



Moira O'Neill

Director

State of New Hampshire

Office of the Child Advocate

SYSTEM REVIEW REPORT

System Review 2018-01

Division for Children, Youth and Families

Enhanced Response to Substance Exposed Infants

November 21, 2019

ACKNOWLEDGMENTS

The Office of the Child Advocate (OCA) wishes to acknowledge the many partners whose commitment and support to this OCA System Review enhanced and contributed to the review process.

Many New Hampshire Division for Children, Youth and Families (DCYF) personnel generously assisted in giving their time to thoughtful participation in the review. With their assistance, the OCA identified strengths in the current system and opportunities for learning and system improvements.

The OCA also acknowledges and thanks the numerous community partners and stakeholders for their support, education, guidance and precious time in our system review. Through their willingness to share information and resources, the OCA received an extensive amount of information regarding substance exposed infants and the work being done in New Hampshire to support them and their families.

Finally, the OCA wants to recognize the infants and families about whom this report is focused. While the report is largely system focused, it is their lived experiences that inform system improvements. Parent substance use is extremely stigmatizing and this stigma has a lasting effect on infants born exposed to substances. Acknowledgement that recovery from a substance use disorder is a process and takes time may inform how systems operate. More importantly, that understanding is paramount to ensuring children's health and safety during that time.

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EXECUTIVE SUMMARY

The reality of the impact of substance use on children is hitting home in New Hampshire. A recent national report suggested 14,000 New Hampshire children were affected by the opioid epidemic in 2017.¹ In the past five years, 430 children removed from their homes by the Division for Children, Youth and Families (DCYF) because of abuse or neglect had a history of being born exposed to substances.² During this period, some children will stay in foster care or with family caregivers, and they may move back and forth as the parent works toward recovery. Especially for those who come into care at a very young age, their development and wellbeing will be equally affected by the absence of permanency in their lives as by exposure to substance use.

As New Hampshire strengthens family supports, it is with the knowledge that a child's developmental need for permanency and stable relationships will sometimes not align with the timelines for recovery or legal proceedings. It is vitally important that each child be considered individually and with their best interest in mind. Ultimately, children do best with family in their own communities. But to ensure that this happens, we need easily accessible recovery friendly services and many layers of support for parents and children. This Office of the Child Advocate (OCA) System Review examines DCYF's response to infants impacted at birth by virtue of being born exposed to substances in the context of the system intended to preserve families and keep children safe.

Numbers tell the story of the extent of the problem. From July 1, 2018 to September 16, 2019, New Hampshire hospitals reported 499 infants were monitored for signs of opioid withdrawal or neo-natal abstinence syndrome (NAS) in a total of 14,162 births (3.5%).³ In a December 2018 Data Report, the New Hampshire Pregnancy Risk Assessment Monitoring System (PRAMS) Team reported that, from 2013 to 2017, an estimated 14,650 women⁴ smoked cigarettes at some time two years before pregnancy, and, 13,230 smoked in the three months before pregnancy.⁵ The numbers declined slightly during pregnancy with 6,515 estimated to have smoked during that time, then rose again in the postpartum period to an

¹ Brundage, S., Fifield, A., Partridge, L. (2019, Nov.). The Ripple Effect: National and State Estimates of Opioid Epidemic's Impact on Children. United Hospital Fund, available at <https://uhfnyc.org/publications/publication/ripple-effect-chartbook/>.

² Division for Children, Youth and Families, (2019). *Annual Data Book 2019*. State of New Hampshire Department of Health and Human Services.

³ New Hampshire Department of State, Division of Vital Records Administration, Birth Records Situational Surveillance data, updated Sept. 16, 2019. NOTE: This data does not include New Hampshire residents who gave birth out-of-state and may include in-state births by out-of-state residents. All opioid exposure includes both illicit substances and substances that may have been prescribed for therapeutic use, including medicated assisted treatment and other lawfully prescribed opioids.

⁴ PRAMS eligible women are identified as "all NH residents who have a live birth in one calendar year. Approximately one in 12 women are randomly selected and asked to participate between two and six months after giving birth. Out-of-state births to NH residents are included in the sampling plan due to the high proportion of births occurring out-of-state (approximately 10% annually)." New Hampshire New Hampshire Pregnancy Risk Assessment Monitoring System Team, Maternal and Child Health Section, Div. of Public Health Services, NH Dep't of Health and Human Servs, Data Report, Perinatal substance use among New Hampshire Women 2013-2017 at 15. (Dec. 2018). Accessed at <https://www.dhhs.nh.gov/dphs/bchs/mch/prams/documents/perinatal-substance-use.pdf>.

⁵ *Ibid.* at 19.

estimated 8,135.⁶ In two years prior to pregnancy, an estimated 48,775 women drank alcohol. Slightly fewer, 43,465, drank alcohol in the three months prior to pregnancy and in the last three months of pregnancy, an estimated 6,725 consumed alcohol.⁷ Substance exposure in utero may predict high risk of developmental, behavioral and physical health concerns.⁸ This System Review of the Office of the Child Advocate (OCA) examines DCYF's response to infants impacted at birth by virtue of being born exposed to substances.

Timing is everything. Prenatal care is the very best, most effective intervention for the protection of mother and baby. Comprehensive, consistent prenatal care increases the odds of a healthy delivery and connects new mothers to supports and services for managing a substance use problem. Postnatal care is equally important for ensuring child's and mother's health, and mother's parenting capacity.

Barriers, including bias, often prevent and discourage women and families from seeking treatment and/or pre-or post-natal care. The importance of trauma-informed, recovery-friendly care across *all* disciplines cannot be underscored enough. Understanding and recognizing barriers, and implementing strength-based, recovery friendly practices across the state will go a long way to opening the door to families to ensure support for parents in recovery and the complexities of parenting ahead.

When an infant is born exposed to substances the public health and, if necessary, the child protection system must be prepared to respond in a way that ensures child safety and overall family health. New Hampshire's system includes two key responses: a federally mandated Plan of Safe Care and, if there are identified concerns for abuse or neglect, the Division for Children, Youth and Families (DCYF) Enhanced Response Assessment that includes, in addition to the assessment, a safety plan.⁹

Development of a federally mandated plan of safe care occurs for any infant born exposed to substances, although providers may decide to develop plans of safe care with all new mothers and infants. Developing a plan of safe care takes time and engagement with a mother, and, preferably, the rest of the family. It reinforces existing supports and coordination of referrals. A plan of safe care is helpful, but often is not developed until after delivery. Ideally, a plan of safe care is started prenatally and serves as a fluid document throughout pregnancy and after birth. Mothers should be well supported in implementation of the plan of safe care. It is also essential to share the plan with the infant's primary care provider and all other people and professionals providing support to the mother and the infant.

DCYF's *Enhanced Response Assessment* policy recognizes the importance of early intervention after birth.¹⁰ The policy's rigid, prescribed number of visits, minimum 60-day length, a DCYF safety plan and

⁶ *Ibid.*

⁷ *Ibid.* Note: Low survey question response rate may not be fully representative of total population.

⁸ For purposes of this review, "substance(s)" includes, but is not limited to, alcohol, tobacco, prescription drugs, misused medications or bath salts, inhalants, hallucinogens, barbiturates, cocaine, marijuana, methamphetamine, and opioids.

⁹ DCYF Policy 1184 *Enhanced Response*, <https://www.dhhs.nh.gov/dcyf/documents/dcyfpolicy1184.pdf>

¹⁰ It is important to note that the federally mandated plan of safe care is a separate and distinct plan than any plan required under the DCYF enhanced response policy. A plan of safe care is developed for every infant born exposed to substances whereas DCYF's *Enhanced Response Policy* applies only in cases involving suspected abuse and neglect.

referral to Early Support Services reinforces a structure in which DCYF staff can deliver focused casework and parents can understand and demonstrate healthy parenting.

This OCA System Review ultimately sought to examine DCYF's response to infants exposed to substances and determine whether DCYF is doing enough to support them and their families. The aim of the review was to answer the question: Is DCYF's Enhanced Assessment Response sufficient? The system review revealed systemic problems impacting DCYF's response to the infants and their families. Themes emerged demonstrating barriers to communication, inter-professional unfamiliarity, unproductive relationships, and inconsistent practices. These are all themes the OCA has identified in other reviews.

There are promising solutions emerging. The DCYF Southern district office established a Drug Exposed Infants specialist (DEI Specialist) role to focus on substance exposed infants and their families. The advent of this role has improved relationships and lines of communication with hospitals and providers, and most importantly, relationships with families. Master Licensed Alcohol and Drug Counselors (MLADCs), when available, are proving helpful in understanding substances and addiction, supporting families and easing engagement of families in recovery services. Parent Partners with the Strength to Succeed program, individuals with lived experience who are trained as recovery coaches, are serving as mentors to parents in recovery involved with DCYF. DCYF's Rapid Safety Feedback¹¹ program is proving effective in helping families in select cases. It uses a comprehensive assessment to establish deep understanding of a family's circumstances, identifying opportunities for positive pressure towards better outcomes.

The Concord Region Perinatal Community Collaborative at the Concord Hospital is facilitating increased understanding of DCYF. Understanding the agency strengthens system knowledge and collegial relationships among partners working to support families and newborns in their current situations. They work together to support families' needs. In addition, there are providers and organizations around the state examining this issue, and increasing opportunities for collaborative communication and strengths-based support for infants who are born substance exposed and their families.

It is instructive to note that each of the promising solutions identified in this review all address the themes of concern identified in the 2019 *OCA System Learning Reviews Summary Report*: barriers to communication, inter-professional unfamiliarity, inconsistent practice, and unproductive relationships. New Hampshire is on to something. Partners for families are building relationships, establishing understanding, and informing each member of the community team of the role, responsibilities and restrictions of each member or agency.

The OCA recommendations resulting from this System Review are simple:

- DHHS launch an initiative promoting the Concord Region Perinatal Community Collaborative model in all regions of the State of New Hampshire
- Integrate inter-professional education in DCYF core training involving all relevant partners
- Expand the DEI specialist role to all DCYF district offices and fill MLADC positions in every district
- Expand the *Rapid Safety Feedback* program to include all cases of substance exposed infants

¹¹ Eckerd Connects' Eckerd Rapid Safety Feedback® is a child safety model combining data analytics and coaching to support front line staff resulting in improved outcomes for children and families. Recognized nationally for its success, the model works to ensure critical safety practices are being implemented in high risk cases.

- Examine the content of DCYF core training and ensure adequate coverage of substance use disorder and recovery, basic child development, and available resources for families with substance exposed infants
- Develop and implement consistent practice guidance across district offices, including consistent referral and communication practices
- New Hampshire Pediatric Society, American College of Obstetricians & Gynecologists, with support of DHHS Maternal Child Health Services, launch an aggressive educational initiative promoting trauma-informed, strengths-based recovery-sensitive pre- and post-natal care for all pregnancies and recovery-friendly pediatric practices
- Establish a common release of information form for all services required for healthy parenting
- Provide all families with infants born substance exposed the opportunity for WIC enrollment, early support services, and connection to Family Resource Centers
- Establish liaison relationships with home visiting services in each DCYF district office to provide general education for casework staff and ensure timely referrals for home visiting

OCA AUTHORITY

The OCA is an independent and impartial state agency statutorily mandated to oversee DCYF, the state agency responsible for child welfare and juvenile justice services; to assure that children’s best interests are protected and to promote effective reforms. The OCA has independent access to all DCYF records that are not otherwise available to the public. This allows the office to objectively review and investigate concerns, and use the information to make informed recommendations for system reform.

RSA 170-G:18 is the OCA’s guiding statute. Under RSA 170-G:18, III(i), the OCA shall “[u]pon its own initiative or upon receipt of a complaint, review and if deemed necessary, investigate actions of the division for children, youth and families, or any entity that provides services to children under contract with and at the direction of the division, and make appropriate referrals. Findings of all investigations and responses to all complaints received shall be summarized in the annual report of the office of the child advocate.” The OCA does not have the authority to investigate allegations of abuse or neglect; review or investigate complaints unrelated to DCYF; overturn a DCYF decision or court order; or offer legal advice.

To ensure transparency of government and build trust with citizens, the OCA will periodically conduct system-wide reviews to identify opportunities for system strengthening. The opening of a system review does not indicate any confirmed violations or practice concerns regarding DCYF or DCYF-sponsored service. Upon initiating a system review, the OCA will conduct a comprehensive, independent study of relevant facts, records, and witness statements. If necessary, the OCA will also conduct independent research on evidence-based practice to offer informed, educated recommendations.

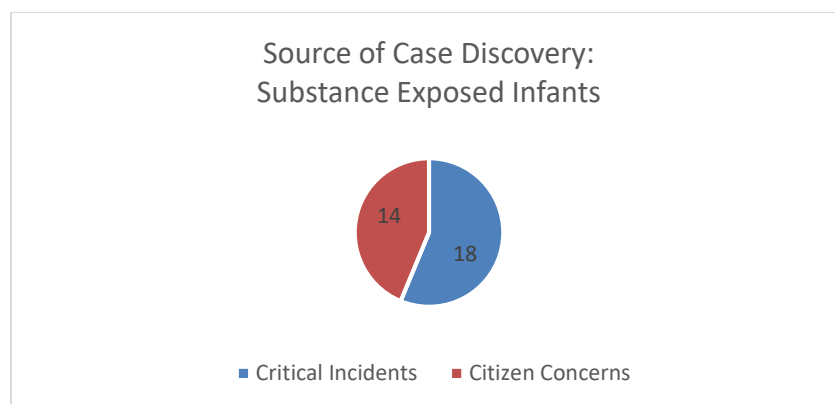
At the completion of a system review, the OCA may make recommendations or share any key points for learning to improve DCYF policies, practices or procedures or influence broader systemic reform. The OCA strives to provide citizens and stakeholders clear and concise information concerning the system reviews in which the OCA issues recommendations. The OCA will not release the names, addresses or any other identifying information of individuals subject to any confidential proceeding or statutory confidential provision, *see* RSA 170-G:18, III-a(d)(1), nor shall the OCA release system review findings publicly if there is a pending law enforcement investigation or prosecution, *see* RSA 170-G:18, III-a(d)(2).

SYSTEM REVIEW ISSUE & HISTORY: DCYF's ENHANCED RESPONSE TO SUBSTANCE EXPOSED INFANTS

In 2018-2019, the circumstances of 32 children who were born substance exposed came to the OCA's attention. First, in 2018 the OCA was notified by DCYF of two critical incidents involving the deaths of children. DCYF had previously been involved following each child's birth exposed to substances. One child was twenty months old and the other was twenty-three months old. One child was born exposed to cocaine and the other was born exposed to buprenorphine, amphetamine and methamphetamine. At the time of their births, DCYF opened assessments for neglect on each family. Both assessments closed as unfounded. DCYF had no further contact with one child and two subsequent assessments for neglect on the other prior to their deaths.

During the 2018-2019 period, the OCA received alerts to 16 additional critical incidents involving children who were exposed to substances at birth, totaling 18 children. In addition to the children involved in critical incidents, the OCA encountered 14 children through citizen concerns brought to the OCA's attention or through case discovery in OCA case reviews. (Figure 1. shows the sources of OCA's case discovery of children born substance exposed).

Figure 1. Source of Case Discovery: Substance Exposed Infants



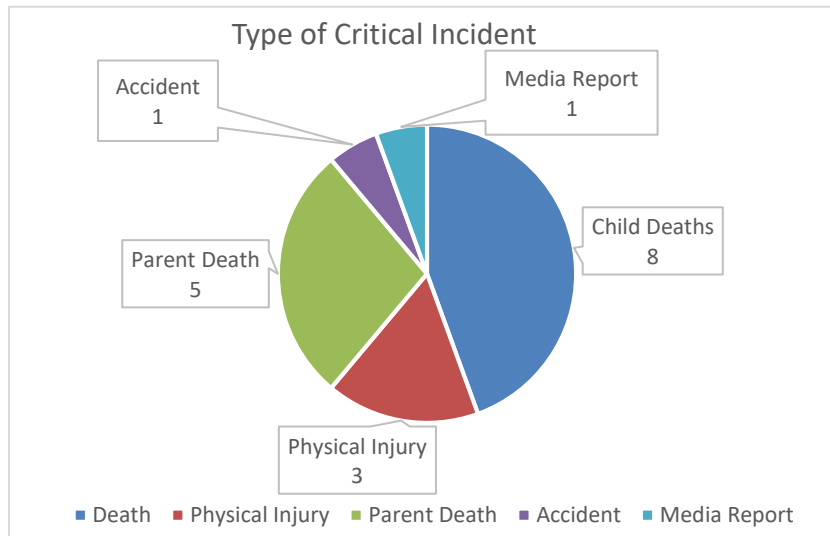
Data source: Office of the Child Advocate case management system

Pursuant to RSA 170-G:18, IV(a), the OCA receives incident reports, including those of critical incidents from DCYF. DCYF Policy 1099 *Critical Incident Reporting (Case & Staff Specific)* requires DCYF supervisors to complete a critical case incident report following certain enumerated critical incidents, including, but not limited to, any time a child dies, any time a child sustains a serious injury due to abuse or neglect, and any time a parent dies.¹² Media reports are also identified as a critical incident on DCYF's Critical Case Incident Report form.¹³ Figure 2. shows the type of critical incident for each of the 18 children about whom the OCA was informed.

¹²DCYF's Policy 1099 *Critical Incident Reporting* at 2. Accessed at <https://www.dhhs.nh.gov/dcyf/documents/dcyfpolicy1099.pdf>.

¹³ See DCYF's Form 1099 Critical Case Incident Report.

Figure 2. Type of Critical Incident



Data source: Office of the Child Advocate case management system

In response to the critical incident reports, the OCA conducted an independent review of the prior DCYF cases for each of the children involved. Seventeen of the children were the subject of a DCYF assessment conducted at birth due to substance exposure. One child was not the subject of a DCYF assessment at birth for exposure. The circumstances of that child's birth became apparent to the OCA through history documented in a later assessment on a sibling. Four had open assessments for exposure at the time of death, ages ranging from one day to two months. All four children died from natural causes, three from congenital conditions and one from a viral infection. Seven children had multiple prior referrals and closed assessments leading up to the reported critical incident. Seven children had cases opened for abuse or neglect. At least three of the critical incidents involved families with closed assessments that occurred prior to the subject child's birth.

Of the children identified through citizen calls or OCA case discovery, the concerns generally alleged insufficient action or safety plans to ensure child safety or insufficient support of parents and families in their case plans. Permanency for this cohort of children, like many of the other children the OCA receives concerns about, is a consistent concern for those whose parents are struggling with recovery. Ten children had an open case with DCYF at the time of OCA case review.

The incident reports, concerns received, and similar observations made by other Child Advocate offices in the region, raised questions about the possibility of a trend in risk that might exceed the adequacy of current policy and practice. As a result, the OCA undertook a system review of DCYF's response to substance-exposed infants, a feature of which is the Enhanced Response assessment process specific to this population. The system review was designed to examine DCYF's policies, practices and procedures regarding assessments involving substance-exposed infants as well as the broader system in which DCYF operates to ensure the safety of all infants and better outcomes for families.

This system review endeavored to answer the following questions regarding New Hampshire's response to infants born exposed to substances and their families:

- How does DCYF's *Enhanced Response Policy 1184* operate in practice?
- Is *Policy 1184* sufficient to assist families to protect exposed infants and other children in the home while parents address substance use?
- Is there consistency across the state in handling assessments involving infants exposed to substances? If not, should there be or are the inconsistencies beneficial?
- What factors may have influenced the decision to close the prior assessments identified in cases of infants born exposed to substances who are later subject to a critical incident report?
- Are there ongoing factors or barriers that impair the effectiveness of *Policy 1184* to adequately support parents and protect children from subsequent harm?
- Should there be a differential response depending upon the substance?
- What do families need, and what resources are available to support them with substance exposed infants?
- Should there be more long-term supports or monitoring for children born substance exposed?
- What other New Hampshire laws and policies impact the care and treatment of infants born exposed to substances?
- What is the response in other states to infants born exposed to substances, and are there more effective ways to continue to support families and keep children born substance exposed safe?
- What substance use prevention and unintended pregnancy prevention initiatives are available and how are prevention of exposed births considered in those initiatives?

SUBSTANCE-EXPOSED INFANTS IN NEW HAMPSHIRE

The prevalence of prenatal substance exposure varies widely and is difficult to establish due to, among other factors, differences in methods of sampling, drug detection, maternal screening and timing of data collection.¹⁴ However, it is estimated that each year 15% of infants are impacted by prenatal alcohol or illicit drug exposure.¹⁵ In New Hampshire, the Department of State, Division of Vital Records Administration has collected information on tobacco and alcohol use during pregnancy for many years. On July 1, 2018, it began tracking opioid exposure by using a Situational Surveillance feature on birth records. The two questions on the Situational Surveillance feature are:

- (1) Was there documented opioid exposure at any time during the pregnancy?
- (2) Was the infant monitored for signs of opioid withdrawal or neo-natal abstinence syndrome (NAS)?¹⁶

¹⁴ Behnke, M., Smith, V. (2013). Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus. American Academy of Pediatrics. *Pediatrics*, 131 (3) e1009, e1009-1024.

<https://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf>.

¹⁵ National Center on Substance Abuse and Child Welfare. Infants with Prenatal Substance Exposure. Accessed 11/18/19 at <https://ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx>.

¹⁶ 07/02/2019 Email correspondence with New Hampshire Department of State, Division of Vital Records Administration providing language from the Situational Surveillance.

From July 1, 2018 to September 16, 2019, hospitals reported 499 infants were monitored for signs of opioid withdrawal or NAS from a total of 14,162 births (3.52%).¹⁷ Specifically, from July 1, 2018 to December 31, 2018, hospitals reported 240 infants were monitored for signs of opioid withdrawal or NAS from a total of 6,111 births (4%).¹⁸ As of September 16, 2019, hospitals reported 259 infants were monitored for signs of opioid withdrawal or NAS from a total of 8,051 births in 2019 (3.22%).¹⁹

NAS “is a set of conditions occurring when a newborn experiences withdrawal symptoms after birth from drug exposure before birth.”²⁰ NAS is primarily caused by opioids and can occur after any opioid exposure during pregnancy, including heroin and OxyContin.²¹ NAS can also occur from exposure to medications used to treat opioid use disorder.²² NAS is on the rise in New Hampshire, but newborns who are treated can recover.²³ In New Hampshire most, if not all, hospitals now manage infants born with NAS with the *Eat Sleep Console* method. This method often reduces or eliminates the need for infants to receive medication assisted treatment. Instead, the model encourages parental presence with the infant, skin-to-skin contact for the infant, on-demand feeding, and infant swaddling. It is difficult to determine the long-term effects of prenatal drug exposure “because of the challenge of isolating the independent effect of prenatal opiate exposure, prenatal co-exposure to other substances (tobacco, alcohol, other illicit drugs), and behavioral health and environmental factors (mental health, poverty, poor prenatal care).”²⁴

The negative effects of exposure to alcohol during pregnancy have been well documented. “[C]hildren diagnosed with fetal alcohol syndrome demonstrate delays in motor functions, poor coordination, delays in fine motor skills, and cognitive disability that persists into childhood.”²⁵ Children exposed prenatally to alcohol may also later suffer Fetal Alcohol Spectrum Disorder (FASD). FASDs refer to “several diagnoses emerging from prenatal exposure to alcohol, including fetal alcohol syndrome (FAS), partial FAS, and alcohol-related neurodevelopmental disorder.”²⁶

The effects of prenatal exposure to opioids are difficult to isolate from environmental and genetic factors.²⁷ However, exposure to opioids during pregnancy has been associated with congenital

¹⁷ New Hampshire Department of State, Division of Vital Records Administration, Birth Records Situational Surveillance data, updated Sept. 16, 2019.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ Smith, K. *As Opioid Use Climbs, Neonatal Abstinence Syndrome Rises in New Hampshire*, at 5 (Dec. 19, 2017) University of New Hampshire Carsey School of Public Policy. Accessed at <https://scholars.unh.edu/cgi/viewcontent.cgi?article=1330&context=carsey>.

²¹ Patrick, S.W., Faherty, L.J., Dick, A.W., Scott, T.A., Dudley, J., & Stein, B.D., (2019). *The Ecology of Neonatal Abstinence Syndrome*. Rand Corporation. Accessed at <https://doi.org/10.7249/RB10054>.

²² *Ibid.*

²³ Smith, K. *As Opioid Use Climbs, Neonatal Abstinence Syndrome Rises in New Hampshire*, *supra* at 1.

²⁴ *Ibid.* at 3.

²⁵ *Ibid.*

²⁶ Rutman, D. (2016). Becoming FASD Informed: Strengthening Practice and Programs Working with Women with FASD. *Substance Abuse: Research and Treatment* 2016:10(S1) at 13, 13-20. See also Carroll, A. E. (2019, Aug. 19). Why Warning Pregnant Women Not to Drink Can Backfire, *The New York Times*.

²⁷ Nygaard, E., Vibeke, M., Slinning, K. & Walhovd, K.B. (2015). Longitudinal cognitive development of children born to mothers with opioid and polysubstance use. *Pediatric Research*, 78, 330-335. Accessed at <https://www.nature.com/articles/pr201595>.

malformations²⁸ disrupted neurodevelopment, and delayed developmental growth in early months.²⁹ Long-term effects of prenatal exposure to opioids are beginning to emerge as well. Children, especially boys, appear to experience worsening cognitive ability over time.³⁰ The risk of autistic features also appears to be higher among opioid exposed infants.³¹

The incidence of marijuana use during and after pregnancy has increased in parallel to legalization of the drug. Research on the effects of marijuana are still lacking and control for co-occurring factors is difficult. However, early studies suggest negative effects on growth, stillbirth, congenital anomalies, neurodevelopment,³² cognition, memory and attention.³³

Marijuana use during pregnancy has been associated with increased startles and tremors in infants,³⁴ and some studies suggest that infants exposed to marijuana prenatally have higher rates of stillbirth, premature birth, and admission to the neonatal intensive care unit.³⁵ Prenatal exposure to marijuana may also lead to decreased cognitive function and academic ability, lower IQ scores, and attention problems in children.³⁶ Prenatal tobacco exposure has also been proven to be harmful to an infant. Such exposure is known to cause premature birth, small for gestational size, and an increased risk for Sudden Infant Death Syndrome (SIDS).³⁷

²⁸ Lind, J.N., Interrante, J.D., Ailes, E.C., Gilboa, S.M., Khand, S., Frey, M.T., et al, (2017). Maternal use of opioids during pregnancy and congenital malformations: A systematic review. *Pediatrics*, 139 (6) e20164131. Accessed at <https://pediatrics.aappublications.org/content/pediatrics/139/6/e20164131.full.pdf>.

²⁹ Reddy, U. M., Davis, J. M., Ren, Z., & Greene, M. F. (2017). Opioid Use in Pregnancy, N. A. S., & Childhood Outcomes Workshop Invited. Opioid use in pregnancy, neonatal abstinence syndrome, and childhood outcomes: Executive summary of a joint workshop by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Maternal-Fetal Medicine, Centers for Disease Control and Prevention, and the March of Dimes Foundation. *Obstetrics and Gynecology*, 130(1), 10–28. Accessed at <https://doi.org/10.1097/AOG.0000000000000205>.

³⁰ Nygaard, E. Longitudinal cognitive development of children born to mothers with opioid and polysubstance use, *supra*.

³¹ Rubenstein, E, Young, J.C., Croen, L.A., DiGuseppi, C., Dowling, N.F., Lee, L, et al. (2018). Brief report: Maternal opioid prescription from preconception through pregnancy and the odds of autism spectrum disorder and autism features in children. *Journal of Autism and Developmental Disorders*, 49: 376-382. Accessed at <https://doi.org/10.1007/s10803-018-3721-8>.

³² Stickrath, E. (2019). Marijuana use in pregnancy: An updated look at Marijuana use and its impact on pregnancy. *Clinical Obstetrics and Gynecology*, 62(1): 185-190. Accessed at <https://journals.lww.com/clinicalobgyn/pages/results.aspx?txtKeywords=Marijuana+use+in+pregnancy%3a+An+updated+look+at+Marijuana+use+and+its+impact+on+pregnancy.+Clinical+Obstetrics+and+Gynecology;>

Furray, A. (2016). Substance Use During Pregnancy, *F1000 Research*, 3. Accessed at: [10.12688/f1000research.7645.1](https://doi.org/10.12688/f1000research.7645.1).

³³ Sharapova, S.R., Philips, E., Sirocco, K., Kaminski, J.W., Leeb, R.T. & Rolle, I. (2018). Effects of prenatal marijuana exposure on neuropsychological outcomes in children aged 1-11 years: A systematic review. *Pediatric Perinatal Epidemiology*, 32(6): 512-532. Accessed at <https://doi.org/10.1111/ppe.12505>.

³⁴ Behnke, M., Smith, V. Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus, *supra*.

³⁵ Factsheet About Perinatal Substance Exposure. Accessed on 11/18/19 at <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

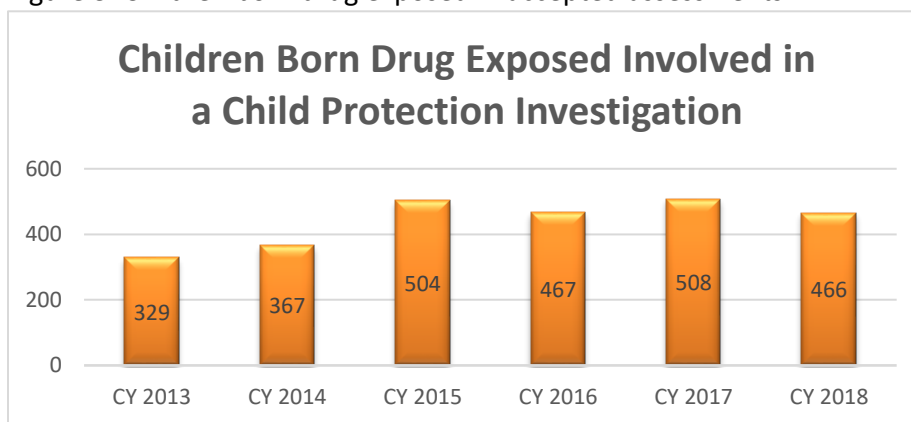
³⁶ *Ibid*.

³⁷ Furray, A. (2016). Substance Use During Pregnancy, *supra*.

Prenatal exposure to other illicit drugs may also pose physical and developmental health risks to an infant. Exposure to cocaine and methamphetamine has been linked to reduced fetal growth and abnormal neurobehavior at birth.³⁸

Although many infants exposed to substances at birth will not experience abuse or neglect, such exposure places them at a higher risk for maltreatment and child welfare involvement than unexposed infants.³⁹ Figure 3. shows the number of children involved in DCYF child protection assessments accepted each year in which the characteristic “Child Born Drug Exposed” was documented. This does not mean that the child was born in that particular year or that the child suffered from NAS. Categorizing “Child Born Drug Exposed” indicates in infancy (0-12 months) the child was exposed to substances in utero, whether prescribed or not. The infant may have exhibited withdrawal symptoms at birth and, if completed, had a positive toxicology test of the meconium and/or the umbilical cord.

Figure 3. Children born drug exposed in accepted assessments



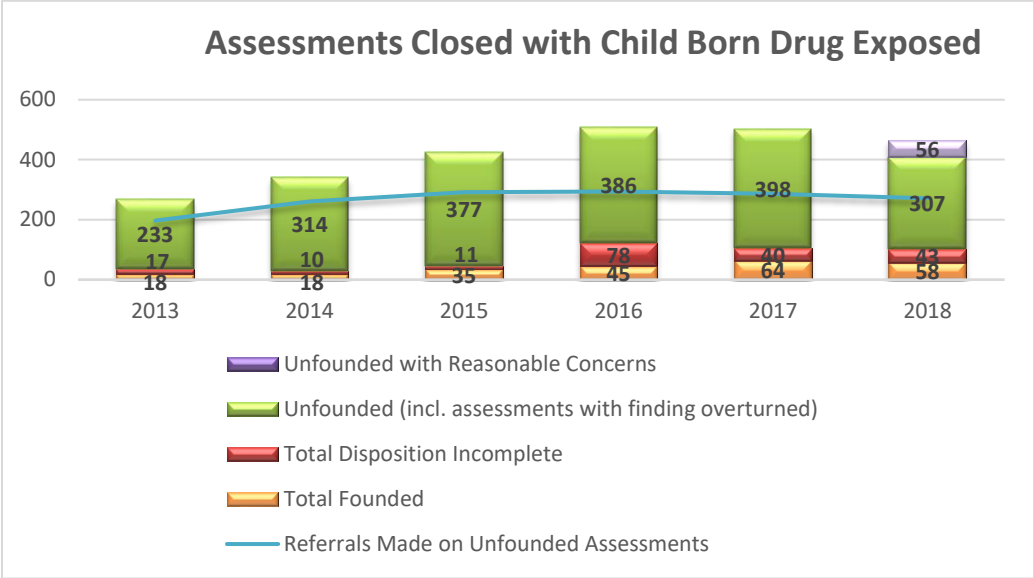
Data Source: DCYF Statewide Automated Child Welfare Information System

Figure 4. shows the number of assessments closed that involved the “child born drug exposed” characteristic in the neglect referral.

³⁸ Behnke, M., Smith, V., (2013). Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus, *supra* at e1013; Forray, A. (2016). Substance Use During Pregnancy, *supra*.

³⁹ Smith, K., (2018). *Parental Substance Use in New Hampshire: Who Cares for the Children?* Carsey Research, Regional Brief #53, at 1.

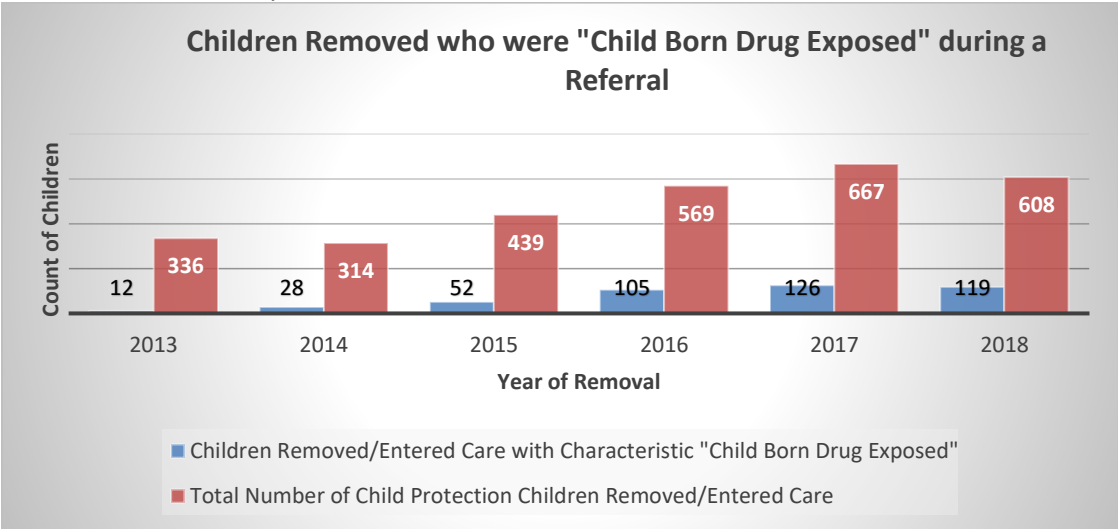
Figure 4. Assessments Closed with Child Born Exposed characteristic



Data Source: DCYF Statewide Automated Child Welfare Information System

In turn, an increasing number of children or youth removed from parental care were involved in an assessment, at some point in time, in which the allegation indicates “child born drug exposed.” Although the good news is that the numbers declined slightly in 2018. Figure 5. shows the number of children removed from parental care each year who had a referral with a characteristic indicating “child born drug exposed.” The year of removal is not indicative of the year of the referral. Thus, some children could have been removed in 2014, but the referral was received in 2013. In addition, the child counts may be duplicative if more than one removal occurred in separate years; however, each child is only counted once in any given year even if removed more than once during that year.

Figure 5. Children who were characterized as “Child Born Drug Exposed” in a referral and later removed, shown by the Year Removal Occurred



Data Source: DCYF Statewide Automated Child Welfare Information System

Science is not yet definitive for the long-term effects of all substances exposed in utero. Most studies of infants born exposed to opioids and polysubstances “have virtually exclusively focused on infancy and early childhood.”⁴⁰ One examining the longitudinal cognitive development of children born exposed to opioids and polysubstances suggested a “continuous negative effect of factors related to prenatal drug exposure over time.”⁴¹ However, the study notes that it is “important to investigate how prenatal risk factors interact with other risk factors as children grow older.”⁴² Family patterns increase risk, “Research shows that adverse childhood experiences such as a parent’s addiction and drug use increase the likelihood of the child using drugs by age 14 and of continuing use into adulthood.”⁴³ Children born to parents with substance use disorders have higher risk of exposure to other factors, including police presence, fear of parents’ incarceration or fear of a parent’s death by overdose.⁴⁴ Thus, it is difficult to discern whether an association of prenatal exposure to substances contributes to subsequent drug use versus other factors such as “socioeconomic, environmental and genetic influences.”⁴⁵

Exposure to parental substance misuse classifies as an adverse childhood experience (ACE). ACEs are traumatic experiences including exposure to violence, or disruptive experiences that can undermine a child’s sense of safety, stability, and bonding such as growing up in a household with substance misuse. Yet, children “can be remarkably resilient.”⁴⁶ Exposure to the stress and trauma of parental substance misuse does not mean, “a child is destined to suffer the ill effects of toxic stress.”⁴⁷ “[T]he key to thriving in the face of adversity is often the presence of at least one stable and committed relationship with a supportive parent, caregiver, or other adult.”⁴⁸ Thus, it is clear that to support the health and well-being of infants born substance exposed, strong support for the health and well-being of the infant’s parent or caregiver is a support for the infant.⁴⁹

⁴⁰ Nygaard, E, Moe, V, Slinning, K & Walhovd, KB, (2015). Longitudinal cognitive development of children born to mothers with opioid and polysubstance use. *Pediatric Research*, 78, 330-335. Accessed at <https://www.nature.com/articles/pr201595>

⁴¹ *Ibid.*

⁴² *Ibid.*

⁴³ Smith, K., (2018). Carsey Research, Regional Brief #53. *Parental Substance Use in New Hampshire: Who Cares for the Children?*, 1.

⁴⁴ Rowe, C., “The Opioid Crisis Comes to the Classroom as Soaring Numbers of Children Born in Drug Withdrawal Reach School Age”, *Seattle Times*, May 24, 2019. Accessed at <https://www.seattletimes.com/education-lab/the-littlest-children-of-opioid-addicts-are-throwing-schools-into-unprecedented-turmoil-heres-what-new-hampshire-is-doing-about-it/>

⁴⁵ Nygaard, E., et al. Longitudinal cognitive development of children born to mothers with opioid and polysubstance use, *supra*.

⁴⁶ *Ibid.* at 13.

⁴⁷ *Ibid.* at 14.

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

SCOPE AND METHODS OF REVIEW

The OCA opened a System Review on DCYF’s response to infants exposed to substances in December 2018. Methods of review included:

- Individual case and critical incident review
- Stakeholder/expert interviews
- Meeting and conference attendance
- Data analysis (vital statistics, public health surveillance, incidence of exposure, DCYF caseload)
- Legal analysis (federal and state)
- Policy analysis (DCYF, NH, other states)
- Practice review (standards, NH, and other states)
- Review of the literature (practice, child development and effects of exposure)

Over the ten months the OCA conducted the System Review, the OCA interviewed:

- DCYF employees, including district office supervisors, assessment supervisors, assessment child protection social workers (CPSWs), field administrators, and specialty staff
- Department of Health and Human Services employees, including staff from the Maternal and Child Health Section of the Division of Public Health and the Division of Behavioral Health
- Hospital social workers
- Pediatricians
- OB/GYN providers
- Substance-use recovery clinicians
- Community providers
- Mothers in recovery
- New Hampshire designated non-profit Area Agency staff
- Massachusetts Department of Child and Families employees
- Connecticut Office of the Child Advocate employees
- Harvard Kennedy School Government Performance Lab employees
- Health Law and Policy Director, University of New Hampshire School of Law
- Advocates for children and families
- Planned Parenthood of Northern New England

The OCA did not receive responses to inquiries from the following resources:

- Two (2) Family Resource Centers
- One (1) Early Supports and Services program
- Four (4) addiction treatment programs, including two (2) methadone clinics

The OCA attended the following meetings and conferences:

- Perinatal Substance Exposure Task Force of the Governor’s Commission on Alcohol and Other Drugs
- Concord Region Perinatal Community Collaborative
- DCYF Conference 2019, Prevention Services: Creating opportunities to support the upstream approach in NH Child Welfare – CWST Workshop
- Effects of Substance Use on Young Children Conference, NH-MA LEND and Dartmouth Hitchcock Medical Center

The OCA’s review also included the following:

- DCYF’s Results Oriented Management System Data
- DCYF policies
- New Hampshire Revised Statutes
- Federal Child Abuse and Prevention Act
- Federal Comprehensive Addiction and Recovery Act
- Practices in other states around infants born substance-exposed, including Massachusetts, Connecticut and Rhode Island
- Literature and research on impact of in-utero substance exposure and prenatal and postnatal best-practices

This report does not detail identifying specifics of the cases or critical incidents involving the thirty-two children the OCA reviewed. However, themes with de-identified examples are provided to emphasize significant opportunities for practice enhancement or system improvement.

SYSTEM REVIEW FINDINGS

Relevant Federal and State Laws

Due to the high health and safety risk associated with exposure to substances at birth, federal laws mandate two responses for states to address these births. First, under the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act of 2016 (CARA), to be eligible for a grant under the Act, governors are required to provide assurance that the state has a law or a statewide program relating to child abuse and neglect that includes policies and procedures “to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.”⁵⁰ This state law or program is to include a requirement that health care providers notify child protective services of the occurrence of such condition in infants.⁵¹ Second, CAPTA requires assurance of the development of a plan of safe care for infants “born and identified as being affected by substance abuse or withdrawal symptoms” to ensure the safety and well-being of such infants following release from the care of health care providers.⁵²

In New Hampshire, RSA 132:10-e requires health care providers to develop a plan of safe care for infants “born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder.” This plan shall be made “in cooperation with the infant’s parents or guardians and the department of health and human services, division of public health services, as appropriate, to ensure the safety and well-being of the infant, to address the health and substance use treatment needs of the infant and affected family members or caregivers, and to ensure that appropriate referrals are made and services are delivered to the infant and affected family members or caregivers.”⁵³ Additionally, any plan of safe care “shall take into account whether the infant’s prenatal drug exposure occurred as the result of medication assisted treatment, or medication

⁵⁰ 42 U.S.C. §5106a(b)(2)(B)(ii)

⁵¹ *Ibid.*

⁵² 42 U.S.C. §5106a(b)(2)(B)(iii)

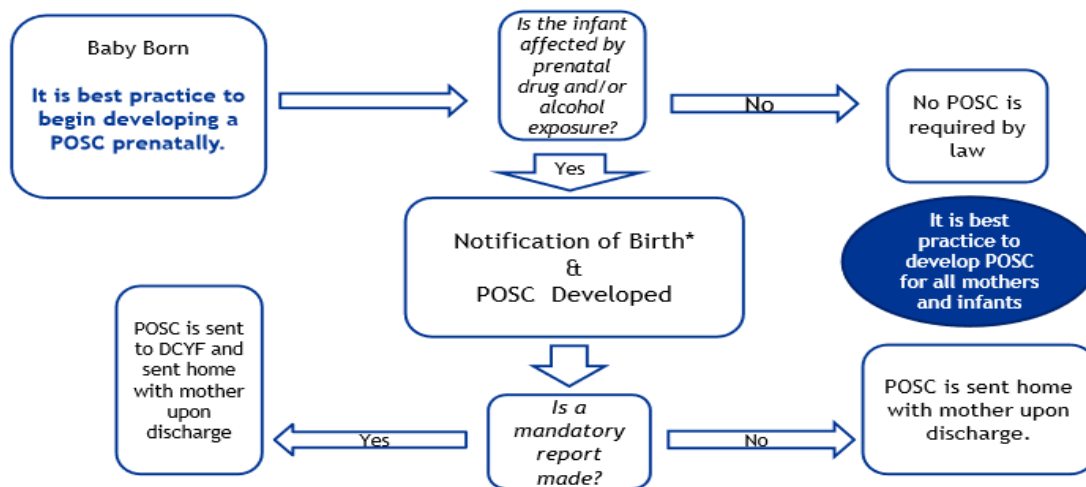
⁵³ RSA 132:10-e

prescribed for the mother by a health care provider, and whether the infant's mother is or will be actively engaged in ongoing substance use disorder treatment following discharge that would mitigate the future risk of harm to the infant.”⁵⁴ A copy of the plan of safe care must be included in the discharge instructions from the hospital or health care provider.⁵⁵ Under, RSA 132:10-f, health care providers are mandated to report suspected abuse or neglect of an infant to DCYF, and, if the infant has a plan of safe care under RSA 132:10-e, such plan shall accompany the report.⁵⁶ Figure 6. demonstrates the process of plan of safe care development and reporting.

An infant’s prenatal exposure to substances does not itself require a mandatory report to DCYF. Additionally, a provider’s development of a plan of safe care with a mother does not mean that the provider necessarily suspects abuse or neglect. Rather, a report must be made to DCYF if the hospital or provider has reason to suspect that the infant “has been abused or neglected.”⁵⁷

Figure 6. Overview of Plan of Safe Care Process

Overview of POSC Process



*Notification is captured through two situational surveillance questions on the birth certificate.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ RSA 169-C:29 mandates that any person “having reason to suspect that a child has been abused or neglected shall report the same” to DCYF.

⁵⁷ RSA 169-C:29

⁵⁸ Hodder, L.C., Laflamme, D.J., Giovanditto, K., Sreedhara, R., & Schoemmell, M. (July 3, 2019). “What is a Plan of Safe Care? An Introduction to Best Practices in New Hampshire,” (Presentation slides).

CAPTA does not specifically define “plan of safe care.” However, as noted, the CARA amendments require that a plan of safe care:

- Is ideally started prenatally “and serves as a living document throughout the pregnancy and after birth.”⁵⁹
- Addresses “the health and substance use disorder treatment needs of the infant and affected family or caregiver.”⁶⁰
- Reinforces “existing supports and coordinates referrals to new services to help infants and families stay safe and connected when they leave the hospital.”⁶¹
- Is consistent with good casework practice, including input from parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family,⁶²

Best practices for hospitals and providers include sharing the plan of safe care with the infant’s primary care provider and encouraging the mother to share the plan with all people and professionals who are or will provide support for her and her infant.⁶³

The Perinatal Substance Exposure Task Force of the New Hampshire Governor’s Commission on Alcohol and Other Drugs (Task Force) has been instrumental in working with key stakeholders in New Hampshire to develop a plan of safe care template as well as share information and guidance regarding plans of safe care.⁶⁴ The Task Force’s mission is to identify, clarify, and inform the Governor’s Commission on Alcohol and Other Drug’s (Governor’s Commission) regarding issues related to perinatal substance exposure, “including ways to lesson barriers pregnant women face when seeking quality healthcare; aligning state policy and activities with best medical practices for pregnant and newly parenting women and their children; and increasing public awareness about the dangers of exposure to prescription and illicit drugs, alcohol and other substances during pregnancy.”⁶⁵ The Task Force is comprised of a multi-disciplinary group including physicians, attorneys, substance-use disorder treatment providers, state officials, and other relevant stakeholders.

Another resource, the Northern New England Perinatal Quality Improvement Network (NNEPQIN) serves to “improve perinatal health across Northern New England through collaboration on clinical guidelines, QI projects, case review, and educational conferences.”⁶⁶ NNEPQIN has a perinatal substance use learning collaborative.⁶⁷ The collaborative is open to all and primarily made up of maternity care

⁵⁹ NH’s POSC Guidance Document. Accessed at <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

⁶⁰ US Department of Health and Human Services, Administration for Children and Families Program Instruction, ACYF-CB-PI-17-02 at 4. January 17, 2017.

⁶¹ NH’s POSC Guidance Document, *supra*.

⁶² Administration for Children and Families Program Instruction, ACYF-CB-PI-17-02, *supra* at 4.

⁶³ *Ibid*.

⁶⁴ Center for Excellence Addressing Alcohol or Drug Misuse in NH, Plans of Safe Care (POSC). Accessed at <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

⁶⁵ New Hampshire Center for Excellence Perinatal Substance Exposure Task Force, <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/>.

⁶⁶ Northern New England Perinatal Quality Improvement Network, <https://www.nnepqin.org/>.

⁶⁷ November 18, 2019 email from Daisy Goodman, facilitator, NNEPQIN perinatal substance use learning collaborative.

providers who meet monthly to learn from expert speakers and share implementation strategies for improving the care of perinatal women with substance use disorders.⁶⁸ There are also various other practitioner perinatal substance use disorder collaborations and projects around the state, including one on pediatric recovery friendly practices.

On July 15, 2019, DCYF and the Division for Public Health Services sent a letter to all relevant healthcare providers regarding plan of safe care requirements.⁶⁹ The letter explained the statutory requirements for the development of a plan of safe care and provided a template plan of safe care form created by the Task Force with input from medical, legal, child welfare and public health professionals.⁷⁰ The letter further made clear that a plan of safe care need only be shared with DCYF when there is a mandatory report of abuse or neglect pursuant to RSA 169-C:29. The letter advised that “[i]nfants with prenatal exposure due to prescribed medication under a clinician’s direction AND without any child safety concerns do not need to be reported to DCYF.”⁷¹ The letter also highlighted statewide efforts being made to reduce the stigma affiliated with substance use disorder to encourage pregnant mothers to seek prenatal care and substance use disorder treatment as early in pregnancy as possible.⁷²

DCYF Enhanced Response Policy 1184

DCYF practice with substance exposed infants is guided by *DCYF’s Enhanced Response Policy 1184*. The policy defines “substance exposed infant” as an infant “exposed to alcohol, prescription drugs, misuse of over the counter medications, inhalants, and illicit drugs (cannabis, hallucinogens, opioids, stimulants, sedative hypnotics) while the infant is in utero, whether prescribed or not which result in the infant exhibiting withdrawal symptoms at birth.”⁷³ When there is an accepted report by DCYF of an infant “born with and identified as being effected by substance use or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” the policy requires an “enhanced response assessment.”⁷⁴

The *Enhanced Response Policy 1184* requires:

- A minimum of four face-to-face visits in a prescribed time period for any substance-exposed infant.⁷⁵

⁶⁸ *Ibid.*

⁶⁹ July 15, 2019 POSC Provider Letter to Healthcare Providers from Joseph Ribsam, Director, DCYF and Lisa Morris, Director, Division of Public Health Services. Accessed at <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

⁷⁰ *Ibid.* The Perinatal Substance Exposure Task Force of the Governor’s Commission on Alcohol and Other Drugs continues to collaborate around implementation of, and issues related to, plans of safe care. In addition, the Task Force provides updated information on plans of safe care for the public. See Center for Excellence Addressing Alcohol or Drug Misuse in NH, Plans of Safe Care (POSC). Accessed at <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ See *DCYF’s Enhanced Response Policy 1184*, at 2. Accessed at <https://www.dhhs.nh.gov/dcyf/documents/dcyfpolicy1184.pdf>

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

- A safety plan that “includes engagement with the parent and an additional primary third party caregiver.”⁷⁶
- Gathering of certain specified information as circumstances allow, prior to making a determination, including:
 - Parental substance use/abuse history;
 - Information from the child’s pediatrician; and
 - Professional collateral contacts.⁷⁷
- Keeping the assessment open for at least the full 60-day assessment period.⁷⁸
- At the first home visit with the infant and family, the Child Protection Service Worker (CPSW) must:
 - Ensure that an Early Supports and Services referral is made;⁷⁹
 - Inquire about the family’s plan of safe care;
 - Discuss safe sleep as well as referrals to relevant community resources.⁸⁰
- A final home visit with the infant and family within 10 days of the assessment closure.⁸¹

The CPSW may discontinue the safety plan and institute an action plan only if the parent is in a prescribed treatment program and the CPSW has been able to confirm the parent’s attendance and compliance in the program.⁸²

System Review Findings Themes

Four primary themes emerged from the system review:

- Communication
- Consistency of practice
- Unrecognized barriers and biases
- Timing and importance of early supports and services

The four themes are not unique to DCYF’s response to substance exposed infants. Concerns regarding communication and consistency are two of the most frequent complaints the OCA receives with regard to DCYF’s work with children and families. Delays in accessing early supports and services may be a

⁷⁶ *Ibid.* at 3. The policy defines a “safety plan” as “a document developed with families, inclusive of a third party/primary third party caregiver, used to identify immediate concerns, resources and tasks to avoid potential danger to the child(ren)/youth and defuse situations as the need arises. The ‘Safety Plan’ clearly outlines what needs to be in place for the child(ren)/youth to remain free from danger.” *Id.* at 2.

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ In New Hampshire, Family-Centered Early Supports and Services (FCESS) are designed for children birth through age three who have a condition that has a high probability of resulting in delay, are experiencing developmental delays, or are at risk for substantial developmental delays if supports and services are not provided. Services can include: Family support, education and counseling; vision; hearing; health and nursing; medical and diagnostic and evaluation; nutrition counseling & assessment; occupational therapy; physical therapy; special equipment; special instruction; speech and language therapy; transportation; and service coordination.

<https://www.dhhs.nh.gov/dcbcs/bds/earllysupport/index.htm>

⁸⁰ DCYF’s *Enhanced Response Policy 1184*, at 4-6.

⁸¹ *Ibid.* at 3.

⁸² *Ibid.* at 5.

reflection of insufficiencies in the available service array, or of referral and follow-up processes. Implementing early supports and services for families as early as possible meets the immediate needs of families, but also serves as a risk reducing, prevention practice.

Effective communication and consistent case practice builds strong, trusting relationships. Relationships, in turn, contribute to responsive, collaborative systems. It is through enhanced systems that infants and their families are best served. When system interactions between DCYF, families, and other systems lack consistency of practice or clear communication, the parties disconnect. The frustrations of those disconnects breed resentments between DCYF and families, hospitals, treatment providers, community agencies and the public. They lead to network partnership breakdown and increased risk for infants and their families.

Barriers to ensuring health and safety for children were consistent across individual cases examined for this review. Caring for a newborn while recovering from or living with a substance use disorder further compounded those barriers. Bias toward women with substance use disorders appeared to inhibit healthy recovery and may have broad reach to discouraging women from seeking postnatal care and support.

The postnatal environment is a significant factor in determining outcomes for infants born substance exposed. As a result, providing early intervention and support services for these families may have a significant impact on reducing the risk of future harm and ensuring healthy development.⁸³ Intervening early optimizes children's development, but also provides necessary education and resources to parents and caregivers.⁸⁴ Intervention and early support programs can help caregivers and parents with necessary skills and knowledge to support their strengths as well as ensure a healthy environment for the child.

The importance of each of these four themes is woven throughout the discussion of each of the findings from all sources of data collection discussed below.

Individual Case Reviews

Of the thirty-two children born substance exposed and identified for this review, the OCA conducted eighteen in-depth individual case reviews. In addition, the OCA tracked recurring themes from the other fourteen cases. Several themes in practice, attitude and awareness emerged.

Checking the Box

In DCYF assessments involving substance exposed infants, communication delays and inconsistent practices were recurring themes of practice associated with missed opportunities for family engagement

⁸³ See generally Belcher, H., Butz, A., Wallace, P., Hoon, A., Reinhardt, E., Reeves, S., Pulsifer, M. (2005). Spectrum of Early Intervention Services for Children With Intrauterine Drug Exposure. *Infants and Young Children*, 18(1): 2-15. <file:///S:/Unrestricted/SYSTEM%20REVIEWS/DEI%20and%20Assessments/Resources/2005%20-%20Spectrum%20of%20Early%20Intervention.pdf>.

⁸⁴ National Institute on Drug Abuse. (March 9, 2016). *Principles of Substance Abuse Prevention for Early Childhood*. Chapter 3: Intervening in Early Childhood. Accessed at <https://www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/chapter-3-intervening-in-early-childhood>.

and ensuring supports. As discussed further herein, the requirements of the enhanced assessment policy share similar risk to most practice checklists in the development of rote response or simply “checking the box” practice. The task of making four home visits, for example, is intended to facilitate development of a meaningful, helping relationship and ensure the infant’s safety. Superficial visits designed to complete the task and check the box may not nurture relationships or inform assessments. Requiring a certain number of referrals may have similar effect. In three of the enhanced assessments reviewed, referrals were limited to those specific services required under the policy, even though other services might also have benefitted the families. Of referrals made, follow-up to ensure parent engagement with the service was often not evident. Cases reviewed revealed assessment inquiries to pediatricians, obstetrics and gynecology providers, treatment providers, or other collateral contacts left without evidence of contact or documentation of their feedback on family functioning.

Similar incomplete processes have been examined in the use of checklists in health care. Although checklists have significantly improved patient outcomes in health care, the implementation of the checklist is far more multifaceted than checking a box. Family situations, like hospital patients, can be messy and complex. Meaningful completion of check lists or policy-driven tasks requires decision makers (caseworkers) feel the support of agency-wide buy-in, team support, incentives for cooperation, open communication, and latitude to adjust the tasks to meet individual child or family needs. The policy, like a check list, will not be effective if barriers are not removed.⁸⁵ In this case, barriers to meaningful home visits may include workload, time constraints on other assigned cases, or lack of expert support to work with a family.

Maternal Focus

The primary focus of DCYF interventions or referrals to services was on the mother’s needs to the exclusion of the father’s. In one case, the father continually identified the need for additional substance use treatment and support while on a wait list for a program. He was referred to the MLADC in the district office to access support until the waited for program opened up. By case closure, there was no follow up to ensure that the connection was made and the father was offered supports.

Barriers to Success

A common theme among assessments reviewed was parents struggling to meet basic needs. Housing, transportation, and consistent employment were identified as common significant barriers to parents’ ability to move forward with treatment and/or rectify DCYF-identified safety concerns. In one open neglect case involving a substance exposed infant, the case notes documented that the caseworker repeatedly left messages for the mother letting her know that a gas card was available for her to pick up at the district office. The mother had recently moved to a town approximately twenty miles away from the district office in order to secure safe housing as part of the reunification plan. She was struggling to get to the district office to get the gas card. Although she had explained the situation, the assessed transportation need was rectified with yet another unnoticed barrier. Without careful identification and understanding of barriers, remedies, such as gas cards that require gas to retrieve them, may not fit the need. In another case, the parents moved to a neighboring town as part of a DCYF safety plan. At the final home visit of the assessment, the mother explained to the caseworker that the move created

⁸⁵ Bosk, C.L., Dixon-Wood, M., Goeschel, C.A. & Pronovost, P.J., (2009). Reality check for checklists. *The Lancet*, 374 (9688): 444-445. Accessed at [https://doi.org/10.1016/S0140-6736\(09\)61440-9](https://doi.org/10.1016/S0140-6736(09)61440-9).

difficulty getting to her counselor's office due to distance and limited transportation to the area. The assessment was closed without a remedy.

Transportation and employment barriers may also interfere with parents adhering to treatment schedules and drug testing. Parents are often not given warning of required same day drug testing. In many cases, parents responded with concerns for missing work or lack of transportation to get to the testing site. These concerns were magnified in the more rural parts of the state where public transportation options are limited. Personal history could also create a barrier. One treatment provider shared that she works with mothers who have suffered from domestic violence who fear traveling alone in a vehicle with a man. As a result, they will decline coordinated transportation for medical or treatment appointments, further delaying recovery or progress with DCYF-imposed obligations.

Bias and Knowledge Deficit

Treatment providers described a lack of understanding of the nature and source of addiction on the part of DCYF staff. An example is the use of punitive language when addressing parents rather than acknowledging the difficulty of managing recovery while parenting a newborn. Monitoring treatment and safety plan compliance without examining barriers like transportation to treatment also reflected lack of understanding about family circumstances.

Differential Response

The OCA's review of cases and critical incidents involving substance exposed infants also revealed a differential response to substances. Concerns for opioid or methamphetamine use frequently overshadowed concerns for any other substances. Cases involving the use of marijuana were often minimized. This was reflected in interviews with DCYF caseworkers and supervisors who expressed frustration with the inability to relax the requirements of the policy in cases involving marijuana. Additionally, there was minimal mention of alcohol and no mention of the risks associated with tobacco use in any of the cases reviewed by the OCA.

Only three DCYF staff members expressed concerns about the perception marijuana exposure does not harm infants. Consequently, cases of infants exposed to marijuana are not as frequently reported to DCYF.⁸⁶ For example, one intake staff member reported that one hospital routinely reported to New Hampshire and Vermont. However, Vermont does not take reports of marijuana exposed infants. The staff member speculated that, despite New Hampshire's acceptance of those reports, Vermont's practice has led the hospital to decrease its reporting of marijuana exposed infants to DCYF. Another hospital reported rarely reporting infant exposure to marijuana, if ever. A third hospital reported tracking and reporting only infants monitored for NAS which typically includes exposure to opioids, but can include exposure to cocaine or alcohol. The third hospital does not track infants exposed to marijuana. A staff member from the third hospital reported marijuana exposed infants are harder to track due to delays in accessing day-of-birth urine drug tests. If a urine cannot be obtained from the infant the day of birth, the hospital does not always get test results back until after the infant is discharged to home.

⁸⁶ As explained herein, prenatal exposure to substance and/or parental substance use alone does not necessarily necessitate a report of abuse or neglect to DCYF Central Intake. RSA 169-C:29 mandates that any person "having reason to suspect that a child has been abused or neglected shall report the same" to DCYF. *See also* RSA 169-C:3, II (defining ("[a]bused child"); XIX (defining "[n]eglected child").

The DCYF intake staff member concerned about lack of reporting on marijuana-exposed births cited new research findings on the negative impact of marijuana on a child's brain and development. More is known now about marijuana's impact on infants prenatally. The staff member also cited parent behavior when influenced by marijuana use as leading to greater risk for newborns.

Surface Level Safety Assessments

In the majority of assessments reviewed by the OCA, the sole focus of the assessment was to address the imminent safety concerns related to the allegation made in the intake report. This narrow focus does not afford a broad view of unmet concerns across the whole family unit. Safety of siblings and other household members, for example, or basic needs and long-term stability are all risk factors. Focusing only on immediate safety concerns identified in an abuse/neglect allegation, is actually an appropriate implementation of child protection services. However, taking a long or futuristic view affords DCYF staff opportunities to refer families on to services or support that will keep the child and family safe for the long run. In addition, other points of intervention may prove useful to support families prior to opening a case for abuse or neglect. For example, DCYF Policy *1209 Voluntary Services* provides that DCYF may "offer short-term, voluntary services in an endeavor to stabilize [a] family."⁸⁷ These encompass "an array of services provided in response to concerns of abuse and/or neglect in an effort to promote safety and mitigate risk."⁸⁸

Screened-out Reports

DCYF does not have the ability to track reports of substance exposed infants that are not screened-in for an assessment. Intake staff reported that the number of reports of suspected abuse or neglect made to Central Intake that are not screened in is low, however, the information contained in a screened-out report is often useful to assessing whether to screen in a subsequent report. One of the steps taken by intake staff to determine whether to screen-in a report is to review all prior reports, screened in and out. When viewed in conjunction with the information the hospital provides upon the birth of a substance exposed infant, prior reports can provide a useful story of risk. Intake staff reported that there have been times that prior reports revealed information the hospital did not have that raised risk level and led DCYF to screen-in a report. For example, DCYF may have a history of other substance exposed infants born to the family along with screened out reports of concerns that a mother was not regularly attending treatment during pregnancy. This information indicates a higher level of risk to the newborn, or a higher level of family support needs.

DCYF is in the midst of a major overhaul of the Bridges electronic case management system. Those improvements, along with the integration of a new Structured Decision Making instrument used to determine level of risk and urgency of safety assessment, should translate to more easily tracked encounters with a child or family, including screened out reports of substance exposed infants, going forward.

⁸⁷ DCYF's Policy 1209 *Voluntary Services* at 1. Accessed at <https://www.dhhs.nh.gov/dcyf/documents/dcyf-policy-1209.pdf>.

⁸⁸ *Ibid.*

DCYF Staff Impressions of Enhanced Response Policy 1184

Interviews with DCYF staff revealed varying perspectives on DCYF Policy 1184, *Enhanced Response*. However, several themes emerged in staff impressions of the content and implementation of the policy.

Workload stress

DCYF staff, already managing heavy workloads, discussed the increased workload accompanying an enhanced assessment. Nonetheless, staff appreciated the rigidity of the prescribed visits and time line. They expressed appreciation in a policy that confines them to conduct casework the way they believed it should be conducted: spending more time helping families.

Unnecessary Constraints

Some staff members reported that the requirements in the enhanced assessment are too constraining. For example, when working with a family in which a parent uses marijuana or is in recovery from an opioid addiction with a confirmed medication assisted treatment prescription, staff reported wanting more discretion to reduce the number of home visits or close the assessment earlier than 60 days. Staff suggested that allowing for some discretion in the number of visits depending upon the circumstances of the case and substance the infant was exposed to, or the level of treatment for the parent would be helpful. The desire for an option of differential response reflected varying degrees of knowledge about the effects of various substances on infants and their development. Staff also expressed frustration with the requirement of having to find a third-party caregiver as a back-up in case of relapse or incapacity, in all circumstances. They suggested that there are some circumstances in which they did not believe one was necessary.

Quality/Meaningfulness of Visits

A number of staff members identified concerns about the quality or meaningfulness of home visits. For example, as referenced above, one supervisor spoke of CPSWs feeling like they have to “check the box” of the required four visits rather than using them as an opportunity to develop a stronger relationship with families. Good relationships are built on trust. Trust has positive effect on family engagement in services and long term success.

In these concerns about the actual implementation of the *Enhanced Response Policy* the potential for false assurance of better practice and protection of infants could be wedded to policy rigidity. Loss of meaning in routine tasks is equally problematic. While a caseworker may be meeting the policy’s requirements, there remains the question as to whether the quality of the work is sufficient to identify risk, including future risk, and ensure an infant’s safety while promoting and supporting parenting capacity. In addition, the question remains whether caseworkers are missing risk factors or opportunities to intervene due to the false assurance an already intensified case management process.

In-depth Case Review and Action Planning with Parents

DCYF staff expressed appreciation for the opportunity to review family history in greater depth required by the *Enhanced Response Policy*. Better understanding of family dynamics facilitates better assessment of safety needs and risks. Staff also spoke highly of having to create Action Plans with parents. An Action Plan is defined as “a document to be used with the families to identify specific actions and strategies to

avoid, disrupt, or escape high-risk situations.”⁸⁹ An Action Plan “is a fluid document that may change with the family’s progress and enhances the case plan.”⁹⁰ Action Plans may be used when a concern does not rise to the level of a “Safety Plan.”⁹¹ The design is intended to be parent/family-driven. Determining their own goals and paths to achievement empowers families and cultivates a partnership rather than authoritarian punitive relationship with DCYF. Staff reported that this ensures that they work with the parents closely. The family-driven Action Plan also provides a clear outline of expectations on the family and DCYF, minimizing misunderstandings and creating clear paths for accountability.

Differential Response to Substances

DCYF staff expressed varying opinions about whether the policy should have a differential response to certain substances. The practice guidance in the policy states that staff may consult with a supervisor on the appropriateness of a second level screening if the staff member is able to confirm and document within ten days of the receipt of the assessment that the only substance the infant was exposed to was marijuana, there are no other concerns, the family is receptive to community referrals and the family is following through with the plan of safe care.⁹² Nonetheless, some staff members expressed frustration that the policy does not allow for a more differential response to marijuana, suggesting that a less-intensive response to marijuana should be permitted and not just part of the practice guidance.

On the other hand, three staff members expressed frustration with the practice guidance allowing for this slightly differential response. These staff members highlighted anecdotal concerns of observed parenting practices among parents under the influence of marijuana and the risks associated with being under the influence while parenting a newborn.

Overall Staff Impressions of *Enhanced Response Policy*

All of the DCYF staff members interviewed agreed on the need for an enhanced response policy to infants born exposed to substances. Some recognized that there was significant thought invested in crafting required time frames for conducting visits. The policy design was intended to be sensitive to the experiences of substance exposed infants as well as the developmental phases of parenting from birth, to weeks in, and as the child continues to grow and develop. One staff member reported that the enhanced assessment practice “really helps families and gives the caseworker the ability to really talk with families about supports.” Some staff appreciated the prescribed outline of steps for follow-up in enhanced assessments. They also reported that reviewing parents’ substance use/abuse history helped in determining safety and risks in each case. In addition, staff members appreciated the authority to employ drug testing as a means to ensure adherence to treatment and a measure of risk to child safety. This was particularly helpful when there were substance use indicators present but no concrete evidence of use.

⁸⁹DCYF’s *Enhanced Response Policy 1184*, at 1.

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² *Ibid.* at 7.

DCYF's Communication with Healthcare and Community Providers

Details, Timeliness & Responsive Communication with Hospital Staff

DCYF staff described hospital staff as not adequately providing essential information necessary to assist parents and children. For example, DCYF staff expressed frustration when hospitals neglected to share specifics about substances an infant was exposed to. Caseworkers explained that details of substance use exposure informs appropriate supports for a parent's recovery needs. This information helps also identify potential health concerns the infant may experience. Similarly, hospital staff reported they receive little information about families involved with DCYF. Although they recognized the confidential nature of DCYF's work, hospital staff explained that if they were equipped with more information when DCYF is involved, they would better be able to serve infants and families.

Both hospital and DCYF staff perceived initial notification of and response to a substance-exposed birth as delayed. Hospital staff identified a need for a faster response time from DCYF to assist in needed planning for infants. DCYF staff described timing of hospital reports as being delayed. They explained the need for time to build relationships with families. Early reporting provides DCYF with the best opportunity to engage a family in the hospital to ensure development of a safety plan and assist with community referrals and supports prior to the infant's discharge from the hospital.

Hospital staff reported seeking guidance from DCYF caseworkers involved with families effected by substance use, but receiving inconsistent responses, and sometimes no response at all. Community treatment providers also described inconsistent or sometimes nonexistent communication from DCYF. Inconsistent communication reportedly can result in poorly informed decision making. For example, one hospital maternity social worker described a case in which the DCYF caseworker made a safety plan with a family without consulting hospital staff.⁹³ The hospital staff had an experience with the father causing significant safety concerns about his behavior. Once aware of the concerns, the caseworker changed the DCYF safety plan. This experience was difficult for both hospital staff and the family who had already relied on the previously made plan.

Plans of Safe Care

One DCYF staff member also related that there are difficulties in obtaining the federally required plans of safe care from hospitals despite the statutory requirement that they be sent to DCYF when a referral is made. Ideally, the plan of safe care would inform the DCYF safety plan and any action plans. It loses meaning when it is not shared.

One mother with lived experience reported that plans of care can be overwhelming to a new mother in recovery or struggling with a substance use disorder. Coordinating or following-up on referrals and plans detailed in a plan of safe care without support can prove difficult and unworkable while parenting a newborn. She also explained that a mother may have completed parenting and/or recovery-related course, but no one checks or updates the plan of safe care to note the mother's progress. Identifying a support person and communicating among relevant entities to assist the mother with follow-up and encouragement would serve to assist mother's in following the plan of safe care.

⁹³ As explained herein, the DCYF safety plan is separate and distinct from the federally mandated plan of safe care.

Factors Affecting DCYF Relationships

Inconsistency in Practice

DCYF staff reported hospitals vary in reporting practices. Some hospitals report the births of nearly all infants born substance-exposed to DCYF. Other hospitals report less frequently, or only report opioid or other related exposures. Hospital staff confirmed varying reporting practices.

Hospital staff described families in similar situations receiving what hospital staff perceived as a different response from DCYF, even from the same DCYF district office. Staff noted that inconsistent case practice makes it difficult for hospital staff to prepare families for DCYF involvement. They judged the inconsistencies as leading to family mistrust and lack of engagement.

Community treatment and medical providers described consistency as essential to success in treatment of addiction. They too noted inconsistency in district office case practices and CPSW's practice resulting in differing case outcomes for families in similar situations both across district offices and in the same district office. They frequently reported not understanding the reason why DCYF acted one way in one case and another way in a different case. The inconsistency left providers with the perception DCYF decisions can be arbitrary and punitive, depending upon the caseworker or circumstances.

Inter-professional Understanding

Hospital and provider staff discussed their need to understand DCYF processes.⁹⁴ They reported they received little information about DCYF case practices, including the services and resources DCYF may be able to offer a family. They noted this knowledge would equip them for effective coordination of in-patient care and post-discharge referrals.

Hospital staff's experience of untimely communication with DCYF affecting discharge planning as described above, reveals a lack of knowledge on the part of DCYF staff about hospital processes. Even with complicated births, maternity hospital stays tend to be brief. Short response time for engagement is not conducive to comprehensive safety planning.

Hospital staff also reported confusion over when to report concerns for abuse and neglect. This may reflect a lack of knowledge on mandated reporting, a statutory obligation. It also may reflect confusion about the protocol for communicating new concerns in an open case. The OCA has also heard conflicting explanations of these communications (e.g. whether to report new allegations of abuse or neglect to the assigned case worker or to Central Intake).

DCYF reported frustrations with a lack of abuse/neglect reporting from substance use treatment providers. They noted provider's may actually have a policy against reporting or lack knowledge of their statutory mandate to report under RSA 169-C:29. DCYF staff members expressed particular concerns about provider's knowledge of a parent's use of illicit drugs and not reporting possible related neglect to DCYF, in light of the presumption under RSA 169-C:12-e described below.

⁹⁴ The OCA interviewed three treatment providers and one former provider utilizing varying approaches to treatment. However, none of the providers interviewed included a methadone clinic as the OCA did not receive a response from the two methadone clinics contacted during the system review.

Communication Practices

All parties interviewed reported varying levels of difficulty in communication with each other. One clinical social worker explained that she witnesses both “an incredible amount of accountability and attention” and a “total lack of communication and coordination” in cases involving DCYF. She explained that families who are in close communication with the CPSW during an assessment or open case do the best even if they do not like what the CPSW is asking them to do. She noted the lack of communication with families creates an anxiety that leads to increased risk of relapse and poor case outcomes.

One hospital staff member shared that families, particularly mothers need more information about recovery services and the DCYF case process. She explained that mothers “are trying to do all of the right things, and when they are not given information, it just creates more stress.”

Consequences of Fear

Hospital and birthing staff, treatment provider staff, community agency staff, and mothers with lived experience reported that parents fear DCYF’s involvement corresponds to their newborn being taken from them. This may underlie treatment provider’s reluctance to report active substance use for fear of disengaging the parent from treatment. In addition to obstetrical health, prenatal care is also an avenue for access to substance use treatment and development of a plan of safe care.

Hospital staff expressed frustration at rarely, if ever, receiving a plan of safe care created prior to birth by prenatal providers. They described this as resulting from women’s general lack of prenatal care or a perceived fear on the part of obstetricians to broach the complex and personal issues involved in substance use disorder. Hospital staff explained that having that connection prior to birth helps them to get better outcomes. In addition to resulting in higher risk pregnancies, absence of prenatal care is a missed opportunity to develop a comprehensive plan of safe care. Without a plan in place prior to a child’s birth, hospital staff feel behind in the ability to effectively support the baby and mother. They described frequently “scrambling” to get enough information to develop the plan of safe care and determine whether to contact DCYF, all within the confines of a brief hospital stay without the benefit of an established relationship.

Undue Burden of Parenting in Recovery

Treatment providers described DCYF as lacking knowledge regarding the nature of addiction and provision of trauma-informed response to parents in recovery, particularly to mothers. They described DCYF’s response to families with substance-exposed infants as punitive. One former treatment provider explained that the approach a caseworker takes with a family is vital to the relationship. When the approach is solely punitive, the provider observed increased difficulty in relationships. Treatment providers also discussed the importance of including families in critical case decisions and ensuring that they have support during critical case meetings.

One treatment provider referred to mothers as the “bearers of all responsibility,” explaining that if a mother has a substance use disorder during or after pregnancy, she “bears the weight of shame and blame” from the community for placing her infant at risk of harm and being unable to overcome her addiction. The provider described case plans requiring mothers to bear the responsibility for safe, infant care and complex substance use treatment. They saw little or no mention in the plan of the father’s role or responsibility. The provider further explained, if a father has a substance use disorder, the mother is often tasked with ensuring his sobriety or required to separate from the father if the father is viewed as

posing a risk to the child. In either scenario, the provider described mothers being asked to remove themselves and make life-changing decisions from their familiar environment in the absence of support.

A pediatrician reported that there is often a loss of trust between DCYF and parents because of the lack of strength-based supports. He explained that the first year of a child's life is crucial to development, but so is the first year of recovery. He echoed the sentiment of treatment providers that a punitive investigative approach can be harmful to relationships and deter families from seeking care and treatment. He advocated for using a strengths-based approach when working with parents with substance use disorders to show the strength in their recovery efforts and provide them with pride in their parenting skills, no matter their capacity. He suggested reframing the skepticism and fear that so often accompanies working with families with substance use disorders and instead recognizing that every new parent needs assistance. He stated that "[t]he things we do to present opportunities need to make people feel good about being a parent."

He advocated for families to enroll early with the Women, Infants and Children (WIC) program. WIC is a federal grant program that provides supplemental nutritious foods and nutrition education and counseling for parents, as well as screening and referrals to other health, welfare and social services.⁹⁵ He explained that children should get early support services beginning around the second month, but that unfortunately many do not because of the stigma parents feel and the fear of what will happen when they reach out.

Tension in Interpretation of Independent Roles

Tension between the differing roles of treatment providers and DCYF further creates barriers to system collaboration. This tension was exemplified in the varying interpretations of RSA 169-C:12-e. Under RSA 169-C:12-e, "[e]vidence of a custodial parent's opioid drug abuse or opioid drug dependence, as defined in RSA 318-B:1, I or RSA 318-B:1, IX, shall create a rebuttable presumption that the child's health has suffered or is very likely to suffer serious impairment." The provision allows for a parent to rebut the presumption by presenting evidence that the parent is in compliance with treatment for opioid use or dependence.⁹⁶

DCYF staff supported this provision, referring to the provision as "life changing for the state." DCYF staff reported that the law allowed them to help children where they otherwise would not have been able to despite knowledge of the parent's opioid drug abuse or dependence. On the other hand, providers expressed strong concern that, despite the ability of a parent to overcome the presumption, the law causes women who would otherwise obtain prenatal care to avoid such care for fear of a neglect finding. In that sense, providers expressed frustration with the law as further harming mothers and children.

The Law – Treatment Conflict

Pressures for situating a child safely immediately, and for the long term are driven by legal mandates. Under federal law, if a child is removed from the home due to abuse or neglect, a permanency hearing must occur within twelve months to determine when the child will return home with his or her parents

⁹⁵ USDA Food and Nutrition Service. Accessed at <https://www.fns.usda.gov/wic/about-wic-wic-glance>

⁹⁶ RSA 169-C:12-e

or be placed for adoption.⁹⁷ Treatment providers and DCYF staff alike discussed the difficulties in reconciling this law with the addiction recovery timeframe, noting that addiction recovery can be lengthy and involve multiple relapses before success. Child development experts note that critical junctures in child development for consistency of relationships, attachment and trust-building are generally accommodated by neither the federal law nor a lengthy addiction recovery.

Obstacles to Case Resolution: Substance Use Treatment Providers

DCYF staff rely upon treatment providers and medication assisted treatment clinics for information that reflects parent engagement and adherence to substance use treatment. Engagement and adherence are indicators of child safety as well as readiness for case closure. Lack of evidence may delay case closure and prompt the opening of an ongoing Family Services case with potential for child removal. DCYF staff described significant difficulties accessing information from the providers in a timely manner, or at all. DCYF staff described difficulty in working with methadone clinics specifically, even when they have a signed release of information from the relevant parent. One DCYF staff member spoke of continually having to submit different releases regarding the same parent to a methadone clinic. She explained that each time she submitted a release of information form, the clinic returned it saying it was not sufficient, but the clinic would not explain why or provide its own form. In one case reviewed by the OCA, the provider returned a signed release form months after the assessment opened because the provider name DCYF wrote on the form was incorrect by one word. It was not until the caseworker reached out to the provider in an attempt to close the case that the provider returned the release, noting the name was incorrect and therefore denied.

There were instances of positive DCYF-provider relationships with productive communication processes. One former director of an integrated residential treatment program for pregnant and new mothers attributed the success of the program to her staff outreach to, and collaboration with, DCYF. She explained that when a program does not engage with DCYF, there are increased problems with treatment and recovery. She identified the biggest predictor of family success as communication among all parties. She described processes involving clear communication by the program with DCYF to share information about recovery that would ensure children are protected, but also support mom during the process. She reported that if the mother understands that the treatment provider is working as a team with DCYF to support her recovery, then the mother is more likely to engage in treatment and work with DCYF. She further explained that when entities do not work together, often times the parent is never held responsible for their recovery and parenting. She explained the program forged collaborative relationships with DCYF and also with treatment providers, including methadone clinics, stating it was those relationships that led to the success of the women in the program.

The OCA was unable to determine the reason for stakeholder difficulties communicating with methadone clinics. One explanation is that these clinics are overburdened with the need for services, however, further study on this issue may prove useful. Methadone clinics offer a point of interface with women with substance use disorders. Opportunities for engagement in prevention services and collaboration in substance use treatment abound and should be examined by clinics and the Department of Health and Human Services as the certifying entity of substance use treatment programs.

⁹⁷ 42 U.S.C. §675(5)(C); *see also* 42 U.S.C. §675(5)(E) (requiring the state to file a petition to terminate the parental rights of the child's parents if the child has been in foster care for 15 of the most recent 22 months); 42 USC §671(a)(16).

A SPECIAL ROLE: DEI SPECIALIST

In 2017, the DCYF southern district office created a Drug Exposed Infants Specialist (DEI Specialist) position. The position intrinsically addressed all of the concerns described by DCYF and other staff in this review. The specialized role eases caseworker burden. It provides the caseworker time to build necessary relationships with families. It promotes engagement with all stakeholders to ensure the safety of substance exposed infants and support their families.

The DEI Specialist is assigned cases involving “all drug exposed infant assessments” in the southern and southern Telework areas.⁹⁸ The position is tasked with building “relationships with the local hospitals to ensure better communication with the case managers that call in” substance exposed infants reports.⁹⁹ The DEI Specialist meets regularly with the MLADC in that office for consultation on substance abuse needs, resources and client information.¹⁰⁰ Anticipating the intensive engagement required of an enhanced response, the southern and southern Telework offices monitor the number of assessments the DEI Specialist receives and will cap the assessments if the workload gets too high or the DEI Specialist receives multiple assessments in one day.¹⁰¹

The OCA interviewed DCYF staff in the Southern district office and relevant community stakeholders to assess the impact of the position. Time and relationships were consistent themes that emerged from those interviews. They and others are described below.

Welcome Relief

DCYF staff in the southern district office reported that the DEI Specialist position has been well-received by the Office. They reportedly were eager for the position to be established. They felt by having the office implement the position, their voices were “heard.” DCYF staff explained having one staff member assigned to assessments involving substance exposed infants relieved the burden of these assessments on multiple staff members. It also increased the ability of supervisors to track the cases to ensure that all applicable timeframes are met. DCYF staff described the position as being “fantastic” for the office. They discussed feeling more in control of assessments involving substance exposed infants than prior to the position being established.

Increased Expertise

DCYF staff explained the position allows for the DEI Specialist to acquire a higher level of expertise in matters concerning assessments with substance exposed infants. An MLADC explained that there are often complex medical concerns that arise with these cases. Having a staff member with high level knowledge and expertise is a valuable resource to understanding and supporting families. Equally as valuable to the staff and families, the specialty focus includes building expertise on the various substances infants are exposed to and the nature of addiction.

⁹⁸ DCYF Southern District includes Amherst, Atkinson, Brookline, Danville, Derry, Greenville, Hampstead, Hollis, Hudson, Litchfield, Londonderry Mason, Merrimack, Milford, Mont Vernon, Nashua, Newton, Pelham, Plaistow, Salem, Sandown, Wilton and Windham.

⁹⁹ DCYF Southern district office Specialist Position Description.

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.*

Time for Relationships/Responsive Partnerships

Staff reported less dissatisfaction with the requirements of the *Enhanced Response Policy*, and a higher quality of work being performed during these assessments due to the increased amount of time the DEI Specialist has to spend with each family. The Specialist explained relationships with families is also enhanced by a predictability of her time commitments and ability to manage her time, avoiding disruptions and rescheduling appointments due to issues in other cases. Similarly, the benefit of a specialist role is reflected in the strength of relationships built with community stakeholders.

Staff reported that the response time for reporting and responding to DCYF by one of the area hospitals and the relationship with that hospital has improved since implementation of the DEI Specialist position. The DEI Specialist now serves as a contact person for hospitals if there are questions even when there is not an assessment. Additionally, DCYF's relationship with local treatment facilities has improved, leading to ease of referrals for families. The DEI Specialist reported having the ability to build these relationships has given her a greater understanding as to why the relationships were traditionally difficult. As a result, she understands and can repair the break down in some of the former communication barriers.

The DEI Specialist also reported having stronger relationships with families. Although the *Enhanced Response Policy* requires four face-to-face visits, the DEI Specialist reported often meeting more frequently with families. She reported she has experienced parents reaching out to her, even after an assessment is closed, sharing pictures, sending text messages or asking for assistance.

The improvement of relationships was confirmed by staff at a local hospital as well as former staff member from a local treatment provider. Hospital staff reported having a productive working relationship with the DEI Specialist. They stated that they have had DCYF come to the hospital to educate staff on DCYF's role. One hospital social worker explained that the response she has observed from DCYF is not punitive, but supportive of families with the goal of having a safe, healthy infant and mother. She explained that the DEI Specialist is good about educating her regarding DCYF policy and practice, and, as a result, she is confident that she can explain to a mother what is going to happen when DCYF is involved with accuracy. The former treatment provider reported that, after implementation of the DEI Specialist position, DCYF became part of the team to support mothers and improved the working relationship.

Time for Family Stability

Staff in the southern district office reported being surprised at the lack of founded assessments resulting from assessments with substance exposed infants. Staff speculated that this could be due to the amount of time the DEI Specialist is able to devote to each assessment. The extra time allows DCYF to address concerns with the family "on the front end" avoiding and immediately lowering the risk of abuse or neglect, rather than having to open an abuse or neglect case.

Other DCYF Staff Impressions

DCYF staff in other district offices praised the DEI Specialist model, however, concerns persisted. In the context of an agency with broad workforce shortages. DCYF staff contemplated whether there are enough assessment staff to limit enhanced response assignments of substance exposed infant to one staff member. DCYF staff in several district offices indicated that they planned to pursue implementing

this model, or a variation of the model, once all staffing positions are filled.¹⁰² Some staff members expressed concern that having the specialized role would cause other assessment staff to “lose touch” with the enhanced assessment process in substance exposed infant cases and that this could hinder their ability to manage those cases if later assigned.

Staff in other district offices reported a perception of an increased number of assessments involving substance-exposed infants being founded for abuse or neglect and opened for ongoing family services. This is in contrast to impressions from southern district office staff who believed there are fewer cases founded and opened for family services. According to southern district staff, the lower incidence of substantiated cases is due to the ability of the specialist to spend more time with families and ensure their stabilization and infant safety with access to necessary supports and services. Due to data limitations resulting from the small sample size, the OCA was not able to confirm the perceived variation in findings by district office.

Overall staff in other district offices recognized the strengths of the model in building relationships and allowing for increased communication with families and stakeholders. They identified the possibility that management of those cases would be smoother with the benefit of the specialist having expertise in the area of substance exposed infants. All staff members interviewed recognized that having one dedicated substance exposed infant specialist would streamline the enhanced assessment process.

OTHER RESOURCES

As a means to support families caring for infants born substance exposed, DCYF has two additional essential resources: MLADCs and the Strength to Succeed program. DCYF staff reported referring all families involved in enhanced assessments to the two resources when they are available.

Master Licensed Alcohol and Drug Counselors¹⁰³

Although MLADCs work out of DCYF offices, they are not employed by DCYF. Independence from the agency can serve as a benefit for creating relationships with families who are otherwise reluctant to work with DCYF. The MLADCs are employed to both provide substance use treatment counseling, and co-occurring mental health and substance use treatment. They provide a bridge to services and supports for parents involved with DCYF who do not have other community supports. This is especially important in areas where there are waitlists for treatment programs. In those cases, the MLADC can support a parent until the parent is able to get into a recovery program.

DCYF staff reported that there is a greater need for MLADCs in cases involving substance exposed infants because of the high risk the infants’ exposure presents. The MLADCs provide:

- Assistance to parents with accessing wraparound services
- Education around infant care and risks associated with substance exposure

¹⁰² Senate Bill 6 relative to child protection staffing and making an appropriation therefor, passed and signed by the governor allocates 27 child protective workers in FY2020 and 30 in FY2021. The bill also allocates funding for hiring 9 child protection service supervisors in FY2020 and an additional 11 supervisors in FY2021.

¹⁰³ MLADCs working with DCYF are either master licensed alcohol and drug counselors or individuals eligible for the MLADC credential but lack required hours of supervised clinical practice. The latter may complete the supervised hours in DCYF employment.

DCYF staff and providers alike identified the need for increased numbers of MLADCs. Currently, there are six MLADCs for the entire state, including one clinical supervisor who floats across all districts. In addition, there is one DCYF administrator who oversees the MLADCs. There were two additional MLADCs, but in the past year one retired and one left the position. There is an additional contract for an MLADC funded through the Bureau of Drug and Alcohol Services. Table 1. demonstrates the distribution of MLADCs by district office.

In 2018, SB 592, an act relative to the child welfare system, authorized funds in the fiscal year ending June 30, 2019 for the Department of Health and Human Services for an additional two MLADCs. One of those positions was filled, however one remains open and DCYF is not able to fill it due to concerns raised by the Attorney General’s Office regarding the individual contracting process.

Historically, each MLADC operated as an independent contractor. DCYF will now be required to hire one entity to employ all of the MLADCs. DCYF staff anticipate that the contract with this entity will be in place by the summer of 2020 at which time all DCYF offices would have a MLADC. Until then, the shortage persists.

Table 1. MLADC Distribution in DCYF District Offices

DCYF District Office	MLADC
Berlin	No
Claremont	Yes
Concord	Yes
Conway	No
Keene	Yes
Laconia	No
Littleton	No
Manchester	Yes Clinical Supervisor
Rochester	Yes
Seacoast	No
Southern	Yes
Southern Telework and Manchester	Yes

Strength to Succeed

The Strength to Succeed program is a voluntary program based on a trust-based model of peer-to-peer support. “Parent Partners” are parents who have experienced their own adversities and achieved positive outcomes. Parent Partners are employed by Granite Pathways and the Gorham Family Resource Center, the two agencies awarded the contracts through a grant to implement the Strength to Succeed program in New Hampshire.¹⁰⁴ They partner with parents currently involved with DCYF referred to the program by their caseworkers.¹⁰⁵

¹⁰⁴ November 18, 2018 Email from Geraldo Pilarski, Parent Partner Administrator.

¹⁰⁵ Granite Pathways, <http://granitepathwaysnh.org/strength-to-succeed/>

New Hampshire is one of several states implementing the program.¹⁰⁶ New Hampshire has developed and implemented a Strength to Succeed model initially implemented in Kentucky where parents with lived experience in recovery are employed to support parents impacted by substance use disorders.¹⁰⁷ Parent Partners are trained as recovery coaches to serve as mentors to parents in recovery and involved with DCYF.¹⁰⁸ Every DCYF district office has a Parent Partner to provide peer support. The grant that funds the New Hampshire Parent Partners is part of a larger grant that New Hampshire was awarded to respond to the opioid crisis, and, thus, the focus of the program is on substance use disorders.¹⁰⁹ Several other states are implementing Parent Partner Programs within child welfare, but, in those states the Parent Partner serves any parent involved with the child welfare agency.¹¹⁰

Every DCYF assessment staff member interviewed spoke highly of the Parent Partners, noting the critical nature of their involvement in making connections with and supporting parents. One mother with lived experience reported that having support from someone with similar life experience helps with the fear people have of DCYF. By providing a trusted support and easing communication with DCYF it brings everyone to the same page. One hospital staff member referred to the Parent Partner is helping to normalize in a positive way what new parents with a substance use disorder are going through when they work with DCYF. DCYF staff and providers reported a need for more parent partners and expansion of the Strength to Succeed program in DCYF district offices. One DCYF staff member stated that she would recommend every family with a substance use concern be referred to a Parent Partner because of the critical nature of their support to parents, but limited resources prevent her from doing so.

DCYF's Rapid Safety Feedback

In May 2018, DCYF launched the *Rapid Safety Feedback* program designed by Eckert Connects.¹¹¹ Eckert developed a predictive analytics tool that identifies common risk factors in the highest risk cases.¹¹² The *Rapid Safety Feedback* model is based upon four essential factors:

- Shared responsibility and action planning
- Open communication among DCYF staff
- Respect for DCYF assessment staff decision-making
- Continued collaboration throughout an assessment.

The predictive analytics tool screens referrals for *Rapid Safety Feedback*. The cases must have at least one prior report to DCYF in the past twelve months. Two DCYF staff members who work in the DCYF Central Office are trained to review the cases identified by the tool. They work with DCYF assessment staff, providing support and a “second set of eyes” on assessments. Every case in the *Rapid Safety Feedback* program includes a thorough review of a family’s entire history of involvement with DCYF. *Rapid Safety Feedback* staff members follow each case to provide accountability and ensure thorough

¹⁰⁶ November 18, 2018 Email from Geraldo Pilarski, Parent Partner Administrator.

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

¹¹¹ Eckerd Connects. Accessed at <https://eckerd.org/family-children-services/ersf/>.

¹¹² *Ibid.*

assessments. When concerns are identified, they work with the assessment staff to review and address barriers to getting things done and create action plans.

The two *Rapid Safety Feedback* staff members described the following successes of the program:

- Comprehensive assessments including prior history, and all family unit and household members
- DCYF assessment staff appreciate having information from prior DCYF cases
- Teaming on cases encourages brainstorming
- Assessment staff provided with clear direction and assisted with prioritizing tasks
- Improvement in documentation quality and type
- Improvement in safety planning by assessment staff
- Staff enabled to address and mitigate long-term risk in addition to initial safety allegations
- Ensures that gaps in contacting collateral witnesses are closed
- Provides data on system trends and gaps in staff training

Rapid Safety Feedback staff reported that, because a child or family has to have history with DCYF for a case to be considered for the program, substance exposed infant cases are not frequently referred unless the family is otherwise known to DCYF. However, staff reported receiving a number of cases involving children whose earlier cases were prompted due to substance exposure at birth. The staff reported that, if the program were ever to be expanded beyond the current model, substance exposed infants would be an ideal population to include in *Rapid Safety Feedback* assessment. They explained that having the thoroughness, structure and accountability of the *Rapid Safety Feedback* program would be beneficial to addressing both imminent safety concerns and known long-term risks in cases involving substance exposed infants.

Concord Region Perinatal Community Collaborative

In 2018, the Concord Region Perinatal Community Collaborative (Collaborative) was established to streamline local processes in the area of communication and allow for collaboration of services for perinatal care. It was based upon the premise that families need more than a hospital can provide and that, by having relevant stakeholders come together to share knowledge, policy and practice, it will broaden education for all stakeholders. The goal is coordinated care and better supported infants and families. The Director of Maternal Child Services at Concord Hospital hosts the Collaborative, meeting monthly at the hospital. Membership includes representatives from the following multidisciplinary roles:

- DCYF Concord district office
- Obstetric providers
- Family medicine providers
- Pediatricians
- Maternal Child, VNA and Home Visiting Nurses
- Early supports services teams and case workers
- Integrated Behaviorist
- Social work
- Nurse Navigation
- Perinatal Coordinator
- MAT Provider

In October 2019, the Collaborative also initiated the process to involve women with lived experience. The Collaborative is working to have two to three women partnering in their work by January 2020.

Participants in Collaborative meetings have the opportunity to better understand each other's roles, practice, and areas of shared responsibility. They apply knowledge learned in the Collaborative to facilitate supporting each other to better serve families. Participants shared that through the Collaborative they have also learned of resources in the community to which they connect families. One hospital social worker attested to having a better working relationship with DCYF since development of the Collaborative.

The DCYF Concord district office staff member who participates regularly in the Collaborative shared that she feels the Collaborative has strengthened relationships between DCYF and the community. It has provided the opportunity to answer questions and explain DCYF's role. As she stated, "People don't know why we do what we do, or why we don't do some things. With communication, it erodes the frustration with DCYF from the lack of understanding." She explained that, "Having the opportunity to share information helps to move practices forward."

Staff interviewed from other New Hampshire hospitals recognized the value of the Collaborative and expressed interest in starting something similar in their area. As a result, during the System Review, the OCA connected several hospital social workers and the Concord Collaborative with the aim of sharing the model throughout the state. As of this writing, the OCA understands that two other hospitals are working with Concord Hospital's Director of Maternal Child Services to develop teams in their region.

Integrated Treatment Models & Co-location of Services

Programs that integrate treatment with parenting skills classes, on-site child-care, transportation and housing assistance, as well as medical care, are more successful in outcomes of sustained recovery and risk reduction.¹¹³ Treatment providers discussed the overwhelming nature of recovery paired with parenting newborn. In New Hampshire, there are a limited number of integrated programs. DCYF staff interviewed most often referred to *Moms in Recovery*, a Dartmouth Hitchcock program in Lebanon, *Willows Substance Use Treatment Center with Families in Transition* in Manchester, and the *Cynthia Day Family Center at Keystone Hall* in Nashua. Staff described these programs as being a useful resource in their work with families.

¹¹³ Marcellus, L., MacKinnon, K., Benoit, C., Phillips, R., & Stengel, C. (2015). Reenvisioning Success for Programs with Supporting Pregnant Women With Problematic Substance Use. *Qualitative Health Research*, 25(4) 500, 500-512 ("Community-based, integrated, primary care maternity programs for pregnant women who are affected by problematic substance use are emerging as effective models for engaging women who experience complex forms of marginalization and require multimodal supports for improved health and social outcomes."); see also Goodman, D., Zagaria A., Flanagan V., Deselle, F., Hitchings, A., Maloney, R., Small, T., Vergo, A., Bruce, M. (2019). Feasibility and Acceptability of a Checklist and Learning Collaborative to Promote Quality and Safety in the Perinatal Care of Women with Opioid Use Disorders. *Journal of Midwifery and Women's Health*, 64(1): 104. Accessed at [doi:10.1111/jmwh.12943](https://doi.org/10.1111/jmwh.12943) ("The care of individuals with [opioid use disorder], similar to that of persons with other chronic health conditions, is best offered through an inter-professional team-based approach.").

DCYF staff and treatment providers alike discussed the need for more treatment programs and community supports for families. One DCYF caseworker reported that one of the biggest challenges for families is finding community supports to meet their needs in a timely manner. She stated that parents will get excited about engaging with community supports. However, she reported that “everything’s a wait list” and by the time the support is available, the parent’s excitement often has waned and so parents may not engage. One recent study by the NNEPQIN regional perinatal improvement collaborative looking at issues of quality in the maternity care received by women with opioid use disorder noted that “the problem of perinatal [opioid use disorder] is exacerbated by the scarcity of treatment programs that address the special needs of women, especially in rural communities.”¹¹⁴

Although staff in the DCYF Manchester area felt confident in the number of treatment resources available to serve families, staff in other areas of the state described a consistent need for more programs and a waitlist for many of the existing treatment programs. One treatment provider discussed the need for more residential treatment programs that allow a mother to seek treatment and have her children with her during the process. She explained that when there is a high-need family, residential treatment centers inclusive of children, are critical to providing recovery support. She explained that this is because many women suffering from a drug use disorder do not have a drug-free, safe housing options and often live in situations involving domestic violence. Providing a residential recovery program in which a mother can be with her children and be supported with child-care as well as medical and psychiatric care serves to empower mothers in their recovery process. She stated, “We are asking women who have a huge trauma history to step it up and get better in a system that doesn’t have what they need. The end result is what we expected. What could something really positive look like instead.”

Home Visiting and Early Supports and Services

Home visiting

Home visiting is one of the most well-supported evidence-based prevention strategies available to families today. It provides supports and services to high-risk families with infants and children up to age five. “Quality home visiting programs help parents provide safe and supportive environments for their children, and over time, families and home visitors build strong relationships that lead to lasting benefits for the entire family.”¹¹⁵ Participation in home visiting programs is voluntary. During home visits, parents can expect a range of services including:

- Support by formally trained professionals
- Connection to primary care, provision of health education, screenings, & referrals
- Parenting support
- Assistance and coordination with other services and resources in the community

¹¹⁴ Goodman, D., et al. Feasibility and Acceptability of a Checklist and Learning Collaborative to Promote Quality and Safety in the Perinatal Care of Women with Opioid Use Disorders, *supra* at 104.

¹¹⁵ Woitkowski, R. (2019, Apr. 15). My Turn: Data Shows that Children Need Home Visiting, *Concord Monitor*.

In 2019, the New Hampshire legislature passed SB 274 *relative to newborn home visiting programs*. Under SB 274, the newborn home visiting program shall be available to all Medicaid eligible children and pregnant women. This bill expands access to home-visiting services for families.

Healthy Families America-NH (HFA) is one of the home visiting models offered in New Hampshire. This program is one of only a few evidence-based home visiting models in New Hampshire. The other evidence-based program for children ages 0-3 is Early Head Start. In addition, there are several other state and independently funded home-visiting programs throughout the state.

HFA is a voluntary program that provides comprehensive support to families during and after pregnancy. HFA allows enrollment into the program prenatally through the first three months after birth, but only if the parent survey (HFA assessment tool) is completed within the first two weeks after a child's birth. HFA can work with a family until the child's third birthday. The stringent enrollment requirements could dramatically reduce the amount of DCYF-involved families if timely connection to the program does not occur. However, if a family is referred to HFA, but does not qualify for HFA services due to the enrollment criteria or for any other reason, families are connected with other home visiting or family support and strengthening services in their community.

For families who become involved with DCYF at or around the time of their child's birth, or who are pregnant and receiving services for another child, HFA could be a beneficial referral. DHHS staff are working with local implementing agencies to get the word out so that the program is better known to all DCYF staff, but particularly DCYF assessment workers who come in contact with families around the time of a child's birth. HFA currently has the capacity to serve 250 families statewide although that number could increase in the future. DCYF is exploring partnership opportunities with HFA to allow caseworkers to refer families to HFA to provide ongoing visits with families even after an assessment is closed.

Caseworkers and hospital staff reported a desire to have all families engage with home visiting programs. One caseworker described having a home visiting professional in the home with a family as "really helpful." She reported that having someone else in the home who works to support families with a broader array of services is beneficial.

Other Early Support Services

DCYF staff reported that the most difficult time for families is often when DCYF is closing out an assessment or a family service case is being closed. They explained that this is the time when early support services are essential to providing support for families. Staff reported referrals to early support services and visiting nurse programs are pivotal to the work they do with substance exposed infants. However, DCYF staff reported struggling with some early support service providers because the providers are questioning why so many referrals are being made when, according to the provider, there are not always indicators of need present.

Why Early Supports are Essential

One pediatrician specializing in developmental and behavioral care shared that there are long-term behavioral concerns for children born substance exposed. Among the children for whom she provides care, the ability to regulate emotions is a common concern. She asserted that every child born exposed to substances is eligible and should receive early support services. The pediatrician explained that

referrals to specialists like her could be avoided with early intervention, but that the services are not always available or the primary care physician may not be aware of them. Further, she reported that many times services that do exist do not return calls. She speculated that this is due to those services also being overwhelmed by the need. She stated that she frequently sees supports put into place early on for families with substance exposed infants, only to watch them “fall away” as soon as signs of stability emerge. She stated, “People are thinking that once they (the children) are in a stable environment that they won’t have any long term challenges. My concern is the lack of available supports for them (for the long run).” She surmised that families already at risk may not have the capacity to cope with the stress of a child with dysregulation, short attention, or other complicated behavior. She identified a significant need for more early support and child behavioral health services, including integrated care programs that provide day care, behavior management programs, parenting training, and early intervention services. Referring to recent advances in brain science, the pediatrician stated, “Now we know that these are the consequences of early experiences (adverse childhood experiences), and it is actually neglectful not to intervene. We need to be proactive from birth.”

One early support services provider explained that Infants born exposed to substances are immediately eligible to begin early support services through a variety of ways. Those with documented NAS or neonatal opioid withdrawal system (NOWS) are automatically eligible based on the Medicaid category of "established condition." If there is documented substance use during the pregnancy, but no withdrawal post-birth, the child might be eligible under the "at-risk" category if there are additional at-risk factors affecting the child or family. Some clinicians will use the established condition category because there is a vague category titled "toxic exposure" which could be applicable.

The provider went on to explain general opinion in the early support services community is that the issue is not so much with the eligibility of the children to receive early support and the availability or ready services, but there are roadblocks to getting them into the program in a timely manner. The biggest barrier, the provider explained, is the issue with having to obtain parental consent for each step of the way. That holds up getting the assessment and treatment plan started when the child is in custody of DCYF foster care and the biological parent is not readily available to sign the necessary documents. If the child is still with the parent at the time of the referral, but the parent has a substance misuse history or is actively using, then there may be difficulties making connections with the parent to get services started.

Family Resource Centers

DCYF caseworkers, pediatricians and treatment providers consistently discussed the importance of Family Resource Centers (FRCs). FRCs provide comprehensive supports to children and families. They “seek to strengthen families by promoting health, well-being, self-sufficiency and positive parenting through support and education.”¹¹⁶ Services offered to children and families by FRCs include parenting classes, grandparent support classes, parent-child groups, early learning centers, play groups, transportation assistance, assistance with tax preparation, after-school assistance, or other information and referral services.¹¹⁷

¹¹⁶ DCYF, Department of Health and Human Services, <https://www.dhhs.nh.gov/dcyf/cps/family-resource-centers.htm>.

¹¹⁷ *Ibid.*

New Hampshire lacks a consistent funding structure to support FRCs – leaving many to rely solely on parent fees and philanthropic supports. While FRC programs vary center-to-center, all organizations will soon receive support from the New Hampshire Children’s Trust, which DHHS recently named as a facilitating organization to build infrastructure among the FRCs. To maintain quality and consistency across FRCs, the legislature established the Wellness and Primary Prevention Council as the oversight entity for the FRC of Quality Designation; FRCs with this designation use a two-generation approach. While Quality Designation and a Facilitating Organization is a step in the right direction, Family Resource Centers require consistent program funding in local communities to serve families beyond their current capacity.

Caseworkers reported observing positive outcomes for some families who were willing to engage with a FRC. One DCYF staff member reported referring a mother with a severe anxiety and a substance use disorder to an early support parenting program at a FRC. She explained that the program worked with the mother by helping her to take her children to their medical appointments and supporting her through her recovery. The DCYF staff member credited the early support program’s work with the mother to being able to close the assessment without having to open a case and remove the children.

Substance Use and Unintended Pregnancy Prevention

The New Hampshire PRAMS Team reported an estimated 20,000 pregnancies were unintended in the period 2013-2017.¹¹⁸ Unintended pregnancies were associated with higher tobacco, marijuana, and alcohol use than with intended pregnancies in the three months prior to pregnancy.¹¹⁹

In New Hampshire, efforts are underway to examine and address the health needs of reproductive age women who are at high risk for substance use disorders among a number of providers. For example, over the last two years, Planned Parenthood of Northern New England (PPNNE), with support from the New Hampshire Charitable Foundation, has engaged in projects that prioritize the sexual and reproductive health needs of populations with high risk for substance use disorders. The programs address the unique barriers people in these populations may face in accessing sexual reproductive health information and care. These initiatives have focused on relationship building and knowledge exchange with organizations already serving at-risk individuals or individuals in treatment/recovery for substance use disorders. PPNNE has also been providing workshops for clients of its community partners with the aim to provide information and skills to support individuals in making informed and consensual decisions about their sexual and reproductive lives, as well as providing training for service providers across New Hampshire.

Interviews with DCYF staff garnered varying responses regarding whether they discuss pregnancy planning with families in assessments involving substance exposed infants. One DCYF staff member reported that she would discuss family planning with families in a way that offered resources to a family if the family was interested. Other staff members reported never having conversations about family

¹¹⁸ New Hampshire PRAMS Team, (December 2018). Data Report, Perinatal substance use among New Hampshire Women 2013-2017, *supra* at 9; *see also* Heil et al. (2011) Unintended Pregnancy in Opioid-Abusing Women. *Journal Substance Abuse Treatment*, 40(2), 199-202. Accessed at <https://doi.org/10.1016/j.jsat.2010.08.011>.

¹¹⁹ *Ibid.*, 9.

planning due to concerns about overreaching given DCYF's role. Another caseworker reported talking with families about the impacts of drug use while pregnant and what could happen if the mother continued to use substances while pregnant.

Other States

Massachusetts and Connecticut address substance exposure at birth in slightly different ways from New Hampshire. The OCA briefly reviewed programing in those states and gleaned aspects of their programs that could be useful in New Hampshire.

The Massachusetts Department of Children and Families (Massachusetts DCF) reported that they have been working with the Department of Public Health to share information with hospitals regarding reporting requirements for substance exposed infants. Additionally, Massachusetts DCF is collaborating with the Department of Public Health to draft a universal release of information for caseworkers to use with treatment providers that meets the federal release of information requirements. Although Massachusetts DCF reported screening in almost all cases involving substance exposed infants, they were the first state to track cases that are not screened-in so as to have that information if there is a subsequent call involving the child.

Massachusetts DCF Policy 86-015 *Protective Intake* governs the intake system for receiving, screening and responding to reports concerning, among other things, abuse or neglect of children.¹²⁰ The policy includes screening and responding to reports regarding substance exposed newborns (SENs).¹²¹ The policy's definition of substance exposed newborn is broader than that in DCYF's Policy 1184 *Enhanced Response Policy* in that it covers newborns whether or not they are exhibiting withdrawal symptoms.¹²² The policy does not otherwise differentiate case practice for cases involving substance exposed newborns except to allow for a report to be screened out if "there are no other protective concerns, and the only issue is maternal use of appropriately prescribed medication resulting in a SEN(s), AND the only substance affecting the newborn(s) was appropriately prescribed medication, AND the mother was using the medication(s) as prescribed which can be verified by a qualified medical or other provider."¹²³

Connecticut has developed a newborn notification portal "to give birthing hospitals the ability to file online reports (DCF 136) of abuse or neglect to the Department of Children and Families [DCF] OR to create a CAPTA notification for those newborns identified as substance exposed and consistent with the

¹²⁰ Massachusetts DCF, 86-015 *Protective Intake Policy* at 2. Accessed at <https://www.mass.gov/files/documents/2017/08/bac/Protective%2520Intake%2520Policy.pdf>

¹²¹ *Ibid.* at 8.

¹²² *Ibid.* The policy defines "substance exposed newborn" as a "newborn who was exposed to alcohol or other drugs in utero by the mother, whether or not this exposure is detected at birth through a drug screen or withdrawal symptoms. A SEN may also be experiencing Neonatal Abstinence Syndrome (NAS), which are symptoms exhibited by a newborn due to drug withdrawal. NAS is subset of SEN. Fetal Alcohol Syndrome (FAS) as diagnosed by a qualified licensed medical professional is also a subset of SEN."

¹²³ *Ibid.* at 17.

criteria associated with notification.”¹²⁴ During the portal submission process, the provider is asked a number of specific questions that help to guide filing to the most appropriate pathway.¹²⁵

Connecticut DCF also has policy designed for reports from hospitals or other medical providers “regarding a newborn child considered to be at high risk due to his or her own special needs or because of the parents’ condition or behavior.”¹²⁶ Connecticut DCF’s policy 21-11 *High Risk Newborns* covers cases involving a newborn with a “positive urine or meconium toxicology for substances” and indicators in a parent’s condition which may place the newborn at risk, including substance use.¹²⁷ If a child is determined to be a high risk newborn, the following is mandated by the policy:

- Assessment of mother’s prenatal care, parent’s willingness to participate in appropriate services, support services within the family or community, safety and adequacy of the home, potential postpartum depression and other mental illness, and parent ability to provide appropriate care in the home¹²⁸
- Case consultation with DCF Program Supervisor upon discharge of the infant to determine if the infant is at imminent risk of harm if the infant were to go home with parents,¹²⁹
- Case plan including safety assessment, safety planning, need for team meeting regarding removal, services needed and availability¹³⁰
- Visit in the home within three days of discharge from the hospital¹³¹
- In-home visits at least twice a week for four weeks with one of the visits being permissible with an in-home service provider, such as a parent education, public health nurse, or visiting nurse association, so long as visit is confirmed and documented by DCF social worker in the computer system¹³²
- Assess visitation at end of four-week period to determine continued frequency¹³³
- Case transfer conference within five days of transferring to ongoing services using a multidisciplinary approach¹³⁴

¹²⁴ Connecticut Department of Children and Families. Accessed at <https://portal.ct.gov/DCF/CAPTA/HOME>

¹²⁵ *Ibid.*

¹²⁶ Connecticut Department of Children and Families policy 21-11 *High Risk Newborns* at 1. Accessed at <https://portal.ct.gov/-/media/DCF/Policy/Chapters/21-11.pdf?la=en>

¹²⁷ *Ibid.* at 1.

¹²⁸ *Ibid.* at 1.

¹²⁹ *Ibid.* at 1.

¹³⁰ *Ibid.* at 1-2.

¹³¹ *Ibid.* at 2.

¹³² *Ibid.* at 2.

¹³³ *Ibid.* at 2.

¹³⁴ *Ibid.* at 2.

CONCLUSION

In New Hampshire, all systems involved in the care and treatment of infants born substance exposed and their families are overwhelmed by volume and complexity of need. Reduction of barriers between systems may ultimately lead to reduction in births of substance exposed infants because more families will be receiving necessary coordinated supports and treatment.

Communication barriers stem from inadequate efforts to communicate, but also from a lack of education and understanding about different community resources and professional partners. This knowledge deficit leads to missed opportunities for coordination of care among those involved with infants exposed to substances and their families. Inconsistent practice, ineffective communication, and misunderstanding of roles creates frustration and resentment among all parties leading to poor outcomes. These phenomena are also seen in other disciplines, including healthcare.¹³⁵ Increased inter-professional engagement when children and families do become involved with DCYF could improve family outcomes and reduce the incidence of subsequent critical incidents.¹³⁶ This is consistent with CAPTA, which mandates “a multidisciplinary approach to preventing and treating child maltreatment.”¹³⁷

DCYF’s *Enhanced Response Policy* is designed to ensure the health and well-being of the infant and to support parenting capacity to meet the infant’s needs. Although the policy’s requirements are viewed by some caseworkers as overly burdensome or cumbersome in certain cases, the necessity of a policy addressing assessments for substance exposed infants is undisputed. Significantly, caseworkers reported that the policy’s requirements compel them to connect and meet with families in the way that they wish they could with *all* families. As one caseworker described it, the requirements force caseworkers to do the work they came to DCYF to do. Maintaining meaning in the enhanced assessment through deep team support and guidance, buy-in across the agency and elimination of casework barriers will prevent superficial check-the-box implementation. Meaningful implementation will build lasting relationships for families and DCYF.

Nonetheless, the practices outlined in the policy, alone, are not enough to ensure the health, safety and success of infants born exposed to substances. Consistent, recovery-friendly practice across the state is also crucial to supporting families in healthy outcomes. Hospitals, mental health and substance use treatment providers and community agencies all identified inconsistency in practice and case decisions as well as punitive practices as key barriers to engagement with DCYF and a parent’s recovery process. Consistent, trauma-informed, strength-based practice builds understanding and trust across relationships leading to increased engagement from all parties involved. When hospitals and providers understand DCYF practice and trust that it will be applied in a consistent, recovery-friendly manner to

¹³⁵ Forunda, C, MacWilliams, B. & McArthur, E. (2016). inter-professional communication in healthcare: An integrative review, *Nurse Education Practice*, 19:36-40 (“The link between miscommunication and poor patient outcome has been well documented.”).

¹³⁶ Phillips, J.Dd & Walsh, M.A. (2018). Teaming up in child welfare: The perspective of guardians ad litem on the components of inter-professional collaboration. *Children and Youth Services Review*, 96: 17-26. Accessed at <https://doi.org/10.1016/j.childyouth.2018.11.016>

¹³⁷ *Ibid.*

their patients, they are more likely to engage with DCYF in supporting families and encourage families to view DCYF as partner.

Pre-and post-natal care is essential to healthy outcomes for infants and their families. Developing a plan of safe care as early as possible and encouraging families to share the plan with all providers helps to ensure infants are healthy and safe, and parents' needs are met while being well-supported.

Overarching all of this is the communication barriers that often prevent families from receiving the supports that they need to ensure children's long-term safety and continued support for parents. When families and treatment providers do not understand DCYF practices and procedures, they are less likely to trust and engage with DCYF. As one former treatment provider explained, "you have to make the time [to establish communicative relationships] because right now, there is no system in place" and if you do not do so, "you end up putting everyone in a box" rather than understanding their role and perspective in the care of infants born substance exposed. Creating spaces across the state like the Concord Region Perinatal Community Collaborative where DCYF, hospitals, providers, specialists, and community agencies can come together to learn about each other's work and practices will increase communication and understanding leading to better collaboration and support for infants and families.

Additionally, the development of the DEI Specialist position in DCYF's southern district office has served to address many of the obstacles identified in this report. By allowing one caseworker to focus on families with substance exposed infants, the southern district office has alleviated the burdens on staff arising from the policy and created consistent case practices and stronger relationships with families and community stakeholders.

Understanding and recognizing the many barriers, including bias, that prevent and discourage women and families from seeking treatment and/or postnatal care is critical to ensuring recovery and healthy infants and families. Implementing strength-based, recovery friendly practices across all disciplines will ensure that women are supported in navigating the complexities of parenting and comfortable seeking assistance for their children and themselves. Equally important are family planning supports and education, particularly among women who may need time for recovery before taking on responsibility of a child.

Ultimately, children born substance exposed present a complex and potentially long term challenge to human services. Policy and practice must be driven by a clear and consistent knowledge base of all substances and their impact on child development. Every child exposed to substances must be provided early support services, and their families continued support through the child's development. As one pediatrician shared, we all "need to be proactive from birth."

RECOMMENDATIONS

THEME: Communication

- Promote inter-professional understanding, communication and collaboration to support infants born substance exposed and their families. Specifically,
 - Establish perinatal collaboratives in every district, based on the Concord Regional Perinatal Collaborative model, each with a designated DCYF liaison.
- Integrate inter-professional education in DCYF core training for all staff in partnership with all relevant partners

THEME: Consistency of practice

- Fund and implement DEI specialist and MLADC positions in every DCYF district office. Make the DEI Specialist position a promotional position and support increased training and education opportunities for the position
- Expand the *Rapid Safety Feedback* program to include all substance exposed infants; obtain resources for additional positions
- Examine the content of DCYF core training and ensure adequate coverage of substance use disorder and recovery, basic child development and impact of substance exposure, and available resources for families with substance exposed infants
- Implement consistent practice guidance across district offices. Recognize what works and model it. Including consistent referral and communication practices
- Track reports regarding substance exposed infants that are not screened-in for assessment

THEME: Unrecognized barriers and bias

- New Hampshire Pediatric Society, American College of Obstetricians & Gynecologists, with support of DHHS Maternal Child Health Services, launch an aggressive educational initiative promoting trauma-informed, strengths-based recovery-sensitive pre- and post-natal care for all pregnancies and recovery-friendly pediatric practices
- DHHS-DCYF collaborate across divisions to develop a universal Release of Information that meets federal and state requirements for DCYF to use with treatment providers
- Support increased transportation opportunities for families in all areas of the state
- Combine opioid recovery resources across state agencies to support the development of additional integrated treatment models, including residential treatment models for mothers and children

THEME: Timing and importance of early supports and services

- Provide all families with infants born substance exposed the opportunity for WIC enrollment, early support services, and connection to Family Resource Centers
- Establish liaison relationships with home visiting services in each DCYF district office to provide general education for casework staff and ensure timely referrals for home visiting
- Continue to support and expand eligibility for home visiting to all infants