Association of University Centers for Disabilities
Emerging Populations: Challenges for the Early Childhood System
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Remote CART Captioning

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[Captioner standing by]

>> THE MODERATOR: Hello. And welcome to the Emerging Populations: Challenges for the Early Childhood System. My name is Anna Costalas and I'm the manager here at AUCD. We like to thank everyone for joining us here today. Before we begin, I like to begin with a few logistical details and introduce the speaker. And after the speaker, there will be time for questions. The telephone lines will be muted throughout the call, however we'll unmute your phone at the end of the Q & A. You have to press # to be unmute to do ask your questions. If you're using a microphone on your computer, you can raise your hand by clicking the icon on the screen that looks like a person raising their hand. You can also submit questions at any point during the presentation via the chat box webinar county consul. And we'll combine the questions at the ended of webinar and dress them at the end. Please note we may not be able to address any questions and combine some questions. There will be a short question evaluation at the end of the seminar. This webinar will be recording and will be available on the AUCD library. And now I'm going to pass the microphone over to Mary Lou Beth who will introduce our speakers. Marybeth.

>> Thank, Anna. I want to welcome everybody here on behalf of AUCD-SIG in early childhood development and tell you how excited I am to hear about the information that Maureen Greer is going to be presenting over the next hour. Maureen has a long history in early intervention and she was a Bureau of Chief Development, bureau, forgive me if I said it wrong, in Indiana which included Part C. She was one of the founders of Part C system. She was the founder of the infant toddler coordinator and she's been there for 17 years. She has a long history in looking at the intersection of health and development.

And the intervention of children who have vulnerability for all kinds of reasons. And I know that this area that she's going to be sharing with you is very, very important and dear to her heart. Before I turn it over to her, may I also just ask you all to pay attention if you will to the AUCD conference in November.

We will be having a preconference day sponsored by the SIG as well as the Early intervention/ Early Childhood Special Interest Group to focus on cross-disciplinary competencies, and Maureen is one of the team member on AUCD and besides helping

me a lot on AUCD, she's a friend. So I look forward to learning from her and I turn it over to you, Maureen.

>> MAUREEN: Thanks, Marybeth. I'm so pleased to join you today.

As Marybeth says, this particular topic is a major focus of a lot of the work that I'm doing right now. I spend about half of my time on maternal child health issues as well as Part C or early childhood issues. So this is a sub that is near and dear to my heart. And I am spending, I know more than I ever thought I would need to know. And my goal today is to bring this issue to your awareness as well.

As we go through the slides, I'd like to think about couple of issues that we can dress in the question-and-answer session. I'd like you to think about what does this mean around professional development? How do we prepare our workforce to address the needs of these children and their families? What kinds of services will these children need and how will their development occur, not just initially, but as they become old enough to enter the school system and what kinds of services and supports will they need?

And then, finally, we never work with just the child, so we're working with families who have had substance abuse issues. What does that mean to both Part C and 619 programs? And what do we need to do to adjust to this new emerging population?

When we talk about neonatal abstinence syndrome, we're talking about a drug process right after birth when the substances that their mothers were ingesting during the pregnancy is cut off at the time of delivery.

And, so, you frequently hear, I don't know if there's any state or area in the country where you haven't been subjected to the newspaper headlines, and certainly the television headlines about the opioid epidemic. But most frequently, we see this neonatal abstinence syndrome or withdrawal where the mother has abused opioids and it can be seen in infancy exposed to a variety of drugs. We all know the impact of alcohol, potential impact of alcohol on the fetus.

It's a little bit less studied, because it's a more newer phenomena. But it's an issue that is with us and is increasing, and one where we need to begin to lesson what the possible effects are to us.

This occurs because mothers are dependent. The pregnant intent woman is dependent or addicted to opioids. And one thing to remember about this topic is that often, that pregnant women will have been prescribed those drugs and under the doctor's care at the same time and what we know about pregnancy, for many of these drugs, it would be worse to take the mother off of them during pregnancy than to leave her on. So we have the first condition.

And then we have mothers who require prescription opioid for another disease process that is in addition to the pregnancy and then, finally, we have mother who receive MAT, Medicaid Assisted Therapy to facilitate safe withdrawal from other drugs they may have been using. So switching to a methadone or Buprenorphine are drugs that will help the mother stay table at the time of her pregnancy and mitigate some of the impact on the newborn.

One of our major challenges is the amount of prescriptions per person that are prescribed legally by physicians. It could be dentist, it could be physicians. I live in Indiana. Indiana has some of the highest rate of prescription prescribed. And we look

at this as a collection of that. So if you find your own state, you can get a sense of how high or how low your prescription rate is.

We've moved to -- Indiana moved to put in as many as other states some large data systems where pharmacists enter the prescription and every time it's refilled, trying to in fact adjust that and monitor that. But we have people who are addicted who have become very skilled in physician shopping, dental shopping, and drugstore shopping. Even where they are on border states crossing over. So the prescription, the rate of prescription is a huge contributor to the issue that we're seeing with pregnant women.

Drug overdose rates are at high levels. If you see, again, look at your own state. And look at what that means. We're approaching all-time high nationally in some age categories. The number one cause of death in that particular age category. So a real issue across-the-board, whether you're in early childhood, early childhood special education, Earl childhood intervention or think of any age group where this has an impact. Whether it's on the child itself, or whether it's on the family unit.

If we look at just the changes from 2015 to 2016, you look at the differences one year to the next. We are seeing rapid changes in the overdose deaths, and we are looking at essentially a public health crisis related to drug use.

The opioid retain relievers and benzodiazepines is commonly prescribed in United States. If you've had any type of medical procedure or if you've had a tooth pulled, you have been most likely prescribed some type of pane reliever. And that can result in multiple adverse health outcomes for individuals taking that. But when you're pregnant, that is not only affecting you, but it's also affecting the fetus you are carrying. There's wide variation from one state to another. And many states are moving to monitoring the prescribing patterns of what is happening in their medical community.

There are drugstores and chains that are looking at how they monitor that from we'll only prescribe one per day for a maximum of seven days. If your prescription is longer than that, you have to go back and get another prescription. So we're trying to, UC states are trying to attack this problem in a variety of manners with a variety of strategies. But it is a real crisis across-the-board.

If you look at the prescribing rates per 100 persons. You look at the type of opioid. So you have opioid pain relievers, long-acting extended release. High-dose opioid and benzodiazepines and all the type of drugs that are being prescribed. If you look at the most current data I could find for maternal opioid use was 2009 data. One of our challenges is that a number of states are not accurately capturing the data around maternal opioid use. And, so, it becomes difficult to look at that on a per 1,000 birth basis. But you can see that the line is going from 2006 to 2009 is going straight up. I think 2010 was right at 6. And we know that 7 years later, our rates are much higher.

If we look at the prevalence of NAS, we see, again, a dramatic rise from 2000 to 2013. We are still trying to capture that data. Very few states are doing Universal screening of pregnant women as they come in to deliver. So all of these numbers are under reported. In addition, you can look at the number of babies who are exposed prenatally to substances even if they don't rise to the level of official NAS diagnosis and we now have codes, ICD-10 codes that look at both confirmed NAS diagnosis as well as prenatal exposure. So we're recognizing that it isn't just the diagnosis, the children with the diagnosis that we need to be concerned about, we really need to look at the full impact of exposure and what does that mean both for the baby as well as for the family?

If you look at this from the national institute on drug abuse, every 25 minutes, a baby is born suffering from opioid withdrawal. We know that this is a huge issue. If you look in info graph 8, if you look on the bottom left-hand corner, what the average stay in the hospital for a baby who has been exposed is 16.9 days without any type of drug exposure. Generally around two days. Look at the difference in the cost for a baby who's been exposed to some type of substance at, you know, $66,000 plus dollars compared to the average cost of normal or regular newborn at around $3500. And, so, again, not just the impact on the baby and the family, but the significant cost related to that, and the significant hospitalization.

So we're looking at, again, a major crisis. You see again a reflection of what we had talked about in the previous two slides, but the trajectory for both is going straight up despite many of our efforts to intervene.

When we looked at some of the research around the national cost of healthcare for infants diagnosed with NAS, remember, there's a lot of babies who are exposed to substances but never reach any diagnosis. But look at the escalation in the cost. And, so, this is just for babies with an initially NAS diagnosis. So $190 million in 2000. $720 million in 2009. If you use the same escalator of cost relative to the percentage of births, we're clearly over $1 billion in costs.

When we look at medical issues in the newborn, we're looking at low, generally stunted fetal growth. So low birth rate, low restrictions. The value of breath feeding, which we know is important in terms of better health outcomes as well as social-emotional bonding between mother and infant. We look at the issue of alcohol and tobacco. And what the benefits or negative impact is on breastfeeding, as well as street drugs transmitted through breast milk and methadone use. So we're really looking at two things, appropriate fetal growth that leads to outcome and social-emotional bonding with healthy outcomes. Both of those health indicators are impacted with substance use is involved.

One of the challenges that we have as a community is to know both what the short-term and long-term effects on the infant are. This is a chart that came out of a study published in the academy of pediatric journal. And it looks at 6 specific substances. So nicotine, alcohol, marijuana and there's no consensus. And we look at that from a short-term surrounding birth, and then we look at long-term effects.

If you look over at opiods you see no data, no data. Primarily because number of infants born affected by those substances have not been around long enough for us to have major studies that will allow us to really identify what happens around language and cognition and behavior. What happens when that infant is a 6-year-old or 7-year-old, or 8-year-old? And what is the impact on their ability to learn and function effectively academically? And we know behavior issues arising and affect the nicotine on the behavior. Strong effect of alcohol. And alcohol because of our research around fetal alcohol syndrome disorder, we know what that does frequently to infants who have been strongly affected by that.

We have less information around some of our newer drugs, opiates, some information on cocaine and nothing on meth. But we know the substances have some impact at the birth level. You can see on opiate withdrawal and growth and neurobehavior. And what we look at is not just what the effect is on the baby at that point, but if mother is going through withdrawal herself, think about what that means for

that social-emotional bonding that we know is important in that newborn area. We have a mother who is distracted, and a baby that's easily excitable. And the combination of those two creates some real problems for both intervention as well as treatment and support.

In the infant total coordination, we do an annual survey type points and between 2015 and 2017, we felt a stronger issue to track this on an annual basis and we'll continue to do so. As you look at this data, it tells us how the expansion of neonatal abstinence or perinatal substance use is on our system. So we have in 2015, 13 states identified they were addressing neonatal abstinence system. And in 2016, that grew to 20 states and in 2017, we asked a question different way. And we wanted to know states doing extensive around this, some efforts, or beginning to address. And you look at what that number is. Where at 40 states they have some type of involvement with neonatal abstinence syndrome. Some of the children in these states will meet the eligibility criteria under the medical diagnosis. In some states, these children may in fact, under eligibility risk category, but these children are coming in both from direct referrals from neonatal intensive care units as well as the increase in our cap to population and Kappa referrals. So we're seeing both the medical and as well as the social science end.

So what does this mean for Part C or early childhood special education or early care in education? What it means is that it's a new population that we haven't been serving in the past. We, as we talk about this, there's eligibility criteria that states have established. We look at that mother-baby dyad and what's the impact of the drug use on that mother-baby dyad? What happens with even the most supportive child welfare systems in terms of how do we keep the mother-baby dyad together if it's appropriate and safe? What are the family dynamics that occur? Because the mother and baby don't exist in a vacuum. How do we deal with the entire family and support that entire family? Particularly as we're looking at Part C in terms of a family service plan, working with the family in terms of implementation of any intervention for that baby. But, really, beginning to look at this is a new population that is not the traditional population that we have served in early intervention and early childhood. We've certainly had experience an fetal alcohol, but adding all of these drugs makes it a different ballgame for all of us.

What types of services need to be provided? One of the challenges and issues that we have is thinking that either Part C or 619 can do this all on their own. This becomes a real collective community effort to address the multiple needs that the families will have. So it can't be just addressing the child's specific needs, but really beginning to look at who are all the players, whether it's social services, whether it's home visiting, any of the kinds of support or services that the family may need in order for that mother and baby to stay together and for that baby to continue to move developmentally.

Provider training. What does that mean? I ask you to think a little bit about that around professional development. We've trained providers around all types of disabilities, but what have we trained them about medical issues and addiction issues? And what does that mean in terms of their interaction? Not only with each other, but with that baby and with that family?

So with a kinds of new types of training in addition to new partners do we need to bring in? But also, doing this very intentionally, recognizing the many challenges that

that family will have. Not that Part C or 619 needs to address all of them, but they need to be part of a team approach to jointly addressing the issues that the child and family have together.

And then, finally, system capacity. As these numbers continue to rise, what is the impact on our overall system? What does this mean in terms of the numbers of children that will need to be referred, evaluated, eligibility determined, and service provision identified? What does that mean in a time when in most states Part C resources are stretched? How do we build a workforce that has the capacity to meet, not just the needs of the family, but volume of children that will be referred?

So we have some huge issues to begin to address as a community. We have increasing referral of numbers. We need to understand the impact of drug exposure on infant development both assessment as well as the intervention. We need to understand the needs of mothers experiencing addiction. A new mother is in the best place to be able to address her addiction issue, because almost uniquely, they care about their baby and they want to do the right thing by their baby. So it's a Window of opportunity for us to intervene to impact both the baby as well as the mother and impact that young child and its family to really help them change the trajectory for everyone.

Again, as I've said, we need to look at collaborating with other community partners. It would be inappropriate for us to think we can be all things to these families. And that, in fact, there are other community partners that may be more important to be involved that can focus on the mother's issues at the same time that you are addressing that baby or young child's issues. Our job is collectively to wrap those services around there and to really begin to see how we make better outcomes, help make better outcomes, or facilitate those outcome for that family.

If then long-term. What is the need for specialize service coordination that moves beyond what we've typically seen either in Part C or special education, but really beginning to look at how do we -- these are families that will need specialized services, so how do we capture them? How do we work together with them? How do we, again, make sure that this family has the best opportunity for being successful?

I'm going to stop now, because, really, I wanted to leave a significant portion of the hour for discussion and questions. To look at what's your experience in your state and your program? How are you addressing this issue? And how do we collectively begin to create whether it's a community of practice, a learning collaborative, but really learning from each other what works and how, in fact, we can collectively address the needs. So Anna, I'm going to turn this back to you.

>> ANNA: Sorry. Hi. I had my phone on mute. I realized the captioning isn't going. So I we understand ahead and opened the floor for those on the floor. You can press star and pound. You can raise your hand. When you raise your hand I will see it. And I will unmute your microphone. Or you can send the chat on the chat box box below on the slide and I can read them out. So we have plenty of options.

>> MAUREEN: Anna, I see a question in the chat box. I absolutely agree that early after delivery, the mother is prime to make changes around substance abuse. How might the timeline actually service the structural barrier here?

I think that it depends on your state and your local programs. There are states that are actively working within the hospital NICU. Neonatal intensive care unit to identify children prior to discharge. That can really look at linking into services as soon

as the baby is stable enough to do that. We have in many states now looking at what kind of specialty services can we bring to the mother and really working with your child's welfare service to see begin to, the Child Protective Services to see look at how do we get a team together to really address this? If the goal is to keep the mother and baby together, when it's safe, because we know it will be better for both of them, how can we work together to make that happen? I'll give you a little example in Indiana, we are working with the Indiana chapter, the Academy of Pediatrics who developed a care plan that were in addition to the Child Protective Services that can wrap services around by involving the medical home by looking at collectively not a Child Protective Services as an adversary, but an additional resource related to follow-up visiting care. Working with home visiting programs, again torque look at how do we do that? And it may be that your IFSP or your timelines start with a simple service, while whether we're going to have meetings with the mother to help her understand developmental milestones. We can begin to develop an IFSP that gets saved in, but still allows the Part C system to meet the timeline that are needed.

>> ANNA: Great. There's another question. Is there anything being done across states to share the system in regard to prescription drug monitoring programs? For example, if you live near a border and have access to more than one state system, but they don't talk to each other?

>> MAUREEN: It's a challenge. I am not aware of a cross state data system. I think we're ultimately, we like to see some type of national directory of prescriptions. I'm not sure the environment is correct for that right now with state Sovereignty. But I think that where states are specifically impacted, they are working together. For example, we learned Indiana learned a lot from West Virginia and they were ahead of this process and learned from them what worked and what were challenges and what kind of protocols did we need to establish? And I think much like the Part C and early childhood community, this is a community of people who are impacted by this who don't want to have every state reinvent the wheel and generosity across the states to share their learning, to share information, protocols that will keep other states from reinventing the wheel, or making the same mistakes or errors by learning from the other state's experience. So the generosity across states has been impressive. And I think will help us address when issues come up. How do we collectively solve them? Even if it's cross state border and we keep working in that direction.

>> ANNA: Great. Question. Who have been the main players within those agencies that found to be the most effective to be working with in your states?

>> MAUREEN: I have to tell you this is sort of a standing running dialogue with my assistant commissioner, in that, we put out a call. We establish a perinatal substance abuse task force and we put out a call for anybody interested. And we had 75 people show up and those 75 people to a larger extent are still involved two years later. The manage care, MediCare manage organization has been putting resource into this and have been big players. The medical direct of the MC is one of the Co-Chair of the task force and certainly, healthcare professionals are there. We have representatives from the Academy of Pediatrics, ACOG which is the pediatrician gynecology program and we have not, Indiana Rural Health Association, I think that once you ask, the response has been incredibly gratifying. People are willing to give their time and energy. We put out and we've been doing a pilot now in hospitals, we

started with four hospitals just to get a sense of the prevalence of substance exposure. Those four hospitals, we gave them no money and they did all of the protocols, and incurred the cost without, literally, once they were stable and had all the protocols identified, we can organize and we can reach out and maybe we'll get another 4 hours. We had 24 more hospitals volunteered to be part of the pilot process.

So we now have about 27 hospitals that are involved in various phases. 17 of them actively screening and testing core tissue for substance exposure. And the other 6 or 7 coming on by the ends of this year.

So, I think you would be gratified to reach out and do that.

Our Child Protective Services, and while their mission may be different than ours in that we're trying to keep -- we're trying to keep the mother-baby dyad together. And I think it would be incorrect to say they don't want that either. But they have an overall responsibility to protect the safety of that baby. But they have been outstanding in their local offices and working with our hospitals to work collectively together. So there's not an agency that we have asked to participate that has not been supportive.

>> ANNA: Great. Couple of more questions. When I started reaching out and asking for a training on how to work with these children within the first step system, I also want to know what things to look for and how it can be any source for the family and trial and across the family. We had DCE representatives come and represent and what are some of the other resources?

>> MAUREEN: I think, and certainly, your physician community, your both pediatrician as well as family doctors and obstetrician are a good source on this. My guess is you've got somebody whether it's Department of Health that is specifically addressing this. Many states have created special commissions or cabinet-level positions for what they call "drugs." And I think there's no shortage of information. I think the issue is how do you collect the information and identify on any single individual family? What the most appropriate services are?

I'm looking at the next comment around the Part C may not be the best provider for these services.

I would argue that they are an appropriate provider service. I think that we have to be careful about the training they have. I agree it's a parent-child issue. And I think infant mental health providers are excellent. As you know, Mark, there's few and far in between and they're growing and we like to see that. I think we just, OSEP funded social-emotional center which we hope will help move that issue forward. But the guidance or caution I would do, we want Part C involved, but we need Part C providers to understand their boundaries. And not assume, because they are a Part C provider, that they actually know everything and can address every issue for that child or that family.

But having them in the Part C system with appropriate support, recognizing that there will be a lot of other players involved with that family can be beneficial for continuity of care. And for coordination of services and resources that that child may need.

>> ANNA: Thanks. So how does trauma informed care fit into all of this?

>> MAUREEN: That's an interesting question. I'm certainly not an expert in that area. But I think that we depend very much on community mental health centers who have joined in our pilot project in Indiana and served and have prioritized pregnant

women and for treatment services. We've also looked at, we've established a number of residential facilities for pregnant women where they can also bring their children with them. And can return after delivery to provide that sort of safety cushion for them. But, again, who are you partnering with? And how are you doing ongoing support? We're actually sponsoring a conference here in Indiana on Thursday with three national speakers. Two of them are going to speak. There's actually six people coming. Two of them are coming to talk about how do you give take care of the caregivers which is important for the early childhood staff. We're bringing in Dr. Mathew Grossman from Yale who has a new method of treatment for babies instead of diagnosis, let's give them nurturing and support, certainly much more infant mental health approach to it than the traditional, let's watch the baby, and see how many times the babies Blink. Whether they have contraction and then give them a diagnosis.

And then our third speaker is Stephen Maxwell from Virginia that's led their efforts. So I think that's one of the pieces around professional development, you've got to be able to support the staff who are going to be involved with these children and their families and make sure they have accurate information and again, respect the boundaries of their own professional licensure and scope of influence. But ensuring they're partnering with the right people who can wrap those services around the child and family.

>> ANNA: Looks like someone is typing. So I'm going to give them a second.

>> MAUREEN: I guess while we're waiting for the typing to finish, the thing I would say is there's no quick fix to this. There is no magic formula. It is a lot of hard slugging work to both address the issue and try, you know, in many states, to contain or reduce the dependence on drugs. I'll tell you Indiana, just in our sample pilot areas, we're far exceeding the national sample around opiate and comparable in states are marijuana. and, so, it's a complicated issue which is why it takes a real cross-disciplinary, cross-agency team to be able to impact it.

>> ANNA: Thanks. Yes. We have a few more questions. Are children and families born with the natal abstinence syndrome are qualified to receive best practices in many states?

>> MAUREEN: In many states. Some states still look at it as a risk condition. Well, I believe the majority of states are viewing it as a medical diagnosis.

>> ANNA: And another question. Are we doing child in the methadone clinic with pregnant mothers?

>> MAUREEN: There is certainly outreach programs in those clinics. Obviously, it's readily identified population. We are doing that, not through Part C, but we're doing that through manage care, Medicaid manage program. Our community mental health.

So I don't know if this is good news, but we would say from a bad news standpoint, Indiana does not have sufficient medically-assisted treatment. So we do not have, and we are not expanding at this point in our methadone clinic capacity. But we are looking at typically around Buprenorphine, increasing the number of Buprenorphine providers that are available, and particularly in or pilot hospitals to see if we can get in earlier. But the mental health centers are really critical to identifying that population early. We also have high-risk OB nurses that are working with that population to get them the support and services that they need prior to delivery.

>> ANNA: Great. Are there any cases where prenatal care professionals will be brought in a way to increase prevention in this? Or is that beyond the scope of this particular issue?

>> MAUREEN: No, they have been very, very involved in this. We've developed a number of materials for the OB/GYN family docs that are providing prenatal care and we've provided education both in English and Spanish for women who are pregnant and are known substance users as well as women who are pregnant and we have no information on their substance use. So we've developed a lot of that. And, again, these high-risk OB nurses can work with the individual practices. But the OB/GYNs are critical, because what you want to happen is that screening in many of our pilot hospitals, screening takes place as the first prenatal visit. And they're screening not only for drug use, but they're screening for depression as well as domestic violence which we know are comorbidity with drug use. So all those impact the family and have the potential obviously to impact the newborn. So we're very active at the OB/GYN prenatally to address this issue and our goal would be to get the women in a treatment plan as soon as possible so that we improve the odds that the baby will be born in a more stable and appropriate health and developmental condition.

>> ANNA: Okay. Craig Jones suggest contacting the local state or state department to find out who provides substance abuse prevention in your area. And it could be a training for best practices for families and, et cetera, depending on your area of their expertise.

>> MAUREEN: That's excellent and you know, two of the logical places are your maternal child health department within your state Department of Health. If you live in a very urban area, usually your county or parish will have a health development and have a fairly strong maternal health program. But the other place is your department. In Indiana we call it the Department of Mental Health and Addictions. But you'll have some type of state agency that is responsible for that area as well.

And there is significant funding. SAMHSA has the federal level has put out a lot of funding to address this substance use in pregnant women. So whether it's training, or resources, those are two logical state agency that is you could look at.

>> ANNA: Another question from Toby highway is this drug used from the 80s and 90s and given training for parent-child relationships. Did they see programs stop attending to directing [Indiscernible] for epidemic subsided?

>> MAUREEN: I won't say it for sure, because I haven't checked with every state, but I think it's fair to say that there was a lull in that.

I think what the city is about, the newest, there's couple of reasons. The newest epidemic. First of all, the fact that it's prescription drugs and the fact that you can legally get these, and there was less of an issue around that these were street drugs, and that that changed the dynamics of it. And we also know, the other challenge was that as states are sort of cracking down on the prescribing rates that's pushing people out to more street drugs, which as many of you know, are not and can be cut with all kinds of substances. And, so, we're seen much more impactful reactions to that.

So, again, why we're seeing so many overdose deaths, I think that Part C systems did not focus on that. We're certainly aware of alcohol and have paid attention to that. I don't think there's any state that doesn't include fetal alcohol syndrome as part of their eligibility criteria. But I think there was less incidents of drugs. And I think the

other challenge that we're seeing in this particular epidemic is that it is not -- it is not isolated to any socioeconomic educational racial or ethnic population. It is unfortunately, an equal opportunity set of drugs that whether you're the highly educated woman in suburbia, or you're the inner-city poor woman with minimal education.

It does not seem to be a respecter of any of that. And part of our challenge has been that people have become comfortable saying it doesn't, my population isn't affected by that. When, in fact,, if we were doing Universal screening of every newborn, we would find that it's a problem Universally. And that's why what scares us about the numbers that we do know, it's very under reported. It's very under reported. So if you think the rate is 6 or 7 or 8, it's probably at a minimum of 50% higher if not 100% higher.

>> ANNA: Can you explain more about how screening positive for domestic violence and substance abuse is not been linked to trauma informed care and infant mental health resources? If those avenues are not who these families are linked to, who are you referring these families to?

>> MAUREEN: If I misstated that, they are referred to all of those. So it is very much an infant mental health issue. It's very much domestic violence, substance use, all of that. So when I may be defining trauma informed care. When I look at trauma informed care, I'm thinking of bringing a whole cadre of resources for the pregnant women or mother. And all of which include substance abuse programs and include domestic violence program, include infant mental health resources. I think the challenge that we all need to acknowledge is those resources are not available in every community. And what is available in an urban, or suburban area is very different from the resources that are available in more rural parts of our state.

And the bottom line is there are insufficient resources at this point to meet the demand that this epidemic has created. Hopefully that explains that better.

>> ANNA: We still have time for a question or two. Let's give everybody a second

>> MAUREEN: I would just say, the screening tool that we are using here is the 5P tool. We started out with 4Ps. But that, only screened only for substance use and we decided because of co-morbidities that we wanted to screen more broadly. So we moved to the 5P tool, which in addition to being an evidence-based tool and tested is free. Which was a critical issue when we were not supporting much of the activity finally that was occurring in these hospitals. But screens for both domestic violence as well as the substance abuse and depression.

>> ANNA: Well, it looks like we don't have any questions. I will let you guys off a few minutes early to enjoy the rest of your day. I like to thank Maureen for an awesome presentation. Thank you, all, for attending the webinar. This webinar has been recorded and will be archived in the webinar library at AUCD.org. If you would like anymore information about the EIEC, contact us and the information is up on the screen. And before we close out, a short survey will pop up on your screen. Please take a few minutes to complete it. Thanks again, everyone, and have a great rest of your day!