

Rapid Rounds: Clinical Essentials for Perinatal Mental Health Webinar Series



When to Report, When to Refer: Clinical and Legal Considerations for Perinatal SUD

Tuesday, January 13, 12:15 – 1:00 PM

Speakers: Erin Bider, MD and Tara Chettiar, MD, PMH-C, FACOG, and Erica Hunter, LBSW

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KCC Program Components

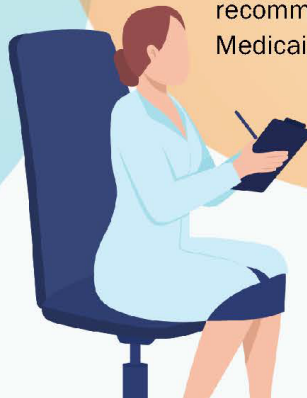
Training



- Didactic and case-based learning led by a collaborative and multi-disciplinary training team
- Monthly virtual training on treatment, medication management, and special topics in perinatal behavioral health
- On-demand modules, webinars, and additional custom training options available
- Training scholarship opportunities and up to 6 free CME/CEs offered annually

Consultation Line

- Psychiatric consultations with perinatal behavioral health team
- Resources and referral support
- Connection to training and technical assistance services
- Information about best practices, recommendations and research, and Medicaid billing and reimbursement



Technical Assistance



- Support to implement substance use and mental health screening in clinic, hospital, public health, and community settings
- Coaching to build a referral network and improve care coordination between referral partners.
- Assistance developing custom policies, workflows, and administrative support tools for screening and referrals



Access services to support your work with perinatal clients

Registered KCC Providers Receive

- Early registration access to trainings and PSI scholarships
- Up to six hours of **free CEs** (continuing education credits)
- Access to a **consolidated hub** of KCC and KSKidsMAP (pediatric program) services



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- Streamline use of the Mental Health Consultation & Resource Network



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WHEN TO REPORT, WHEN TO REFER: CLINICAL AND LEGAL CONSIDERATIONS FOR PERINATAL SUD

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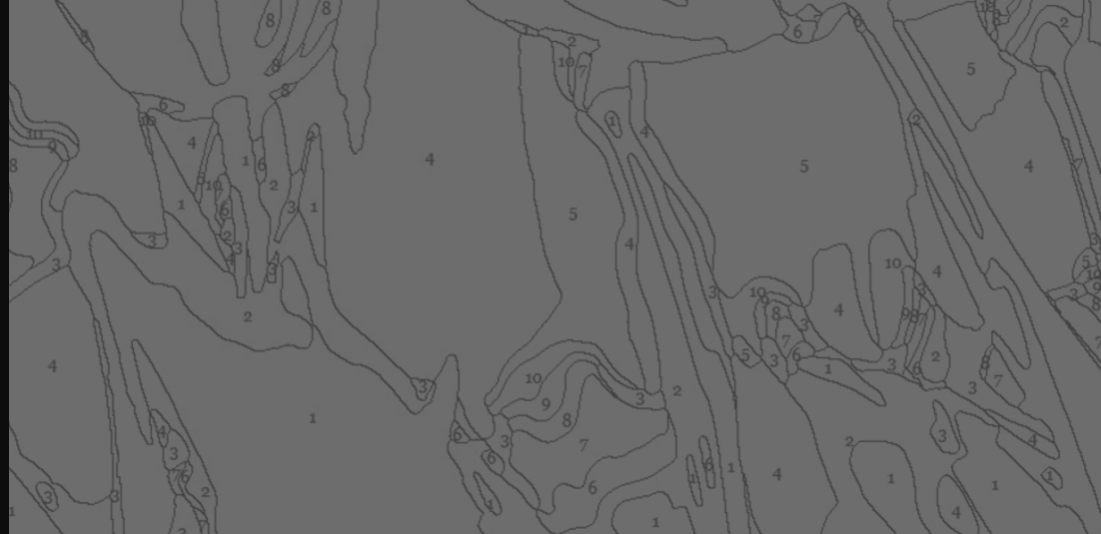


Disclosures

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OBJECTIVES

1. Discuss the epidemiology and clinical presentation of perinatal substance use disorders, and use of the SBIRT model for screening and intervention.
2. Understand mandated reporting requirements, the DCF Kansas Practice Model, and best practices for supporting families experiencing perinatal substance use.
3. Identify prevention-focused strategies and resources for clinical practice that improve the health and well-being of the mother-infant dyad and reduce risk of child abuse and neglect.





Part 1: Screening and Treatment



WOMEN WITH SUD ARE AT HIGHER RISK

Rate of pregnancy

- General population: 1.5 pregnancies/lifetime
- SUD population: 4 pregnancies/lifetime

Unintended pregnancy rates

- General population: 50%
- SUD population: 80%

Use of contraception

- Lower rates of prescription contraceptive use
- Similar rates of adherence
- Long-acting reversible contraceptives (LARCs, such as IUDs or implants)



SAMHSA Survey on SUD in the Last Month (Pregnant Women 15-44 y/o)

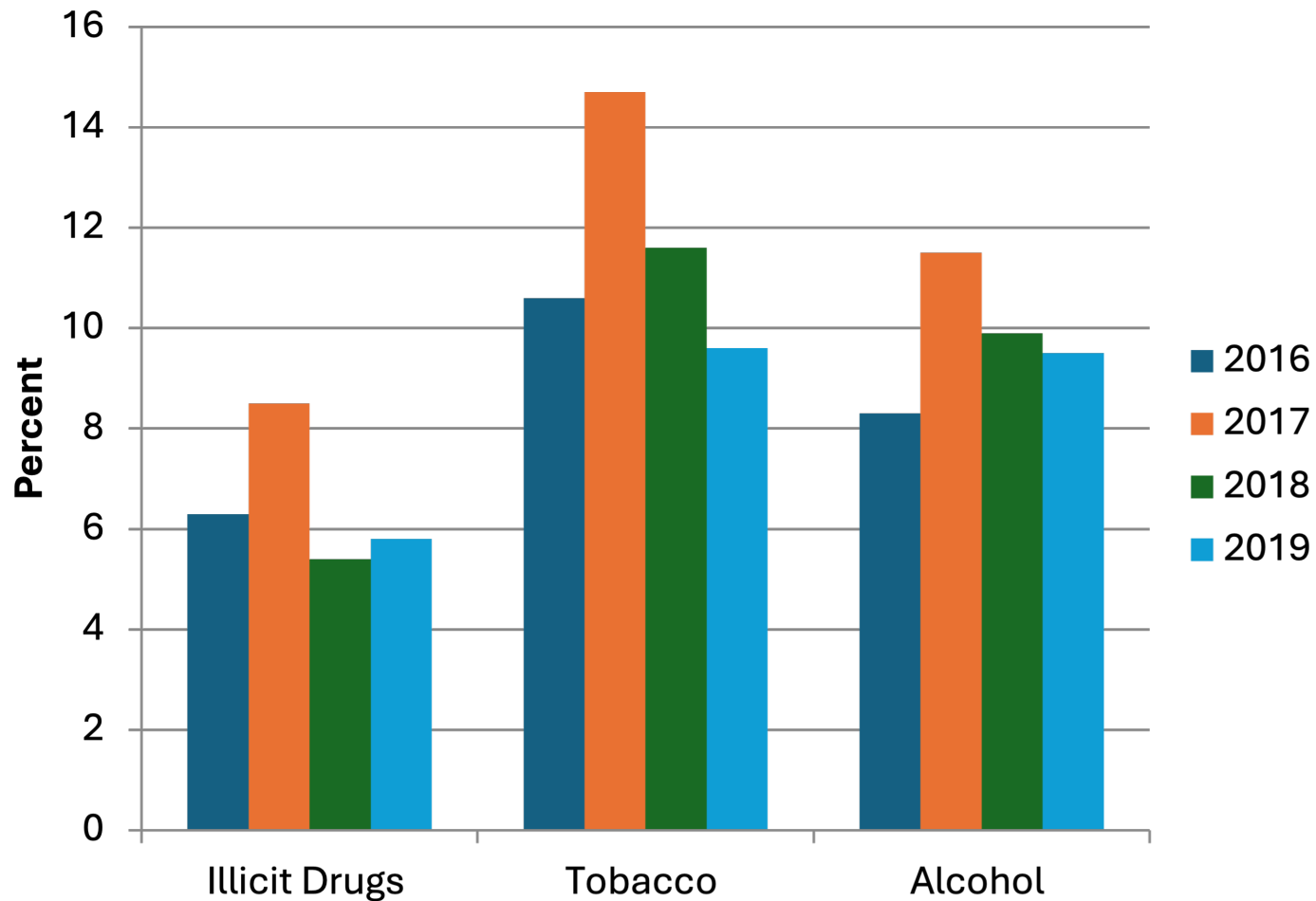


Table III. Adverse Effects of Exposure during Pregnancy

	Tobacco	Alcohol	Benzodiazepines	Opioids	Amphetamines	Cannabis	Cocaine
Miscarriage	+			+	+	+	+
Teratogenic		+	+				
Fetal Morbidity		+	+		+	+	+
Perinatal Mortality	+	+	+	+			
IUGR	+	+					
PROM	+	+					
Preterm Delivery	+	+		+	+		
LBW	+	+		+	+	+	
Neonatal Resp.			+	+			
Neonatal Withdrawal		+	+	+			
Developmental Problems	+	+				+	+

OTHER OBSTETRICAL OUTCOMES

- Unplanned pregnancy
- Late knowledge of conception
- Late or insufficient prenatal care
- Insufficient self-care
- Poor nutrition
- Possible exposure to STIs, violence, and legal consequences





SCREENING

American College of Obstetrics & Gynecology (ACOG) recommends

SBIRT: Screening, Brief Intervention, and Referral to Treatment

•Universal screening

- First prenatal visit, during each trimester, and first postpartum visit
- Validated verbal screening tools: 4Ps, NIDA Quick Screen, CRAFFT
- Urine drug screening is not recommended

•Brief Intervention

- Providing feedback and advice on the impact of substance use on pregnancy

•Referral

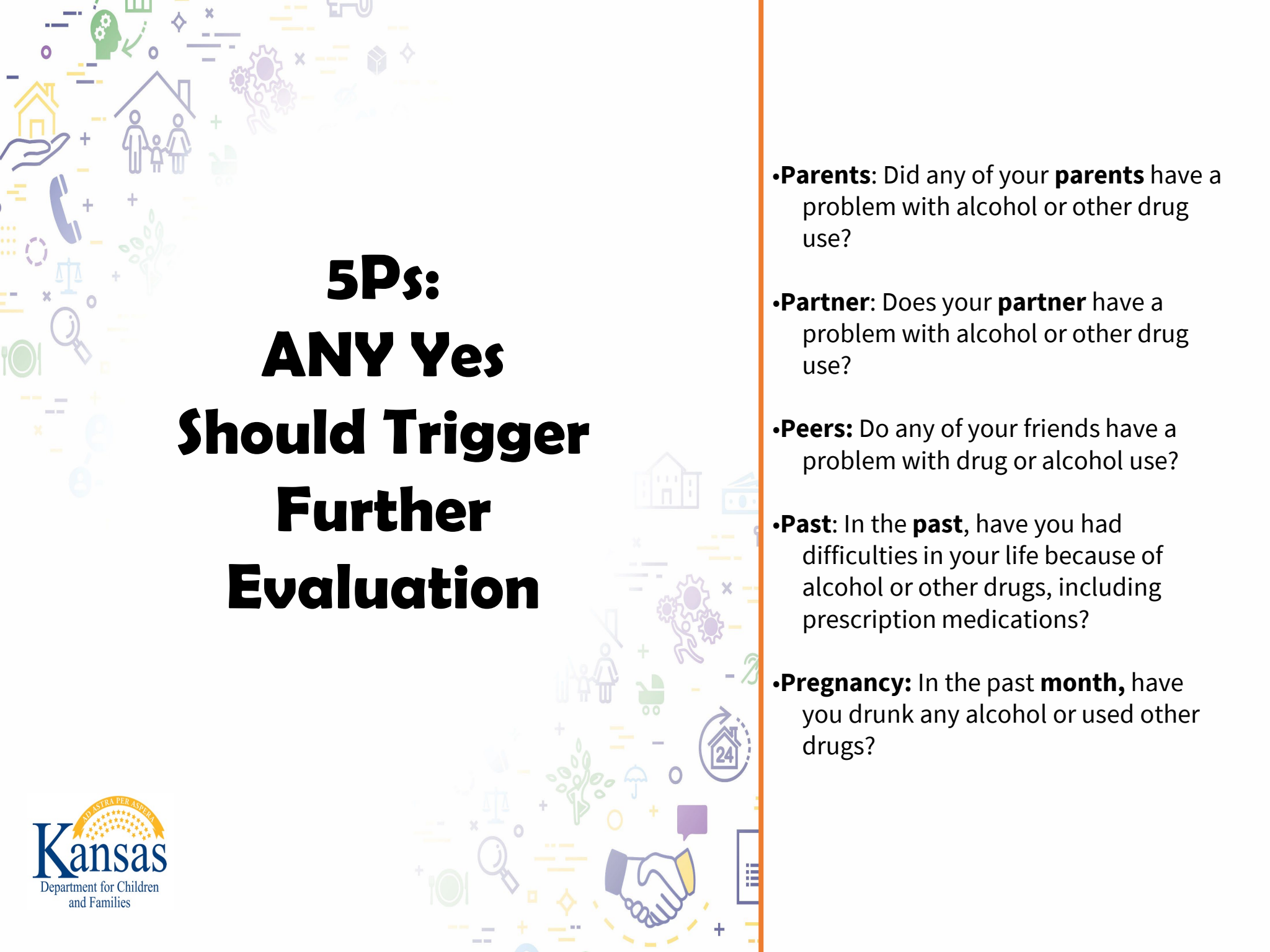
For more options, see the full SBIRT guidance document.



SCREENING

- **4Ps/5Ps**
 - Not free to use, **not currently reimbursable through KanCare**
- **Tobacco, Alcohol, Prescription Medications, and other Substance use (TAPS)**
 - Validated for adults, **reimbursable**
- **CRAFFT**
 - Validated for adolescents (starting at age 12)
- **NIDA Quick Screen**
 - often paired with another screen
- For more options, see the full SBIRT guidance document.





5Ps: ANY Yes Should Trigger Further Evaluation

- Parents:** Did any of your **parents** have a problem with alcohol or other drug use?
- Partner:** Does your **partner** have a problem with alcohol or other drug use?
- Peers:** Do any of your friends have a problem with drug or alcohol use?
- Past:** In the **past**, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
- Pregnancy:** In the past **month**, have you drunk any alcohol or used other drugs?

CRAFFT:

Yes on 2 or more Should Trigger Further Evaluation

- C – Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?
- R – Do you ever use alcohol or drugs to RELAX, feel better about yourself or fit in?
- A – Do you ever use alcohol or drugs while you are by yourself or ALONE?
- F – Do you ever FORGET things you did while using alcohol or drugs?
- F – Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
- T – Have you ever gotten in TROUBLE while you were using alcohol or drugs?

SBIRT Policy

Billing & Reimbursement for Substance Use *Screening, Brief Intervention, and Referral to Treatment (SBIRT)*

- The BHS/MCO 503 SBIRT Policy requires all professionals to complete a one-time 3-hour training before providing and billing for SBIRT services. Training is completed in free self-paced modules and CEs are available at nominal cost.
- The BHS/MCO 504 SBIRT Policy supports reimbursement for 1) one full alcohol and/or drug screen annually, and 2) up to 16 units (1 unit = 15 minutes) of brief intervention per year or rolling 12-month period.



**Complete Guidance
Document**

CPT Codes

- H0049 (\$24): one full alcohol and/or drug screen
- H0050 (\$24): one full screen plus 15 minute brief intervention
- 99408 (\$24): one full screen plus 15 - 30 minute brief intervention
- 99409 (\$48): one full screen plus < 30 minutes brief intervention



**Complete Guidance
Document**

BRIEF INTERVENTION?



- Training available
- In person or online

Training required for SBIRT Medicaid billing

Designated Women's Treatment Services (Referral)



Learn more here!

- Kansas has eight Designated Women's Substance Abuse Treatment Programs, which provide specialized services and give priority admission to pregnant women, women with dependent children, and women using IV drugs.
 - **Pregnant women are given priority status by federal mandate.**
- “All pregnant women must be offered an **assessment within 24** hours of initial contact, and admitted into **treatment within 48** hours, as clinically indicated.”

Designated Women's Treatment Services

Program	Location	Phone Number
*City on a Hill	Garden City	620-276-0840
	Marienthal	620-379-4478
	Sedan	620-710-5060
CKF Addiction Treatment – Bridgehouse	Salina	785-825-6224
	Topeka	
Community Mental Health Center of Crawford County – Women's Renewal House	Pittsburg	620-235-7180
DCCCA - First Step at Lake View	Lawrence	785-843-9262
DCCCA – Women's Recovery Center	Wichita	316-262-0505
Miracles, Inc.	Wichita	316-303-9620

*Does not allow children to remain with mother on site.

TREATMENT

- **Inpatient vs outpatient**
- **Medication assisted vs abstinence**
- Need to also address co-occurring psychiatric illness
- Assessment and treatment of nicotine use disorder is important in this population





Part 2: Mandated Reporting and Referrals

Mandated Reporters

“When (a person) has reason to suspect that a child has been harmed as a result of physical, mental, or emotional abuse, neglect or sexual abuse, the person shall report the matter promptly to DCF and/or Law Enforcement.

(KSA 38-2223)

OUR MISSION:

To protect children, strengthen families and promote adult self-sufficiency.

WHAT WE BELIEVE:



PEOPLE HAVE THE CAPACITY:

- To progress
- To succeed
- To grow
- To do well in life



PEOPLE ARE THE EXPERTS ON THEIR LIVES AND HAVE:

- Voices
- Choices
- Needs
- Strengths
- Life Stories



WE VALUE COMMUNITIES AND THE PEOPLE THAT MAKE THEM UNIQUE:

- We honor the whole person
- We rely on each other
- We are partners, not competitors
- We all benefit from a collective impact approach
- Communities bring strength through relationships and resources



WE LEAD WITH AUTHENTICITY, CURIOSITY, AND RESPECT:

- We are innovative
- We are leaders
- We are authentic
- We are diverse
- We care about each other, our work and the people we serve
- We share success stories

Kansas Practice Model (KPM)

Provides a consistent & customized framework to work alongside families, children & youth.

Engage the family & assist with needed services to support family safety & well-being.

Partner with our communities for prevention.



4 Questions Approach



Before removing a child from a home, have you asked:



1. What can we do to remove the **danger** instead of the child?



3. Can the caregiver and the child go **live with a relative** or **family friend**?



2. Can someone the child or family knows **move into the home** to remove the danger?



4. Could the child **move temporarily** to live with a relative or family friend?

Questions sourced from: *4 Questions, 7 Judges*, an Iowa-based Judicial Pilot Program. Read more in: Tabor, M., 2020. Transformation in Child Welfare. *The Iowa Lawyer*, 80 N5(June 2020), pp.10-12.

Values and Beliefs of TDM



A group can often be more effective in making good decisions than an individual



Families are experts on themselves



The family's assigned worker is invested in making a decision with the family that will ensure the child's safety



When families are engaged and respectfully included in the decision making process, they are capable of identifying and participating in addressing their needs



Members of the family's own community add value to the process by serving as natural allies to the family and experts on the community's resources



Perinatal use and reporting

Infant born *positive* for substances

Infant born *affected* by substances

- Consider safety scaling for infant to go home:
 - On a scale of 0-10 where would you rate the situation?
 - 10 - means the child is completely safe right now
 - 0 - means that if no action is taken, the child could be seriously hurt or injured in the next day or two.
- What protective factors does the family have?
- Are there community supports or referrals the hospital or doctor can make?
- What additional risk factors have been identified?
 - Lack of safe housing
 - Mental health
 - Domestic violence
 - Lack of a support network
 - Newborn with special needs
- Plans of Safe Care

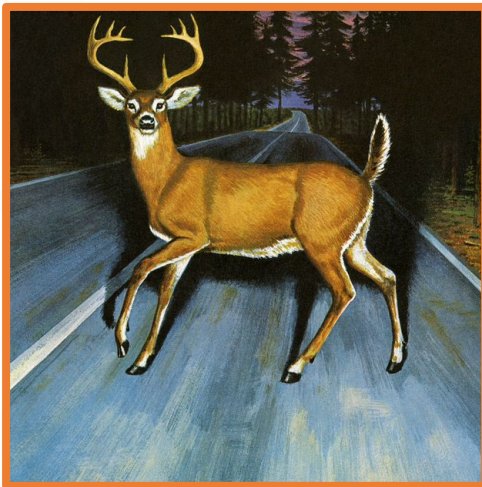
Danger, Risk and Safety

- **Danger** is an imminent likelihood of serious harm.
- **Risk** is the possibility of future harm.
- **Safety** is the condition of being protected from harm.
 - Immediate Safety is the condition of being protected from danger.
 - Lasting Safety is the condition of being protected from risk.

Immediate vs. Lasting Safety

Deer in Road

- Danger is present
- Immediate Safety is threatened
- Deer creates a negative impact



Deer Crossing Sign

- Risk is present
- Worried something *might* happen
- Sign implies a *possible* negative impact in the future

Wildlife Overpass

- Safety is present
- Presence of the overpass is a protective factor that helps to prevent the worries from happening



The Immediate Safety Scale is used to assess immediate safety by gathering information from the family and those who know the family best. During each interview, the immediate safety scaling question should be asked in order to ascertain each person's perspective about how safe the children are for the night and the next few days during the assessment. The information gathered from each person can be used by the practitioner and/or supervisor to make decisions about whether immediate interventions are needed.

Immediate Safety

Immediate Safety Scaling Question: On a scale of 0–10 where 10 is, while there might be some worries for this family, I'm confident the kids will be safe enough staying where they are while the assessment is completed and 0 is things are so bad for these children that I worry they are likely to be seriously hurt if they stay in their current situation even for tonight. Where would you rate this situation today from that 0 to that 10?



Some Factors that Increase Danger:

Child Vulnerability Factors:

- Child under 6 years
- Physical/mental/medical/emotional/developmental impairment of child
- Isolated or has limited contact with safe adults

Threats to Safety:

- Past serious harm to a child by caregiver
- Likelihood of serious harm due to:
 - Hazardous living conditions
 - Family violence
 - Physical threat/abuse by caregiver
 - Unmet basic needs
 - Inadequate protection from harm by others

Caregiver Engagement:

- Caregiver unwilling/unable to engage in safety planning for the child when necessary

Ratings:

Date:

Name	Role	Rating

SAFE: The children can remain where they are while the assessment is carried through and decisions are made about the need for additional services.

SAFE WITH AN IMMEDIATE SAFETY PLAN: Practitioner can leave the house but need action within 48 hours, including supervisor consult to determine need for TDM referral. **Document the Immediate Safety Plan on PPS2021.**

UNSAFE: Practitioner doesn't leave the house until a plan is in place to achieve safety through an immediate safety plan. **Document the Immediate Safety Plan on PPS2021 or request PPC.**

Some Factors that Increase Safety:

Child Capacity Factors:

- All children 6+ years
- Cognitive, physical and emotional capacity to participate in safety plan
- Strong connection to safe adults who know about the worries

Protective Capacities:

- Past pattern of safe and adequate care
- Cognitive, physical and emotional capacity to participate in safety interventions
- Environment/caretaker pose no immediate threats

Caregiver Engagement:

- Caregiver willing to involve natural supports in safety planning, if indicated

TDM Referral. If all three conditions are met, a TDM referral is needed.

1. The behavior (action or inaction) of a parent(s)/primary caregiver(s)...
2. ...is threatening a child's safety, AND
3. ...DCF is considering separating the child from the parent(s)/ primary caregiver(s).

CASE STUDIES

Harris Family

- MO and FA reside together.
- MO has extensive history of drug use and admitted using methamphetamine week prior.
- MO expressed having mental health issues.
- No prenatal care.
- Has two older children who've been adopted.
- Considering putting the infant up for adoption.
- No concerns with infant at birth.
- No information on extended family support.

What are risk factors?

What is the danger?

What are protective factors, supports or services?

What referrals could be made for the family?

Discussion on reporting to DCF

How can you partner with DCF?



Part 3: Q&A



Thank you



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