

COORDINATING SERVICES AND SUPPORTS FOR PREGNANT WOMEN AND MOTHERS WITH SUBSTANCE USE DISORDER (SUD) AND THEIR BABIES

Compassionate, non-judgmental, and supportive relationships with providers and other supports are associated with engagement in prenatal and postpartum care, improved birth outcomes, healthy attachment, and use of supportive health and treatment services. While all pregnant women and mothers can benefit from support,¹ those with Substance Use Disorder (SUD) have complex interrelated issues that must be addressed across the continuum of care through a coordinated, evidence-based, public health approach. Care that is well integrated and coordinated across systems offers opportunities to address the challenges experienced by pregnant women and mothers with SUD and affords them and their babies the best chance for healthy outcomes.

This brief reviews the needs of pregnant women and mothers with SUD, and highlights several effective New Hampshire-based programs that have developed innovative ways to support these women and their babies. These examples illustrate different approaches incorporating key elements that enhance services for this population, such as trauma-informed care, integrated services, and collaboration with community partners.

¹ While this document throughout refers to pregnant women and mothers, we recognize that individuals with other gender identity or expression may also become pregnant and give birth. Therefore, we expressly include these individuals as well in our recommendations for care and support related to pregnancy and parenting with SUDs.

² Prenatal treatment for opioid use disorder in the form of medication assisted treatment (MAT) is also associated with likely birth of an infant with NAS/NOWS.

Pregnant women and mothers with SUD are at increased risk for:

- lack of prenatal care
- using multiple substances
- sexually transmitted infections
- unplanned pregnancies
- unhealthy family dynamics
- interpersonal violence
- mental health issues (e.g., mood disorders, anxiety, post-traumatic stress disorder [PTSD])
- unstable living arrangements
- lack of transportation
- food insecurity
- poor nutrition
- legal issues, including involvement with the NH Division for Children, Youth and Families (DCYF)

Lack of prenatal care for women with SUD treatment may result in:

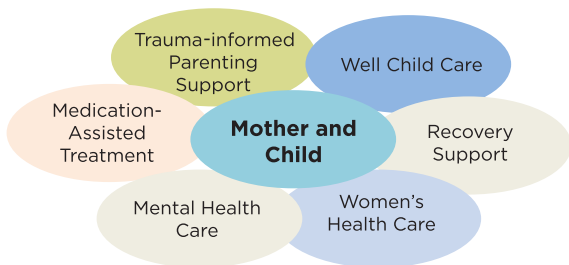
- prematurity
- low birth weight
- placental abruption
- stillbirth
- birth of an infant with neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS)²

Lack of reliable childcare and/or transportation may be a barrier to accessing early and consistent prenatal care, attending postpartum medical visits, and/or participating in SUD treatment appointments or with other recovery supports.

Pregnant women and mothers with SUD often deal with guilt due to the stigma related to prenatal substance use, and fear of losing their children to child protective services if they reveal their use of substances.

The main goal of this brief is to continue to enhance care for this population by helping NH providers identify peer resources and/or models of care that may be replicable in their own organizations and communities.

The complex health and social needs of pregnant women and mothers with SUD often require specialized medical, social and educational services to ensure the best possible outcomes. While comprehensive services may vary based on individual client needs and available community resources, effective care for these clients starts with a coordinated, integrated, multidisciplinary, relationship-based approach that focuses on harm reduction. Ensuring that adequate support is in place to care for service providers is also essential to a successful program of support for pregnant women and mothers with SUD.



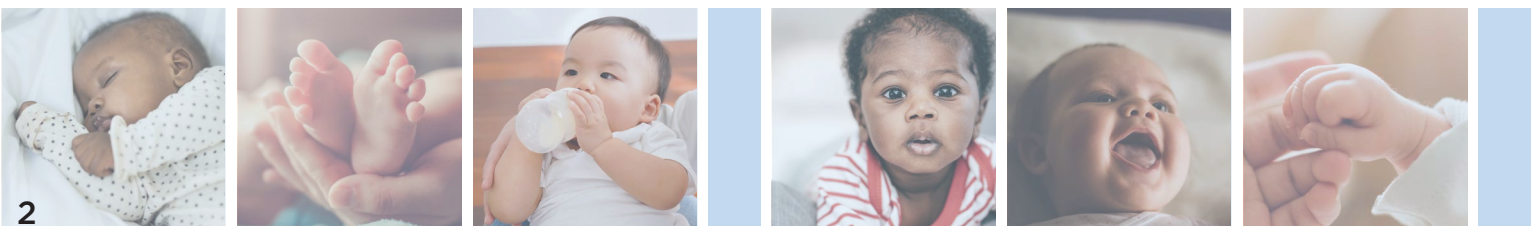
“Treatment that addresses the full range of ... needs is associated with increased abstinence and improvement in other measures of recovery, including parenting skills and overall emotional health.”

-Center for Substance Abuse Treatment (2007)

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Elements that Enhance Care for Pregnant Women and Mothers with SUD

- Designated positions to coordinate services
- Family-centered and trauma-informed approach to reduce stigma
- Universal screening with validated tools, brief intervention, and referral to treatment for alcohol and drugs
- Integrated services/team-based care (including screening, assessment, treatment and referral processes) with frequent and ongoing communication, and co-location of healthcare, behavioral health providers or addiction treatment programs, or other referral agencies to allow for warm hand-offs
- Communication and collaboration with community partners
- Connections to services and supports (recovery-friendly supports, family planning)
- Incentive programs that offer population specific rewards (gift cards, massages, diapers, etc.)
- Family engagement and follow-up



— INNOVATIVE NEW HAMPSHIRE PROGRAMS —

Five examples of innovative programs providing coordinated support for the unique health-related and social medical needs of women and their infants in New Hampshire communities are provided below. These examples illustrate how hospital- and clinic-based programs incorporate various elements that enhance care for these clients into their approaches, and may serve as models for other service providers aiming to build capacity to address the complex needs of this population.

Common elements across all programs include universal screening for substance use and ensuring designated positions to coordinate a trauma-informed, non-stigmatizing approach that fosters safety, empowerment and healing. Continuity is critical to fostering relationships between clients and service providers, a key underpinning of these successful approaches.

All of the families who attend the innovative programs described below give birth at hospitals that provide the [Eat, Sleep, Console](#) (ESC) model of care⁴ with use of the ESC Care Tool for infants with Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal (NOWS). New Hampshire is a leader in the development of this specific tool, and to date, 16 of the 17 New Hampshire birth hospitals have fully implemented the ESC model of care, an infant-centered and family-focused approach to care. The ESC model uses regular functional assessments to determine how an infant is eating, sleeping and consoling. The model encourages family involvement in care, and a variety of non-pharmacologic interventions such as rooming-in with infants for the duration of their stay, frequent holding, skin-to-skin contact and when appropriate, breastfeeding. These non-pharmacologic interventions have been shown to reduce medication use, length of stay and hospital costs for care of infants with NAS/NOWS. They also help to reduce stigma, and to position parents as first-line caretakers for their infants.

In addition, all programs featured here initiate or contribute to a [Plan of Safe Care](#) (POSC). A POSC is a valuable tool for all caregivers and their infants. Federal and state laws require the development and implementation of a POSC for all infants affected by prenatal drug or fetal alcohol exposure, in order to support caregivers, infants and their families. Developed collaboratively with the mother, it coordinates existing supports and referrals to new services to help infants and families stay supported and connected when they leave the hospital. A collaborative of health care providers and stakeholders has developed a range of tools that medical practices are recommended to use to implement effective [POSC protocols](#).⁵

More than Just Prenatal and Pregnancy Care

Recovery-friendly pediatric practices, such as the [Dartmouth-Hitchcock Recovery-Friendly Pediatrics Program](#), support healthy development of young children whose caregivers are impacted by addiction. Recovery-friendly pediatrics practices have embedded staff from family resource centers³ to help families connect to [WIC \[Women, Infants and Children Nutrition Program\]](#), home visiting services³ and parenting and job training resources. This model can help to develop strong parenting skills and create strong parent-child bonding that can reduce exposure to adverse childhood experiences and support long-term positive health impacts for children.

[Planned Parenthood of Northern New England \(PPNNE\)](#) works with health centers statewide offering free trainings to professionals related to sexual and reproductive health information and referrals, including contraceptive counseling training and trainings on other topics such as trauma-informed care. PPNNE's health centers also provide preconception education, pregnancy testing, reproductive life planning, and more.

³Home visiting programs and family resources centers are located throughout the state, and offer a range of supportive resources, depending upon availability and eligibility criteria. For more information on home visiting services see <https://www.dhhs.nh.gov/dphs/bchs/mch/home.htm>. For information on family resource centers see: <https://nh.childcareaware.org/family-resource-centers/>

⁴The ESC method of assessing and caring for infants with NAS/NOWS was developed by a collaborative effort between faculty at Yale-New Haven Children's Hospital, Children's Hospital at Dartmouth-Hitchcock, and Boston Medical Center and is currently being tested for inter-rater reliability and construct validity in a Northern New England regional QI network.

⁵For more information: <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>



Dartmouth Hitchcock Medical Center Moms in Recovery Program, Lebanon, NH

Integrated Services / Team-based Care: Moms in Recovery was established through a collaboration between obstetrics and gynecology and psychiatry. The program involves the co-location of midwifery services and a recovery coach within a dedicated addiction treatment program serving pregnant and parenting women with SUD. Services include medication for opioid, alcohol, and tobacco use disorders, an intensive outpatient program for women, onsite prenatal and women’s health visits, group addiction treatment, individual counseling, pediatric well child visits, and psychiatric medication management. A dedicated Resource Specialist embedded in the clinic addresses case management needs of clients in the program. Supervised playtime is offered for children while their mothers attend treatment.

Communication and Collaboration with Community Partners: Representatives from other agencies (e.g., WIC, family violence prevention, public health dentistry, and primary care pediatrics) also provide services on-site, enabling clients to sign up for needed services at the same time that they receive treatment. Moms in Recovery staff coordinate closely with the Dartmouth-Hitchcock Birthing Pavilion and the Children’s Hospital at Dartmouth-Hitchcock to apply a family-centered, trauma-informed approach at delivery. A POSC is initiated, and a copy provided to the caregiver, the infant’s pediatrician, and to the Division for Children, Youth and Families, if indicated. Community collaborations allow the program to provide access to an on-site food shelf and diaper bank.

Incentive Program: Clients are able to access and take home food and diapers. A “swap closet” is also available where clients may exchange maternity, baby and children’s clothes, as well as toys.

Connections to Services and Supports: The Resource Specialist assists clients to attend their appointments by sending reminders, rescheduling as needed, and arranging transportation. In addition, clients receive assistance in accessing housing, insurance, and employment support. Clients receive education to ensure that they are prepared for the birth experience, neonatal assessment and care when withdrawal symptoms are present, and support for family bonding through private rooming-in, frequent skin-to-skin contact, and breastfeeding support. Family planning services are available through the clinic. The program utilizes [The Doorway](#) as needed for additional supports.

Family Engagement and Follow up: The Resource Specialist and Peer Recovery Coach meet each client in person on-site at the initial appointment to begin to establish a relationship, and continue to engage with clients through face-to-face on-site meetings, follow-up text messages, and meeting clients in homes or community, as needed. Hospital discharge planning includes parenting education, follow up with a pediatrician, arranging home visiting services, and navigating the challenges of parenting in recovery. Women are encouraged to continue in the Moms in Recovery program for several years postpartum, with many moms remaining engaged with the program three to five years postpartum.

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Catholic Medical Center Pregnancy Care Center, Roots for Recovery Program, Manchester, NH

Integrated Services / Team-based Care: Designated program staff include an registered nurse (RN) Coordinator and perinatal social worker (MSW) who work closely with each participant to develop individualized, manageable recovery plans. This office-based treatment program is embedded in the Pregnancy Care Center at Catholic Medical Center (CMC) which provides medication for opioid use disorder, group therapy with prescriber participation, and individualized case management for clients with substance use disorder. CMC's Childbirth Education Program at The Moms Place provides prenatal and parenting education classes.

Communication and Collaboration with Community Partners: The program conducts outreach to area churches, homeless shelters and methadone clinics, and collaborates with community partners to arrange primary care, pediatric care, behavioral health, and home visits through [Waypoint](#), or visiting nurse associations, as appropriate. A collaboration with Amoskeag Health and Dartmouth Hitchcock Medical Center helps to staff a new participant-established Mommy and Me Group for women and toddlers, after they age out of Roots for Recovery. Co-location of services supports communication between providers. Frequent text messaging with participants ensures they get their lab tests, attend appointments, etc. Each participant is encouraged to develop a POSC during prenatal period with the assistance of the Perinatal MSW. A copy is given to the family and can also be shared with appropriate caregivers, pediatrician, and DCYF (if indicated).

Incentive Program: Each participant starts the program with a "recovery bracelet" and a journal/appointment book, which encourages women to keep personal journal entries and to take responsibility for attending all scheduled appointments. Participants earn beads for their "recovery bracelets" as prenatal care and weekly group sessions are met, and urine toxicology results are negative for any illegal/illicit substances and positive for prescribed medications. For every four beads earned, incentives may include a locked medication box, bathtub with supplies, car seat/stroller, Pack 'n Play, infant carrier, or baby monitor. Participants earn incentives for personal health goals, such as smoking cessation, breastfeeding duration, and recovery anniversaries. Incentives for personal goals include gift cards to acupuncture, massage, or other personal well-being related services.

Connections to Services and Supports: Groups are recovery-based and infants attend with their mothers. Participants are encouraged to engage in their care, with staff support (for example, making their own appointments). Participants are connected to primary care providers who can prescribe medication for the treatment of opioid use disorder to facilitate a smooth transition from the program upon completion when the infant reaches one year. Social services are provided for individual support to participants to remove barriers to recovery, including helping to arrange transportation through [Coordinated Transportation Solutions \(CTS\)](#) for Medicaid recipients, or Uber, as well as securing safe housing through [Families in Transition](#), [Hope on Haven Hill](#), [Family Willows IOP](#), or the [Cynthia Day Program](#), as needed. Participants receive support to arrange appointments for family planning services prior to six weeks postpartum. The program utilizes [The Doorway](#) as needed for additional supports.

Family Engagement and Follow up: Families tour and meet with staff at The Moms Place and The Special Care Nursery prior to the birth of their baby to prepare them for labor and birth, breastfeeding, possible involvement with DCYF, and caring for an infant exposed to substances. Arrangements are made for program participants in residential programs to remain active in Roots to Recovery, if possible. Participants are encouraged to remain in the program for one to two years postpartum. Active participation in groups following infants' birth provides an indicator of success, as does the development by participants, with program support, of a Mommy and Me Group for women and toddlers, after they age out of Roots for Recovery.

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WENTWORTH-DOUGLASS HOSPITAL

A Mass General Community Hospital

Wentworth-Douglass Hospital (WDH), Dover, NH

Integrated Services / Team-based Care: As a hospital-based program, dedicated staff include a registered nurse (RN), a social worker (MSW) and a patient navigator. The team also includes a child life specialist and occupational therapist who assess infants' developmental needs. Outreach efforts include attending monthly meetings at practice sites for high-risk obstetrics clients, OB/GYN department meetings, and daily unit safety huddles to identify clients with substance use disorder (SUD). Obstetric, SUD treatment, and recovery care is coordinated. Clients may start on medication assisted treatment during hospitalization if they are pregnant with active, illicit opiate use. The team works with a maternal-fetal specialist and a genetics team to provide genetic counseling as needed.

Communication and Collaboration with Community Partners: Staff identify barriers to prenatal care, including access to transportation, insurance, housing, medication for opioid use disorder (OUD), primary care providers (PCPs), and obstetric care, and work with community partners to ensure that clients' needs are met. For example, staff assist clients to obtain the physical identification required to access OUD medication, if needed. Volunteer "Cuddlers" help reduce fatigue of caregivers and address safety concerns regarding infant drops / falls. Staff obtain signed release for communication of personal health information as a standard protocol, and make referrals for Early Supports and Services, and home visiting, when appropriate. A POSC is initiated with caregivers, and a copy is provided to the caregiver, the infant's pediatrician, and to the Division for Children, Youth and Families, if indicated.

Incentive Program: The program offers mothers who deliver at the hospital Halo sleep sacks to promote safe sleep. They also offer NuRoo shirts which help regulate temperature, encourage maternal bonding through skin-to-skin contact, increase the opportunity for on demand breastfeeding / stimulation for milk supply, and offer another option for non-pharmacological treatment for infants transitioning from opiate exposure. The program also provides newborn care items, such as clothing, thermometers, infant carriers, diapers, car seats and pumping equipment. Each family takes a baby book home at discharge.

Connections to Services and Supports: The program initiates [Early Supports and Services \(ESS\)](#) and [Community Action Partnership \(CAP\)](#) referrals as indicated. At discharge, close follow-up appointments are arranged for mom and baby with their pediatrician, obstetrician, and the hospital-based Maternal Infant Home Visiting Program. Postpartum pain management plans are developed, and the client's problem list and lab tests for newborns born to mothers with Hepatitis C are also communicated. The program collaborates with [SOS Recovery Community Organization](#) to ensure that clients are connected to recovery supports, and encourage recovery coach visits during hospitalization to help connect to resources after discharge. Social Work and Behavioral Health consults are arranged for clients identified with depression or anxiety. For women identified as needing more services for anxiety / depression / postpartum depression, a consult is offered with the Perinatal Wellness Counselor. The program utilizes [The Doorway](#) as needed for additional supports.

Family Engagement and Follow up: The perinatal coordinator and patient navigator work together to provide support, tour the Women and Children's unit, and educate families about what to expect during hospitalization, and the importance of parental presence in reducing length of baby's hospitalization. Upon hospitalization, the team works to prepare the family for discharge, following up on areas of opportunity identified prenatally. The perinatal coordinator and social worker make a warm hand-off to the patient navigator, who follows families for three to six months after discharge.

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Integrated Services / Team-based Care: As a hospital-facilitated approach, The Family Place at Concord Hospital builds connections with health system and community partners. The health system team consists of inpatient and outpatient core teams. The inpatient core team includes two MSWs, a LICSW, a family education team (childbirth, prenatal, and postpartum), a team of board certified lactation consultants, a child life specialist, and obstetrics and neonatal providers. The inpatient core team works regularly with the Birth Center and four area obstetric prenatal practices. The outpatient core team includes a perinatal nurse coordinator, an integrated behavioralist, a perinatal high-risk social worker, and a nurse navigator. Team-based coordination occurs through third trimester. Clients and families are introduced to the team, discuss birth plans and prenatal care, receive education, and tour the unit. Perinatal practices meet with the inpatient team monthly to review expected high-risk deliveries, evaluate client needs, and make referrals to clinical and social supports and services. Integrated community partners, such as visiting nursing, home visiting and child and family services may attend pre-admission meetings or routine hospital discharge planning meetings. Client-specific focused discharge meetings are held, as needed, for families with more complex needs up to and including DCYF assessment workers.

Communication and Collaboration with Community Partners: The Concord Region Perinatal Community Collaborative (CRPCC), which includes representation from a wide range of organizations and multidisciplinary roles, meets monthly, facilitated by The Family Place, to learn about each other's work and develop effective systems, processes and workflows. In collaboration with [Community Bridges](#), Concord Hospital developed a supportive network and educational program, Better Together: Parenting One Week at a Time using the Positive Parenting Solutions curriculum. Parents may join this 12-session weekly parenting resource group at any time. Moderated by an early childhood specialist with guest speakers, the first hour of the group is topic-based, with the last half hour available for socializing, informal supports, referring to necessary services, and building parent connections. Mothers/parents are encouraged to bring their infants to the group and on-site childcare is available for siblings ages one to five.

Incentive Program: The Family Place hosts many prenatal and parenting education programs at no charge to the family, and offers most programs with a one-on-one educator for personal sessions, if preferred. Lactation services and Emotional Support Counseling are available to families for one year after delivery at no cost to the family. Families may receive hand knit baby items from a volunteer group, as well as a quilted blanket provided by [Project Linus](#). Meals are provided to participants during Better Together sessions, as well as supportive baby items like diapers or items to help facilitate parenting skills like books and age-appropriate toys. Families are eligible for transportation support and complementary childcare, and receive cash gift cards for active participation.

Connections to services and supports: Utilizing a map of anticipated needs and available services, community partners collaborate to identify the most appropriate organization to provide services. A POSC is initiated and a copy provided to the caregiver, the infants pediatrician, and to the Division for Children, Youth and Families, if indicated. Volunteer "Cuddlers" assist at times when parents need to be away to attend treatment or other appointments. The program utilizes [The Doorway](#) as needed for additional supports.

Family Engagement and Follow up: Coordinated supports and services begin pre-admission during the third trimester, and continue through the CRPCC through the post-partum period. The CRPCC also engages women with lived experience to inform the work of the collaborative and partner on co-designing solutions and continuous quality improvement efforts. Women who attend the Better Together Program for more than a year are encouraged to mentor new mothers in the program.

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Amoskeag Health Perinatal and Prenatal Substance Use Disorder Program, Manchester, NH

Integrated Services / Team-based Care: Designated program staff include a social worker and a community health worker. The program is co-located with the Federally Qualified Health Center (FQHC) with access to a range of supports (including prescribers of medication for opioid use disorder, SUD counselors, pediatricians, obstetricians, primary care providers, nutritionists, dieticians, and billing).

Communication and Collaboration with Community Partners: A range of community partners collaborate to provide families with needed supplies, such as diapers, books, quilts, and clothes. For example, the Manchester Diaper Pantry operates in collaboration with Makeover Ministry, and [The Stork Project](#) (Hollis, NH) donates handmade quilts, books, clothes, etc., for each expectant family. Program staff also communicate with clients to ensure they have what they need to stay with their treatment plans (such as transportation, appointment reminders). A POSC is initiated, and a copy is provided to the caregiver. A copy is sent to Labor and Delivery at the hospital with the mother's records, and the hospital shares with the infant's pediatrician and to the Division for Children, Youth and Families, if indicated. The client is encouraged to share with any other providers or agencies that may be involved.

Incentive Program: The Mom's Moving Ahead program offers women an incentive after every five visits, which may include diapers, massages, and passes to family-oriented activities.

Connections to Services and Supports: Staff attend twice-monthly meetings at the local recovery center and methadone clinic to increase community awareness of the program and encourage early prenatal and general primary care. Program staff are "on call" for the [New Horizons](#) homeless shelter in the event that they identify someone who could use the program's services. Staff provide home visits, as well as information and support to connect with appropriate community resources, including health insurance. Plans are underway to reduce barriers to accessing contraceptive options through a partnership with Planned Parenthood to provide pregnancy tests at the recovery center and homeless shelter, and to offer a prenatal yoga program and AcuWellness (ear acupuncture) services. Both program staff are working toward becoming certified recovery support workers (CRSWs). The program utilizes [The Doorway](#) as needed for additional supports.

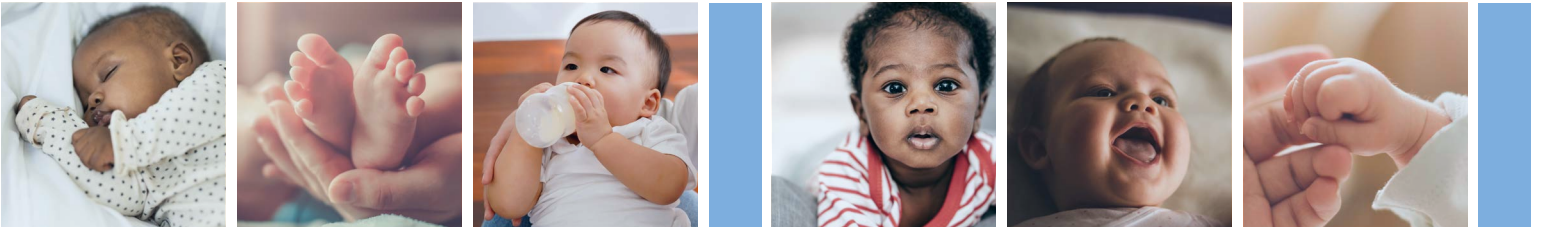
Family Engagement and Follow up: Program staff check in with clients in the hospital when baby is born, and follow up with family at regular intervals for at least a year, providing home visits, in-person check-ins with clients at appointments, and well-checks for clients who miss appointments.

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Perinatal Substance Exposure Task Force
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