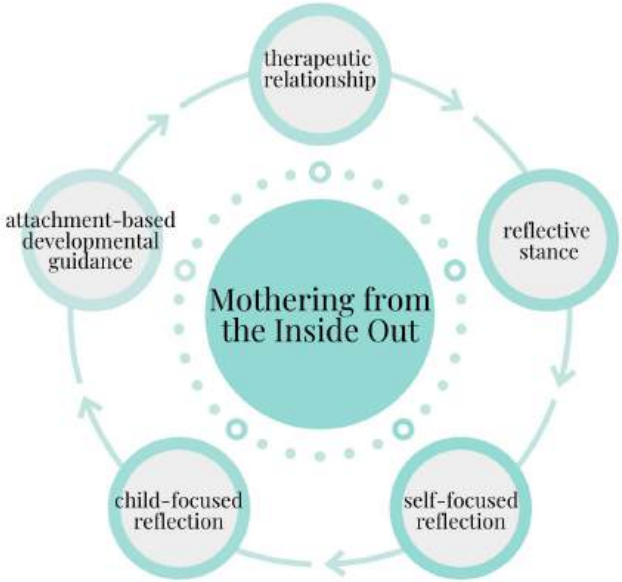
- **Vanessa better able to…**
  - Recognize her daughter's lack of independence and "whininess" as bids for connection
  - Understand her daughter's difficulties with executive functioning as secondary to stress and trauma
  - Acknowledge & tolerate her own part in her daughter's experience of stress and trauma
  - Engage in dyadic trauma-focused treatment with her daughter (e.g., Child Parent Psychotherapy)
  - Further commit to her own recovery
  - Engage in treatment for her own complex trauma

Common elements & necessary ingredients





"I feel that you feel that I feel"



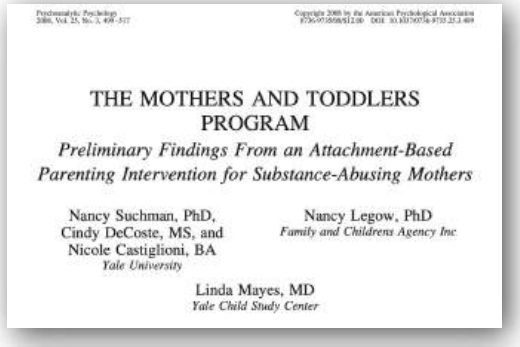
Practice-based evidence

Evidence-based practice

Compared to behavioral & skills-based models…

- Reflective functioning
- Maternal sensitivity
- Dyadic reciprocity
- Child attachment security

- Substance use
- Depression
- Negative emotionality
- Child withdrawal



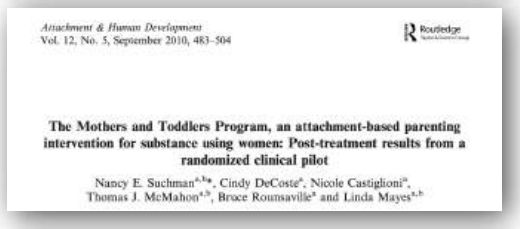
THE MOTHERS AND TODDLERS PROGRAM

Preliminary Findings From an Attachment-Based Parenting Intervention for Substance-Abusing Mothers

Nancy Suchman, PhD, Cindy DeCoste, MS, and Nicole Castiglioni, BA
Yale University

Nancy Legow, PhD
Family and Childrens Agency Inc

Linda Mayes, MD
Yale Child Study Center



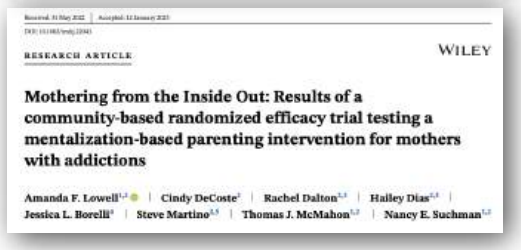
Attachment & Human Development
Vol. 12, No. 5, September 2010, 483–504

The Mothers and Toddlers Program, an attachment-based parenting intervention for substance using women: Post-treatment results from a randomized clinical pilot

Nancy E. Suchman, Cindy DeCoste, Nicole Castiglioni, Thomas J. McMahon, Bruce Rounsaville and Linda Mayes

Mothering From the Inside Out: Results of a second randomized clinical trial testing a mentalization-based intervention for mothers in addiction treatment

NANCY E. SUCHMAN, CINDY L. DeCOSTE, THOMAS J. McMAHON, RACHEL DALTON, LINDA C. MAYES, AND JESSICA BORELLI



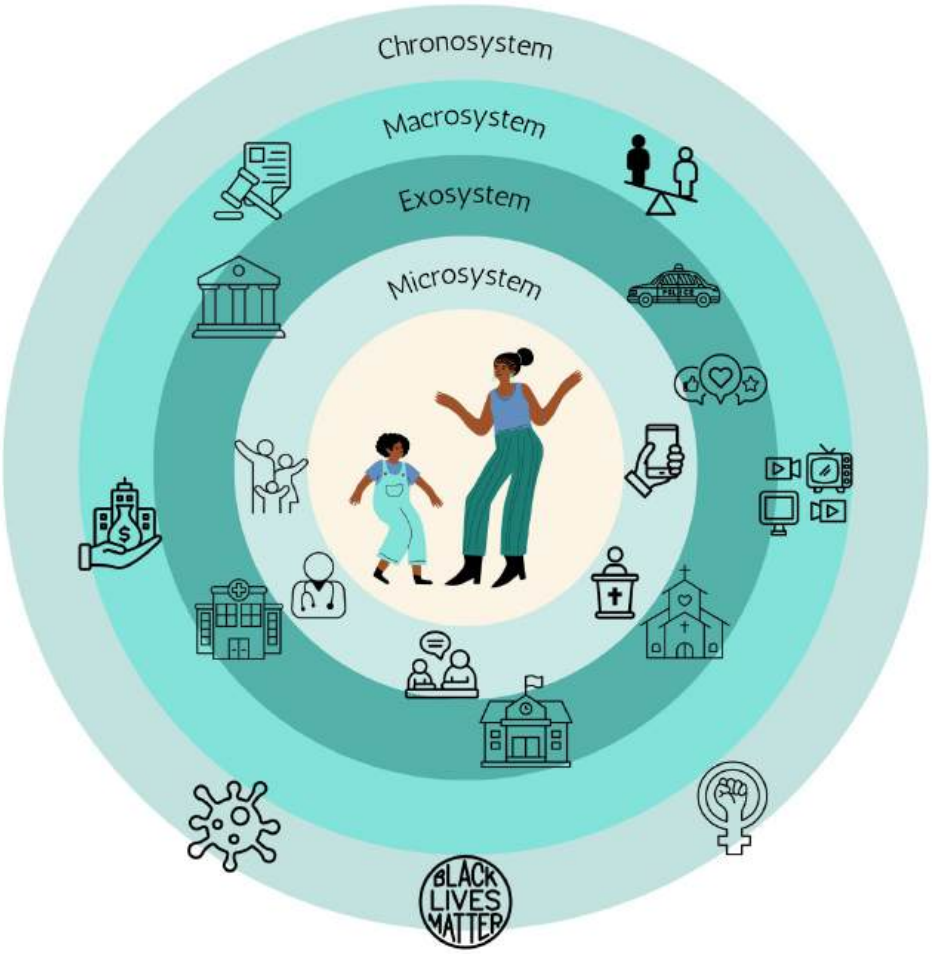
RESEARCH ARTICLE

WILEY

Mothering from the Inside Out: Results of a community-based randomized efficacy trial testing a mentalization-based parenting intervention for mothers with addictions

Amanda F. Lowell | Cindy DeCoste | Rachel Dalton | Hailey Dias | Jessica L. Borelli | Steve Martino | Thomas J. McMahon | Nancy E. Suchman

Systems-level interventions


Chronosystem
Macrosystem
Exosystem
Microsystem
BLACK LIVES MATTER

Adaptive mistrust

- **Many parents with SUD have:**
  - Many needs
  - History of relational trauma
  - Mixed feelings about help
  - High levels of mistrust

- ***<u>Mistrust is adaptive!</u>***
  - we need to adapt our practice

gain trust

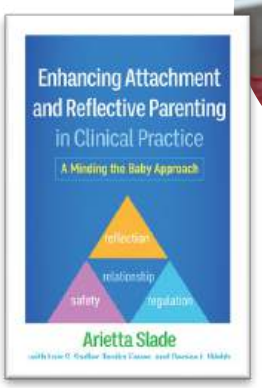
become trustworthy

Reflective functioning is the heart of the matter

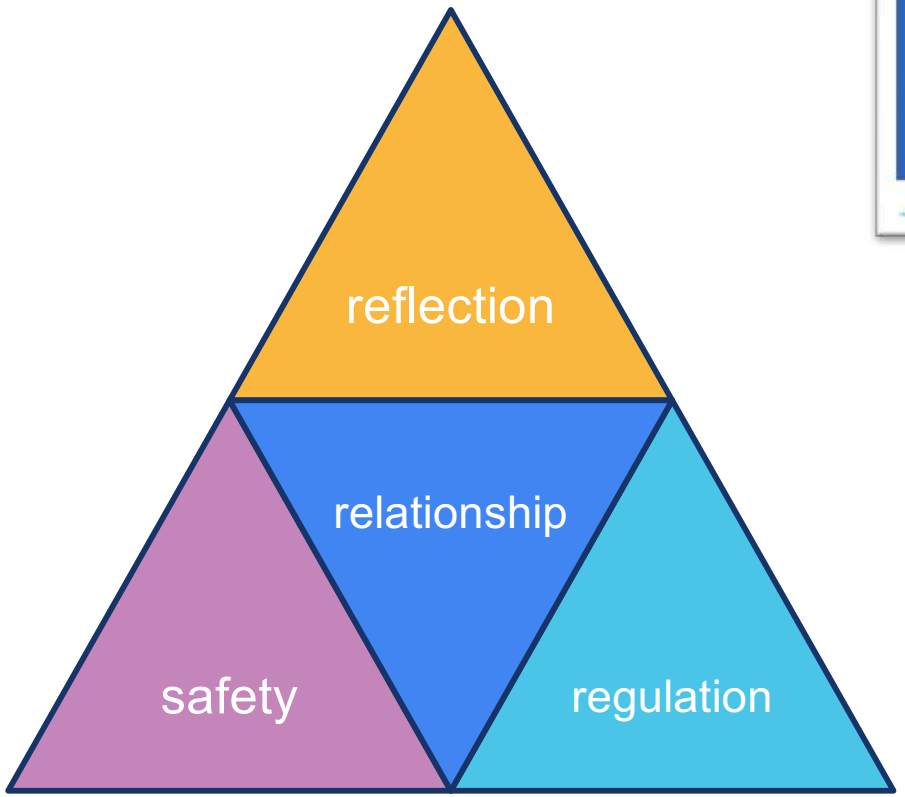
What? A system of care which uses reflection to support the client, network, and providers working with the client/family

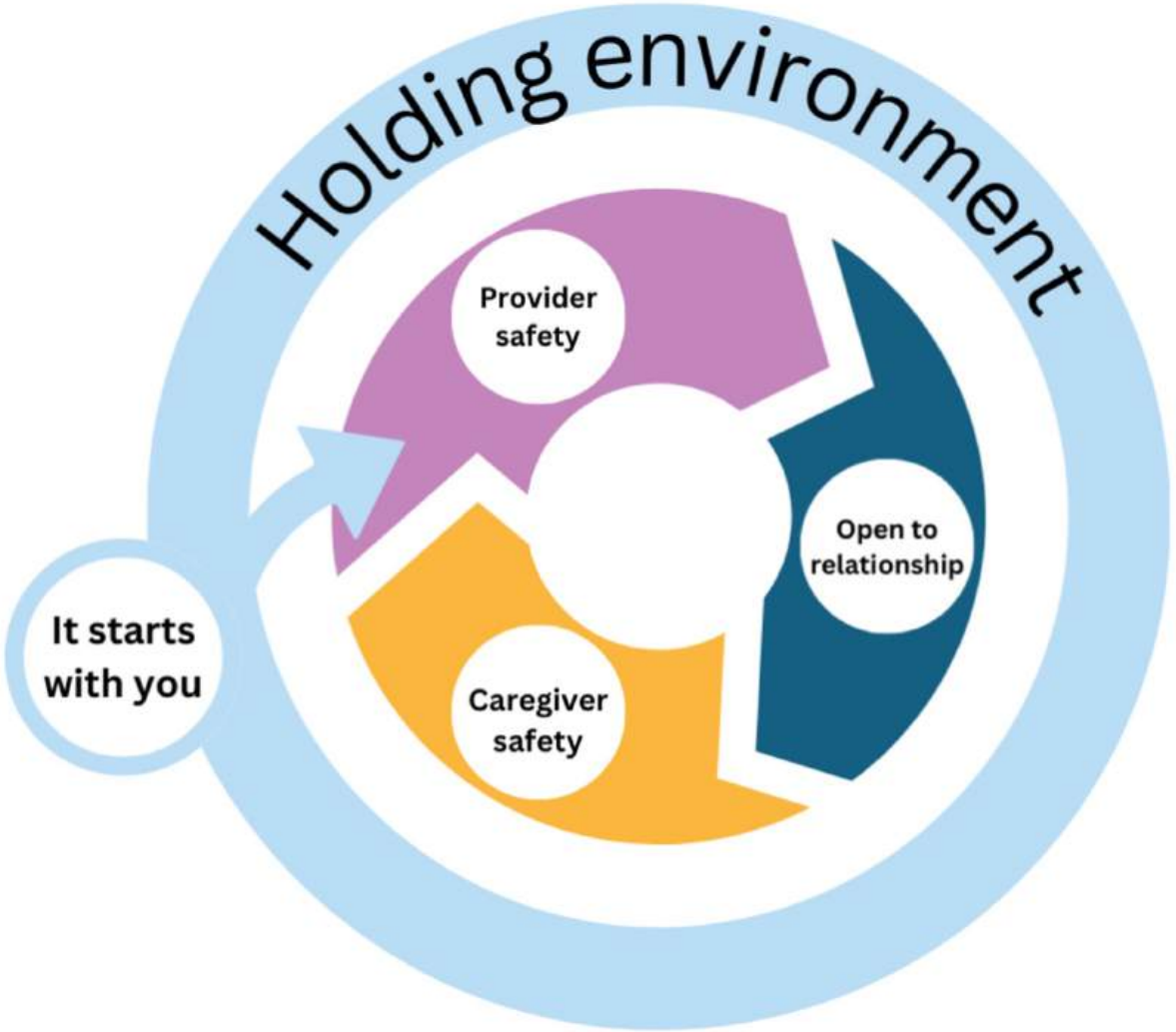
Why? To support teams who care for particularly complex families who struggle with trust and the belief that “help” can be helpful

Becoming trustworthy

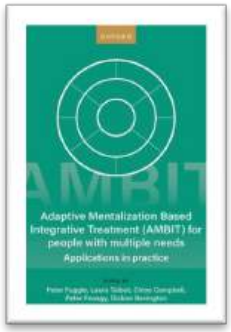


Arietta Slade, PhD




Holding environment
Provider safety
Open to relationship
Caregiver safety
It starts with you

Healthy systems of care



Reflective culture

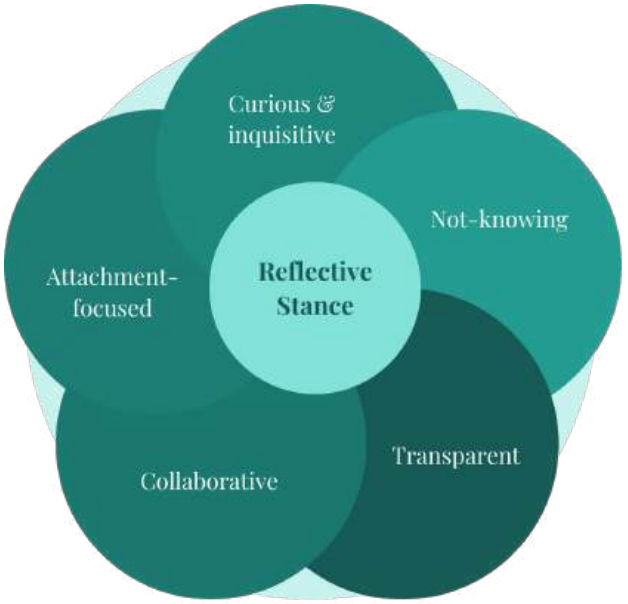
confidence that distress will be met with comfort

Secure attachment

"I feel that you feel that I feel"

Building reflective systems

- **At the systems level…**
  - **Recognize intersectionalities**
  - **Work to remain curious**
    - About ourselves, our colleagues, our clients
  - **Work to remain transparent**
    - With our colleagues, our clients
  - **Work to remain collaborative**
    - With our colleagues, our clients
  - **Decrease stigmatizing language**
  - **Develop policies that recognize the importance of trust as a pre-requisite for engagement in services**
    - And a pre-requisite for healthy systems



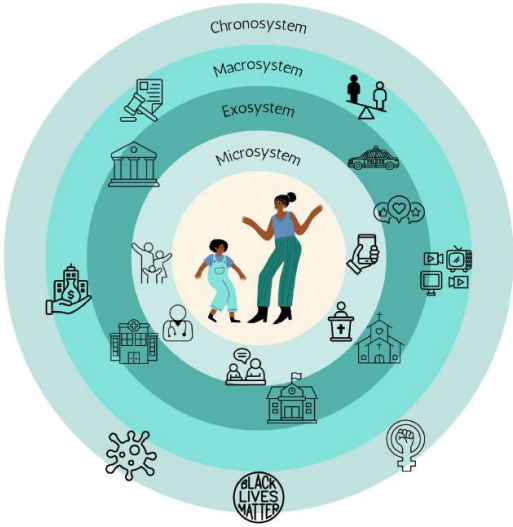
Building reflective systems

- **Moving from "best practices" to "best principles"**
  - You don't need to be a therapist to be therapeutic!
- **Train all providers in reflection regardless of discipline**
  - We should all speak the same reflective language!
  - Hold a shared frame of how parental reflective functioning impacts family mental health…
    - … and how systems affect parental reflective functioning
    - … and what impacts our own reflective functioning
- **Building systems that are trustworthy**
  - Early Relationships Across Systems (ERAS)

In summary...

Parental substance use is an intergenerational problem with risks to dyads via attachment & parental reflective functioning

Evidence-based practice & practice-based evidence suggests we should intervene at the level of the parent-child relationship



To support parental reflective functioning, we must become trustworthy by building reflective systems

Special thank you:

- Nancy Suchman
- Arietta Slade
- Lili Peacock-Chambers
- Amanda Zayde
- Tom McMahon
- Linda Mayes
- Helena Rutherford
- Nancy Close
- Research participants & clients

Elmo Learns About Parental Addiction

TTAC
Perinatal and Early Childhood Mental Health Network
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NEW YORK CENTER FOR CHILD DEVELOPMENT

McSILVER INSTITUTE
FOR POVERTY POLICY AND RESEARCH
NEW YORK UNIVERSITY

Lunch Break

UPLOAD YOUR PHOTOS!

Perinatal and Early Childhood Mental Health Network
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NEW YORK UNIVERSITY

NYC Health

What's Working (or Not) in Policy Approaches to Prenatal Substance Use

Andra Wilkinson PhD, MSPH

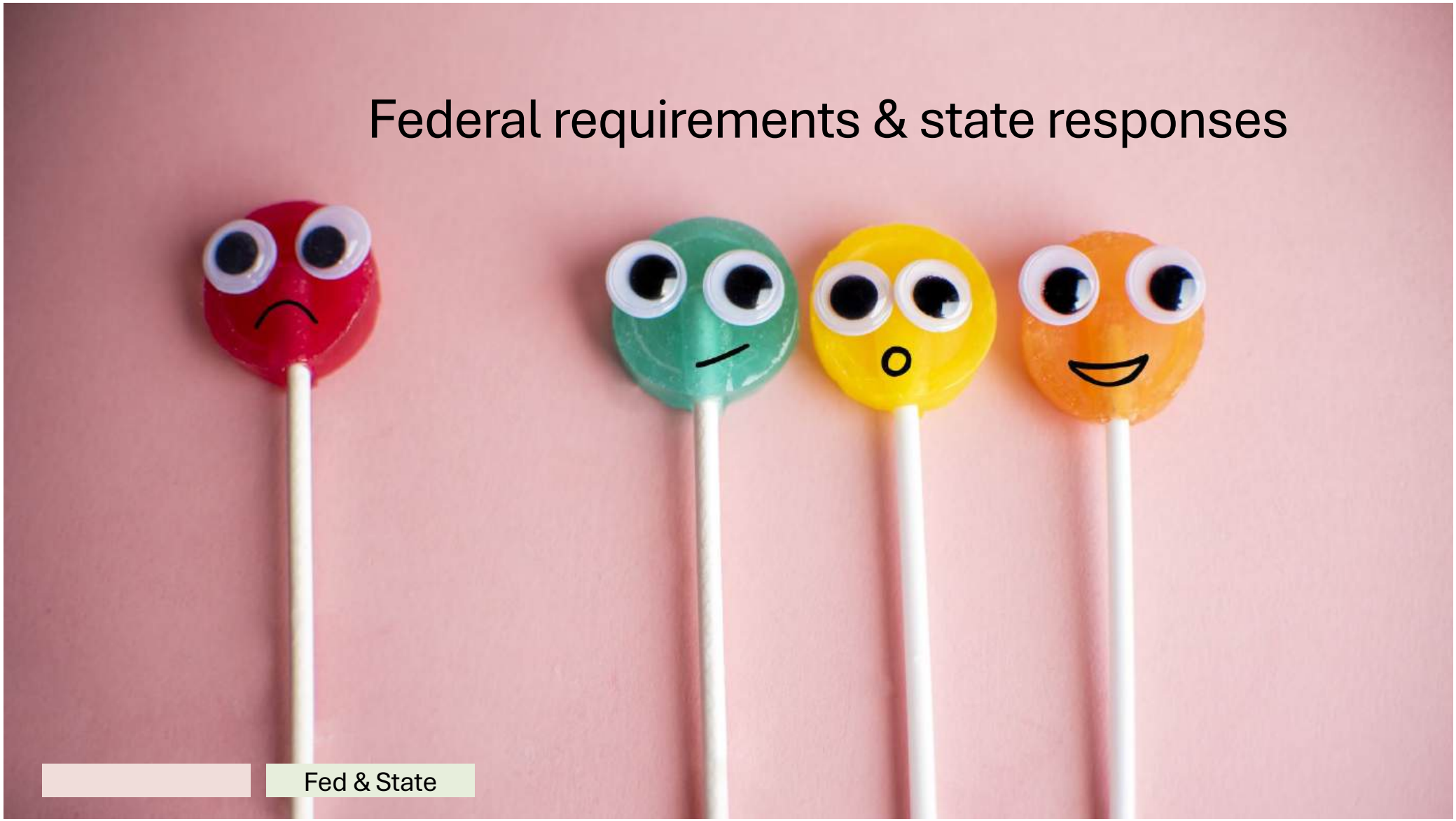
Outline

1. Introduction
2. Federal requirements and state responses
3. Outcomes associated with state approaches
4. Implementation challenges
5. Q&A

Andra Wilkinson, PhD, MSPH

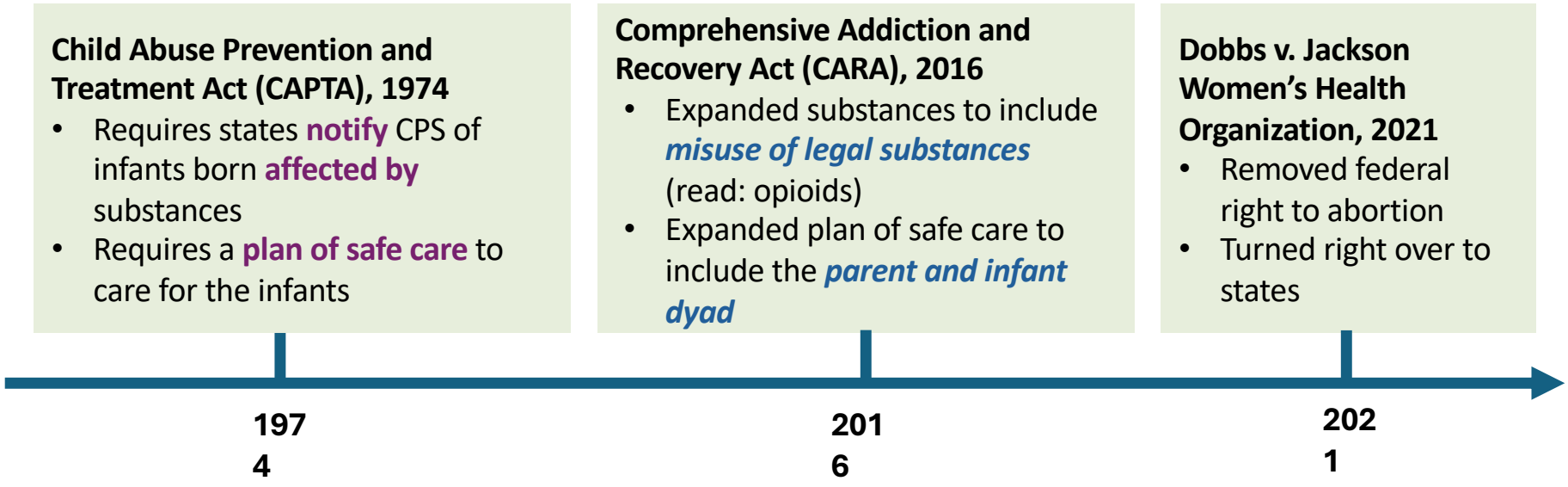
- Senior Research Scientist at Child Trends
- Adjunct Assistant Professor at University of North Carolina at Chapel Hill
- Member of the Research to Policy Collaboration, Pennsylvania State University

Federal requirements & state responses



Fed & State

Federal requirements



Fed & State

State responses - Notification

De-identified counts

LA County
- Only hospitals can report
- Risk matrix: https://tinyurl.com/5fcrds2e

Referral to child welfare

25 states consider prenatal substance use to be child abuse (Faherty, 2019)

Prosecution

South Carolina
- Women can get up to 10 years in prison for prenatal substance use

Source: Legislative Analysis and Public Policy Association. June 2024

Fed & State

State responses – “affected by”

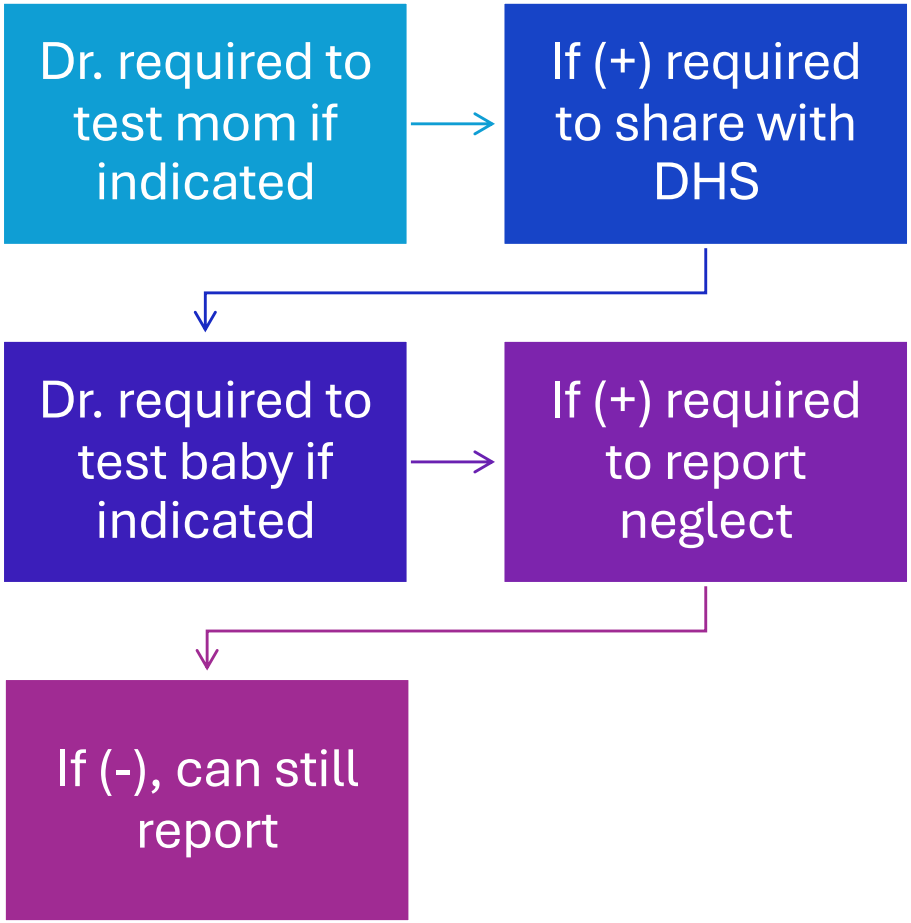
- Patient disclosure
  - ACOG recommends universal screening for alcohol, tobacco, and drug use during prenatal care
  - 2018 – 95% of patients reported being asked about alcohol/tobacco, 80% asked about drugs (Patel, 2021)
- Testing
  - Test everyone vs. allow physician discretion
  - Test urine, blood, meconium, hair, umbilical cord blood
  - Consent?
- Diagnosis of Neonatal Opioid Withdrawal Syndrome (NOWS), Neonatal Abstinence Syndrome (NAS)
  - NOWS presentation can mimic sepsis, hypoglycemia, hypocalcemia, etc. (Jansson, 2020)
  - When withdrawal presents depends on half life of the opioid (Hudak, 2012)
  - Not all infants with prenatal substance exposure develop NOWS/NAS

Fed & State

State EXAMPLE – “affected by”

MINNESOTA – Testing

No reports required for prenatal alcohol or cannabis use



Fed & State

State EXAMPLE – “affected by”

Fed & State

MINNESOTA – An infant is “affected by” substance use if:

- Testing of mother at delivery, infant at birth
- Withdrawal symptoms present at birth
- Medical effects or developmental delays during the child’s first year of life that medically indicate prenatal exposure to a controlled substance
- Presence of Fetal Alcohol Spectrum Disorder

State EXAMPLE – “affected by”

INDIANA – Exceptions

Similar to MN, adds

- “including a ***trace*** amount of controlled substance, prescription drug, or metabolite of either”
- Test urine, umbilical cord tissue, and/or meconium

- AND the child needs care/treatment they are not receiving/unlikely to receive
- NOT in cases of “mother’s good faith use” IF she has a prescription
- NO requirements for provider reporting

Fed & State

State responses – plan of safe care

- Who owns it?
  - Hospital?
  - Child welfare?
  - Both?
  - Pregnant person?
- When does it start?
  - Prenatally?
  - Postpartum?
- Warm referrals?

Fed & State

State EXAMPLE – plan of safe care

New Mexico

- Plan of care plan must be designed in partnership with hospitals, birthing centers, medical providers, Medicaid managed care organizations, and private insurers
- Created before hospital discharge post delivery by the provider and family, together
- Shared with the child's pediatrician, child's insurer (to monitor implementation), parent/caregiver, and child welfare (the notification)
- May include other groups to meet family's needs like public health agencies, maternal and child health agencies, home visiting, substance use disorder treatment providers, early intervention, courts, local education agencies, etc.
- Remains in effect for at least the first year of child's life, remains active as long as services are needed

Fed & State

State EXAMPLE – PLAN OF SAFE CARE

Connecticut

https://www.sepict.org/family-care-plan/

Step 1: Select the type(s) of resources that you need assistance with

- ☐ Cannabis Awareness and Education
- ☐ Medication Assisted Recovery/Treatment (Methadone, Buprenorphine, Naltrexone)
- ☐ Mental Health Counseling
- ☐ Substance Use Counseling
- ☐ Medical Care
- ☐ Reproductive Health
- ☐ Secure Environment & Medication Storage Plan
- ☐ Safe Sleep Plan
- ☐ Peer Support Meetings (12 Step Groups, SMART Recovery, etc.)
- ☐ Other Recovery Supports
- ☐ Childcare
- ☐ Home Visiting
- ☐ WIC
- ☐ Birth to Three
- ☐ Housing Assistance
- ☐ Insurance Support
- ☐ Financial Assistance
- ☐ Parenting Groups

Fed & State

State EXAMPLE – plan of safe care

New York

- Substance use disorder treatment programs develop plan of safe care with pregnant patient and anyone else they identify
- "The clinical staff person with primary responsibility for the patient" should help them develop a written person-centered treatment/recovery plan. It must include prenatal care.
  - If patient refuses, they must acknowledge in writing that prenatal care was offered, recommended, and refused
- Treatment programs must provide pregnancy tests
- Priority admission to treatment for pregnant people with opioid use disorder

Fed & State

Other decisions states must make

- Fund treatment for prenatal substance use (24 states)
- Prioritize pregnant people's access to treatment (25 states)
- Prohibit treatment programs from discriminating against pregnant people (4 states)
- Require providers to test (4 states)
- Require providers to refer positive cases to treatment and/or child welfare (23 states)
- Treat prenatal substance use as a crime or ground for involuntary commitment (7 states)

Source: Wilkinson, 2024

Fed & State

Outcomes associated with state responses

Outcomes associated with state policies

Funding MOUD for pregnant people

- Decrease in overdose
- Increase in MOUD

Prioritizing pregnant people's access to MOUD

- Increase in prenatal care
- Small improvement in infant health

Prenatal substance use = maltreatment

- Decrease in MOUD
- No decrease in NAS/increase in NOWS
- No decrease in prenatal substance use
- Decrease in prenatal care

Criminalize prenatal substance use

- Increase in overdose
- Increase in foster care admissions

Outcomes

Implementation challenges

Implementation

Hospitals

- Hospital testing policies are often stricter than state requires
- Hospital tests and cut points are all over the map
- Racial bias in who is tested; white pregnant people more likely to test positive (Jarlenski,2023; Malekmadani, 2024)
  - Black, low income, publicly insured, limited prenatal care all more likely to be tested
- Studies of hospital testing have found:
  - No documented consent, less than third of tests had medical indication (Malekmadani, 2024)

Physicians

- Pregnant people less likely to be asked about prenatal substance use in states that consider prenatal substance use to be child abuse (Patel, 2021)

- NY study: "Obstetricians, neonatologists, SUD treatment providers, and child welfare providers (all of whom may be involved in a case where substance use occurred prenatally or perinatally) *may each see the "patient" and the goals of treatment differently*." (Jose, 2025)

- Potential for implicit bias

Child welfare

- Funding not aligned with POSC requirements
- Dyad (mom/baby) treatment opportunities are rare
- Positive examples have these things in common: Integrating Ob/Gyn care with addiction treatment with pediatric care AND referral to other services.
  - NC Horizons: Has residential programs, helps parents navigate child welfare
  - MA HOPE Clinic: Provides two years of postpartum and pediatric care after delivery

Fetal personhood

- South Carolina: State Supreme Court decided “child” includes a viable fetus. Prenatal substance use can be prosecuted as:
  - Unlawful neglect (10 year max sentence)
  - Homicide by child abuse (20 year min sentence)
- Alabama: Created ‘chemical endangerment of a child’ in 2006 to combat home meth labs. Now applied to prenatal substance use. Child includes those born and unborn.
  - Stillbirth or miscarriage can lead to Class A felony (99 year max sentence), even with no discernable link between prenatal substance use and miscarriage. One county has charged 257 pregnant people.
- Oklahoma: Changed stillbirth definition from 20 weeks to 12 weeks to help parents get a death certificate. But, fetal remains are drug tested during autopsy, parent can be charged with felony.
  - At least 26 women have been charged for prenatal use of marijuana. Two counties have charged 7 women with felony child neglect for prenatal marijuana use.

Source: Marchiony, 2024


Q&A
brain
genius
creativity
PLAN
TEAM
WORK
WORK
PLAN
Idea
search
Time
concept
Team
POWER
success
PLAN
IDEA
TEAM
WORK
IDEA
PLAN
WEB
BUSINESS
Q&A

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The Evolving Focus of Child Welfare: Supporting Families with Substance Use Disorders in the Perinatal Period

presentation to:

Perinatal and Early Childhood Mental Health Network
Training and Technical Assistance Center (TTAC)
Annual Spring Conference
June 11, 2025

Katherine Haver, Policy, Planning & Measurement, ACS
Jill Krauss, Office of the Commissioner, ACS

NYC Children

ACS protects and promotes the safety and well-being of New York City's children and their families by providing child welfare, and juvenile justice services, and by funding community supports and child care services.

- Through **Child and Family Well-Being**, ACS offers support to families and children including child care vouchers and through our network of Community Partnerships and Family Enrichment Centers.
- In **Prevention Services**, ACS contracts with nonprofit organizations that provide secondary and tertiary preventive services to support and stabilize families.
- **Child Protection** responds to reports of suspected child abuse or neglect to assess safety and offer supports to families.
- In **Family Permanency**, ACS contracts with non-profit organizations that deliver foster care services that achieve safety, permanency, and well-being for children and families.
- **Juvenile Justice** administers services for youth and families, including detention, residential placement, and intensive community-based programs.

From Reporting to Supporting

1. Our Evolving Responsibilities to Families
2. Families with Substance Use Disorders in the Perinatal Period
   a. Screening and Testing
   b. Plans of Safe Care
   c. When to Report to the SCR
3. Supportive resources
4. Questions/Discussion

Our responsibility to children and families is evolving

Involvement with the child welfare system can be traumatic for families

Fear of child welfare involvement can discourage help-seeking, which can increase risk

New York State Office of Children and Family Services (OCFS) has shifted from "when in doubt call the SCR" to "You can support a family without having to report a family"

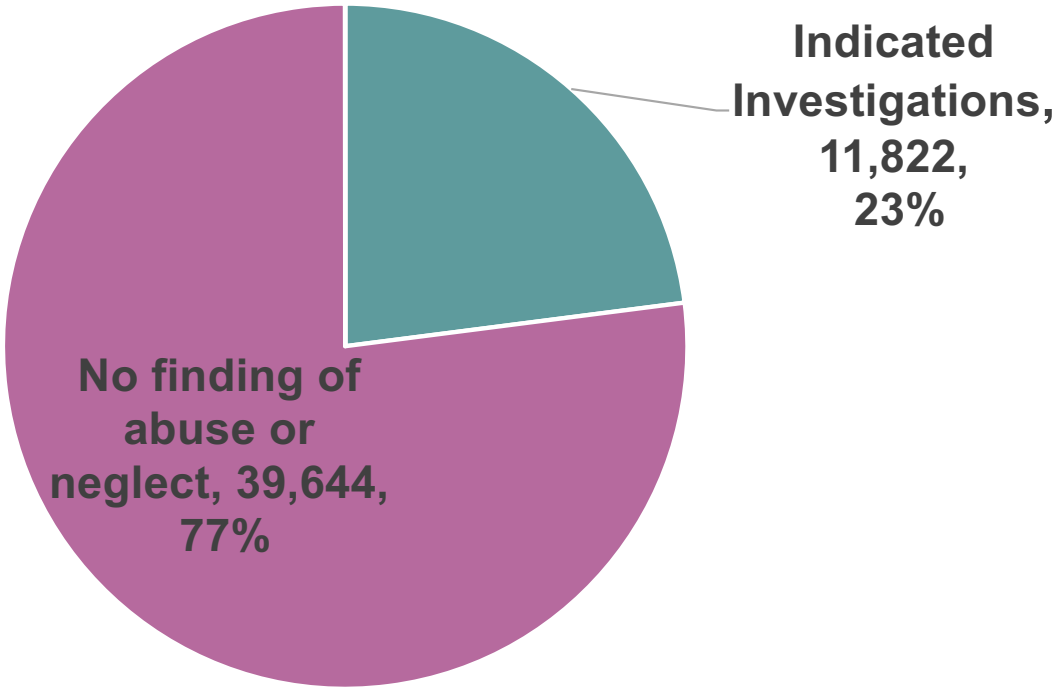
ACS is partnering with many City systems and partners to make this shift a reality

From Reporting to Supporting

Goals:

- Reduce unnecessary reports to the State Central Register of Child Abuse and Maltreatment (SCR)
- Increase supports accessed directly by families, without a call to the SCR, when there is no reasonable cause to suspect abuse or maltreatment by the child's caregiver

Child Protection Cases in NYC, 2023



Racial disproportionality in child welfare in NYC

8x

Black children are **8x** more likely than white children in NYC to be in an investigation

7x

Hispanic/Latinx children are **7x** more likely than white children to be in an investigation

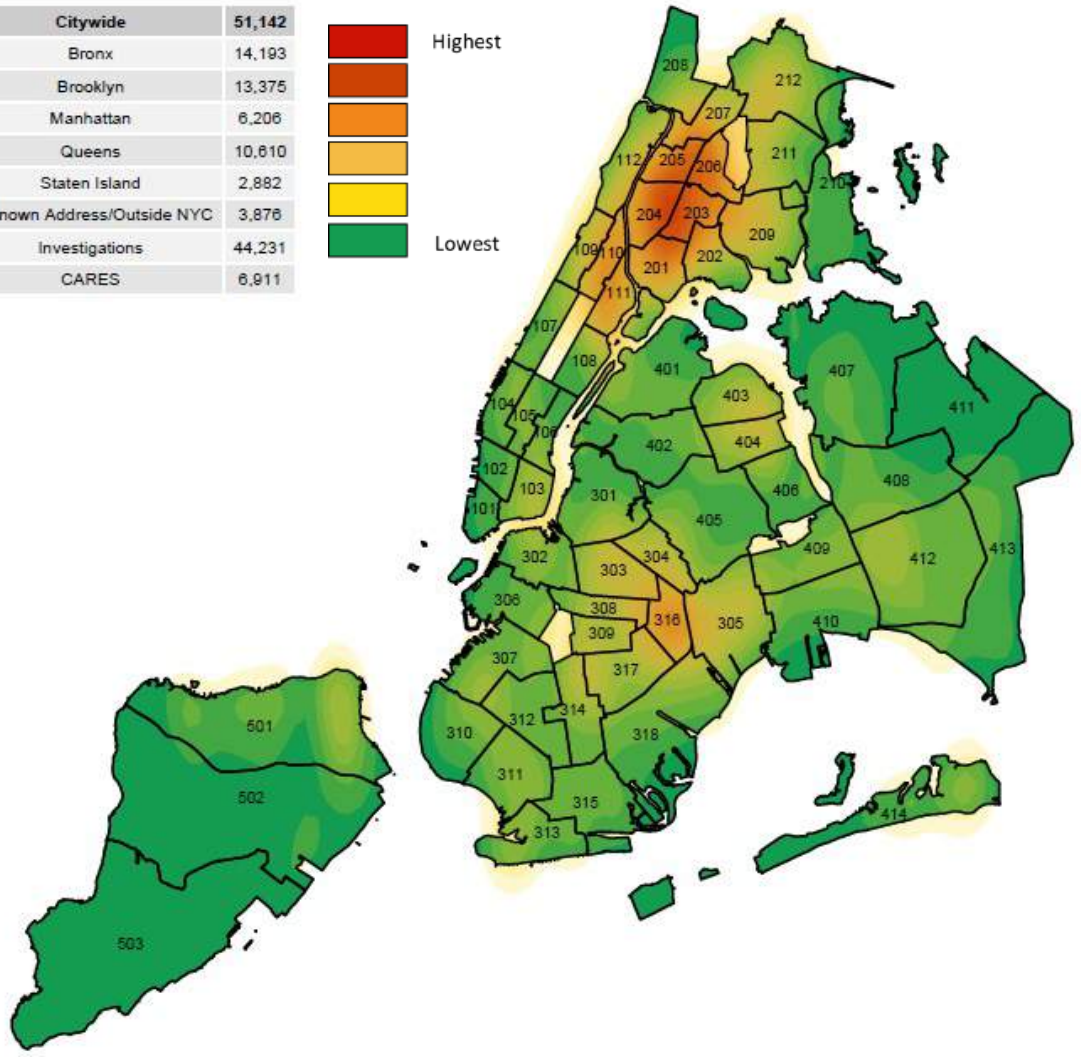
44 %

One recent study estimated that **44%** of Black children in NYC experienced an investigation before age 18

SCR Reports, Citywide

2022 Child Protection Cases (Investigations and CARES)

Citywide	51,142
Bronx	14,193
Brooklyn	13,375
Manhattan	6,206
Queens	10,610
Staten Island	2,882
Unknown Address/Outside NYC	3,876
Investigations	44,231
CARES	6,911



New OCFS Mandated Reporter Training

1. You can support a family without having to report a family.
2. Poverty in and of itself is not maltreatment
3. Consider your biases and focus on objective facts.

All mandated reporters must take the new training (verification upon issuance or renewal of professional licenses / certification).

nysmandatedreporter.org

NYC Children

When Must Mandated Reporters Call the SCR?

When in their professional role, they are presented with reasonable cause to suspect child abuse or maltreatment by a parent or other person legally responsible for a child.

- **Abuse** includes non-accidental serious physical injury, risk of serious physical injury, or sex abuse.
- **Maltreatment** involves failure to provide the minimum degree of care and that failure results in impairment or imminent danger of impairment to the child's physical, mental or emotional condition.
  - The determination of whether a minimum degree of care was taken (in providing food, clothing, medical care, etc.) hinges upon whether the parent was financially able to do so or was offered other financial or reasonable means to do so
  - **Poverty, in and of itself, is not child maltreatment**

Source: New York State Office of Children and Family Services (OCFS)

When Deciding Whether to Report

- Consider the urgency. In many situations, it's okay to **pause** and take a breath.
- Obtain more information, **ask clarifying questions**. This is not the same as investigating.
- Where possible, **huddle** or **consult** with colleagues.
- **Think critically:** Examine facts versus assumptions, stay curious**,** keep an open mind.
  - Bias may be more likely at certain times: at the end of a long day, when stressed/emotionally charged, tired, or hungry.
  - Remember: just because you disagree with a parent's decisions or actions does not mean a child is being abuse or maltreated.
  - Has the parent failed to provide a minimum degree of care? Did that result in impairment or imminent risk of impairment?
- The **individual** who has reasonable cause to suspect abuse or maltreatment makes the report

Supporting Substance Affected Newborns and Their Caregivers

Screening and testing

- Verbally screen pregnant patients for use
- Toxicology testing of pregnant/birthing person or newborn to be conducted:
  - When medically necessary and with written consent from the patient, documented in the patient's medical record; **or**
  - In an emergency situation

Supporting Substance Affected Newborns and Their Caregivers

On their own, the following do not require an SCR report:

- Positive toxicology
- Pregnant person's past or present drug use
- Lack of baby supplies or perceived readiness to bring home a baby
- Late, limited or minimal prenatal care

When is an SCR report required?

When, in your professional role, you develop a reasonable cause to suspect that a child is being maltreated or abused by a parent or person legally responsible for the child

Factors that may be relevant:

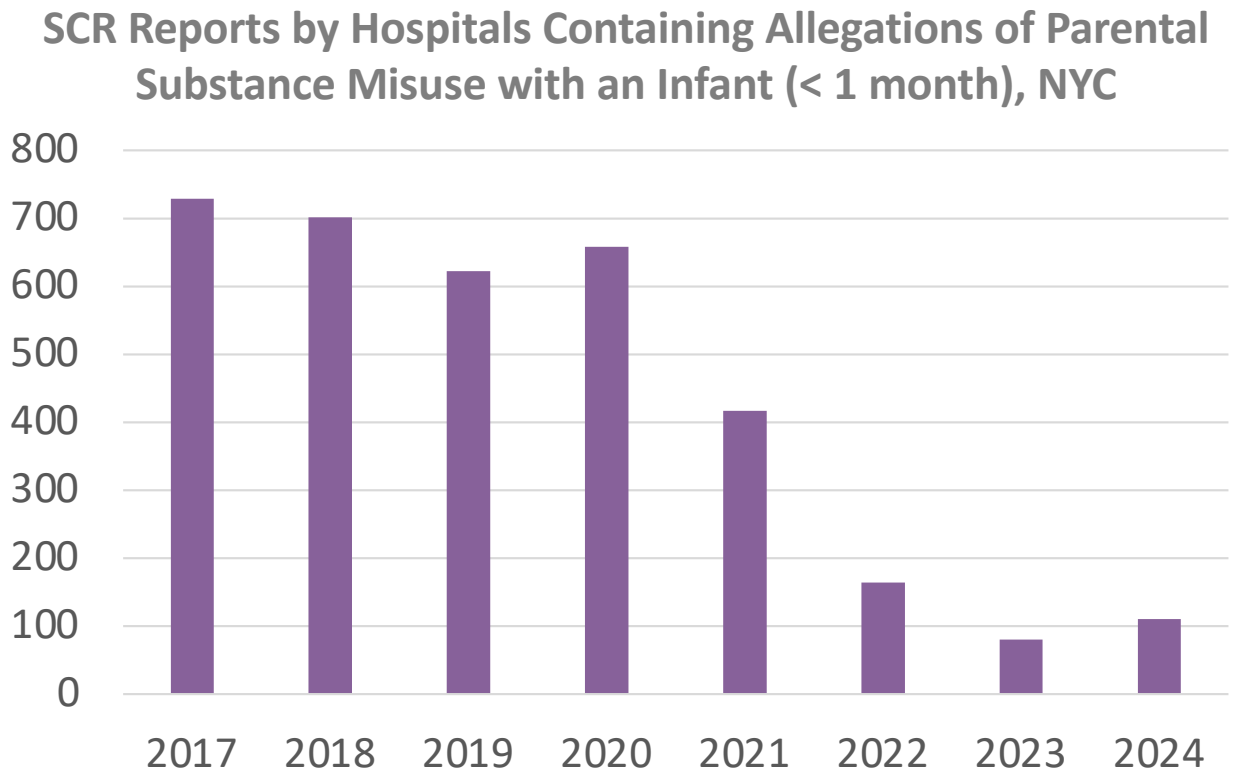
- Caregiver's ability to respond to the newborn's needs;
- the newborn's physical condition, treatment needs and family's ability to meet those needs;
- Where relevant, caregiver's engagement in appropriate care or treatment

Supporting Substance Affected Newborns and Their Caregivers

Plans of Safe Care (POSC)

- Required to support newborns affected by substance use and their families or caregivers
- "Substance affected newborns" are those who:
  - display symptoms of substance withdrawal and have a positive toxicology screen
  - receive a diagnosis of Neonatal Abstinence Syndrome (NAS) **or**
  - receive a diagnosis of a Fetal Alcohol Spectrum Disorder (FASD)

Substance Affected Newborns and Their Caregivers: Data on SCR Reports



Prevention In Your Community

NY State Official Definition:
"Prevention Services are for families experiencing circumstances that may lead to child maltreatment. They aim to support families in the community, promote family stability and well-being."

Families can be referred to prevention directly, without a call to the SCR

Eligibility for Prevention Services

- Provided by community-based organizations
- Available regardless of language
- Prevention Services are available free of charge, no insurance required, regardless of immigration status
- For families with children 0-18 years of age (**up to 21** if exiting foster care)
- Also available to expecting parents (teens or adults)
- Voluntary: we value “voice and choice”

Ways that Prevention Services Can Support Families

- Case management
- Casework counseling
- Day care services
- Heavy-Duty Cleaning
- Homemaker services
- Family planning services
- Home management services
- Clinical referrals
- Understanding developmental needs

- Parent training
- Transportation services
- Emergency cash or goods
- Emergency shelter outreach
- Housing advocacy
- Home-based therapeutic treatment (domestic violence, trauma, family conflict, mental health, and substance abuse) **specific to the agency*

Prevention Services at a Glance

44+ contracted providers

130+ programs

15,000 families

31,000 children served annually

Family Support programs

Evidence-Based Therapeutic Models

Family Treatment and Rehabilitation (FT/R)

- **Population:** families with mental health and/or substance misuse concerns that may pose risks to children
- **Approach:** families move through phases of treatment based on assessments by multidisciplinary teams
- **Clinical Staff:** teams include specialists in mental health and substance misuse

17 programs

12 providers

1,952 contracted slots*

**as of FY26*

17% of system capacity in FY24

1,310 families served in 2024

NYC Family Treatment and Rehabilitation (FT/R) Providers

Manhattan
Lower East Side Family Union
Graham Windham

Queens
SCO Family of Services
Coalition for Hispanic Family Services
Forestdale, Inc.

Staten Island
Seaman's Society for Children and Families

Brooklyn
Forestdale, Inc
Good Shepherd Services
Heartshare – St. Vincent's
Graham Windham
Jewish Child Care Association
Coalition for Hispanic Family Services

The Bronx
University Behavioral Associates
Good Shepherd Services
Graham Windham.
Cardinal McClosky Community Services
SCAN-Harbor, Inc.

A directory of all prevention programs, including FT/R, may be found here: https://airtable.com/appqlOhkyqxwsElCN/shrzCHXHzOCGEFABQ/tbl0CUtLajUMUN9VC

How Do I Connect a Family With the Right Program?

We are here to assist you!!

Call the **Support Line** at **212-676-7667** or **connect@acs.nyc.gov**. Contact us anytime for all inquiries or questions about the most appropriate services and resources.

Social workers are on hand to respond to your inquiry and provide options to you and/or speak to families directly.

Additional resources:

- Prevention Provider Directory: https://airtable.com/appqlOhkyqxwsElCN/shrzCHXHzOCGEFABQ/tbl0CUtLajUMUN9VC
- Flyers about prevention (Family Support Services) in 10 languages: Contact connect@acs.nyc.gov

Prevention support line 212-676-7667 (M-F, 9-5) or connect@acs.nyc.gov

Contact us anytime for inquiries or questions about services and supports

Bringing It All Together: Panel Discussion

Moderators: Susan Chinitz, Psy.D. and Gilbert Foley Ed.D.

Speakers

- **Leah Habersham, MD**
- **Amanda Lowell, Ph.D**
- **Andra Wilkinson, Ph.D**
- **Katherine Haver, NYC ACS**
- **Jill Krauss, NYC ACS**

Resources & Feedback Survey

RESOURCES

URL: bit.ly/2025ttac-conference

FEEDBACK SURVEY

URL: bit.ly/2025ttac-conference-feedback

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