Substance Exposed Infants/Fetal Alcohol Spectrum Disorders (SEI-FASD) Statewide Initiative

5-YEAR STRATEGIC PLAN
2022-2027

CT DEPARTMENT OF CHILDREN AND FAMILIES
CT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
WHEELER

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In 2014, the Connecticut Department of Children and Families (DCF) in partnership with the Connecticut Department of Mental Health and Addiction Services (DMHAS) received Substance Exposed Infants In-Depth Technical Assistance (SEI IDTA) from the National Center for Substance Abuse and Child Welfare (NCSACW). The Substance Abuse and Mental Health Services Administration (SAMHSA) funded SEI IDTA to strengthen the capacity of states to improve the safety, health, and well-being of substance exposed infants and support the recovery of pregnant and parenting birthing people and their families. The SEI IDTA project later developed into a 5-year statewide strategic initiative, jointly funded by both state agencies, now known as the Substance Exposed Infants/ Fetal Alcohol Spectrum Disorders (SEI-FASD) Statewide Initiative.

As we close the 2016-2021 plan and begin this new chapter, we want to thank our dedicated partners for their work in making the initiative's first cycle a great success. The progress in the last five years would not have been possible without the dedication and support of many stakeholders, agencies, and organizations.

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OUR COMMITMENT TO INCLUSIVITY

The new 5-year strategic plan has a commitment to prioritize equity and inclusivity and is committed to respect and support the health of people across the LGBTQIA+ spectrum. This initiative is cognizant that the topics addressed in this plan that fall under the umbrella of “women’s health” are not exclusive to cis-gender individuals and can impact people across all gender identities. Wherever possible in this document and in work that is produced as a part of this initiative, gender inclusive language will always be used. When the words “women” or “female” are used in this document or in the work that is produced as a part of this initiative, they are reflective of instances when we are unable to change the terms, such as when they are a part of agency or program names and/or reported data. The latter calls to attention the need for improvements in inclusive data collection in the space of “women’s health” and we will continue to collaborate with initiatives across the state that share an investment in enhancing the elements that contribute to inclusive care.

SEI-FASD STATEWIDE INITIATIVE: HISTORICAL BACKGROUND

In the fall of 2014, the Connecticut Department of Children and Families (DCF) in partnership with the Connecticut Department of Mental Health and Addiction Services (DMHAS) received Substance Exposed Infants In-Depth Technical Assistance (SEI IDTA) from the National Center for Substance Abuse and Child Welfare (NCSACW). The Substance Abuse and Mental Health Services Administration (SAMHSA) funded SEI IDTA to strengthen the capacity of states to improve the safety, health, and well-being of substance exposed infants and support the recovery of pregnant and parenting people and their families. The focus of SEI IDTA in Connecticut was to identify key stakeholders and work collaboratively with them to advance the state's capacity to improve the safety, health, permanency and well-being of substance exposed infants and support the recovery of pregnant and parenting birthing people and their families through statewide infrastructure development.

The objectives of the SEI IDTA were:

- Assess the state’s capacities and needs related to SEI to serve as the architecture for identifying data infrastructure strengths and challenges and establishing policy and developing infrastructure for prevention and intervention services including workforce development; and developing recommendations for improving the state’s data infrastructure to collect data on prenatal exposure
- Develop a statewide plan to address SEI in a coordinated fashion to offer a continuum of services to vulnerable families, including prevention, through raising public awareness of services and supports, early intervention, and intensive intervention.
- Conduct financial and asset mapping to identify, coordinate, and maximize fiscal resources to support ongoing SEI efforts.

In March 2015, a two-day kick-off event brought together stakeholders across systems to begin the process of identifying needs and gaps and to develop the structure for the IDTA work moving forward. The kick-off provided an opportunity for a wide range of stakeholders to learn about SEI and FASD (Fetal Alcohol Spectrum Disorders) to identify unmet needs and gaps within existing systems that serve pregnant birthing people, infants, and children. Shortly after the kick-off, the initiative hired a Statewide Coordinator under a contract with DCF and DMHAS and a 5-year strategic plan addressing the following priorities was developed: Awareness and Marketing; Early Intervention and Screening; Data; and Training.

CAPTA, CARA, AND THE NOTIFICATION PROCESS

Initially enacted in 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was amended in 2003 by the Keeping Children and Families Safe Act. To receive CAPTA funds, states were required to have policies and procedures to address the needs of "substance-exposed infants born and identified as being affected by ILLEGAL substance use or withdrawal symptoms resulting from prenatal drug exposure." Health care providers were required to notify child welfare in such cases, make appropriate referrals for services to address the needs of the infant, and develop a Plan of Safe Care (POSC). In 2010, the CAPTA Reauthorization Act updated the definition to include FASD and added state reporting requirements.

In 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA), which established a comprehensive, coordinated, balanced strategy through enhanced grant programs that would expand prevention and education efforts while also promoting treatment and recovery. Specifically, CARA clarified the population requiring a POSC to be those "born with and affected by substance use, withdrawal symptoms, or FASD," removing the word "ILLEGAL." Also, CARA required the POSC to include the needs of both the infant and family/caregiver. CARA also specified the need for data to be reported by the States through the National Child Abuse and Neglect Data System (NCANDS), and the need for increased monitoring and oversight for states to ensure that POSC are implemented and that families have access to appropriate services.

In CT, legislation was passed such that effective March 15, 2019, hospitals were required to submit a notification to DCF at the time of the birth event when an infant is believed to have been substance exposed and/or displays withdrawal symptoms. CT state legislation requires the DCF Commissioner, in consultation with other departments, agencies, or entities concerned with the health and well-being of children, to develop guidelines for the safe care of newborns with substance exposure. A substance exposed newborn is one who is exposed in utero to heroin, cocaine, prescription opioids, marijuana, prescription benzodiazepines, alcohol, methadone, buprenorphine, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication, or a newborn with withdrawal symptoms and/or diagnosed with an FASD.

DCF, in collaboration with stakeholders, developed and implemented a notification process and portal for the purposes of giving birthing hospitals the ability to create a CAPTA Notification for newborns identified as substance exposed (as defined by the notification criteria), or, to file online reports (DCF-136) of abuse or neglect. This online system, known as the CAPTA Portal, is on a website managed by DCF. This portal receives data from hospital staff on any newborn children born substance exposed. The DCF Careline continues to receive child protective services (CPS) related referrals. During the online submission process, hospital staff answer specific questions that help formulate the most appropriate pathway, either a portal notification or a 136 referral. The birthing hospital must make the notification as soon after the birthing event as possible and before discharge. Mandated Reporter requirements include referrals to the DCF or Careline within 12 hours of suspicions of abuse or neglect. The portal was carefully designed with a goal to ensure that families that did not need the intervention of CPS and are able to follow their POSC and utilize community-based supports without CPS intervention. In addition to stakeholder collaboration, the team met with several groups of birthing people in recovery to ensure that the portal's development took into consideration their perspective and lived experience. These individuals were an integral component of ensuring that the CAPTA rollout considered potential impacts on the recovery process. This initiative continues to integrate the voice of people in recovery as we move progress forward.

A CAPTA notification to DCF is required when a newborn has been prenatally exposed to substances, but there are no concerns about safety or well-being, such as mothers who are prescribed and take medications during their pregnancy that are clinically indicated but may result in withdrawal symptoms in the newborn. These medications may include Methadone, Buprenorphine, prescription opioids, or other prescribed psychoactive medications such as Benzodiazepines. There is no identifying information on the woman or infant obtained during a CAPTA notification. The information contained in a CAPTA notification includes the hospital's name, the staff's name, zip code for the family, race, and ethnicity of the child and mother, mother's age, the substance that caused the exposure/withdrawal symptom, verification or development of a plan of safe care, and services identified/referred in the plan of safe care. Congress stated that these reports to CPS, on their own, are not grounds to substantiate child abuse or neglect.

DCF took a very person-centered approach to have separate pathways for notifications that would be different than a 136. Some states require hospitals to call their Careline then it is up to the Careline to differentiate a notification from a referral for neglect or abuse. CT developed a system whereby birthing people in recovery with no other concerns of neglect or abuse would enter into a blinded notification process whereby data can be shared by the hospital for the purposes of federal data reporting requirements but neither individual's name (parent or infant) is entered into the portal. DCF has taken the initiative to develop a robust data set and continues to be open to input of sister agencies and stakeholders in adding elements that continue to provide a fuller picture of this population and their strengths and challenges.

Until July 1, 2021, non-prescribed marijuana was an illegal substance in CT, so its use, by definition of this legislation and CT state statutes, made it a substance of misuse. Because, marijuana remains an illegal substance under federal law, the CAPTA notification and plan of safe care requirements still apply in states that have legalized medical or recreational use. We anticipate this will be similar to an alcohol use notification, but we still have more to learn with regard to how the legalization will ultimately affect CAPTA and other systems.

PLAN OF SAFE CARE (POSC)

The development of a POSC for an infant born substance exposed, with withdrawal symptoms, or FASD ensures the safety and well-being of the dyad. The POSC addresses the health and treatment needs of the mother, infant and significant others such as partners or family members. A cross-system, collaborative approach to develop a POSC recognizes that infants have a wide range of needs, including the need to have a safe and stable caregiver. The POSC is an empowerment tool to support the caregiver in making decisions that they feel will best support a lifestyle of health and wellness for themselves and their family. Ideally, the development of the POSC occurs prior to birth, giving the caregiver time to process and understand the CAPTA notification process and to build a resource network prior to delivery. Additionally, the POSC can be a universal precaution and a road map that can be helpful for anyone who is pregnant or preparing to be pregnant.

The POSC provides a roadmap of existing supports and identifies other services that should be in place to support the caretaker, infant, and family/support system. It is important to note that this is a tool utilized by the caretaker and should reflect the supports that they believe the infant and family/support system need. As such, the caretaker chooses the lead professional to help support the plan. As appropriate, the partner should be included in developing and supporting the plan. Natural supports must be encouraged to assist in implementing the POSC and are invaluable sources of lifelong support.

Collaborators on the POSC may include pregnancy care providers, pain specialists, medication assisted treatment providers, OB-GYNs/pediatricians, postpartum providers (visiting nurse, Birth to 3, home visitors),

substance use treatment or other behavioral health providers, and birthing hospital staff. The unique needs of each individual caretaker, infant, and family dictate the contents of the plan. Important components of a POSC include but are not limited to: substance use and/or mental health counseling, safe sleep planning, child care, recovery assistance, medication-assisted treatment, Birth to 3, pediatric care, WIC, housing assistance, parenting/financial support, and other community supports.

The birthing hospital must verify the POSC at the time of delivery as it informs the notification. This may include contacting the lead provider on the plan to verify creation, or, creating a plan with the birthing person if they came in without one. If a POSC cannot be completed or verified at the time of the notification submission, the CAPTA portal process will direct the notification to the DCF 136 referral track. As a result, it is crucial that community and medical providers work collaboratively to ensure that CAPTA education/development of POSC occurs as early in pregnancy as possible, and that plans are verified and shared with relevant providers prior to delivery.

Community provider agencies serving expectant parents with substance use disorder are trained to help them develop their POSC before giving birth and provide education about what having a POSC could mean for themselves and their baby. Connecticut has also partnered with United Way/211 to create a POSC website where the plan can be developed electronically and saved on a smart phone, tablet or other supported electronic device. United Way has promoted the e-Plan of SAFE Care by distributing print media to households throughout the state.

CAPTA & POSC: FUTURE WORK

Extensive training efforts occurred with community partners, birthing hospitals, hospital staff, federally qualified health centers, and other system staff and providers to ensure they are knowledgeable about the POSC and equipped to help birthing people develop them preemptively. Additionally, in collaboration with the United Way/211, the POSC was marketed broadly via radio, billboards, buses, postcards, and the web to increase community knowledge on this valuable resource. Continued education and training are necessary to address staff turnover, aid with integration of policies into practice, and ensure that all systems are updated with the latest reporting requirements.

Continued and expanded CAPTA and POSC outreach and education efforts among providers and hospital systems remains a top priority for this initiative. In the fall of 2021, a new complimentary position was created to support this work specifically. This position will be responsible for increasing awareness and use of POSC throughout the state, as well as train hospitals, community providers, and other state agency staff regarding the CAPTA notification system.

OVERVIEW AND LESSONS LEARNED: 2016-2021

STRUCTURE OF THE WORK

As previously described, the SEI IDTA was the catalyst for the first 5-year strategic plan. The plan goals and original team structure were follows:

Goals of the 2016-2021 Strategic Plan	
Goal 1: Increase knowledge and expertise among professionals, systems stakeholders, and the community at large about substance use during pregnancy and the effects on infants and children.	**Goal 2:** Increase capacity and availability of screening and assessment for substance exposure in infants and children
Goal 3: Increase capacity and availability of screening for substance use with women of childbearing years and pregnant women	**Goal 4:** Ensure that women and their children have access to services/treatment to meet their needs

Executive Team: The SEI-FASD Statewide Coordinator, together with DCF and DMHAS leadership, form the Executive Implementation Team. This group met weekly to maintain consistent communication on the ongoing status of project and provide guidance and support to the Coordinator.

Core Team: The Core Team is a group of stakeholders who provide leadership and direction for the initiative. These individuals and agency representatives have expertise in maternal and child health, behavioral health, substance use, child welfare, pediatrics, neonatology, and advocacy for birthing people. This group met quarterly to discuss updates and emerging/related work in the field.

Workgroups: Initially, the work groups gathered stakeholder input on unmet needs and gaps to propose strategies for addressing concerns. After the creation of the first 5-year plan, the workgroups supported each of the plan's priority areas. The following workgroups met regularly to support each respective priority:

- **Early Identification and Screening:** Improve early identification of substance use and substance use disorders (SUD) pre-pregnancy and during pregnancy
- **Data:** Compile and interpret available SEI data and information from across the state and identify data infrastructure strengths, challenges, and deficits as well as potential sources for data
- **Awareness and Marketing:** Develop and inform educational campaigns, programs, and community forums to raise public awareness.
- **Training Workgroup:** Identify and coordinate training content and tools to provide education across various professions.

The priorities above were supported in partnership with several ongoing DMHAS and DCF programs and services that overlapped with the goals of the SEI-FASD Statewide Initiative.

WORKGROUP SUMMARIES 2016-2021

Core Team: Core Team consists of stakeholders from various private/public sectors and systems of care. The group met quarterly and convened to discuss CAPTA updates, work related to the initiative, and topics related to FASD and SEI. In the final year, the group met for an additional ad hoc meeting to discuss strategic planning. The Core Team will continue to accept members who are interested in providing perspectives on the work as well as helping to move the new deliverables forward.

Early Identification and Screening: The Early Identification and Screening workgroup met once a month to discuss strategies for SUD screening improvements. One important piece of work that emerged out of this group was the advancement of a potential screening protocol. Screening Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice used to assist in guiding providers through the conversation of alcohol or drug use during the perinatal period. The SBIRT model was developed by the Institute of Medicine as a result of a

recommendation that encouraged community-based screening for health risk behaviors including substance use. There have been adaptations of SBIRT for specific populations such as the ABIRT for Adolescents and the SBIRT 5 P's referring to substance use of the client's Parents, Partner, Past or Present (use of substances), and substance use during Pregnancy. Screening for substance use during perinatal healthcare offers a unique opportunity to intervene in a supportive manner with pregnant people who use substances. Based on the evidence, national health care agencies and associations including the National Institutes of Health, The American College of Obstetricians and Gynecologists (ACOG) American Public Health Association and American Medical Association endorse the use of SBIRT as a valuable public health tool to address substance use disorders. It is our intention to delay any statewide recommendation until we learn more from our collective work including input from our healthcare providers and partners. Additionally, it is important to note that our early and continued ongoing consultation with the legislative sector indicates that pursuing mandatory screening is not recommended.

Data: The Data workgroup maintained a bimonthly meeting schedule and convened to discuss data opportunities and challenges across multiple state systems and agencies. Over the course of the five years, the group complied a variety of indicators across the SUD continuum of care related to birthing people and children's health. The group also provided ongoing feedback and support to the CAPTA and POSC data collection efforts. High priority items for the next plan include targeted CAPTA notification education for birthing hospitals, ongoing data monitoring and sharing, and individualized POSC support. Additionally, it is important to recognize the relationship between SUDs and a variety of other health topics such as adverse childhood experiences (ACEs), racial health disparities, etc.

Awareness and Marketing: The Awareness and Marketing workgroup maintained a monthly meeting schedule and created monthly campaigns addressing various topics affecting birthing people and families impacted by substance use. Because substance use can affect anyone, the group also maintained a primary prevention lens. Because of this, the group created campaigns specific to pregnant people struggling with a substance use disorder as well as campaigns targeting all birthing people and families. Depending on the topic, the group recruited various subject matter experts to contribute to the monthly campaigns.

Training: The Training workgroup met monthly and in its final year merged with the Prevention subcommittee of the Addiction Policy and Drug Council (ADPC) to maintain a pulse on emerging policies related to SUDs, pregnant and parenting people, and infants. DMHAS and DCF have conducted more than 50 training events since the inception of CT's CAPTA legislation and will continue to do so in terms of our ongoing implementation efforts. Trainings have been directed to both state and national audiences. Federal partners have made clear that CT's approach to CAPTA and POSC system of care integration is considered a model for other states to consider as a best practice. In the spring of 2020, the workgroup developed and sponsored the "From Stigma to Empowerment: Supporting Women & Families Impacted by Trauma and Addiction" conference. The conference targeted healthcare providers and others who were interested in expanding their knowledge on providing compassionate care to those impacted by addiction; 204 professionals attended, and the hope is to deliver similar trainings annually.

COVID-19 PANDEMIC

Like many other projects and programs across the state and nation, the SEI-FASD Initiative switched to a virtual approach in March 2020 due to the emerging COVID-19 pandemic. Despite the sudden shift, the initiative was able to quickly adapt and sustain momentum across all workgroups. Going virtual allowed for increased attendance, stakeholder engagement, and sustained high quality work.

The work remained virtual through 2020 and 2021. We learned that virtual work did not affect the quality of the work delivered and the overall response was positive. Because of the success, we anticipate a future virtual/in-person hybrid model to accommodate the variety of stakeholders who live across the state.

AN OVERVIEW OF NATIONAL DATA

FETAL ALCOHOL SPECTRUM DISORDERS (FASDS) IN THE U.S.

FASDs are a group of conditions that can occur in a person whose parent drank alcohol during their pregnancy. These effects can include physical, behavioral, and learning problems. Because FASDs make up a group of disorders, people with FASDs can exhibit a wide range of symptoms and severity. There is no known safe amount of alcohol use during pregnancy or when trying to get pregnant. Because brain growth occurs throughout an entire pregnancy, the sooner a person stops drinking the healthier it will be for them and the baby. FASDs last a lifetime and there is no cure. However, research shows that early intervention treatment services can improve a child's development. There are many types of treatment options, including medication to help with some symptoms, behavior and education therapy, parent training, and other alternative approaches (CDC, 2021b).

The Centers for Disease Control (CDC) reports that there are currently only estimates on the full range of FASD in the U.S., fetal alcohol syndrome (FAS) being the most common diagnosis. The most recent 2012 CDC study analyzed medical and other records and found FAS in 0.3 out of 1,000 children ages 7 to 9 years, but earlier studies using in-person assessment of school-aged children in several U.S. communities report higher estimates of FAS of about 6 to 9 out of 1,000 children. Few estimates for the full range of FASDs are available. Based on the National Institutes of Health who funded community studies using physical examinations, experts estimate that the full range of FASDs in the U.S. and some Western European countries might number as high as 1 to 5 per 100 schoolchildren (CDC, 2021a).

This initiative also acknowledges that for some birthing people, drinking alcohol during pregnancy is not simply a recreational choice, but a substance use disorder beyond willpower alone. Birthing people with alcohol use disorders deserve respect and compassionate care before, during and after their pregnancy. Outreach messaging should be across the continuum of care, not just preventative.

ALCOHOL USE BY WOMEN IN THE U.S.

Alcohol use is the most commonly used drug among women. The most recent 2019 National Survey on Drug Use and Health (NSDUH) data reports that past month alcohol use among all women was 54.3% (age 18-25) and 55% (age 26 and older) in 2019. In the same survey, 9.5% of pregnant women age 15-44 reported drinking alcohol in the past month, which decreased slightly since 2017 (11.5%) (DHHS, SAMHSA, 2020e).

Nationally, 1 in 9 pregnant women report drinking alcohol in the past 30 days.

(CDC, 2019)

In a 2019 Morbidity and Mortality Weekly Report (MMWR) article, CDC researchers found that about 1 in 9 pregnant women reported drinking alcohol in the past 30 days. Among pregnant women, about one third who reported consuming alcohol engaged in binge drinking, defined as consuming four or more drinks on at least one occasion in the past 30 days. Of those who reported alcohol use about 40% reported current use of one or more other substances. Substances most used with alcohol were tobacco and marijuana (CDC, 2019).

OPIOID USE AMONG WOMEN AND NEONATAL ABSTINENCE SYNDROME/NEONATAL OPIOID WITHDRAWL SYNDROME (NAS/NOWS) IN THE U.S.

Opioid use among pregnant women in the US has been trending downwards since 2017.

(DHHS, SAMHSA 2020e)

Women may use opioids as prescribed, may misuse prescription opioids, may use illicit opioids such as heroin, or may use opioids as part of medication assisted treatment/ medication for opioid use disorder (MAT/MOUD). During 2008–2012, about 1 in 3 reproductive-aged women filled an opioid prescription in the U.S. each year. The 2019 Pregnancy Risk Assessment Monitoring System (PRAMS) reports that 7% of pregnant women self-reported using prescription opioid pain relievers. Of those women, 1 in 5 reported misusing them; either getting them from a non-medical source or using them for a reason other than pain relief (CDC, 2021).

NSDUH data indicates that of women who are pregnant in the U.S., opioid use has been trending downwards since 2017, 1.4% to .4% in 2019. Opioid misuse has significantly decreased as compared to 2016-2017 for all women ages 12-25 and heroin use continues to decline among all women ages 18-25. Opioid misuse among women over the age of 26 was 3.1% in 2019. The latter has remained relatively unchanged since 2016. Heroin use among all women 26 and older has remained at .2% from 2016-2019. In 2019, Buprenorphine continued to be the most misused opioid with the 24.2% percentage of women acknowledging misuse of the medication. Methadone closely followed at 19.3% (DHHS, SAMHSA, 2020e).

Though use rates remain low, women still struggle with opiate use disorders. MAT/MOUD uses a combination of medications, counseling, and behavioral therapies to treat substance use disorders. 2019 NSDUH data indicates that the number of women receiving MAT/MOUD (either Methadone, Buprenorphine, or Naltrexone) has been consistently trending upwards since 2016. In 2019, nearly 1.5 million women were receiving MAT/MOUD (DHHS, SAMHSA, 2020e).

Current clinical recommendations for pregnant women with opioid use disorder include MAT/MOUD rather than supervised withdrawal, due to better outcomes for both birthing person and baby. Fetuses exposed to drugs while in-utero develop signs of drug withdrawal during early neonatal life, referred to as neonatal abstinence syndrome or neonatal opioid withdrawal syndrome (NAS/NOWS). NAS/NOWS can result in illness and prolonged hospitalization for the infant (Shukla, 2021).

Although NAS/NOWS is an expected condition that can follow exposure to MAT/MOUD, a concern for NOWS alone should not deter health care providers from prescribing MAT/MOUD to a pregnant mother. NAS/NOWS symptoms are treatable if monitored appropriately (CDC, 2020).

The Healthcare Cost and Utilization Project (HCUP), managed by the Agency for Healthcare Research and Quality (AHRQ), reports that NAS/NOWS among newborn hospitalizations have been increasing nationally between 2009 and 2017, the latest data point reporting a hospitalization rate of 7.3 per 1,000 (HCUP, 2021).

MARIJUANA AND OTHER SUBSTANCE USE AMONG WOMEN IN THE U.S.

Experts do not recommend marijuana use during pregnancy, as it can contribute to immediate and long-term health effects for the child.

(NIDA, 2021)

Marijuana use during pregnancy requires further research, but experts recommend avoiding it. Current research on marijuana indicates that (NIDA, 2021):

- THC crosses the placenta, enters the fetal brain, and is transferred to newborns through breastmilk
- In animals, THC administered to mothers while pregnant or nursing may have long-lasting effects on offspring,

including increasing stress responsivity, abnormal patterns of social interaction, and later preference for other substances

- Prenatal marijuana exposure is associated with lower birth weight
- Marijuana use during pregnancy is linked to increased likelihood of being placed in neonatal intensive care, increased startle and tremors, altered sleep patterns, and preterm birth
- Prenatal marijuana exposure is associated with neurocognitive vulnerabilities in children and adolescents, including decreased executive function, behavioral problems, lower academic achievement, and higher levels of self-reported depressive symptoms.

In the 2019 NSDUH survey, 21.3% of women 18-25 and 7.6% of women 26 and older reported past month marijuana use. Both groups saw significant increases since 2016. In 2019, 5.4% of pregnant women ages 15-44 reported using marijuana in the past month and 1.7% reported daily use (DHHS, SAMHSA, 2020b).

Among pregnant women age 15-44 who reported any marijuana use in the past year (DHHS, SAMHSA, 2020e):

- 26.7% reported past year misuse of psychotherapeutic drugs (compared to 2.7% of pregnant women who reported no use)
- 30.3% reported past year illicit drug use other than marijuana (compared to 2.9% of pregnant women who reported no use)
- 27.3% reported past month alcohol use (compared to 6.1% pregnant women who reported no use)
- 14% reported suicidal thoughts (compared to 3.3% of pregnant women who reported no use)
- 14.3% reported serious mental illness (compared to 3.2% of pregnant women who reported no use)

Past Month Marijuana Use, National (DHHS,SAMHSA, 2020b)		
Women 18-25 **21.3%**	Women 26+ **7.6%**	Pregnant Women 15-44 **5.3%**

Of US pregnant women 15-44 who reported ANY marijuana use in the last year.... (NSDUH, 2019)		
26.7% reported past year misuse of psychotherapeutic	**30.3%** reported part year illicit drug use	**27.3%** reported past month alcohol use

Past month use of cocaine, methamphetamine, and LSD have remained low since 2016 among women in all age groups. Of note, misuse of prescription stimulants among women 18-26 has decreased from 2017 to 2019, 7% to 5.2% respectively (DHHS, SAMHSA, 2020e).

Nationally, 2017 data suggests the prevalence of infants potentially affected by pre-natal exposure ranges from 0.5% for heavy drinking, 8.5% for illicit drugs, and 11.5% for alcohol use (NCSACW, 2019).

AN OVERVIEW OF CONNECTICUT DATA

CT LIVE BIRTHS

There were 33,234 births to Connecticut residents in 2020. The number of live births has been declining since 2016 (CT DPH, 2021).

DRUG AND ALCOHOL USE AMONG WOMEN IN CT

In 2019, 14.6% of CT women over the age of 18 reported that they drink excessively.

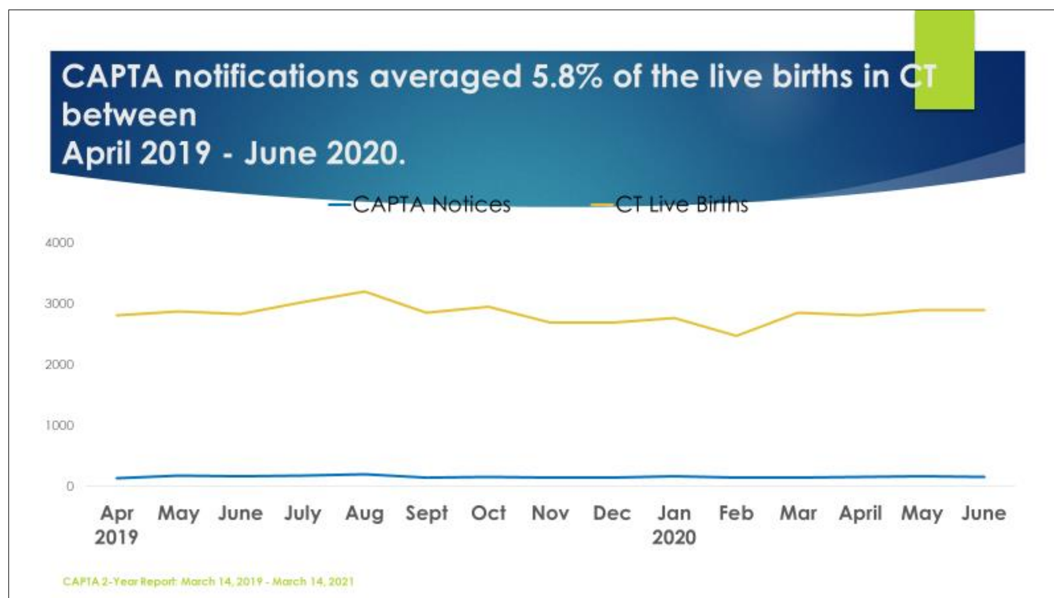
(CT DPH, 2020)

The CT Behavioral Risk Factor Surveillance Survey (BRFSS) is an ongoing telephone survey of adults conducted in all 50 states and coordinated by the CDC. The BRFSS asks questions on risk behaviors, including alcohol use. Of the women 18 years and older surveyed in 2019 (CT DPH, 2020):

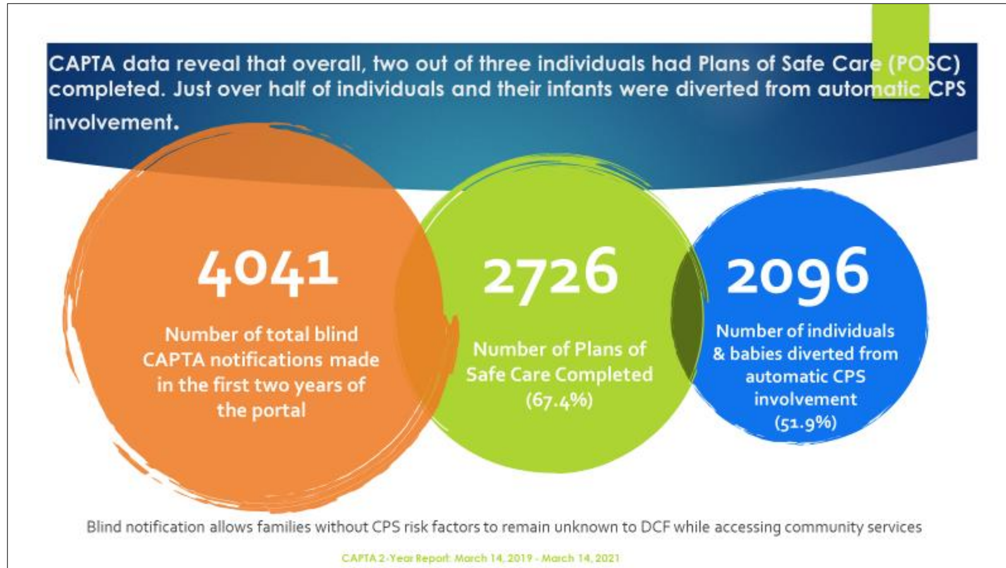
- 12% reported binge drinking (4 or more drinks on one occasion) in the past 30 days
- 6.1% reported heavy drinking (more than 1 drink per day) in the past 3 days
- 14.6% drank excessively (either binge or heavy drinkers)

The 2018 CT Pregnancy Risk Assessment Monitoring System reports that 7.5% of pregnant women reported alcohol use during the last 3 months of their pregnancy (CT DPH, 2019).

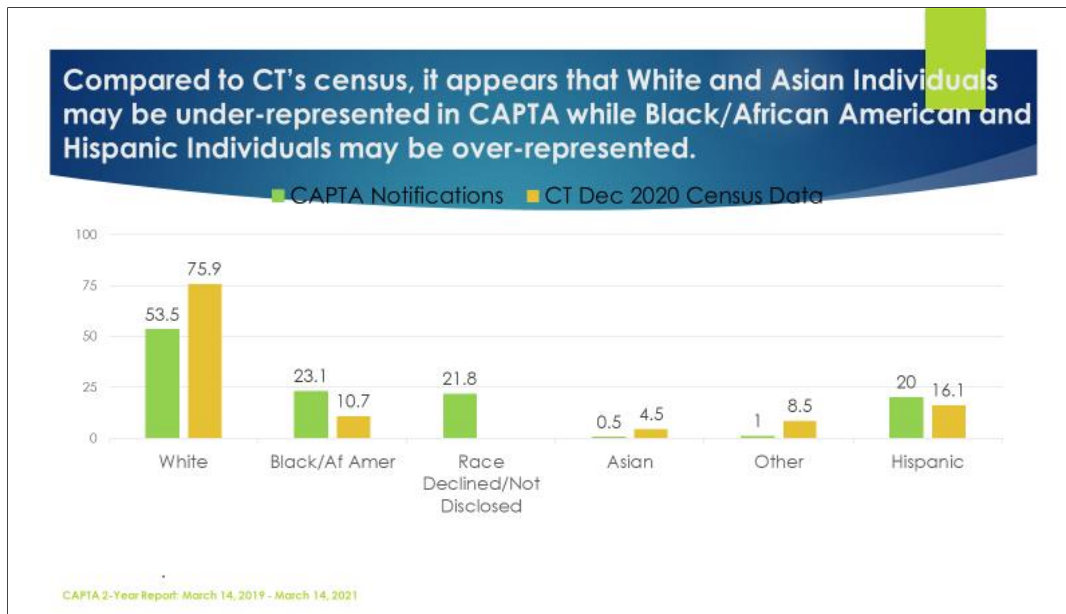
In Connecticut, CAPTA notifications submitted by hospitals between April 2019 and June 2020 reveal infants affected by any type of pre-natal exposure averaged 5.8% of live births. During the first two years of CT's CAPTA implementation, DCF has received on average 168 notifications per month. In total, 4,041 blind notifications were submitted to DCF. CAPTA portal data show that utilization of the notification system by hospitals has been steady and consistent over time.

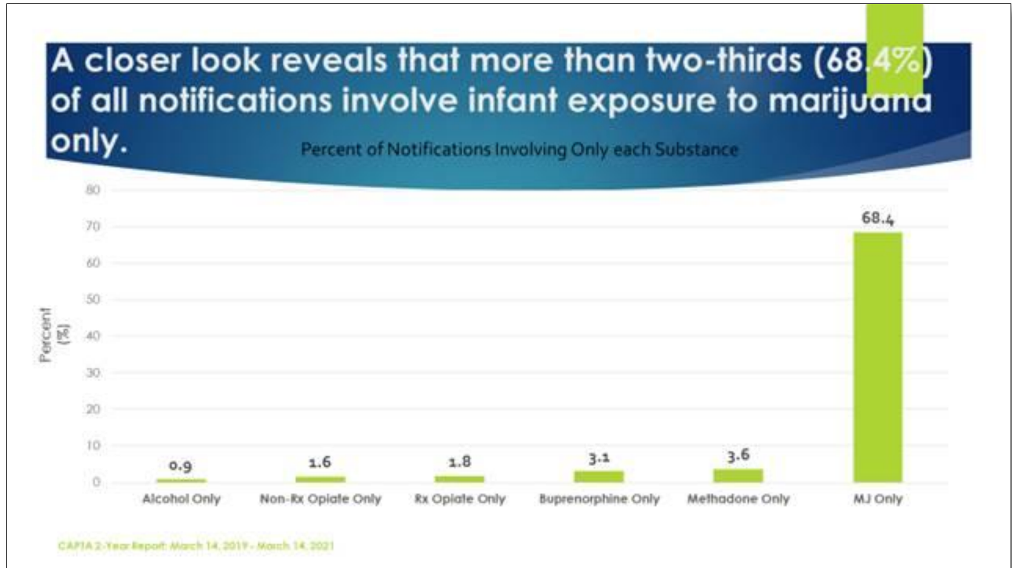


Data from DCF's CAPTA Two Year Implementation Report shows that during that period 2,096 infants and their birth parents were in recovery, had a POSC, and had no concerns for abuse or neglect at the time of the birth event. It is anticipated that the data in this report will help tell the story about how the CAPTA Notification Portal and POSC affect the caretaker, infants, significant other, partner, family, and/or other support persons impacted by substance use disorders in CT.

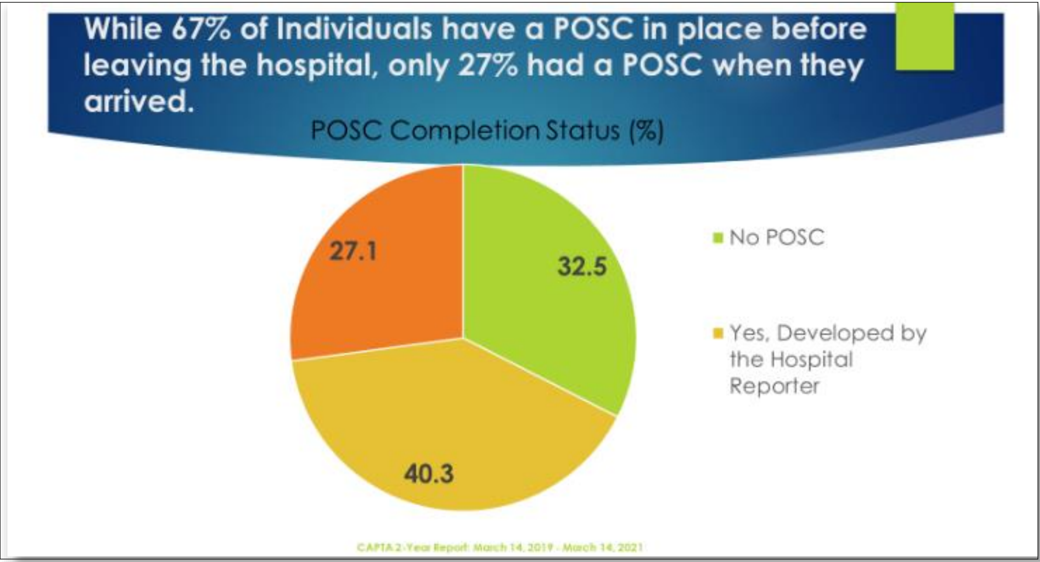


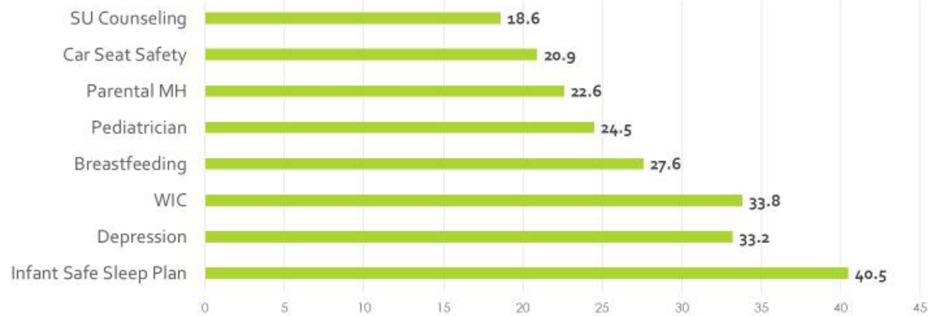
Of note, one in five (21.8%) CAPTA notifications are missing or have an undisclosed race. Ensuring that we capture complete data on race and ethnicity will allow us to observe any potential over or under representations of groups moving forward. Data shows that of infants that are identified as exposed to only one substance, the most common exposure is to marijuana (78%, n=2,764). The high rate of marijuana exposures is not surprising given the prevalence of marijuana use in the population and the substance's long detection window.





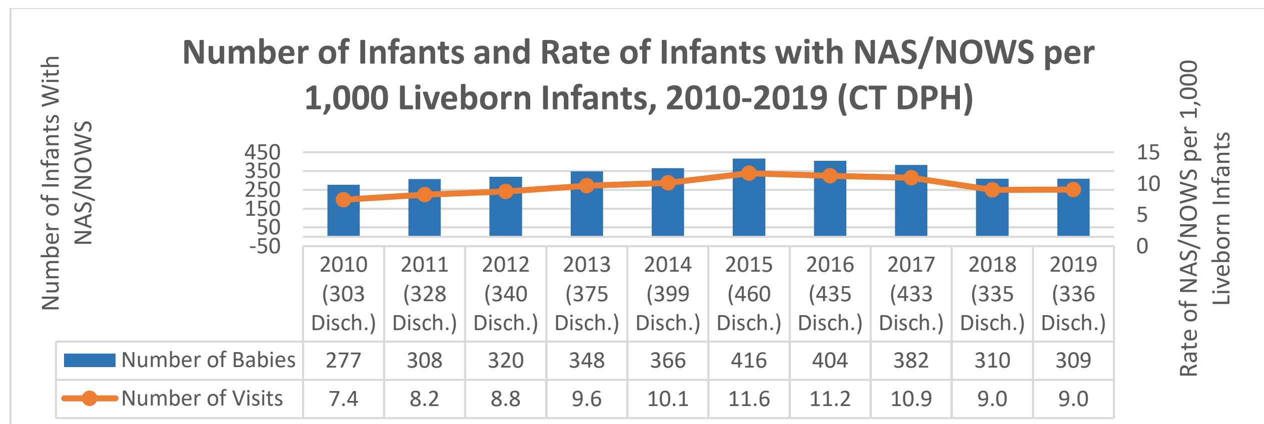
The state's efforts to help birthing parents have a POSC have shown positive results during CT's first two years of implementation. Two-thirds (67%) of mothers (n=2,726) have a Plan of Safe Care in place before leaving the hospital. Despite these early positive results, only 27% of individuals arrive at the hospital with a plan of safe care already in place leaving the burden of safe care planning to hospital staff during the brief hospital stay in the post-natal period. Future efforts to strengthen POSC implementation should focus on the network of stakeholders, state agencies, healthcare systems, and community-based providers to develop POSC in the prenatal period.





CT NAS/NOWS DATA

CT DPH reports that the rate of NAS/NOWS infants increased from 7.4 per 1,000 in 2010 to 11.6 per 1,000 in 2015. The rate then declined each year until 2018, which then stabilized at 9.0 per 1,000 live born infants (CT DPH, 2021a).



Of all CT NAS/NOWS cases from 2017-2019 (n=1,001), 89% or 891 were infants with Medicaid insurance with most of these infants being White Non-Hispanic and on Medicaid (63%). Moreover, the median length of stay for infants born with NAS/NOWS in CT decreased from 16 days in 2013 to 7 days in 2018, which remained at 7 days in 2019. In comparison, the median length of stay for all newborns was 3 days from 2010 to 2019. The decline in length of stay may reflect improved treatment of NAS/NOWS infants (CT DPH, 2021a).

HEALTH INEQUITIES & SUBSTANCE USE DISORDERS

CT DEMOGRAPHICS AND NATIONAL SUD RATES

According to the 2020 US Census, Connecticut has a population of about 3.6 million with race and ethnicity estimates of 65.9% White non-Hispanic, 16.9% Hispanic, 12.2% Black or African American, 5% Asian, .6% American Indian and Alaska Native (AI/AN), and .1% Native Hawaiian and Other Pacific Islander. Women make up 51.2% of the population.

NSDUH 2019 results indicate that nationally, 7.7% (19.3 million) of adults over the age of 18 struggle with a substance use disorder and 20.6% (51.5 million) had a mental illness (DHHS, SAMHSA, 2020). Because the BIPOC (Black, Indigenous, People of Color) population makes up over one-third of the CT population, it is critical for us to consider the racial SUD and mental health disparities that exist using the national data available. According to the 2019 NSDUH results, nationally:

- 7% (2.9 million) of Hispanics over the age of 18 struggle with a substance use disorder and 18% (7.4 million) had a mental illness (DHHS, SAMHSA, 2020d).
- 7.6% (2.3 million) of African Americans over the age of 18 struggle with a substance use disorder and 17.3% (5.2 million) had a mental illness (DHHS, SAMHSA, 2020a).
- 10% (142,000) of AI/AN over the age of 18 struggle with a substance use disorder and 18.7% (260,000) had a mental illness (DHHS, SAMHSA, 2020b).
- 4.8% (745,000) of Asian, Native Hawaiians, and Other Pacific Islanders over the age of 18 struggle with a substance use disorder and 14.5% (2.3 million) had a mental illness (DHHS, SAMHSA, 2020c).

Another population of note are those who identify as lesbian, gay, or bisexual (LGB). The same national survey reports that among those over the age of 18 who identify as LGB, 18.3% (2.6 million) struggle with a substance use disorder and 47.4% (6.8 million) had a mental illness (DHHS, SAMHSA, 2020f).

In 2019, 18.3% of those who identified as lesbian, gay, or bisexual struggled with a SUD – almost two and a half times the national average of 7.7%.

(DHHS, SAMHSA, 2020f)

In the 2019 CT BRFSS survey, Hispanics were the highest reporters of excessive drinking (20%) among minority populations, compared to Non-Hispanic Blacks (10.8%) and Non-Hispanic others (12.8%). Similarly, Non-Hispanic Whites also had high rates of excessive drinking (18.6%) (CT DPH, 2020). The latter data was not further stratified by gender, but is important information to consider as targeted outreach efforts develop.

CT PRAMS: EXPERIENCES OF DISCRIMINATION

The CT PRAMS asks pregnant people about their experiences of discrimination. This data is important for us to monitor as discrimination could have direct implications on access to and delivery of care. In 2018, 14.2% of women surveyed reported any kind of discrimination or harassment because of race, ethnicity, or culture in the 12 months prior to pregnancy (CT DPH, 2019).

Additionally, the CT PRAMS collects information on experiences of discrimination based on different maternal characteristics at health-related services during pregnancy. Those characteristics include race, ethnicity, or culture (3.2%), age (3.3%), language spoke (3.1%), citizenship (2.2%), insurance/Medicaid status (3.8%), and other (2.4%).

CT MATERNAL MORTALITY

Released in December 2020, the Maternal Mortality in Connecticut report summarizes the findings from the Connecticut Maternal Mortality Review Committee (CT MMRC) reviews of deaths that occurred between 2015 and 2017. The classifications of death were as follows: pregnancy-related, pregnancy-associated but not related to pregnancy, or, undeterminable. A "pregnancy-related death was a death that occurred during pregnancy or occurred within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by a pregnancy, or the aggravation of an unrelated condition by the psychological effect of a pregnancy. A death that was "pregnancy-associated but not related" was a death that occurred during pregnancy or occurred within one year of the end of pregnancy from a cause not related to pregnancy. Pregnancy-associated deaths for which pregnancy relatedness could not be determined were "undeterminable" (CT DPH, 2020a).

34% of pregnancy-related deaths in CT were due to accidental overdoses and mental health conditions.

(CT DPH, 2020a)

During 2015-2017, there were 32 pregnancy-associated deaths. Of 32 pregnancy-associated deaths, 11 (34%) were determined by CT MMRC to be pregnancy- related; 19 (59%) were determined to be pregnancy-associated but not pregnancy-related. Committee was not able to determine pregnancy-relatedness in two cases. Of important note for our purposes, about 34% of pregnancy-associated deaths were due to accidental overdoses and mental health conditions (CT DPH, 2020a).

Additionally, persons of color were overrepresented among pregnancy-related deaths. About 64% of pregnancy-related deaths were those of black and Latino people. By contrast, persons of color accounted for about 45% of live births in Connecticut in 2015-2017 (CT DPH, 2020a).

CT COVID-19 DISPARITIES DATA

In January 2021, the Connecticut Collective for Women and Girls (CCWG) and the Connecticut Data Collaborative (CTData) released the "Essentially Equity: COVID-19 and Rebuilding CT." This report documents the disproportionate impact of COVID-19 on women and girls, and particularly those of color. The report analyzes several topics; a few of note for our purposes include (CCWG, CTData, 2021):

- CT females experienced higher cases (54% of total cases) and deaths (52% of total deaths) compared to male cases and deaths
- People of color have experienced disproportionate impacts compared to white people: 46% of Hispanic and 42% of Black residents knew someone who tested positive, compared to 30% of white residents
- 20% of Black and 15% of Hispanic residents knew someone who died from Covid-19, compared to 12% of white residents
- 15% of Covid-19 deaths were Black individuals, while Black individuals make up only 10% of the state's population
- 70% of females reported experiencing mental health concerns, 75% of Hispanic females report experiencing mental health concerns

During June 24–30, 2020, U.S. adults reported considerably elevated adverse mental health conditions associated with Covid-19. In a CDC study, 40% of adults reported struggling with mental health or substance use. Of these individuals (CDC, 2020a):

- 31% experience anxiety/ depressive symptoms
- 26% experience trauma/stressor-related disorder symptoms
- 13% started or increased substance use
- 11% seriously considered suicide

In CT, overdose deaths between January 2020-July 2020 were 20% higher compared to January 2019-July 2019, 802 and 667 respectively (CPES, 2020).

Additionally, a recent 2021 retrospective case control study that looked at electronic health data found that patients with a past year SUD diagnosis were at significantly increased risk for Covid-19, the risk being highest among those with an opiate use disorder. Covid-19 patients with a past year SUD diagnosis had significantly worse outcomes (death: 9.6%, hospitalization: 41.0%) than general Covid-19 patients (death: 6.6%, hospitalization: 30.1%) and African Americans with Covid-19 and SUD had worse outcomes (death: 13.0%, hospitalization: 50.7%) than Caucasians (death: 8.6%, hospitalization: 35.2%) (Wang et al., 2020).

Covid-19 disproportionately affected communities of color, women, and individuals with SUD as a diagnosis.

CT SCREENING PRACTICES

We do not have any recent data on provider and/or systems SUD screening practices, but our community partners anticipate releasing related data in 2021. Our long-term goal is to encourage universal screening and discourage selective screening practices.

The American College of Obstetricians and Gynecologists (ACOG) makes the following screening recommendations (ACOG, 2017):

- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
- Routine screening should rely on validated screening tools, such as questionnaires, including 5Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).

2022-2022 STRATEGIC PLANNING PROCESS

NEW STRATEGIC PRIORITIES AND STRATEGIES

In the fall of 2020, the Executive Team convened over a series of meetings to close the 2016-2021 plan and to begin planning for the next phase of the work. After thorough review of the previous plan and discussions with existing workgroups, the team identified several continued and new high priority topics. To determine a starting point for the work, Core Team members completed a survey ranking the topics in order of priority. After reviewing the survey results and qualitative feedback from the Core Team, the following priority areas were identified, and strategies were developed collaboratively. Workgroups, led by the Program Manager, will be developed and/or maintained to support the new deliverables.

Priority 1: CAPTA & POSC **Goal: Promote broad understanding of CAPTA reporting requirements and the value of Plans of Safe Care (POSC)**
Available Data: • CAPTA Portal Data (March 2019- March 2021): 4041 blind notifications, 2726 (67.4%) POSC completed, 2096 (51.9%) number of individuals and infants diverted from automatic CPS involvement. • CAPTA Portal Data (March 2019-March 2021): 21.8% of CAPTA notifications are missing or have an undisclosed race • CAPTA Portal Data (March 2019-March 2021): Only 27% of individuals had a POSC in place when they arrived at the hospital **Data Limitations:** • CAPTA data is still in the early stages of collection and evaluation • Emerging work for 2022 (POSC Coordinator) will provide additional data • CT marijuana legalization in July 2021 may impact data collection and reporting practices
Strategy 1: *Provide ongoing educational opportunities for providers and systems that touch birthing people and families to remain current on accurate CAPTA reporting practices and statewide progress and opportunities within CAPTA* • After nearly 2 years of CAPTA portal and POSC implementation, there was unanimous agreement that continued system and practice improvements would be necessary to ensure accurate reporting practices and positive outcomes for families. Increased and ongoing provider education on CAPTA and POSC fundamentals will be necessary to not only provide a consistent flow of current information, but a channel for providers to voice reporting questions or concerns. We anticipate that the new complimentary position (POSC Coordinator) will provide the additional capacity and data to support this work. • Broader education on CAPTA and POSC will also be necessary across agencies and organizations that work with and serve birthing people impacted by a SUD. It will be important that the individuals that work with this population understand the fundamentals and the practice so that they can continue to promote transparency and education on CAPTA and POSC.
Strategy 2: Explore the ethical, stigma, and health equity themes that surround CAPTA reporting practices • Individualized work with birthing hospitals will be vital to understanding their unique strengths and opportunities within reporting, work with them on ongoing quality improvement efforts, and promote understanding of health equity as it applies to CAPTA.

- Development of a presentation on CAPTA and the intersection of reporting bias will be important to educate broadly on biases that may result in selective reporting practices and disproportionate community impact.

Strategy 3: Normalize and destigmatize the POSC as a tool for anyone who is thinking about becoming pregnant, currently pregnant, or has recently given birth and provide individualized POSC support to empower mothers to reach their goals

- It is important that the POSC continues to be broadly marketed among birthing people. This includes marketing via community outreach as well as digital marketing via social media and other media outlets. Additionally, efforts will be made to train "non-traditional" birthing person facing entities to ensure the information is readily available and understood. For birthing people who are struggling with a substance use disorder, it is critical that we empower them to utilize the POSC as a tool to reach their goals while also providing transparency on CAPTA reporting processes at the time of delivery.
- The initiative will explore opportunities for standardized POSC discussions within medical appointments, including OBGYN or after birth, that would ensure no birthing person misses the information and avoids an unnecessary Careline report due to a missing POSC.
- Per federal legislation, the initiative will also explore opportunities to create a follow up mechanism for people who have developed a POSC to provide them with support in meeting their goals.

Strategy 4: Explore continued opportunities to enhance CAPTA portal data

- Continued monitoring and quality improvement efforts will be necessary to ensure the portal data is informing the work to the highest degree. There is also still much to learn about how marijuana legalization will impact the data.

Screening and Referral: Improve substance misuse and substance use disorder screening, interventions, treatment referrals through provider education and enhancement of local and statewide systems

Available Data:

- 2019 NSDUH Survey: Of the US pregnant women 15-44 who reported any marijuana use in the last year 26.7% reported past year misuse of psychotherapeutic drugs, 30.3% reported past year illicit drug use, and 27.3% reported past month alcohol use
- CAPTA Portal Data (March 2019- March 2021): Of infants exposed to only one substance, 78% of them are exposed to marijuana
- 2020 Maternal Mortality in CT Report (2015-2017): 34% of pregnancy-related deaths in CT were due to accidental overdoses and mental health conditions
- CT PRAMS 2018: Among pregnant women, 95% reported their healthcare provider discussed alcohol use during prenatal visits, but only 78.3% reported they discussed illegal drugs
- CT PRAMS 2018: 7.5% of women reported alcohol use during the last 3 months of their pregnancy

Data Limitations:

- No available data on current screening practices across the state

Strategy 1: Understand barriers to screening from a provider perspective and provide opportunities to build screening capacities within our local systems

- Broad substance use and misuse screening practices across the state are still unclear. Though universal screening is a long-term goal, we recognize that providers and healthcare systems have varying levels and capacities to implement comprehensive substance misuse and use disorder screenings. Creating awareness and visibility around the importance and best practices of substance misuse and use disorder screening through provider education and outreach remains a high priority for the initiative. Utilizing new and emerging data related to screening practices, we hope to identify champions within health care settings to understand and/or enhance screening, brief intervention, and/or referral to treatment within their systems and grow this work by sharing these lessons learned with other systems.
- Providing broadly available SBIRT/screening trainings, including education on SBIRT reimbursement and stigma as it applies to screening, will be important to continue to enhance screening practices, including moving upstream from primarily case finding to identifying risky use and opportunities for early intervention.
- The recent state legalization of marijuana also presents an opportunity to educate providers on the potential implications of use during pregnancy as well as best practices screening and intervention.

Strategy 2: Promote strategies that enhance brief intervention and referral to treatment practices and understanding of community and state SUD treatment and recovery resources.

- It is critical that providers feel confident providing appropriate resources and referrals after a positive screen, as well doing so in a supportive nonjudgement manner. The state has readily available treatment and recovery resources for birthing people who are struggling with a substance use disorder. Broad and targeted efforts will be made to ensure providers and healthcare systems able to readily identify referral pathways and are aware of the resources available at the state level.

Marketing and Training: Create and enhance opportunities for SEI-FASD professional development and promote statewide awareness and knowledge

Available Data:

- CAPTA Portal Data (March 2019- March 2021): Of infants exposed to only one substance, 78% of them are exposed to marijuana
- CT PRAMS 2018: 7.5% of women reported alcohol use during the last 3 months of their pregnancy
- 2020 Maternal Mortality in CT Report (2015-2017): 34% of pregnancy-related deaths in CT were due to accidental overdoses and mental health conditions

Data Limitations:

- No recent national or state data available on what percent of birthing people who drink have an alcohol or marijuana use disorder vs misuse alcohol or marijuana due to limited knowledge of impacts
- No state baseline for provider knowledge on FASD and or SEI best practices

Strategy 1: Increase knowledge, awareness, and professional development opportunities regarding the FASD and SEI and other topics that are related to and impact substance use and recovery such as: stigma, trauma informed care, adverse childhood experiences, and other overlapping public health topics

- Overview or "101" trainings on FASD and SEI have not been standardized for the purposes of this initiative. While information on the topics are widely available, live trainings with consolidated information and state specific resources will not only continue to raise FASD and SEI awareness and knowledge broadly, but also promote the work of this initiative and further recruit stakeholders.
- The initiative will maintain a website with updates, resources, and other relevant content.
- Recent marijuana legislation also prompts the need for increased outreach and education efforts for both the birthing person population and providers.
- Additionally, it will be important to continue highlighting how SUDs, FASDs, and SEI intersect with other comorbidities and other related work in the state. This will be accomplished by continuing our monthly digital campaign series as well as collaborative work with new and existing partners in other domains of public health as opportunities are identified.

Treatment, Recovery, and Wellness Support: Ensure birthing people, children and families have access to SEI-FASD and SUD treatment, recovery, and support resources

Available Data:

- CAPTA Portal Data (March 2019- March 2021): 56% of notifications identify depression and/or parental mental health needs
- 2020 US Census: A third of CT's population consists of minority populations (16.9% Hispanic, 12.2% Black or African American, 5% Asian, .6% American Indian and Alaska Native, Native Hawaiian and Pacific Islander)
- 2018 CT PRAMS: Experiences of discrimination based on different maternal characteristics at health related services during pregnancy; Race, ethnicity, or culture (3.2%), age (3.3%), language spoke (3.1%), citizenship (2.2%), insurance/Medicaid status (3.8%), and other (2.4%)
- 2020 Maternal Mortality in CT Report (2015-2017): 34% of pregnancy-related deaths in CT were due to accidental overdoses and mental health conditions; About 64% of pregnancy-related deaths were those of black and Latino people. By contrast, persons of color accounted for about 45% of live births in Connecticut in 2015-2017
- 2019 NSDUH Survey: In 2019, 18.3% of those who identified as lesbian, gay, or bisexual struggled with a SUD – almost two and a half times the national average of 7.7%.

Data Limitations:

- No baseline state data on the LGBTQIA+ community and their experiences with accessing SUD treatment and recovery resources
- No baseline data on state services/resources specific to children impacted by SEI-FASD
- Follow up mechanism for POSC of still pending

Strategy 1: Maximize the use of existing CT resources available to birthing people, children, and families including substance use treatment and recovery supports, health care, developmental assessments, etc.

- The state has resources available to individuals and families impacted by SUDs. Efforts will be made to ensure this information is broadly available and to continue enhancing and growing these systems of care as needed. However, less information is readily available on state specific resources available for children impacted by SEI-FASD. Not only will efforts be made to consolidate information on existing child resources, but the initiative will further explore the successes and challenges that families experience when navigating these systems.

Strategy 2: Enhance opportunities for priority SUD treatment entry for minority birthing people
• National data (and limited state data) has noted the disproportionate impacts of substance use and mental illness on minority communities, including the LGBTQIA+ community. Our systems of care have a responsibility to provide accessible and respectful services to minority communities and to also ensure there are pathways in place for immediate treatment and recovery support. Because there is limited data on the LGBTQIA+ community and their utilization/engagement with CT treatment and recovery services, efforts must be made to identify strengths and opportunities for system improvements.
Strategy 3: Continue to support, enhance, and/or create opportunities for family centered interventions   • Social supports are critical to navigating recovery. The state has programs such as PROUD, REACH, and Women's Specialty Programs that factor in the needs of families, partners, and/or significant others. The initiative will continue to collaborate with the latter programs as well as create new partnerships with other programs that serve fathers and other support people.
Strategy 4: Empower individuals to work with their provider and/or local community resources to gain support with alcohol use and/or substance use disorder treatment   • In addition to systems level work, we must continue to empower individuals to seek assistance with their substance use and share the recovery friendly resources that are available in the state. This will be accomplished through continued collaborations with public and private agencies that serve our population and through community outreach via print and digital campaigns.   • When individuals are introduced to CAPTA and POSC, either pre or post-delivery, they should be provided with resources that help to facilitate their understanding and trust, as well as next steps if treatment needs are identified. It is important that birthing people and families feel supported in their parenting and recovery journey.

FIVE POINTS OF FAMILY INTERVENTION

SEI-FASD and SUDs involve several systems and points in time in a woman and child's life. Because of this, a broad approach to the work is necessary. The Five Points of Family Intervention are key points in time when comprehensive cross-system efforts can help to prevent prenatal substance exposure, address the needs of pregnant and parenting women with substance use disorders, and respond to the needs of children who are affected. These points are Pre-pregnancy, Prenatal, Birth, Neonatal/Infancy/Postpartum, and Childhood. For our purposes, referring to these points will ensure we address the depth of policy and strategies that could be deployed within each point as they apply to our priority areas. (NCSACW, 2020).

TARGET POPULATIONS

The Social-Ecological Model provided a starting point for defining our target populations. This model presents various levels within a society and how those levels interact. It allows us to understand the range of factors that put individuals at risk, or conversely protect them, from public health concerns (SEI-FASD and SUD in this case). The overlapping levels illustrate that each influences the other, emphasizing the need of attention to all levels for broad societal change or improvement (CDC, 2021c).

The target populations identified for the 2022-2027 plan were:

- General Population
- Birthing People of Reproductive Age
- Children and Family/Support System
- Workforce Individuals & their Respective Systems, including Behavioral & Medical Providers/Hospitals, Educators/Schools, Human Service Workers/Agencies, Legislators/Policy

ADDRESSING HEALTH DISPARITIES AND HEALTH INEQUITIES

The Core team survey results indicated a need to address health disparities and health equity topics that affect our work, such as racial health disparities, ACEs, Covid-19 impact, LGBTQIA+ health, etc. Rather than developing one priority area to address each of the several topics that affect our work, health equity is a lens that needs to be addressed throughout all the priorities identified. This overarching lens also includes data and cultural competence, which influence and inform the all the work significantly:

- We must ensure our work is informed by and measured by data. Additionally, efforts must be made to identify and collect data beyond the national and state indicators that are currently available publicly, particularly new data collected as a part of this initiative.
- The initiative will also incorporate cultural competence into ongoing and future work. Cultural competence plays an important role in promoting and providing respectful, informed, and personalized care to individuals of various backgrounds and will also impact how we tailor our work to fit the needs of different populations of birthing people that fall under the "women's health" umbrella.
- Finally, we must continue to spread awareness on the health disparities and inequities that occur within subpopulations and subsequently identify ways to address them.

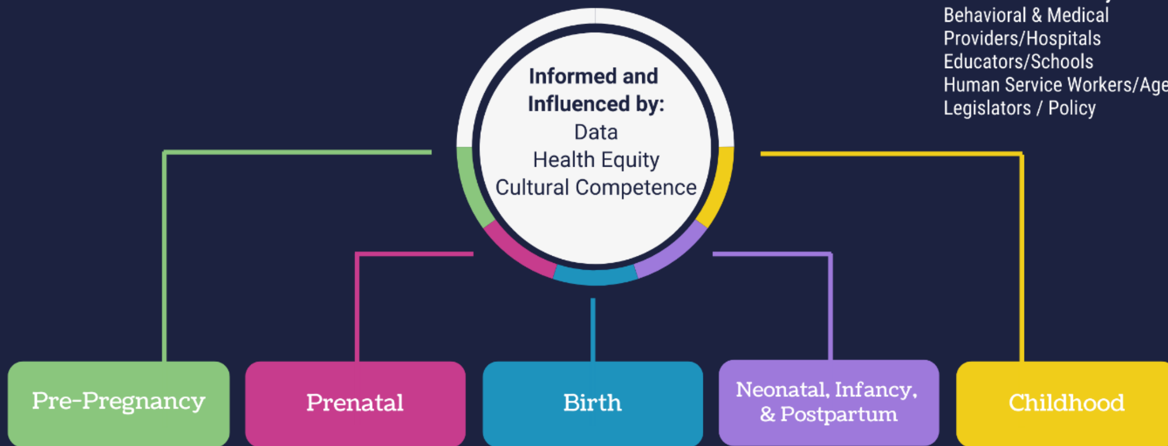
SEI-FASD STRATEGIC FRAMEWORK 2022-2027

The following strategic framework graphic on page 26 outlines the next five years of work. The SEI-FASD Statewide Project Manager will oversee implementation in collaboration with the Executive Team. They will also provide quarterly updates at Core Team meetings and annual progress reports at the end of each state fiscal year. A website will also be maintained that will contain imitative updates and related resources.

SEI-FASD Strategic Framework 2022-2027

Target Population/s

General Population
Birthing People of Reproductive Age
Children & Family/Support System
Workforce Individuals & Systems
- Behavioral & Medical Providers/Hospitals
- Educators/Schools
- Human Service Workers/Agencies
- Legislators / Policy



Priority 1: CAPTA & POSC

GOAL: Promote broad understanding of CAPTA reporting requirements and the value of Plans of Safe Care

1. Provide ongoing educational opportunities for providers and systems that touch families to remain current on accurate CAPTA reporting practices and statewide progress and opportunities within CAPTA
2. Continue to empower birthing people to use the POSC and normalize it as a tool for anyone who is thinking about becoming pregnant, currently pregnant, or has recently given birth
3. Explore continued opportunities to enhance CAPTA portal data
4. Explore the ethical, stigma, and health equity themes that surround reporting practices

Priority 2: Screening and Brief Intervention

GOAL: Improve screening for substance misuse and substance use disorders and to provide appropriate services through provider education and enhancement of statewide referral systems

1. Understand barriers to screening from a provider perspective and provide opportunities to build screening capacities within our local systems
2. Promote strategies that enhance brief intervention and referral to treatment practices and understanding of community and state SUD treatment and recovery resources.

Priority 3: Marketing and Training

GOAL: Create and enhance opportunities for FASD-SEI professional development and promote statewide awareness and knowledge

1. Increase knowledge, awareness, and professional development opportunities regarding the FASD and SEI and other topics that are related to and impact substance use and recovery such as: stigma, trauma informed care, adverse childhood experiences, etc.

Priority 4: Treatment, Recovery, and Wellness Support

GOAL: Ensure birthing people, children and families have access to FASD-SEI and SUD treatment, recovery, and support resources

1. Maximize the use of existing CT resources available to birthing people, children, and families including substance use treatment and recovery supports, health care, developmental assessments, etc.
2. Enhance opportunities for priority SUD treatment entry for minority birthing people
3. Continue to support, enhance and/or create opportunities for family centered interventions
4. Empower individuals to work with their provider and/or local community resources to gain support with alcohol use and/or substance use disorder treatment

CONCLUSION

This new SEI-FASD strategic plan expands on work initiated in the last five years, while also addressing new emerging topics and meaningfully incorporating a proactive lens of data, cultural competence, and health equity. We must ensure our work is informed by and measured by data. Additionally, efforts must be made to identify and collect data beyond the national and state indicators that are currently available publicly, particularly new data collected as a part of this initiative. The initiative will also incorporate cultural competence into ongoing and future work. Cultural competence plays an important role in promoting and providing respectful, informed, and personalized care to individuals of various backgrounds and will also impact how we tailor our work to fit the needs of different populations of birthing people that fall under the "women's health" umbrella. Finally, we must continue to spread awareness on the health disparities and inequities that occur within subpopulations and subsequently identify ways to address them.

With the guidance of the Executive Team and Core Team, four priority areas and their respective strategies were identified. The revised priority areas (CAPTA and POSC; Screening and Brief Intervention; Marketing and Training; and Treatment, Recovery and Wellness Support) will be supported by four respective workgroups, in addition to one overarching stakeholder group (Core Team). The focus of the workgroups include:

- **CAPTA and POSC:** Continue to build local and statewide system capacities to enhance CAPTA and POSC implementation, education, technical assistance, including increasing community outreach efforts to educate birthing people on the POSC and continued transparency around the CAPTA reporting process.
- **Screening and Brief Intervention:** Promote universal screening practices while thoughtfully addressing the current barriers that make this challenging to implement broadly. This includes an inventory of the current screening landscape across the state, increasing the availability of practice specific screening related trainings for providers, and targeted outreach and collaborations with providers/systems that are interested in enhancing their screening brief intervention, and/or referral practices.
- **Marketing and Training:** Promote broad understanding of the complexities of perinatal addiction, best practice information including but not limited to resources on supportive strategies for birthing people, families and children who are affected by a SUD and the role of stigma. This includes monthly digital campaigns, ongoing broad outreach efforts, development of a SEI-FASD 101 training (additional related trainings to follow), and collaborations with other intersecting initiatives.
- **Treatment, Recovery, and Wellness Support:** Address individual and system level opportunities and barriers to SUD treatment, recovery, and support services that affect birthing people, families, and children. We will continue to collaborate on two generational interventions. The workgroup will continue to compile available state resources for parents whose children are impacted by FASD or SEI and in doing so, efforts will be made to consolidate the information and address any gaps that might exist. We will also focus on the disproportionate impacts of SUD and mental illness on birthing people in the Black Indigenous, People of Color (BIPOC) and LGTBQIA+ communities, including collection of information on their experiences accessing SUD and/or SEI-FASD services.
- **Core Team:** Will continue to serve as a body of stakeholders who provide subject matter expertise and direction to the work and meet quarterly to discuss initiative updates and progress.

The initiative will continue to maintain a recovery oriented, harm-reduction, and inclusive approach to the work that is stigma free, family centered, and honors the multiple pathways to recovery. This plan has been designed to prompt meaningful shifts that will support the overall wellbeing of infants, birthing people, and families across the state of CT.

REFERENCES

American College of Obstetricians and Gynecologists (ACOG). (2017, August). *Opioid Use and Opioid Use Disorder in Pregnancy*. ACOG. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy.

Centers for Disease Control and Prevention (CDC). (2019, April 25). *Consumption of Alcohol Beverages and Binge Drinking Among Pregnant Women Aged 18–44 Years - United States, 2015–2017*. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/68/wr/mm6816a1.htm.

Centers for Disease Control and Prevention. (2020, April 30). *Treatment for Opioid Use Disorder Before, During, and After Pregnancy*. Centers for Disease Control and Prevention. https://www.cdc.gov/pregnancy/opioids/treatment.html.

Centers for Disease Control and Prevention (CDC). (2020a, August 13). *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic - United States, June 24–30, 2020*. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.

Centers for Disease Control and Prevention (CDC). (2021, April 22). *About Opioid Use During Pregnancy*. Centers for Disease Control and Prevention. https://www.cdc.gov/pregnancy/opioids/basics.html#:~:text=According%20to%202019%20self%2Dreported,other%20than%20to%20relieve%20pain.

Centers for Disease Control and Prevention (CDC). (2021a, February 4). *FASD Data & Statistics*. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/fasd/data.html#ref.

Centers for Disease Control and Prevention (CDC). (2021b, May 21). *Basics about FASDs*. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/fasd/facts.html.

Centers for Disease Control and Prevention (CDC). (2021c), January 28). *The Social-Ecological Model: A Framework for Prevention |Violence Prevention|Injury Center|CDC*. Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html.

Connecticut Collective for Women and Girls (CCWG), Connecticut Data Collaborative (CTData). (2021). *Esssential Equity: Women, Covid-19, and Rebuilding CT.* https://womenandgirls.ctdata.org/docs/Essential%20Equity%20Women%20Covid-19%20and%20Rebuilding%20CT.pdf

Connecticut Department of Health (CT DPH). (2019, October). *Connecticut Pregnancy Risk Assessment Monitoring System (PRAMS) 2018 Data Report*.

Connecticut Department of Public Health (CT DPH). (2020, December). *Connecticut Behavioral Risk Factor Survey Prevalence Estimates for Risk Factors and Health Indicators*. ct.gov. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/CTBRFSS2019_Summary_Tables.pdf.

Connecticut Department of Health (CT DPH). (2020a, December). *Maternal Mortality in Connecticut. Maternal Mortality Review Committee Data 2015-2017.*

Connecticut Department of Health (CT DPH). (2021, May). *CT Resident and CT Occurrent Births 2016-2021 (version 2021-05-20)* [Data File]. Available from CT DPH Web site: https://portal.ct.gov/dph/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports

Connecticut Department of Health (CT DPH). (2021a, May 25). *Neonatal Abstinence Syndrome (NAS) in Connecticut* [PowerPoint slides]. Office of Injury and Violence Prevention.

DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health. (2020). *Trends in Substance Use in Connecticut and the Impacts of COVID-19.* https://portal.ct.gov/-/media/DMHAS/ADPC/Presentations/3-ADPC-SA-Trends-in-CT.pdf

Healthcare Cost and Utilization Project (HCUP). (2021, March). *Neonatal Abstinence Syndrome (NAS) Among Newborn Hospitalizations*. NAS Among Newborn Hospitalizations - HCUP Fast Stats. https://www.hcup-us.ahrq.gov/faststats/NASServlet?radio-2=on&location1=CT&characteristic1=01C11&location2=US&characteristic2=01C11&expansionInfoState=hide&dataTablesState=show&definitionsState=hide&exportState=hide.

National Center on Substance Abuse and Child Welfare (NCSACW). (2020). *Infants with Prenatal Substance Exposure and their Families: Five Points of Family Intervention.* https://ncsacw.samhsa.gov/files/five-points-family-intervention-infants-with-prenatal-substance-exposure-and-their-families.pdf

National Center on Substance Abuse and Child Welfare (NCSACW). (2019). *Special Topic: Understanding Prenatal Substance Exposure and Child Welfare Implications*. https://ncsacw.samhsa.gov/files/toolkitpackage/topic-prenatal/topic-prenatal-slides-508.pdf

National Institute on Drug Abuse (NIDA). (2021, April 5). *Is Marijuana Safe to Use While Pregnant or Breastfeeding?* National Institute on Drug Abuse. https://www.drugabuse.gov/publications/marijuana-safe-to-use-while-pregnant-or-breastfeeding.

Shukla, S. (2021, February 13). *Perinatal Drug Abuse And Neonatal Drug Withdrawal*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK519061/.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2020, September). *The National Survey on Drug Use and Health: 2019*. https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (DHHS, SAMHSA). (2020a, September). *2019 National Survey on Drug Use and Health: African Americans*. https://www.samhsa.gov/data/sites/default/files/reports/rpt31099/2019NSDUH-AA/AfricanAmerican%202019%20NSDUH.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (DHHS, SAMHSA). (2020b, September). *2019 National Survey on Drug Use and Health: American Indians and Alaska Natives (AI/ANs)*. https://www.samhsa.gov/data/sites/default/files/reports/rpt31098/2019NSDUH-AIAN/AIAN%202019%20NSDUH.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (DHHS, SAMHSA). (2020c, September). *2019 National Survey on Drug Use and Health: Asian/Native Hawaiians and Other Pacific Islanders (NHOPI)*. https://www.samhsa.gov/data/sites/default/files/reports/rpt31100/2019NSDUH-NHOPI/Asian_NHOPI.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (DHHS, SAMHSA). (2020d, September). *2019 National Survey on Drug Use and Health: Hispanics*. https://www.samhsa.gov/data/sites/default/files/reports/rpt31101/2019NSDUH-Hispanic/Hispanic%202019%20NSDUH.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (DHHS, SAMHSA). (2020e, September). *2019 National Survey on Drug Use and Health: Women*. https://www.samhsa.gov/data/sites/default/files/reports/rpt31102/2019NSDUH-Women/Women%202019%20NSDUH.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (DHHS, SAMHSA). (2020f, September). *2019 National Survey on Drug Use and Health: Lesbian, Gay, & Bisexual (LGB) Adults.* https://www.samhsa.gov/data/sites/default/files/reports/rpt31104/2019NSDUH-LGB/LGB%202019%20NSDUH.pdf

Wang, Q. Q., Kaelber, D. C., Xu, R., & Volkow, N. D. (2020, September 14). *COVID-19 risk and outcomes in patients with substance use disorders: analyses from electronic health records in the United States*. Nature News. https://www.nature.com/articles/s41380-020-00880-7.