



# Vermont's CHARM (Children and Recovering Mothers) Team:

*A collaborative approach to supporting pregnant and parenting women with opioid use disorders and their infants*

**Anne M. Johnston**, MD, Neonatologist  
University of Vermont Children's Hospital

**Sally Borden**, M.Ed., Executive Director  
KidSafe Collaborative

**Karen Shea**, MSW, Deputy Commissioner  
Vermont Department for Children and Families

Wisconsin Opioid Steering Committee July 16, 2017

# LULU JONES (FICTITIOUS NAME)

- 23 year old woman, pregnant for the first time
- Although the pregnancy was not planned, Lulu and her partner Chad are looking forward to having a baby
- At 12 weeks of pregnancy, Lulu confides in her doctor that she has been using opioids, specifically Vicodin, for the past 3 years.
- She has tried to stop many times and keeps restarting the pills and then used heroin when she couldn't buy pills.
- She wants her baby to be healthy and is desperate to quit and feels ashamed that she cannot.
- Lulu is referred to specialists in obstetrics and neonatology to discuss her options

## LULU JONES (CONT'D)

Lulu meets with the specialists and their teams who obtain the following history:

- Lulu experimented with drugs including marijuana, alcohol, cocaine (once) during her high-school years
- She really liked the feeling of opioids (Percocets) but they did not become a habit at that time
- 3 years ago, Lulu was in a car accident and had several limb fractures which required treatment with oxycodone
- She obtained several prescriptions for oxycodone in the months following, and then bought from the "street"

## LULU JONES (CONT'D)

- Lulu began to suffer withdrawal and when she could not find any pills at a price she could afford, she bought heroin
- At first she used heroin by snorting, however she progressed to injecting, something she “swore she would never do”
- She has repeatedly tried to stop
- Lulu smokes tobacco – ½ ppd and has not used alcohol since she discovered she was pregnant (she reports occasional use of 1 drink every 2 weeks prior to the pregnancy)

## LULU JONES (CONT'D)

- Lulu reports that she grew up in a “good family”, her mother is a nurse and her father has a successful business
- She related that her mother is an alcoholic in recovery, and her father has untreated alcoholism
- Lulu and Chad reside together in a rented apartment
- Lulu also related that she was sexually abused as a child by a distant male relative
- She has a history of anxiety and depression and is on anti-depressant therapy
- She has seen a therapist on occasion but has not confided her drug use to her therapist

## LULU JONES (CONT'D)

- Lulu is currently enrolled in community college with the goal of being an early childhood educator
- When asked, she finds it difficult to discuss her strengths as does Chad
- Chad has no history of substance use and drinks the occasional beer
- It is obvious that Lulu and Chad want very much to be excellent parents
  - What would happen to Lulu if she presented in your community for help today?

# LULU JONES (CONT'D)

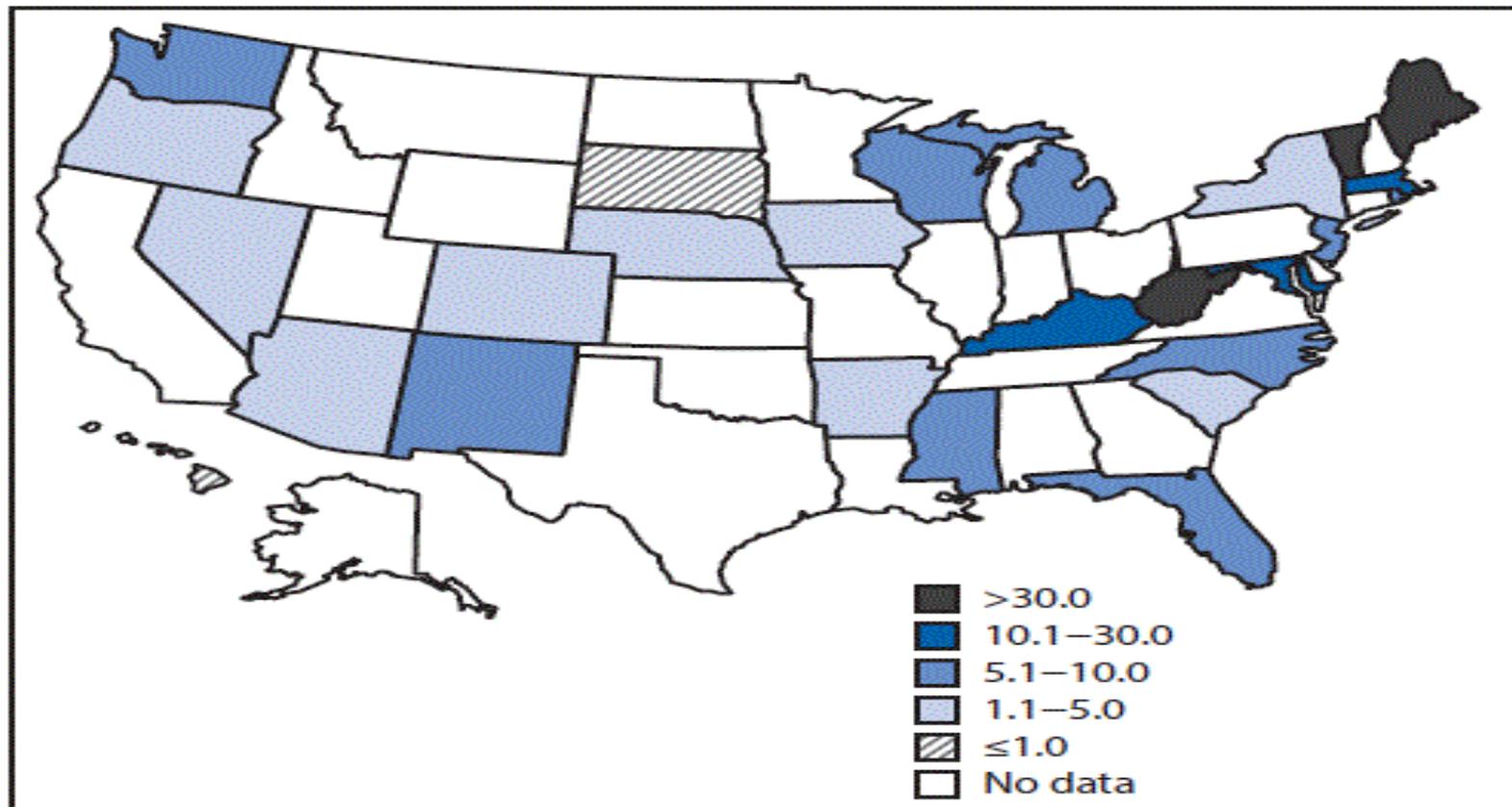
## Vermont's CHARM approach:

- Lulu is assured that effective treatment is available and that part of her treatment will be to reduce the shame she feels
- Lulu was started on buprenorphine treatment with the goals of treating withdrawal, reducing cravings, and decreasing the effectiveness of any additional opioids she uses
- Immediately Lulu starts to feel better although she and Chad continue to worry about the effects of buprenorphine on their unborn baby
- Will our baby be “addicted”? What are the long-term effects?
- Will the state take our baby away?

# Agenda

- Opioid dependence in pregnancy
- Opioid-exposed newborns
- The CHARM collaborative
- Teaming for success: the role of child welfare

# Neonatal Abstinence Syndrome Incidence Rates – 25 States, 2012-2013



Maine	30.4
Vermont	33.3
W Virginia	33.4

Vermont had the highest annual rate increase of states surveyed

# New York Times

## *In Annual Speech, Vermont Governor Shifts Focus to Drug Abuse*

By Katherine O. Seelye Jan 8, 2014



The explosion of drugs like OxyContin has given way to a heroin epidemic ravaging the least likely corners of America - like bucolic Vermont, which has just woken up to a full-blown crisis  
By DAVID AMSDEN

# The New Face of Heroin

PHOTOGRAPH BY FREDRIK BRÖDEN

**E**VE RIVAIT ADDE HER FIRST HORSE WHEN SHE WAS FIVE, too small to get her feet through the stirrups, let alone give the animal a kick that registered. Yet even then, bouncing in the saddle, she was aware that being on the back of a horse provided relief from the boredom and isolation that, for her, were a more dominant part of growing up in Vermont than the snowcapped mountains and autumn foliage that draw millions of tourists to the state each year. As Eve got older, she began spending afternoons exercising the herd at Missy Ann Stables, not far from her home in Milton, a working-class town of about 10,000 located along Lake Champlain, some 30 minutes north of Burlington. Before she could drive a car, Eve was training horses at various barns in the area.



## Myth #1: Opioids during pregnancy → “damaged baby”

- There is no evidence that opioid exposure, in and of itself, results in developmental delay or any other lasting effects on the exposed child
- On the other hand, alcohol exposure can result in profound physical /developmental / behavioral effects

## Myth #2: Every baby born to a mother on opioids is born “addicted”

- Opioid-exposed: exposure to opioids – either prescribed or illicit
- Opioid-dependent: infant exhibits signs of withdrawal severe enough to need medication
- Opioid-addicted: infants cannot be addicts, the disease of addiction requires obsession and compulsion, loss of control, “breaking the rules”
- Vermont data show that only 25% of opioid-exposed infants require treatment.

**“Addicted newborns”**



## Myth #3: If a baby needs treatment for opiate withdrawal, it must be because the mother “used” opioids during pregnancy

- The severity of withdrawal is not associated with the dose of medication during pregnancy
- Exposure to tobacco can increase the severity of withdrawal
- Higher Neonatal Abstinence Scores (NAS) do not indicate that a mother has “used” during pregnancy

## Myth #4: Opioid abuse + pregnancy = child abuse

- >1500 babies born to opioid-dependent women at UVMMC
- Over 90% of these babies were discharged in the care of their mother +/- father (2002 – 2014)
- The majority of parents we see are actively engaged in treatment and display good parenting, many need support in order to do so
- If a parent is not adhering to treatment, does not want to receive treatment **and** is actively using – they may NOT be ready to parent a child

# Medication Assisted Treatment (MAT): Standard of Care for Opioid Dependency in Pregnancy

- WHO 2014: “Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment...rather than...attempt opioid detoxification.”
- Facilitates retention of mothers/infants with decreased use of illicit substances when compared to no medication
- MAT results in NAS which needs Rx in 50-60% patients (Jones et al, 2010)
- The severity of NAS does not appear to differ according to the dose of methadone (or buprenorphine) maintenance therapy mothers received during pregnancy (Cleary et al, 2010; Jones et al., 2013)

# Why is medication assisted treatment the best alternative?

- Decreases prematurity and low birth weight
- Improves the health of the pregnancy
- Lowers infant mortality
- Pregnant woman feels well (not “high”) and has no cravings
- Successful engagement in treatment increases the probability of good parenting
- Detoxification during pregnancy is rarely successful and dangerous to the fetus

**Concern:** anything that drives pregnant opioid-dependent women from seeking treatment results in more prematurity, higher infant mortality, less probability of successful parenting

# The untreated woman with opioid-use disorder who becomes pregnant: obstetric and neonatal effects

- Obstetric Effects
  - Prematurity, low birth weight
  - Placental abruption, placental insufficiency
  - Intrauterine fetal demise
- Neonatal complications
  - Meconium aspiration, transient tachypnea
  - Feeding difficulty, seizures, jaundice
  - Neonatal opioid withdrawal
- If recognized that mother is opioid-dependent
  - Child protective services involvement
  - Challenge of taking care of newborn and starting treatment for addiction



[www.thefix.com](http://www.thefix.com)

## The untreated woman with opioid-use disorder who becomes pregnant: neonatal effects

- **If unrecognized and infant exhibits no withdrawal**
  - After discharge infant may be particularly irritable
  - Family's ability to cope and seek help impeded by fear of discovery
  - Mother will probably remain active in her addiction
  - Exposure of infant to unsafe situations
  - Mother continuously "flying under the radar" and hiding her addiction
  - Mother often unwilling to come forward for fear of losing her child / children

# Opioid dependence : Treatment options

- Detoxification – generally not safe nor advisable in pregnancy

- Medication Assisted Treatment (MAT): the standard of care in pregnancy

- Methadone



- Buprenorphine



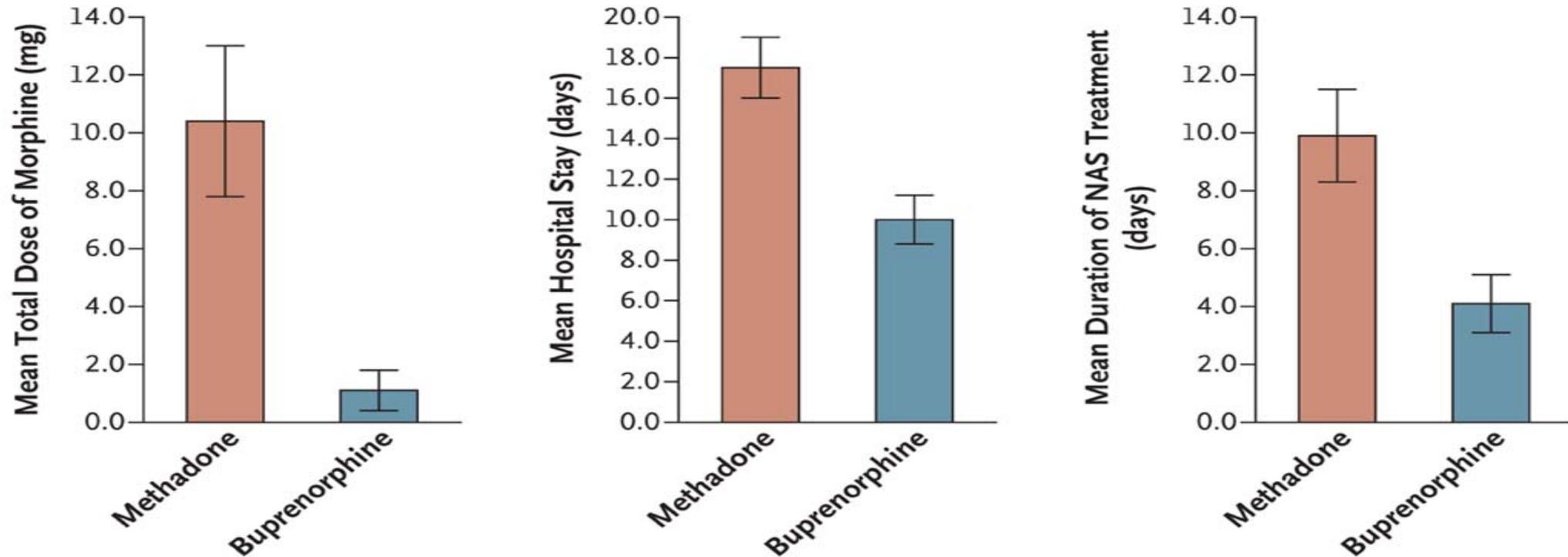
- Harm Reduction

- Needle exchange



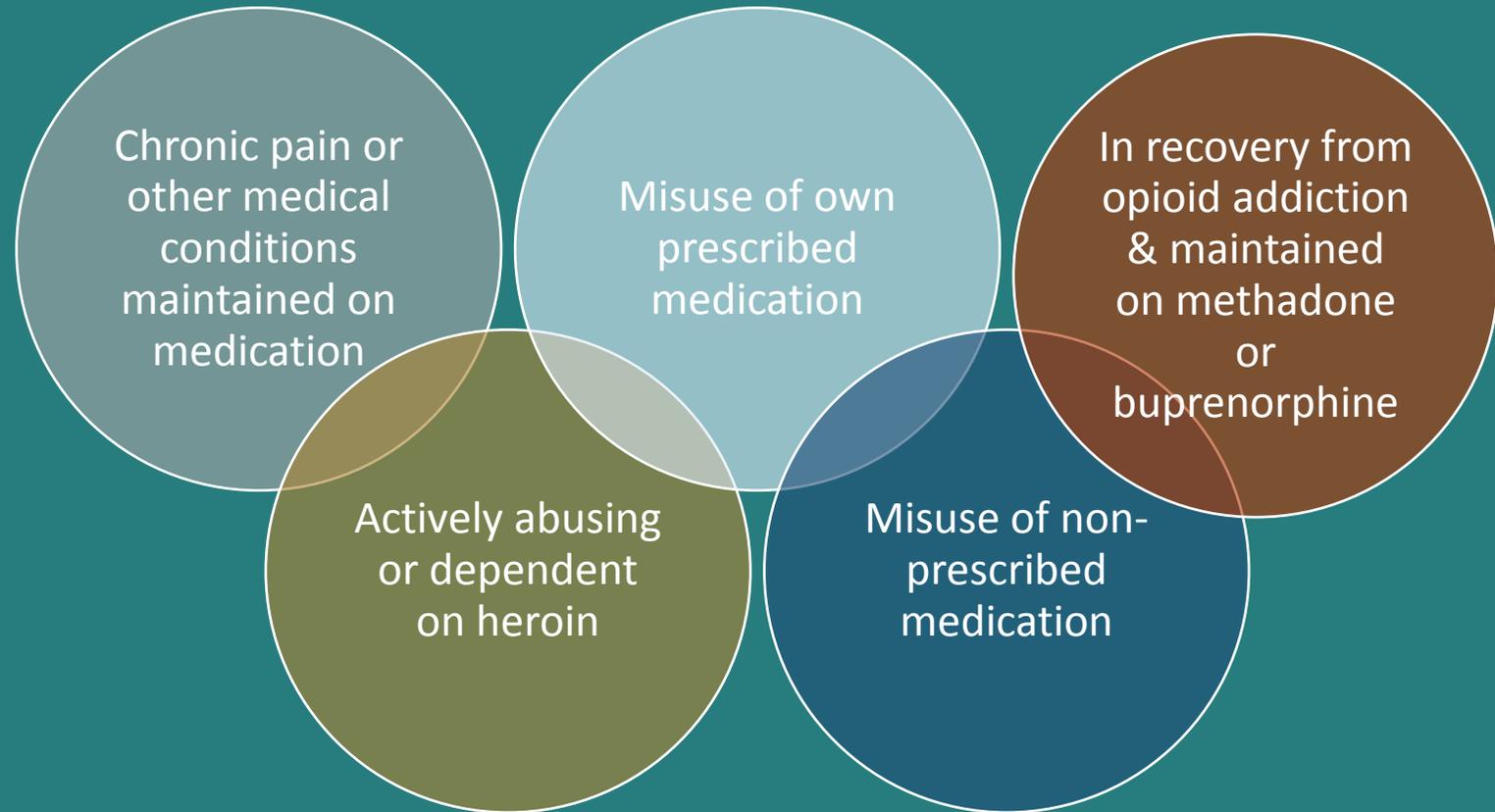
# MOTHER Study

## Mean Neonatal Morphine Dose, Length of Neonatal Hospital Stay, and Duration of Treatment for Neonatal Abstinence Syndrome



Note: % infants requiring pharmacologic treatment was 57% in methadone group vs 47% in buprenorphine group (NS)

# Different Populations of Women Can Give Birth to Infants with NAS Symptoms



# Issues facing substance-using pregnant women and their children

- **Generational substance use**
- **Untreated mental health problems**



- **Legal involvement**
- **Unstable housing**
- **Unstable transportation**



- **Limited parenting skills and resources**
- **Exposure to trauma**



- **Lack of positive and supportive relationships**

# Shame





"I SWEAR TO TELL THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, FROM MY PERSPECTIVE."

# Focus on the mother's health to have better outcomes

- Build trust
- Focus on respect and strengths
- Decrease fear and shame
- **Promote breastfeeding**



# UVM Children's Hospital NeoMed Experience

- Alleviation of fear
  - Care Notebook
  - You are not alone...
  - Ask them for their stories
- Respect
  - Introductions to others on the team
  - “Tell me about yourself”
  - “What are your dreams / goals”
- Recognition of strengths
  - Hearts



# Neonatal Abstinence Syndrome (NAS): Description

- ◆ Neonatal Abstinence Syndrome is an expected consequence of a pregnant woman who
  - ❑ Uses opioids (e.g., heroin, oxycodone)
  - ❑ Is on prescribed opioids (e.g. for maternal pain)
  - ❑ Is on medication assisted treatment with methadone or buprenorphine

- ◆ Defined by alterations in the:

- ❑ *Central nervous system*
  - high-pitched crying, irritability
  - exaggerated reflexes, tremors and tight muscles
  - sleep disturbances
- ❑ *Autonomic nervous system*
  - sweating, fever, yawning, and sneezing
- ❑ *Gastrointestinal distress*
  - poor feeding, vomiting and loose stools
- ❑ *Signs of respiratory distress*
  - nasal stuffiness and rapid breathing

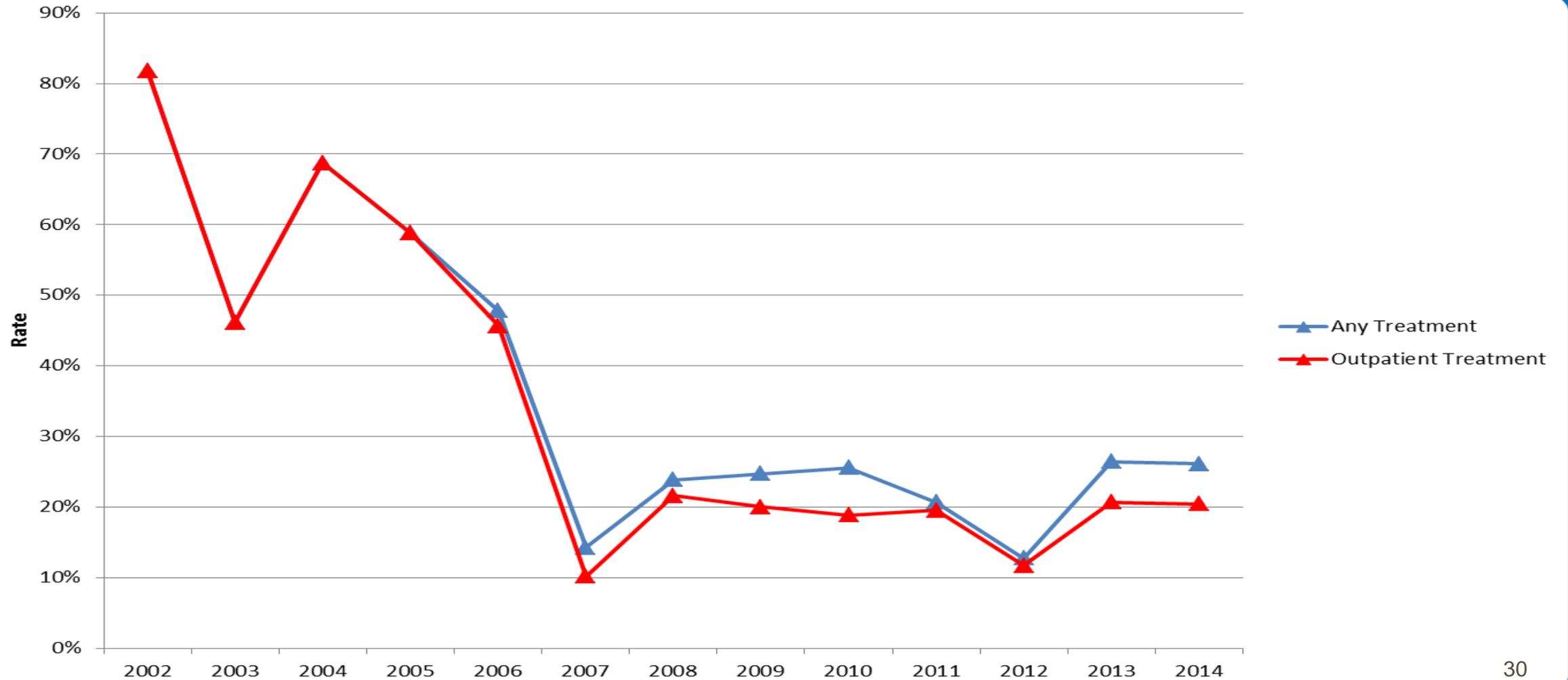
- **NAS is not Fetal Alcohol Syndrome (FAS)**
- **NAS is treatable and does not have any long-term consequences**

# UVM CHILDREN'S HOSPITAL: EVALUATION AND MANAGEMENT OF NAS

- Admit to Mother-Baby Unit, start NAS scoring
- If NAS score is  $\geq 9$  with no contributing factors, transfer to NICU
- Start methadone 0.4 – 0.5 mg every 12 hours, continuous cardiorespiratory monitoring
- Discharge after 72 hours on stable methadone dose
- Parents / Caregivers receive intensive education regarding methadone dosing for the baby, only 1 pharmacy is used with standard child-safe glass bottle
- Follow-up Clinic within 7 days of discharge and every 2 weeks thereafter for weaning of methadone, monitoring of growth and development, monitoring of parent(s) recovery

# UVM Children's Hospital

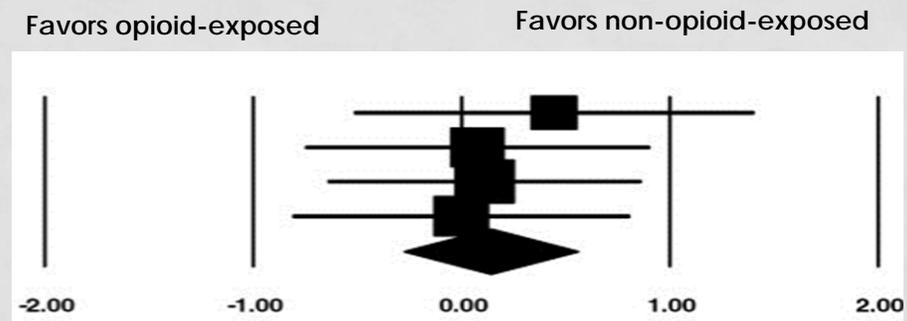
% Infants who received pharmacologic therapy born to women on opioid agonist treatment



# Outcomes: Baldacchino et al, BMC Psychiatry 2014

## Cognition in opioid and non-opioid exposed infants

Study Name	Subgroup	Assessment
Hunt (2008)	3 years old	McCarthy
Ornoy (2001/2003)	5 years old	McCarthy
Moe (2002)	4.5 years old	McCarthy
Walhord (2007)	4.5 years old	McCarthy



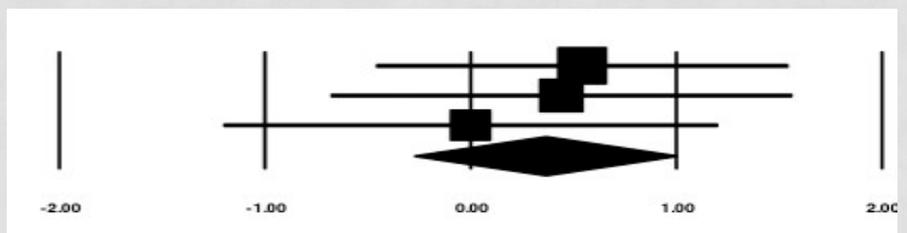
## Psychomotor in opioid and non-opioid exposed infants

Study Name	Subgroup	Assessment
Hunt (2008)	3 years old	McCarthy Motor Scale
Ornoy (2001/2003)	5 years old	McCarthy Motor Scale
Moe (2002)	4.5 years old	McCarthy Motor Scale
Walhord (2007)	4.5 years old	McCarthy Motor Scale

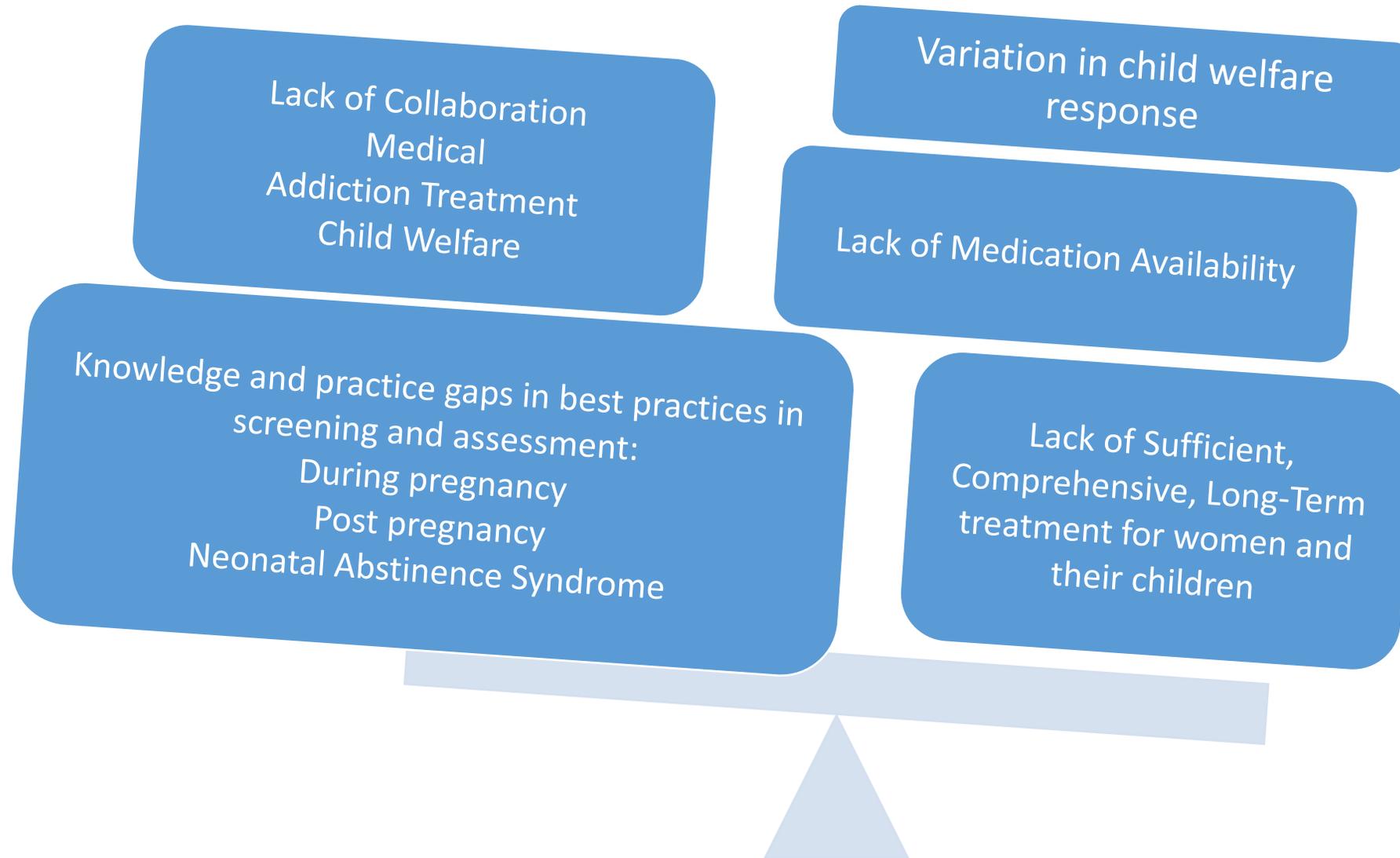


## Behaviour in opioid and non-opioid exposed infants

Study Name	Subgroup	Assessment
Hunt (2008)	3 years old	Vineland Social Maturity
Ornoy (2001/2003)	5 years old	Achenbach
Moe (2002)	4.5 years old	Achenbach



# Barriers to Best Practice





**The baby's health and safety depends upon  
the mother's health**



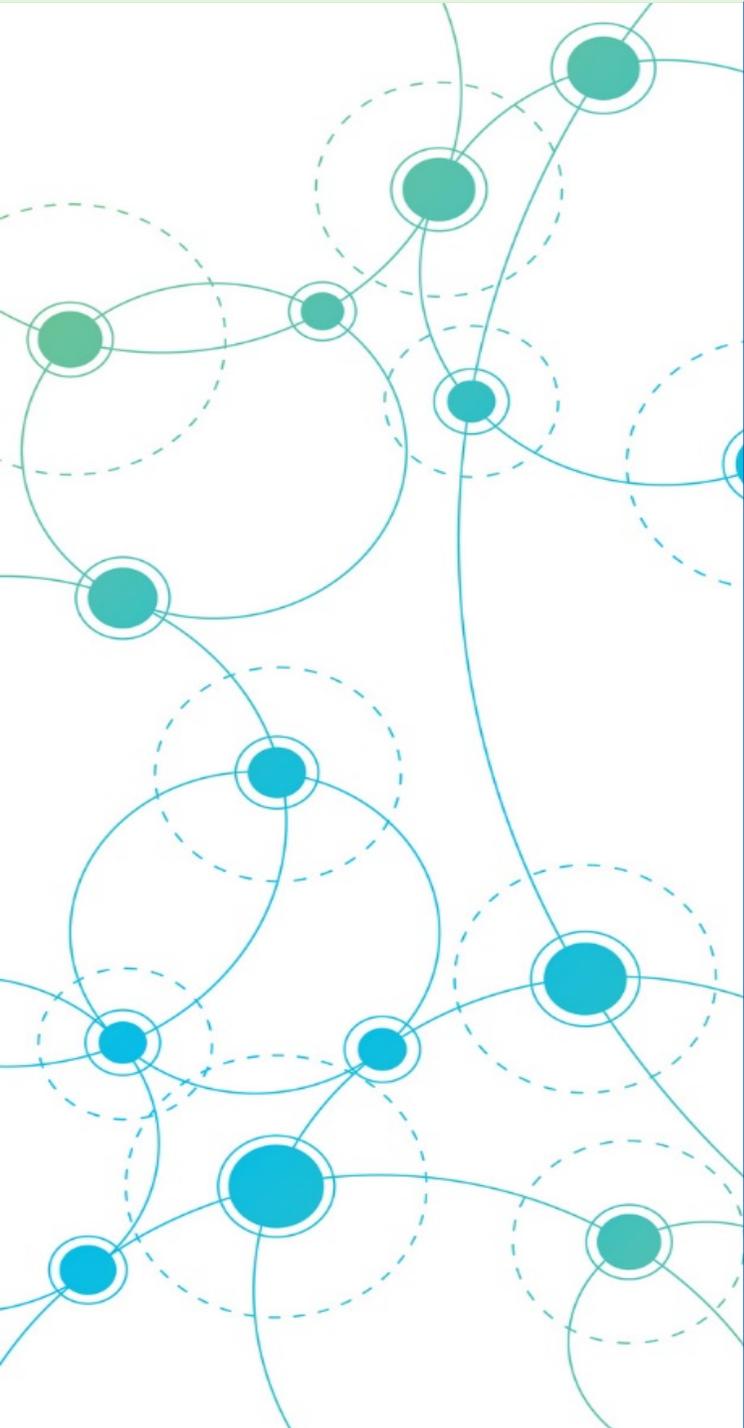
# The Children and Recovering Mothers (CHARM) Team

*Vermont's Collaborative Approach to  
Services for Opioid-Dependent Pregnant  
and Postpartum Mothers and their Babies*

# *What is CHARM?*

- CHARM is an **inter-disciplinary and cross-agency team** which **coordinates care** for pregnant and postpartum mothers with a history of opiate dependence, and their babies.
- **Model collaborative approach**





# CHARM Goal:

to improve the **health and safety outcomes of babies** born to women with a history of **opiate dependence** by **coordinating** medical care, substance abuse treatment, child welfare, and social service supports.



# CHARM: Promising Prevention Model

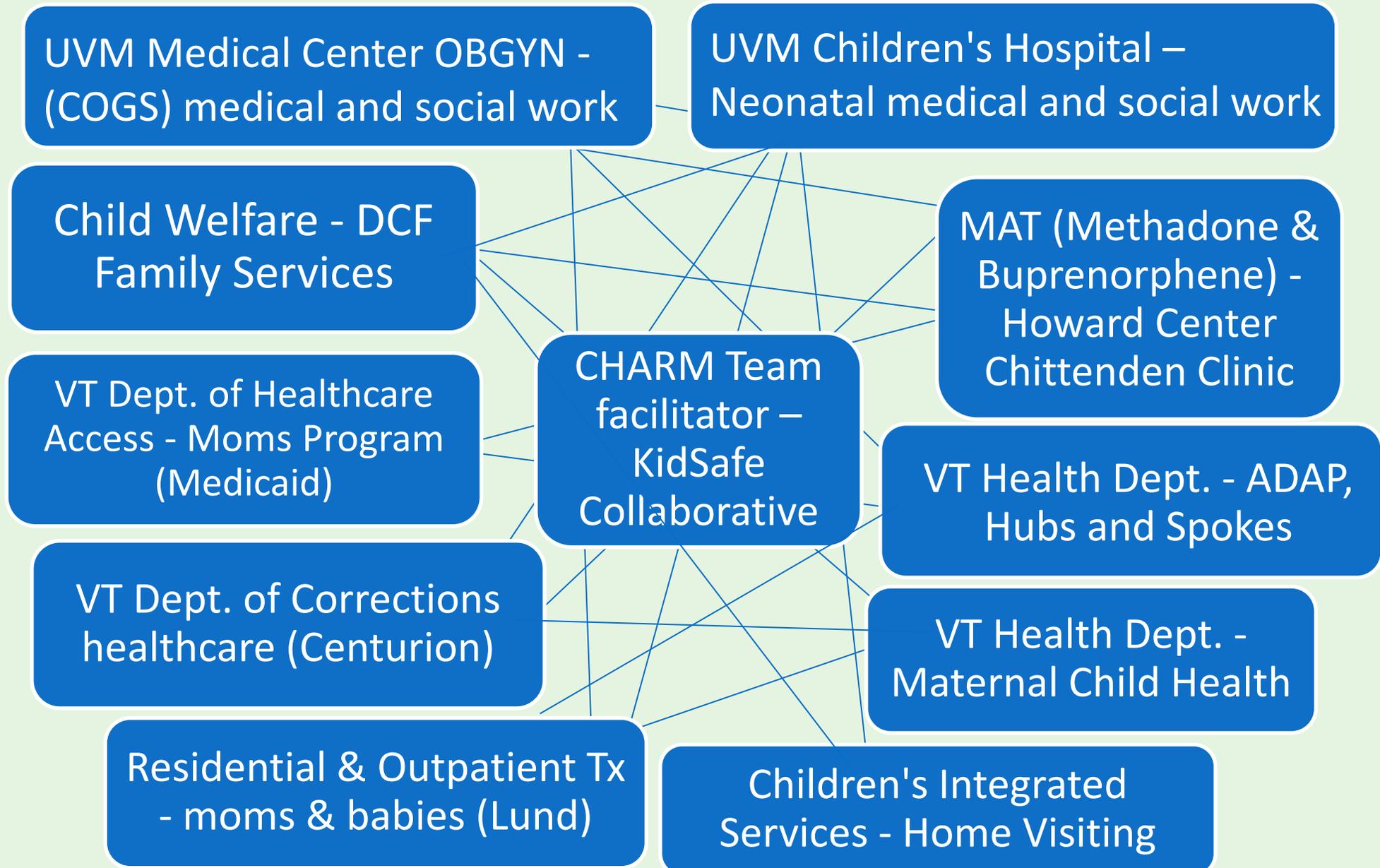
Prevention of substance abuse-related child maltreatment - **Key Elements:**

- Pregnancy: Opportunity for Change
- Early Access to Prenatal Care and Substance Abuse Treatment
- Early child welfare involvement, assessment and develop plans of safe care *prior to birth*
- Coordinated Services and Supports
- Systems for collaboration: information sharing to support health/safety of moms and infants

# Beginnings

- 1998
  - No MAT available in VT for heroin addicted pregnant woman
  - Physician request: individual waivers from Opiate Treatment Authority.
- 2002
  - Substance Abuse physician, OB and Neonatologist meet, coordinate care for pregnant women needing treatment.
  - First methadone clinic opens
- 2003
  - Additional community-based health and social services join coordination – start of multi-disciplinary approach. These efforts lead to the CHARM Team.
- 2004-2006
  - KidSafe joins to facilitate team. Empanelment as VT Multi-disciplinary Child Protection Team; Development of MOU, Release of Information; operating procedures.

# CHARM Team – Partner Organizations



# CHARM Partners: How it Works

Partner	Service(s) Provided	Collaborative Role
Hospital: High Risk Obstetrics Clinic	Intensive prenatal care, Initiation on Medication Assisted Treatment, script; Postnatal care (mother)	Obtains Release of Information; Provides patient updates
Hospital Neonatology; Neonatal Medical Follow-up Clinic	Prenatal consults with mother; NAS: Neonatal Abstinence Syndrome scoring; Infant care and treatment; Developmental assessment	Maintains listing of CHARM families, Releases of Info.; Provides patient updates
Community-based Substance Abuse and Mental Health Agency	Medication Assisted Treatment; Opioid Care Alliance case management	Provides client progress updates re MAT, counseling

# CHARM Partners: How it Works

<b>Partner</b>	<b>Service(s) Provided</b>	<b>Collaborative Role</b>
Child Welfare: VT Department of Children and Families	Child safety and risk assessments; Ongoing services for high risk families.	Consultation on child safety Issues; Child welfare and court case status
Public Health: Maternal and Child Health	WIC; Access to home visiting, Children's Integrated Services	Referrals to MCH services; Updates and follow-up
Public Health: Substance Abuse	State Opiate Authority; Care Alliance for Opioid Addiction	Information on treatment options and standards, coordination
Hospital OB and Pediatric Social Work	Assessment and intensive support	Provides patient updates

# CHARM Partners: How it Works

Partner	Service(s) Provided	Collaborative Role
Home Health Agency	Nurse, social services home visiting; parent support and education	Client referrals and provide updates
Community–based Substance Abuse Treatment and Social Services Agency	Residential care (pregnant/moms and babies); Substance abuse treatment – residential and outpatient; Parent support	Client treatment updates; Referrals for residential care and outpatient
VT Department of Corrections - Health Care	Health care for incarcerated pregnant women	Patient status updates and follow-up
VT Healthcare Access (Medicaid)	High risk pregnancy support program	Information on Medicaid, services
Community-based organization	Case information updates; fund for transportation, unmet needs	Facilitator; MOU

# Key Elements of CHARM Collaboration

- **A Shared Philosophy:** Improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants
- **Shared Information** improves child safety and healthy outcomes
- **Memorandum of Understanding:** provides an important framework for sharing information and coordinating services



# *Framework for Collaboration*

- **Memorandum of Understanding:** provides an important framework for sharing information and coordinating services
- **Consent to Release Information:** Majority of patients sign consent; *information sharing is in their best interest*
- **Vermont Law:** “Empanelled” as a **multi-disciplinary “child protection” team** under VSA Title 33 §4917  
Provides for information sharing among team members for case coordination to identify and treat suspected child abuse/neglect

# *Early Intervention = Healthy Outcomes*

- Medication-assisted treatment with methadone or buprenorphine is the **standard of care** for opioid-dependent pregnant women, both for the **health of the mother** *and* the **health of the fetus**.
- *“One cannot talk about the health [and safety] of the fetus or newborn without addressing the health care needs of the mother.”*

Dr. Anne Johnston, Neonatologist  
University of Vermont Children’s Hospital

# Prenatal Care

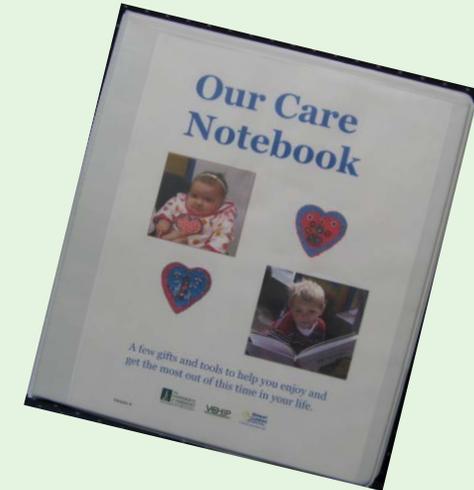
- ❖ **Comprehensive Assessment:** Confirm Pregnancy, Assess for Opioid Dependency. Obtain Release of Info.
- ❖ **Medication Assisted Treatment** during Pregnancy
  - **Enhanced Prenatal Care:** Frequent Prenatal Visits & Monitoring; Urine Drug Tests; Dose Adjustment
  - **Substance Abuse Counseling:** Required for women Receiving MAT
  - **Residential** program option for moms and babies
  - **Case Management and Referrals:** WIC, Nurse Home Visiting; social support services



❖ = point of entry

# Neonatology Antenatal Visit(s)

- **Establishing a Connection**
- **Alleviation of fear**
  - *Our Care Notebook*
  - You are not alone...
- **Education**
  - Provide information and resources:  
Neonatal Abstinence Syndrome, screening,  
treatment, newborn care
- **Respect**
  - “What are your dreams / goals?”
  - Listen actively, reserve judgment; allow the story to change
  - Recognize strengths and accomplishments



# Child Protection

**DCF Policy: Assessment may begin one month before due date** (or sooner if medical findings indicate that the mother may deliver early), **where:**

- serious threat to a child's health or safety,
- mother's substance abuse during third trimester

## **Innovative approach:**

- allows time for family engagement prior to birth
- planning for safe environment for the infant
- child maltreatment prevention: earlier indication of risk/parent is unable to parent safely
- avoid unnecessary placement crisis at birth

# CHARM: Case Review

At each monthly meeting the CHARM team reviews a list of current cases, and prioritizes cases for discussion:

- All **pregnant** patients due in upcoming month
- *Prioritized high risk prenatal* patients
- All **new pregnant** patients
- All **new babies** / post-partum patients
- *Prioritized high risk post-partum patients* and their babies

## CHARM Team Data - Calendar Year 2015

Total number of Adult Patients	150
--------------------------------	-----

Total number of babies	109
------------------------	-----

<b>Total number of individuals served</b>	<b>259</b>
---	------------

<b>TOTAL # of Case Reviews</b>	<b>343</b>
--------------------------------	------------

2.3 case reviews per pt.



# Information Sharing at CHARM Meetings

- Treatment: Methadone or Buprenorphine, (dose); consistency of treatment; provider; problems
- Attendance at prenatal, postpartum appointments, Neomed appointments
- Participation in substance abuse counseling
- Child welfare involvement and status
- Relevant medical and mental health information
- General psychosocial information and barriers to successful treatment: transportation, housing, family/household members using substances



# Lulu: CHARM Staffing

## Initial CHARM case review:

- Added to CHARM list when Lulu presents at UVM Medical Center, Obstetric Clinic
- CHARM Meeting: obstetric clinic presents an overview of Lulu's history and current treatment, and EDD. She is currently 14 wks. She has had an initial prenatal visit and an ultrasound.
- A referral for a NeoMed initial appointment was made.
- She was prescribed buprenorphine (subutex) after assessment.
- The obstetrics Social Worker met with Lulu and Chad. They are stable.
- Home health was offered. The Public Health Nurse notes that Lulu has signed up for an appointment to start WIC next month. She also signed up for a smoking cessation class.

# Lulu: CHARM Staffing

## 2<sup>nd</sup> CHARM: 4 weeks before due date

- Obstetric clinic: Lulu is 36 weeks. Lulu's last UA at 34.5 wks was positive for opiates. Lulu admitted using her friend's Oxy's. Lulu missed her last ultrasound appointment, but just rescheduled it.
- MAT provider: notes that Lulu missed two appointments. She came in last Friday, received dose and met with her counselor
- NeoMed: Lulu and Chad came to their appointment at 28 weeks. Had a lot of questions. Seemed to be very engaged. Plan to breastfeed. Lulu has been going to counseling.
- NeoMed Social worker: report to DCF-Family Services regarding Lulu's use during 3<sup>rd</sup> trimester. Will include positive information from NeoMed appointment.

# Lulu: CHARM Staffing



## 3<sup>rd</sup> CHARM: just before due date

- COGS: Lulu is due any day now. Lulu's last 5 UA's have been negative (except for buprenorphine)
- Vermont Dept. of Health: Lulu and Chad came to WIC and have signed up for a home health nurse after the baby arrives.
- MAT provider: Lulu has been stable for the past four weeks
- NeoMed: Lulu came to 2<sup>nd</sup> NeoMed appointment at 32 weeks.  
Lulu is worried: reports she and Chad had an argument, she is not sure they will stay together. He wants her to get off buprenorphine. They've been staying with his parents, after they lost their apartment.
- DCF-Family Services opened an assessment.  
The social worker has met with Lulu twice and briefly met Chad. They have begun to develop a safety plan for when the baby is born. The social worker will meet them in the hospital after the baby arrives.

# Lulu: CHARM Staffing

## 4<sup>th</sup> CHARM : post-partum / Infant: 7 days

- NeoMed Clinic reports: Baby is being treated with Methadone, based on NAS scoring per NeoMed Clinic protocol.
  - Baby doing well on Methadone dose.
  - Baby is healthy – “baby looks good!”
  - Lulu and baby on Mother-Baby Unit. Likely discharge tomorrow.
  - Lulu is breastfeeding.
  - Chad and Lulu are trying to work things out. Bonding with Baby
- Obstetrics post-partum visit scheduled.
- Nurse home-visitor will meet them early next week. WIC information needs to be updated.
- Baby has a Pediatric Medical Home.



## 4<sup>th</sup> CHARM : post-partum / Infant: 7 days, continued

- DCF-Family Services met with Lulu, Chad and Baby at the hospital.
- The social worker also met with the NeoMed Clinic Social Worker, and together they all developed a Plan of Safe Care.
  - Lulu, Chad and Baby will live with Chad's parents, for now.
  - They will keep all appointments, including NeoMed appointments for baby's wean. Missed appointments: report to DCF-FS.
  - Home Health and other support services will continue. Focus: support services for parents, to help ensure health/safety of Baby
  - DCF-Assessment will remain open for 30 days, then Risk Re-assessment.



# CHARM: Key Elements of Patient Success

- ❖ Start prenatal care early in pregnancy
- ❖ Pregnant women receive pharmacological treatment for opiate dependence
- ❖ Engaged in substance abuse counseling
- ❖ Attend prenatal care appointments
- ❖ Attend Neomed Clinic appointments
- ❖ Family and social supports, stable housing



# CHARM: Key Elements of Patient Success

*continued*



- ❖ Partner: stable, safe, in treatment or no substance abuse
- ❖ Post-partum treatment plan
- ❖ Nurse home-visiting services
- ❖ WIC, Other supports
- ❖ Breastfeeding - attachment
- ❖ Earlier assessment of ability to provide safe care of infant; child safety risk



# Lulu: CHARM Staffing

Final CHARM : 6 months

- Lulu: brief relapse at four months post-partum: UA's + for opiates at Chittenden Clinic. Admitted to using. Reported Chad's drinking increased, they had been arguing a lot.
- Went to residential substance abuse treatment; MAT stable again.
- Lulu left baby in care of Chad's parents while she went to treatment.
- Is in counseling with Chad. They are participating in parenting education.
- DCF-FS report was made when Lulu relapsed. Because Baby was being safely cared for, safety plan still in place, case was not opened.
- Children's Integrated Services: Home health ended at 3 months; started child care search, referrals; continued WIC participation.
- Neomed: Baby's developmental assessment scheduled at 8 months

# CHARM - What Makes it Work

- **Shared Philosophy:** Improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants.
- **Sharing information** is critical to providing the best care and services to moms and babies.
- Decisions are made best with **current information.**



# CHARM Outcomes

- **Improved collaboration = safer babies**
- More pregnant women are in treatment earlier with better prenatal care:
  - Pregnancy: opportunity to engage in treatment
  - Fewer premature births; fewer small birth weight infants
- DCF policy change: Support services accessed and plans of safe care developed prior to birth.
  - Fewer emergency custody orders at time of birth
  - Decisions made based on better information from project partners about safety and risks



# CHARM Outcomes

- **Value of monthly case review meetings:**
  - Time-saver - Develop **trust**
  - Minimize misunderstandings
  - Improved understanding of patients/clients – more comprehensive view
  - Improved understanding of each other’s roles and perspectives
  - Development of expertise among project partners about health and safety issues for opioid-exposed newborns
  - Have a “Go-to” contact for questions
- **Improved collaboration = safer babies**

# Challenges for Collaboration

- Collaboration - requires ongoing attention
- Complex lives: need high level of *ongoing* support
- Best practice: Home Visiting for *all* pregnant/new parents
- *Assessing child safety* with parents with a history of opiate addiction
- *Balancing Act* – child welfare policies and practices: focus on child safety, while not discouraging pregnant women from seeking prenatal care and substance abuse treatment
- *Expand MOU* to include other providers; Confidentiality, limits to info sharing

❖ **The Children and Recovering Mothers (CHARM) Collaborative in Burlington, VT: A Case Study**

*National Center on Substance Abuse and Child Welfare*

<http://www.ncsacw.samhsa.gov/>

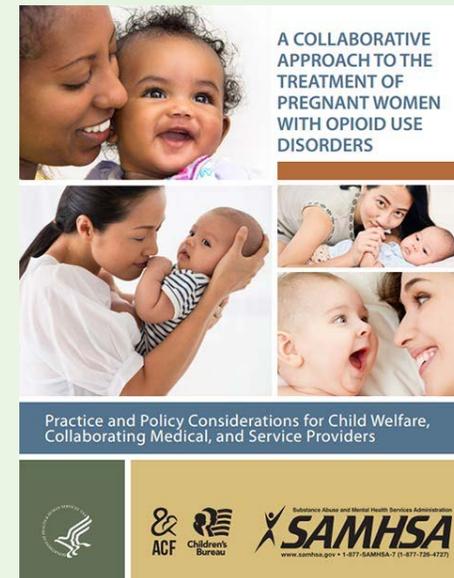
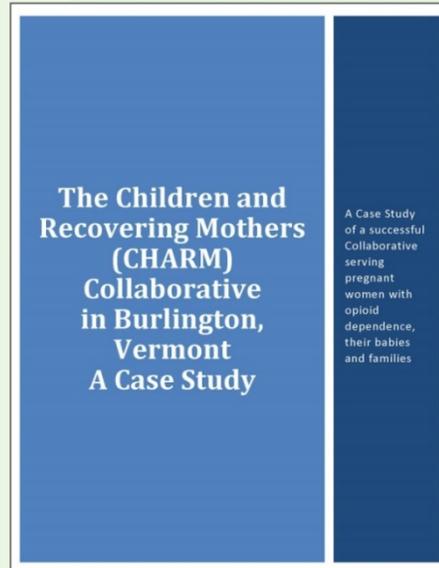
❖ Vermont Health Department - Alcohol and Drug Abuse Programs:

**Care Alliance for Opioid Addiction**

<http://healthvermont.gov/adap/treatment/>

❖ University of VT - VCHIP: Improving Care for Opioid-exposed Newborns (ICON)

<http://www.uvm.edu/medicine/vchip/?Page=ICON.html>



A stylized, light-colored illustration of a plant with several leaves and a cluster of small, round buds or flowers, positioned on the left side of the slide against a dark brown background.

# CHARM AND CHILD PROTECTION – TEAMING FOR SUCCESS WITH SUBSTANCE EXPOSED NEWBORNS AND THEIR FAMILIES

Karen Shea, MSW  
DCF Family Services  
Deputy Commissioner

# Substance Abuse Impact on Caseload

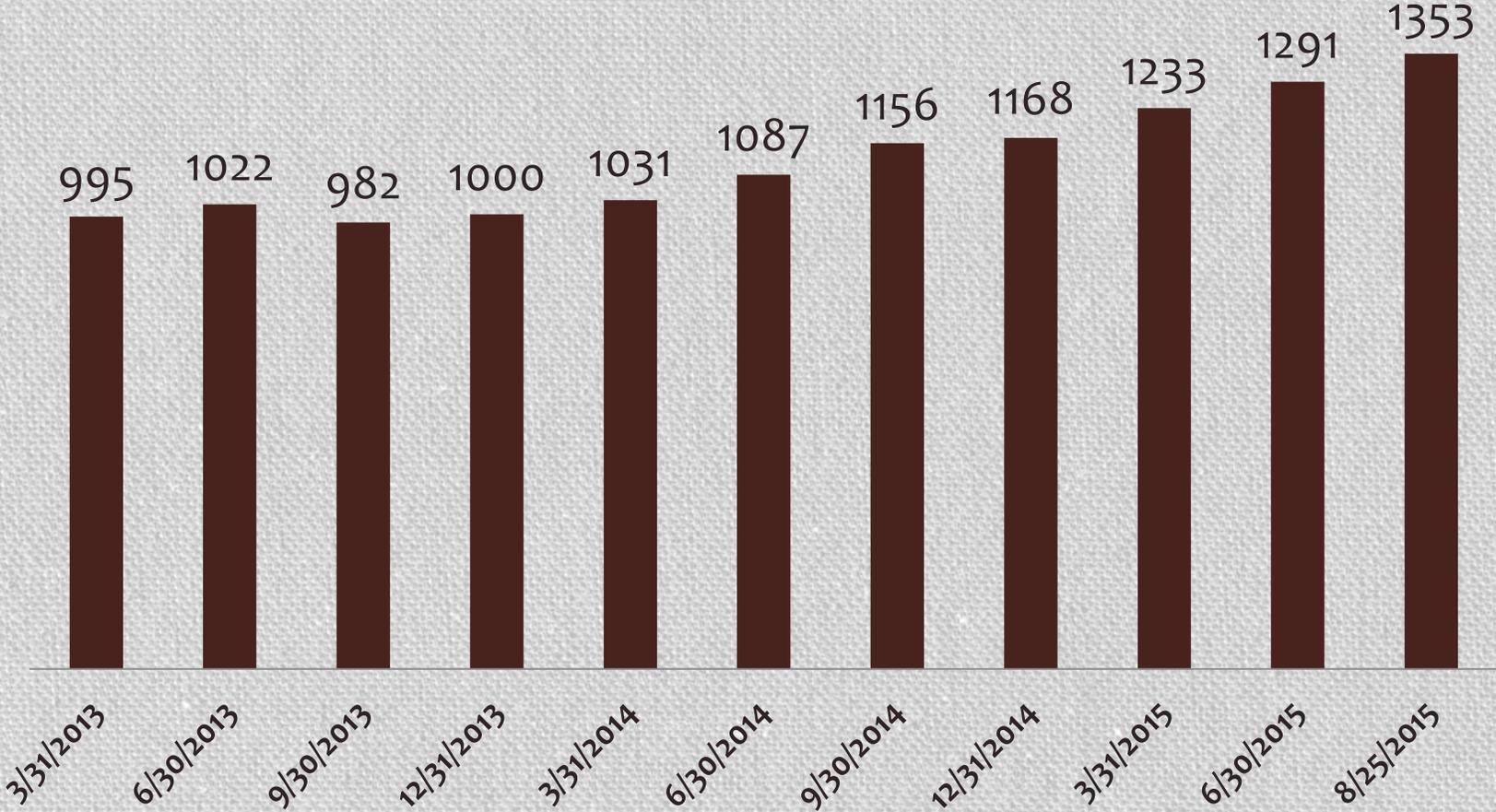
## • 2014

- Districts reviewed all cases of children between the ages of 0-3 that had come into DCF custody during the prior 6 months.
- 70% of children who entered DCF custody during the prior 6 months had parental opioid use disorder as an identified factor in the case.

## • 2016

- Districts reviewed all cases of children between the ages of 0-5 that had come into DCF custody during the prior 6 months.
- 80.28% of children who entered DCF custody during the prior 6 months had opioid use / abuse by a parent as an identified factor in the case.
- 62% of children who entered DCF custody during the prior 6 months had parental opioid use disorder as an identified factor in the case.

# Children in Care



# The Early Days

- DCF Family Services involvement in CHARM was not initially “easy”.
- Much time was spent trying to understand each team members role and perspective and to find “common ground”.
- Much of the concern was centered the what we hoped to accomplish through our involvement with the team – what was our “agenda”.

# The Early Days

- Through meeting regularly, we were able to talk about our “common ground”, discuss areas of disagreement, help others know what our “agenda” was on a case by case basis so that we could build trust and so that there would be no surprises.
- Adaptive challenges – this is a key area to attend to and takes as much or more time than the technical elements of the change process.

# Informing and Being Informed

- Through case dialogue, we all learned from one another and got a cross-disciplinary view of the work being done.
- We were able to identify key areas of challenge for team members with the child welfare approach including:
  - Report Screening Practices
  - Focus of Child Welfare Intervention
  - Case Determination Practice

# Policy Shifts - DCF Family Services Intake Screening Policy

- CHARM members were concerned that reports of prenatal substance use (illicit and MAT) were being treated the same way at the point of screening.
- Policy was shifted to be clear that MAT is not a “valid allegation” that would result in acceptance.

# Policy Shifts - DCF Family Services Intake Screening Policy

Valid allegations if:

- 1) A physician certifies or the mother admits to use of illegal substances or non-prescribed prescription medication during the last trimester of her pregnancy.
- 2) A newborn has a positive toxicology screen for illegal substances or prescription medication not prescribed to the patient or administered by a physician
- 3) A newborn has been deemed by a medical professional to have Neonatal Abstinence Syndrome through NAS scoring as the result of maternal use of illegal substances or non-prescribed prescription medication.
- 4) A newborn has been deemed by a medical professional to have Fetal Alcohol Spectrum Disorder

- Historically, we were opening cases for a child abuse investigation if it was found to be a “valid allegation”.
- Through dialogue, we examined this approach and the unintended implications it may have on treatment “seeking” by pregnant mothers.

- We have another option for accepting cases that does not require a case determination (substantiation or no substantiation). We decided to clarify in policy that cases of prenatal substance exposure would be assigned to receive a Family Assessment (vs. an investigation).
- Shifted the focus from “fact finding” to assessment of risk and planning for the future.

- Charm Team members were concerned about the “when” of our involvement.
- Historically, we would not act on a report of prenatal substance exposure until after the infant was born.

- This approach felt to all of us like we were missing an opportunity to avert a crisis through encouraging earlier treatment, assessment of risk and protective factors prior the infant's birth and engaging a larger network in planning.
- Shifted policy to permit the opening of a case up to 30 days prior to the birth of a child in order to allow time for engagement and planning to avoid unnecessary crisis.

# DCF Family Service's Response

- DCF Family Services will conduct an assessment and determine whether there is a need for on-going involvement with the family.
- The assessment is focused on the future – Can this parent successfully and safely care for the child? Is there a need for treatment for the parent? Is there a need for referrals to services?



- The parent's use of substances while pregnant is the way we become involved but the focus of the assessment is on whether or not there are any concerns about the parents ability to meet the needs of the child into the future.

- Adaptive challenge!!

Many times child welfare staff have emotions about this that we need to face and discuss.

How do we address our own feelings related to addiction to make well-informed decisions.

- DCF does not substantiate mothers for child abuse for using substances while pregnant.
- On-going involvement with DCF Family Services after an assessment occurs if:
  - 1) The child is in need of care and supervision because of identified danger and the court becomes involved or
  - 2) DCF Family Services assesses that the risk is high or very high for future maltreatment and opens a family support case (without court involvement)

**In either situation, DCF Family Services will work with the family to create a case plan to address the risks that exist.**

- There are many cases where we receive reports before CHARM has had the opportunity to be engaged or in regions of the state where we don't have a CHARM – these are the cases that are most concerning
- In some ways, cases that come to our attention through our involvement in CHARM are less concerning than other cases because they are often engaged in the treatment and services
- We have identified the need for better identification and screening of SUDs in the child welfare involved population

# What about Lulu?

- If Lulu is participating in treatment, DCF Family Services may not ever receive a report about Lulu.
- If a report was made and she is engaged in treatment, DCF Family Services would likely not open a case
- If we receive a report about Lulu and she was not participating in treatment and actively using substance, we would accept for an assessment.
  - The assessment would focus on the Lulu's capacity to provide safe and appropriate care for the newborn.
  - Efforts would be made prior to the birth of the child to engage her with treatment and activate a safety network for the newborn.

# On-Going Challenges

- Access to Treatment
  - Mothers who need treatment and they are not pregnant
  - Partners of pregnant woman who can't access medication assisted treatment
- Access to Case Management of Substance Abuse Related Needs
- On-going workforce development needs – staff at different levels of understanding and beliefs about addiction and parenting



# Vermont's CHARM (Children and Recovering Mothers) Team:

## A collaborative approach to supporting pregnant and parenting women with opioid addiction and their infants

Anne M. Johnston, Neonatologist  
Associate Professor, University of Vermont College of Medicine  
University of Vermont Children's Hospital  
Smith 575, 111 Colchester Ave., Burlington, VT 05401  
802.847.3993  
Anne.johnston@uvmhealth.org  
www.uvmhealth.org

Sally Borden, Executive Director  
KidSafe Collaborative  
45 Kilburn Street, Burlington VT 05401  
802.863.9626  
sallyb@kidsafevt.org  
www.kidsafevt.org

Karen Shea, MSW  
DCF Family Services Deputy Commissioner  
280 State Drive, Waterbury, VT 05671-2401  
802.769.2053  
Karen.shea@Vermont.gov  
www.dcf.vermont.gov

*Note: images in this presentation are used with permission;  
stock photos are licensed for use by KidSafe Collaborative*