From Wikipedia, the free encyclopedia

A **Certified Peer Support Specialist** also known as a **Certified Peer Specialist** is a person with significant life-altering experience. This is also referred to as **lived experience**. These specialists support individuals with struggles pertaining to mental health, psychological trauma or substance use. Because of their lived experience, such persons have expertise that professional training cannot replicate.[1] This is not to be confused with peer educators who may not consider recovery a suitable goal for everyone and may focus instead on the principles of *harm reduction.*

There are many tasks performed by peer support specialists that may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, supporting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.[2]

As of September 2012, 36 states had established programs that train and certify individuals with lived experience who have initiated their recovery and are willing to support others in their recovery process.[3]

Peer support specialist

A **Peer Support Specialist** is a person with significant life altering experience who works to assist individuals with chemical dependency, mental disorder or domestic abuse and other life effecting issues. Because of their life experience, such persons have expertise that professional training cannot replicate

GENERAL JOB DESCRIPTION A Peer Specialist is a person with a disability, who is responsible for assisting and empowering peer consumers by identifying a main concern, developing strength based independent living plans that includes a measurable goal and objectives, and carrying out the independent living plans with the peer consumers. A Peer

Specialist helps fellow peers cultivate their independence, self-confidence, and self-esteem. A Peer Specialist empowers other people with disabilities to explore new options, resources, relationships, feelings, attitudes, and rights. A Peer Specialist is a mentor, companion, educator, advocate and friend to consumers

Training and certification[edit]

When peer support specialists work in publicly funded services, the peer support specialists are required to meet government and state certification requirements. Since the adaptation of the Recovery Management Model by state and federal agencies, peer support specialist courses have been offered by numerous state, nonprofit and for-profit entities

Core Components of the Curriculum for Kentucky Family Leadership Academy (15 hours) (note prerequisite for both potential Family and Youth Peer Support Specialists)

Leadership roles

Communication skills

Decision-making skills

Dealing with conflict

Effective advocacy

Collaboration and partnerships

Core Components of the Curriculum for Family Peer Support Specialists (30 hours)

Problem solving

Wellness recovery action plan

Stages in the recovery process

Effective listening skills

Establishing recovery goals

Using support groups to promote and sustain recovery

Core Components of the Curriculum for Youth Peer Support Specialists (30 hours)

System of care philosophy

Wraparound process

Youth support

Group process

Cultural and linguistic competence

Communication

Organization

Self-care

Leadership

Ethics and values

Kentucky Family Peer Support Specialist Core Competency Training

Are you a parent leader? Are people always turning to you for advice about their child's disability? Being a Kentucky Family Peer Support Specialist is a highly skilled parent who is willing and able to provide support to other parents that are raising children with behavioral health challenges. This Core Competency Training is an intensive week-long process that assists you in strengthening and learning skills in: leadership, motivational interviewing, roles and responsibilities, wraparound process and a code of ethics.

This training is geared towards biological parents, adoptive parents or a relative caregiver with permanent legal custody who are raising, or have raised, a child with severe emotional disabilities and have been a client of at least one state funded service.

The five day training session is held Monday – Friday, typically in the Spring. Hosted by KPFC, this training session is not cost. Participants must have successfully completed the KFLA and will be asked to submit an application to ensure readiness.

Support Specialist salaries in Kentucky

$13.08 per hour on the average.

14.0% higher than national average

$8. --$19.85

Family and Youth Peer Support is an important component of the Care Management Entity (CME) approach. These supports play an essential role in helping to build the the resilency of caregivers and youth and strenghthen the capacity of families to care for children at home. Family and youth peer support providers are integral to teams serving children and youth with behavioral health challenges and their families, and they are distinct from traditional mental health services providers in that they operate out of their personal experinces and knowledge.

So in closing think about how important Family and Youth Peer Support is for our Families. We would like to see more Family and Youth hired in Ky.

Regional Interagency Councils
Transition to Second Generation Functions

Promoting healthy children across Kentucky:
Building collaborative partnerships to promote children's social and emotional needs where they live, learn, and play

ACTIVITIES (since last report)

To date, CHES has made return visits to RIAC meetings in 8 of the 18 regions.

August 2016
Cumberland Valley RIAC

Creation of a RIAC policy and procedure template

September 2016
Bluegrass West
Bluegrass South
Lake Cumberland
Gateway
KY River (scheduled)

Followed up with LRCs having delinquent data reports
Met with new LRC for orientation to the second generation functions and strategic planning process
Working with DBHDID staff to plan the next LRC / RIAC Chair Peer Group Meeting

CHES SOLUTIONS GROUP

NOTED STRENGTHS

- Continued understanding and acceptance of second generation functions and their value
- Creative problem solving
- Continued solicitation of new members
- Increased collaboration with FAIR teams

NOTED CHALLENGES

- Feeling "stuck" with where to go next
- Identifying and executing specific actions to move their goals forward
- Lack of funding

NEEDS

- Continued support and empowerment to move forward
- Continued evaluation of and broadening of RIAC membership
- Increased investment and accountability of all members

SPECIFIC QUESTIONS/ISSUES REQUESTED TO BE BROUGHT TO SIAC

Bluegrass East: Reduced referrals to day treatment program (see letter to SIAC from Bluegrass East for details)

Bluegrass South: "Emergency placement" options have diminished and subsequently eliminates the option of a short term placement (one to five days) to allow a safe placement and separation during a crisis, a cooling off period for all involved and time for services to be put in place to resolve issues leading to crisis. This issue relates to both children living in their home and children residing in foster care. In some cases, the absence short term, emergency placement options has led to a more restrictive and lengthy placement in out of home care or irreversible foster home disruption and increased number of moves for committed kids.

The RIAC asks if some of the reinvestment money can go toward emergency shelter resources or if agreements could be made with the therapeutic foster care providers to designate a home or two for these types of situations.

While this issue is brought to SIAC by Bluegrass South, it is an issue having much discussion and dialogue among many of the RIAC teams throughout the state.

MOVING FORWARD: Planned CHES Activities

- Distribution of RIAC policy and procedure template
- Creating new member orientation handbook and presentation that is user friendly to those unfamiliar with RIAC and SIAC history, roles and functions
- Serving as point of contact between RIACs and SIAC
- Providing information / clarification to all RIACs when questions arise
- Planning next 3 LRC Peer Group Meetings
- Assisting with making connections
- Receiving updates from RIACs and in turn, updating SIAC
- Continued collaboration and communication with DBHDID and AOC/SIAC Chair
- Continued focus on mission in all activities and communication
- **ONGOING EMPHASIS ON MAINTAING FOCUS:** Promoting healthy children across Kentucky: Building collaborative partnerships to promote children's social and emotional needs where they live, learn, and play

Summary of RIAC Meetings: Building service array and access

Partnership between RIACs and FAIR Teams:
Through case reviews and service referrals, FAIR Team members are increasingly able to identify what services are used most frequently, what services are not offered locally, and the barriers that prevent families from accessing services. The RIACs are in a unique position to dramatically impact the ability of local FAIR teams to break down barriers and strategically target finite resources so they can fill service gaps, overcome barriers to receive services, and reduce any duplication of efforts. Through FAIR Teams sharing early data results, qualitative information about service barriers, recognized trends and indicators, RIACs can identify what services need to be revised, expanded, or developed in order to better meet the needs of the population of children in each community.

Over a six-month period from February 2016 through August 2016, the Executive Officer of the Department of Family and Juvenile Services at the Administrative Office of the Courts and current SIAC Chair Rachel Bingham met with each RIAC throughout the state to:

- Present data collected on FAIR Team cases and service access thus far, including state and local information;
- Illustrate service barriers identified by FAIR Teams in each region;
- Highlight what is working well to improve access;
- Solicit input from RIACs regarding any barriers;
- Take questions and recommendations for data collection or service access that will better assist the work of the RIAC;
- Develop a local plan for ongoing information sharing between the RIAC and FAIR Teams;
- Request assistance in coordinating training on an evidenced-based practice with justice-involved youth titled the Principles of Effective Intervention (PEI) and What works in Diversion to FAIR Teams;
- Encourage ongoing participation in SIAC standing committees and communication with the SIAC as RIACs need support in overcoming system barriers as they address local service gaps.

Summary of Meetings:
The RIACS around the state were notably engaged in the discussion about partnering with local FAIR Teams. As anticipated, RIAC members were experts on the local needs of their community, and were willing participants to problem-solve service gaps and barriers for children and families to access needed supports in the system of care.

Many RIACS took on a specific challenge that FAIR Teams and the Court Designated Worker Program face in providing appropriate, least-restrictive placements and service referrals for youth on diversion. For example:

- RIAC Region 1 (Four Rivers) is focusing on expanding services for at-risk youth. They have recently applied for and received a grant to open a drop-in center for youth, and are seeking

additional funding to develop a program for adolescents with mental health and substance use disorders. They have also decided to develop a directory on transportation options to various placements because transportation has been a barrier to receive services in the past.

- RIAC Region 2 (Pennyroyal) has been dissecting opportunities to reduce disproportionate minority contact in the juvenile justice system by identifying local resources that target and service minority youth. The RIAC is also promoting and participating in Implicit Bias training provided by Pastor Edward Palmer, Chair of Kentucky's Subcommittee on Equity and Justice for all Youth (SEJAY) of the Juvenile Justice Advisory Board (JJAB).
- RIAC Region 3 (River Valley) is researching and collecting data on present challenges faced by youth in their communities to prioritize efforts to identify solutions. Issues being dissected include substance use, truancy, and suicide prevalence.
- RIAC Region 4 (LifeSkills) has begun exploring possibilities for least restrictive alternative placements to detention and plans to meet with a local board to discuss crisis placements. In addition, the RIAC has identified potential agency resources to provide diversion workshop opportunities to build prosocial skills for youth on diversion.
- RIAC Region 5 (Communicare) is building their own knowledge on resources for youth available within their region to identify gaps in services that may need to be addressed in order for youth to be connected to those services.
- RIAC Region 6 (Seven Counties Rural) identified a local policy barrier that prevented law enforcement from transporting youth across county lines to potentially access an array of additional services, including options for alternative placements to detention. They are working to overcome that barrier by exploring policies and organizing meetings with law enforcement.
- RIAC Region 6 (Seven Counties - Jefferson) has focused on providing feedback and recommendations for modification to the CDW educational workbooks for youth on diversion in Jefferson County. In addition, the RIAC is working with the CDW office to identify solutions for youth to receive mental health assessments at the detention center outside of normal business hours.
- RIAC Region 7 (Northern Kentucky) is identifying the services most frequently utilized in the region, as well as gaps in service options and barriers for families to access services. The region is focusing on increasing participation of community partners in the RIAC to ensure broad perspective in developing solutions to service gaps and barriers identified, such as emergency shelters for youth, insurance limitations, lack of transportation, and lack of family-friendly hours of operation.
- RIAC Region 8 (Buffalo Trace) has focused on identifying appropriate placements for youth in crisis who have received a charge. They have identified Comprehend's Crisis Stabilization Unit to be used as an alternative to detention, including for appropriate youth who are charged with an Assault 4th Domestic Violence offense.
- RIAC Region 9 (Gateway) has committed to explore opportunities to provide alternative placement options for youth who may be experiencing a behavioral crisis but are not appropriate for juvenile detention. They created a specific subcommittee to work through the problem.
- RIAC Region 10 (FIVCO) is working to identify options for reserving beds for alternative placements to detention. They are working to identify potential placement locations, staff resources, funding sources, and referral processes.

- <u>RIAC Region 11 (Mountain)</u> is establishing break-out teams focused on a specific topic with a variety of disciplines represented on each team. The goal for each team is to determine what resources are needed to support the focus area and develop new contacts to bridge any gaps in communication among service providers.
- <u>RIAC Region 12 (KY River)</u> is working with the community on building positive supports for youth, including least restrictive placement options and local drop-in centers for youth. In addition, they are working to provide evidenced-based trainings to local service providers.
- <u>RIAC Region 13 (Cumberland River)</u> has focused on reviewing educational assignments utilized by CDWs with youth on diversion in order to provide feedback for improving the quality and effectiveness of the tools.
- <u>RIAC Region 14 (Adanta)</u> is identifying community resources to address service gaps in target areas identified by the RIAC and building understanding of services across providers. In addition, the RIAC has reviewed educational workbooks assigned to youth in diversion to identify areas of improvement and gain a better understanding of the CDWs' goals for educating youth on diversion.
- <u>RIAC Region 15 (East)</u> has chosen the topic of habitual truancy to dissect and problem-solve. They are collecting data related to truancy and are dissecting the complexities of children who experience chronic absenteeism.
- <u>RIAC Region 15 (West)</u> is developing a template for implementing a crisis procedure that that can be utilized by all agencies and adapted across regions. The template will outline placement options for youth from the least restrictive to the most restrictive to guide professionals in exhausting all options at lower levels of care.
- <u>RIAC Region 15 (South)</u> is dissecting approaches to the prevention of crises. The RIAC is focusing on building local service capacity for crisis prevention through interventions such as respite services and working more closely with Managed Care Organizations (MCOs).

Next Steps:
Local plans for ongoing partnership with the FAIR Teams will vary among RIACs. However, a representative from the CDW program sits on every RIAC and can be a point of contact if any additional information is needed from FAIR Teams or the CDW program. CDW Regional Supervisors will also continue to provide RIACs with FAIR Team data, service barriers identified through case processing, and any other need identified by each RIAC.

Many of the RIACS have also moved forward in scheduling Principles of Effective Intervention and What Works in Diversion trainings for FAIR Teams in their region. RIACs around the state will host and assist with the coordination and registration for these trainings.

RIACS providing opportunities for local service providers to be trained in evidenced-based practices is an extremely valuable resource for Kentucky communities, and may be an appropriate function of RIACS on an ongoing basis.

September 14, 2016

Dear SIAC Chair and Members,

This letter has been drafted to identify an area of need and to suggest a proposal for the SIAC to consider.

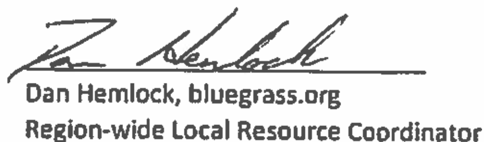
The RIAC representing Region 15E recently began a project in Fayette County to reduce truancy rates. During this process we identified an unintended consequence of SB200. As a result of the bill, there are decreased numbers of youth being sent to court which has reduced the number of referrals to the local Day Treatment Center since it requires a court order. As part of our attendance enhancement plan, the RIAC would like to request the support of the SIAC in examining the merits of broadening the referral scope for Day Treatment Centers. If the SIAC is in agreement, we would ask the SIAC's support amending the statute to expand the referral source to Day Treatment programs.

Currently, Kentucky statue (**505 KAR 1:080. Kentucky Educational Collaborative for State Agency Children**) limits potential at risk youth the opportunity to participate in a Day Treatment setting unless court ordered. In this current environment developing or expanding capacity of established programs and practices can assist to enhance the goal of SB200. To that end, by expanding the Day Treatment Center referral option to include referrals from the FAIR Teams it will provide an additional opportunity to address Habitual Truancy (the number one charge of youth referred to FAIR teams), as well as other academic and behavioral health needs before becoming court involved.

Our RIAC appreciates the SIAC's availability and willingness to look at barriers that effect families and youth at the local, regional and state level. Please feel free to contact us with questions, concerns or additional clarifications.

Sincerely

Rachelle Gardner, DCBS
RIAC Chair



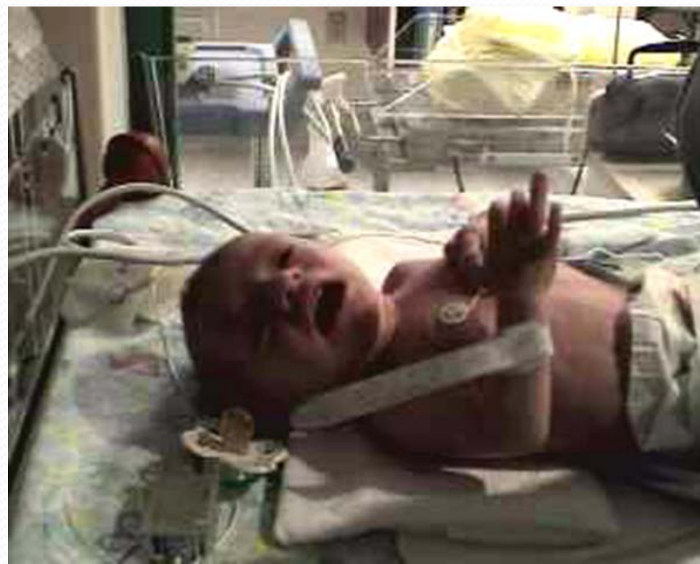
Dan Hemlock, bluegrass.org
Region-wide Local Resource Coordinator

Plan of Safe Care for Substance Exposed Infants

The Impact and Role of SIAC/RIACs

September 28, 2016

Frankfort, KY



U.S. lawmakers call for action to protect drug-exposed newborns

WASHINGTON | BY JOHN SHIFFMAN AND DUFF WILSON

Two senior U.S. senators are calling for swift federal action to help protect thousands of infants born each year to mothers who used opioids during pregnancy.

Senator Robert Casey of Pennsylvania, the top Democrat on the children and families subcommittee, is calling for oversight hearings, in part to understand why a longstanding federal law directing states to safeguard the newborns is not being enforced.

Another Democrat, Senator Charles Schumer of New York, wants the Obama Administration to put "an emergency surge" of funds from the new federal budget toward addressing the growing number of drug-dependent newborns.

The calls come after a Reuters investigation earlier this month identified 110 examples of babies and toddlers whose mothers used opioid drugs during their pregnancies and who die under preventable circumstances after being sent home from hospitals to families ill-equipp to keep them safe. Six women who accidentally killed their babies while on drugs said in interviews that they wished they had received more help from hospitals or social workers. A but one of the mothers were sentenced to prison time in the deaths.

Newborns die after being sent home with mothers struggling to kick drug addictions

- By Duff Wilson and John Shiffman Filed Dec. 7, 2015, 9 p.m. GMT

Part 1: In America, a baby is born dependent on opioids every 19 minutes. But doctors aren't alerting social services to thousands of these infants, many of whom come to harm in families shattered by narcotics.

"VERY SCARED": Tory Schlier accidentally suffocated her baby. At her sentencing, she said she had been "very scared to bring a helpless human being into the world." In a letter from prison, Schlier writes that she needed help. REUTERS/Handout

Child Abuse Prevention and Treatment Act (CAPTA)

Federal Law Requires Discharge Planning for SEI/NAS babies

The *Keeping Children and Families Safe Act of 2003* (P.L.108-36) that amended and reauthorized the **Child Abuse Prevention and Treatment Act (CAPTA)** included the following requirements regarding the identification and notification of infants affected by illegal drug use.

– health-care providers involved in the delivery or care of Infants affected by substance abuse must

(a) notify child protective services, and
(b) a plan of safe care is to be developed for these infants.

Child Abuse Prevention and Treatment Act (CAPTA)

It further requires that State Plans shall contain assurances that there is a state law or statewide program that includes:

- *(b)(2)(A)(ii) Policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants identified as being born with and* ***affected by*** *substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants*

Child Abuse Prevention and Treatment Act (CAPTA)

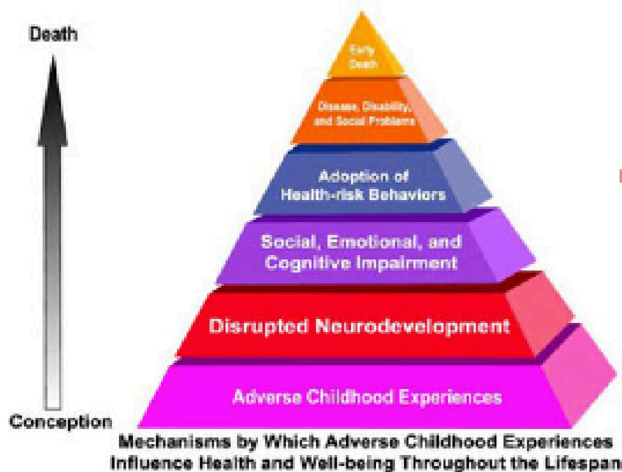
- The CAPTA requirements are intended to provide the needed services and supports for infants affected by prenatal drug exposure, their mothers with substance use disorders and their families to ensure a comprehensive response to the effects of prenatal exposure.
- Congress stated that these reports to CPS, on their own, are not grounds to substantiate child abuse or neglect.
- *The provision is meant to improve the likelihood of new mothers obtaining treatment for their substance use disorder* rather than pre-determine a substantiated case of child abuse and neglect.

Children Exposed to Parental/Caregiver Substance Abuse

- Newborns of a parent engaged in substance abuse may suffer from attachment difficulties that interfere with social-emotional development
- Children of parents with Substance use issues are more likely to experience trauma and its effects
- Children whose parents abuse alcohol and other drugs are 3X likelier to be physically or sexually assaulted and 4X likelier to be neglected
- Substance abuse causes or exacerbates 7 of 10 cases of child abuse and neglect
- Parental Substance abuse and addiction was the chief cause in at least 70 and up to 90% of child welfare cases
- Children and adolescents of parents with SUD may turn to substances themselves as coping mechanisms
- With environmental factors, children involved in the juvenile justice system had a lifetime prevalence rate of SUD of 62.1%
- Children with mental/emotional factors had a lifetime prevalence rate of 40.8% of SUD
- Substance abuse increases recidivism and reflects a deeper involvement in the juvenile justice system.

Substance abuse is a Symptom

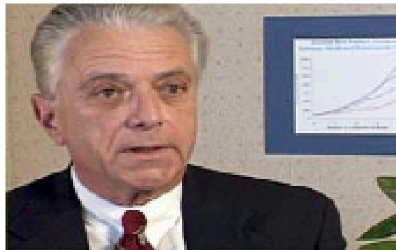
- Children and adolescents of parents with SUD may turn to substances themselves as coping mechanisms
- According to CDC researchers, At least 50% of substance abuse is directly attributable to Adverse Childhood Experiences
- 78% of IV substance abuse in women is attributable to Adverse Childhood Experiences
- Every additional Adverse Childhood Experience increases the risk for substance abuse by 200% to 400%



Adverse Childhood Experiences (ACE Study)

- Public/Private Partnership
- Started in 1985 – Ongoing
- 1995 CDC Partnership - Ongoing
- Largest of kind – 17,000

Changed Nation's Views on Children's Behavioral Health



Dr. Vincent J. Felitti, MD
Internist, Kaiser Permanente

Dr. Robert F. Anda MD (plus MS in Epidemiology)
Centers for Disease Control (CDC) & Prevention

The Adverse Childhood Experiences

When you were growing up, during your first 18 years of life, did you experience:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Domestic violence (mother treated violently)
- **Substance abuse in home**
- Mental illness in parent
- Lost parent due to separation or divorce
- Household member in jail

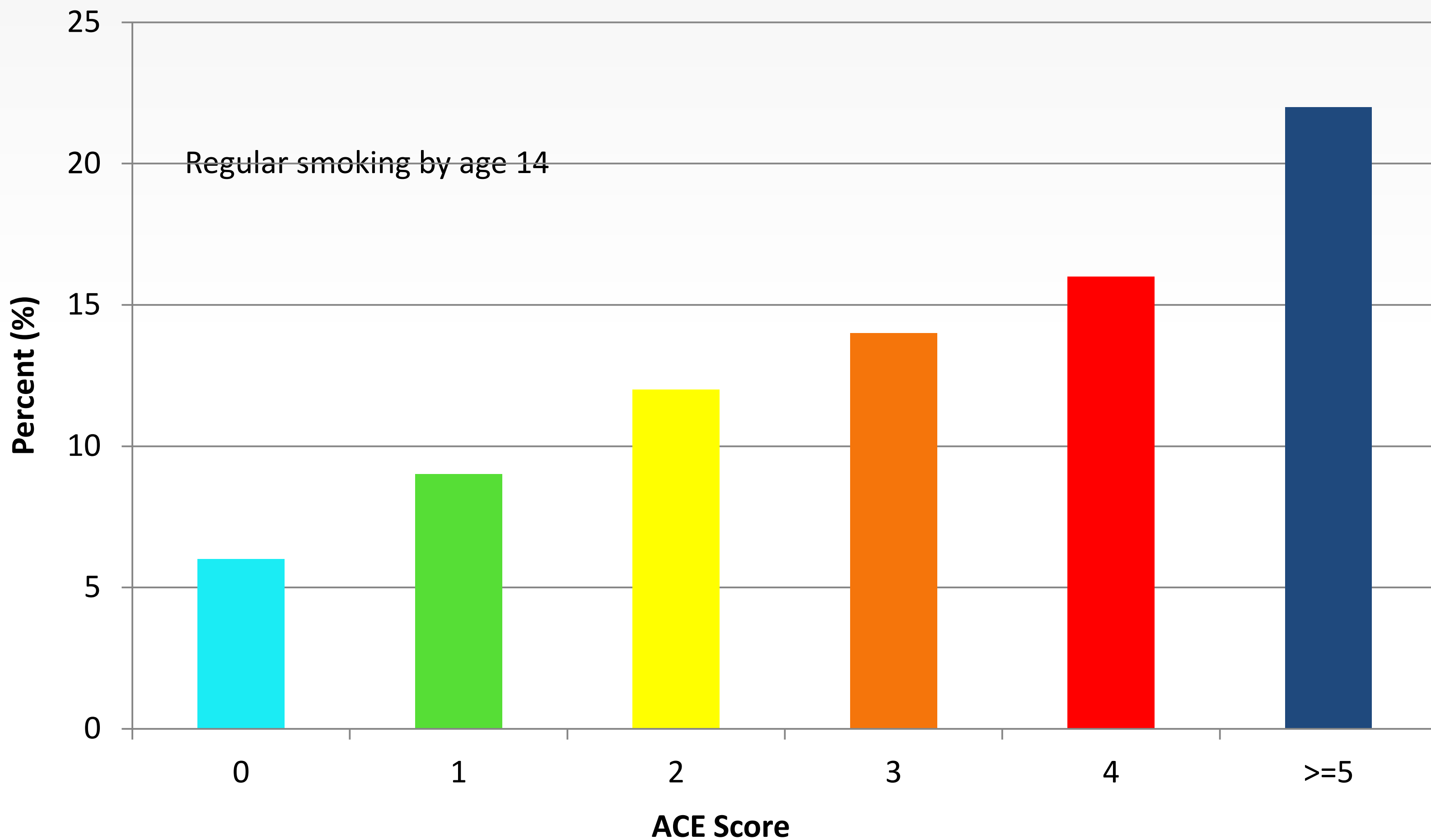
Did you live with anyone who was depressed, mentally ill, or suicidal?

Did you ever see your mother hit, slapped, kicked, punched, or beat up?

Did a parent or adult in the home ever swear at you, insult you, or put you down?

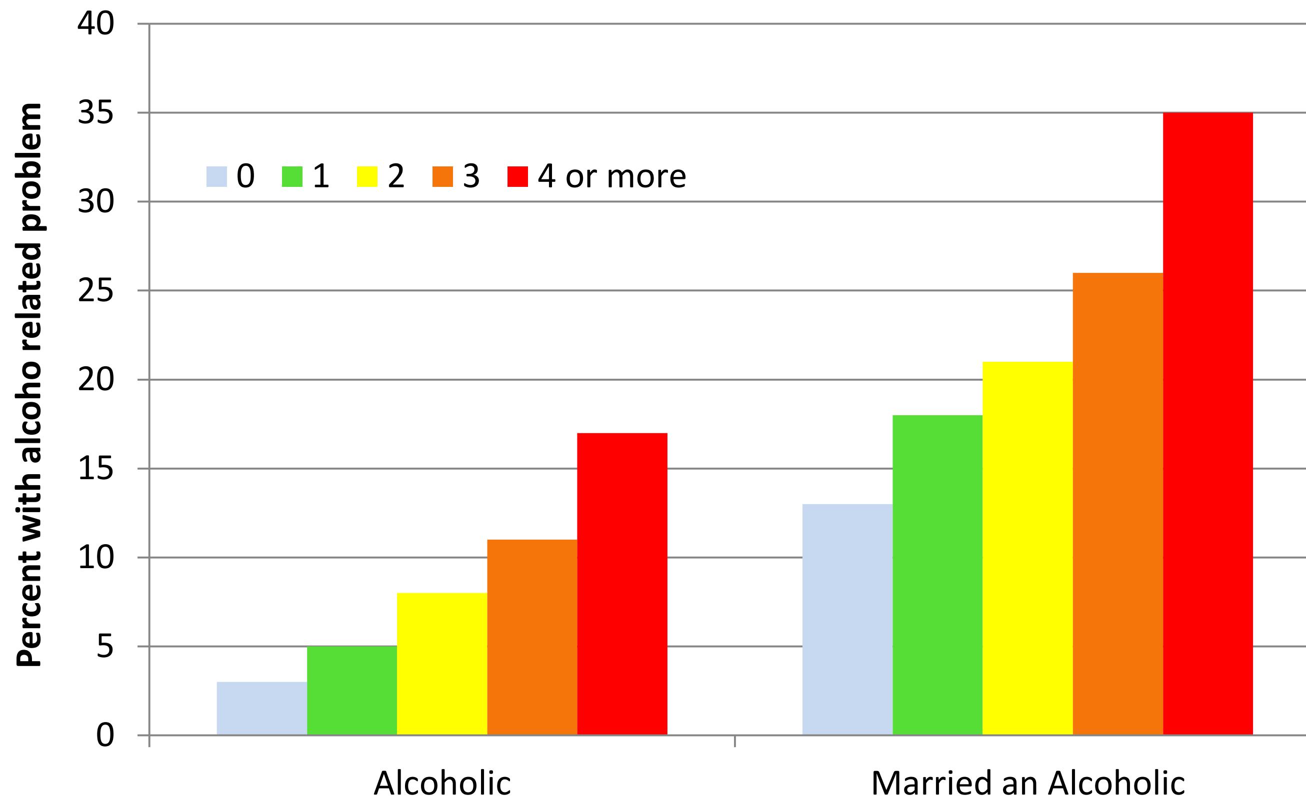
[never, once, more than once, don't know, refused to answer]

Relationship Between ACE Score and Early Initiation of Smoking Cigarettes



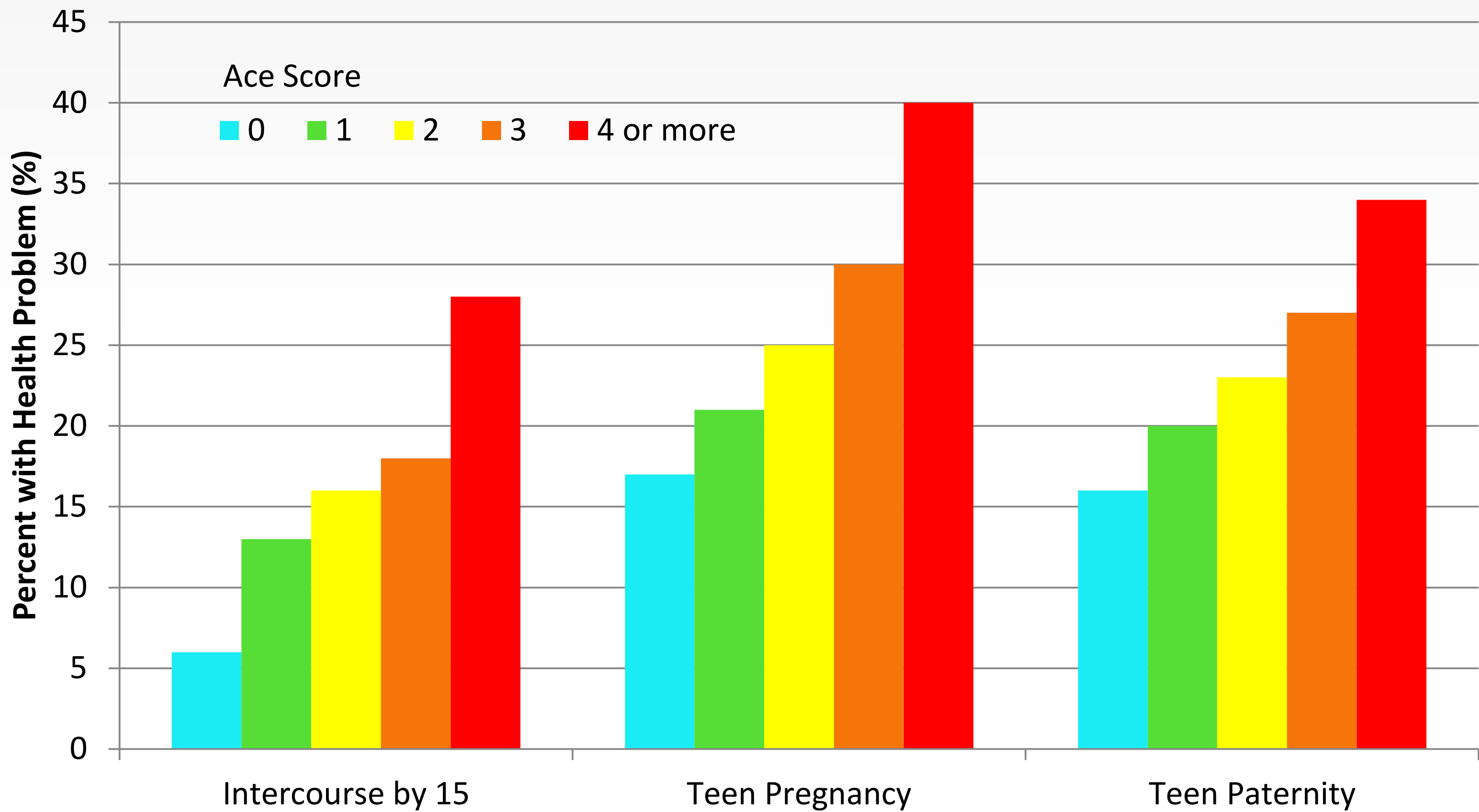
Anda et al., 1999, JAMA

The ACE Score
Alcohol Use and Abuse



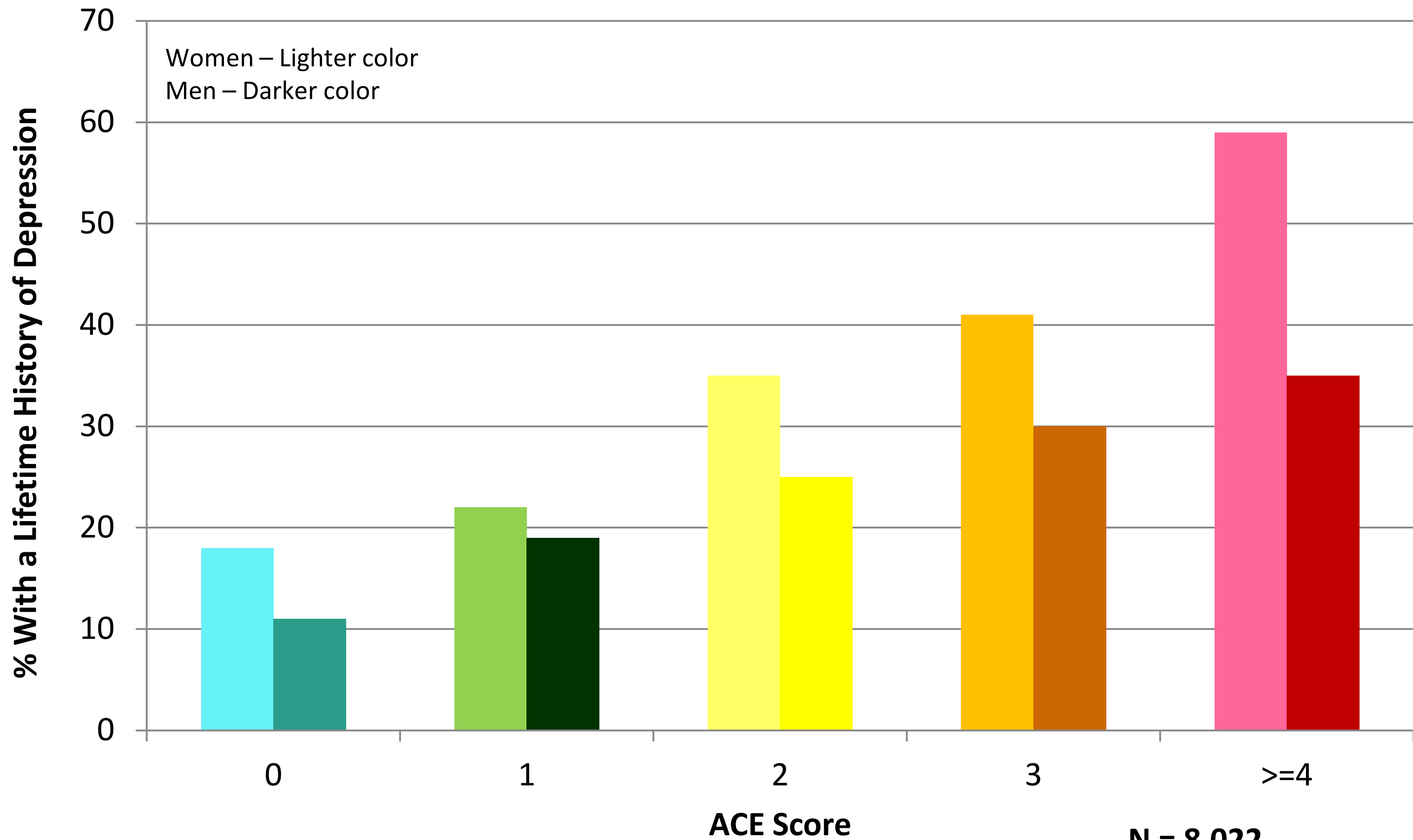
Dube SR et al, Adictive Behavior, 2002

ACE Score and Teen Sexual Behaviors



Hillis S et al, 2001

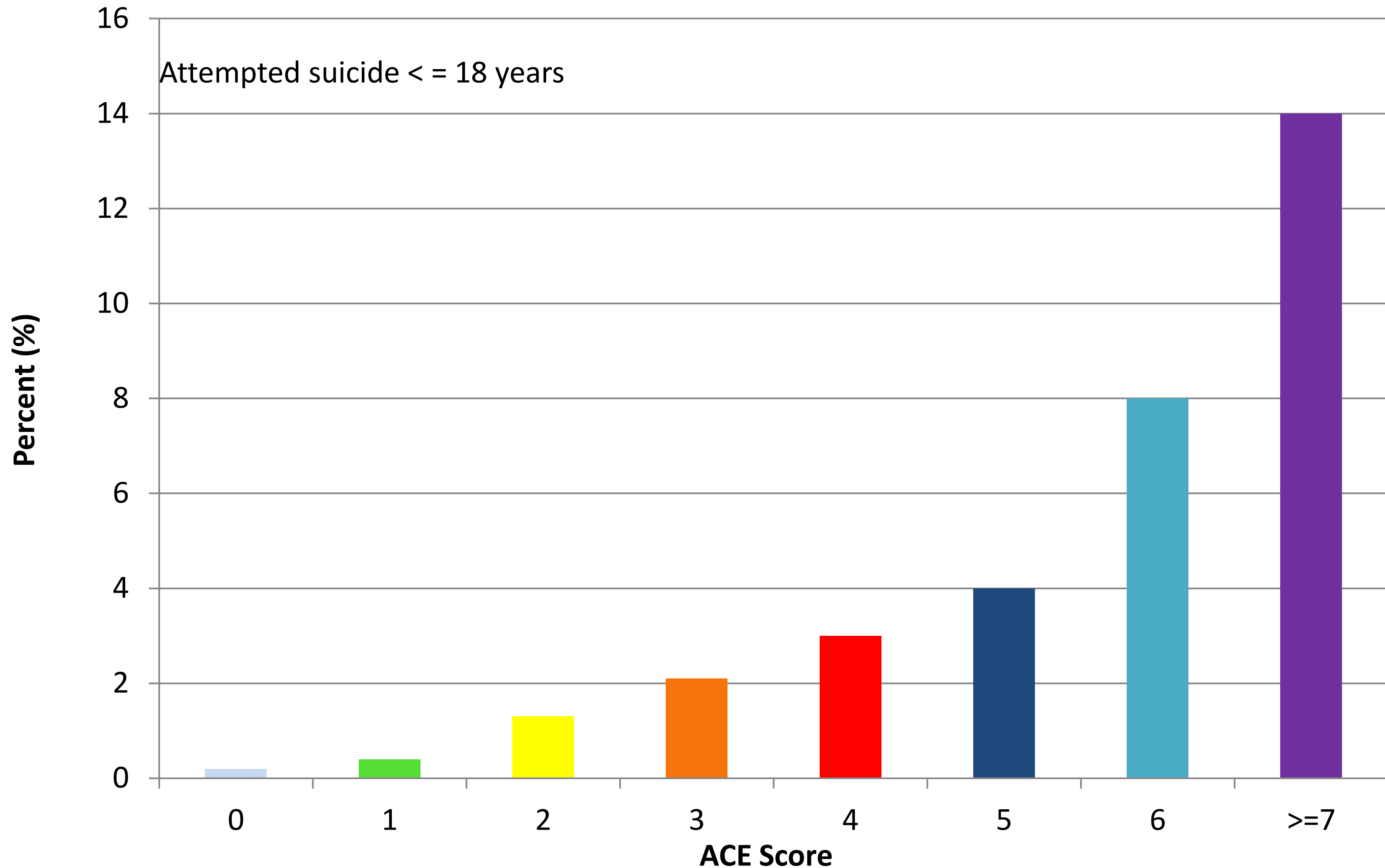
ACE Score and Chronic Depression as Adult



N = 8,022
p<0.001

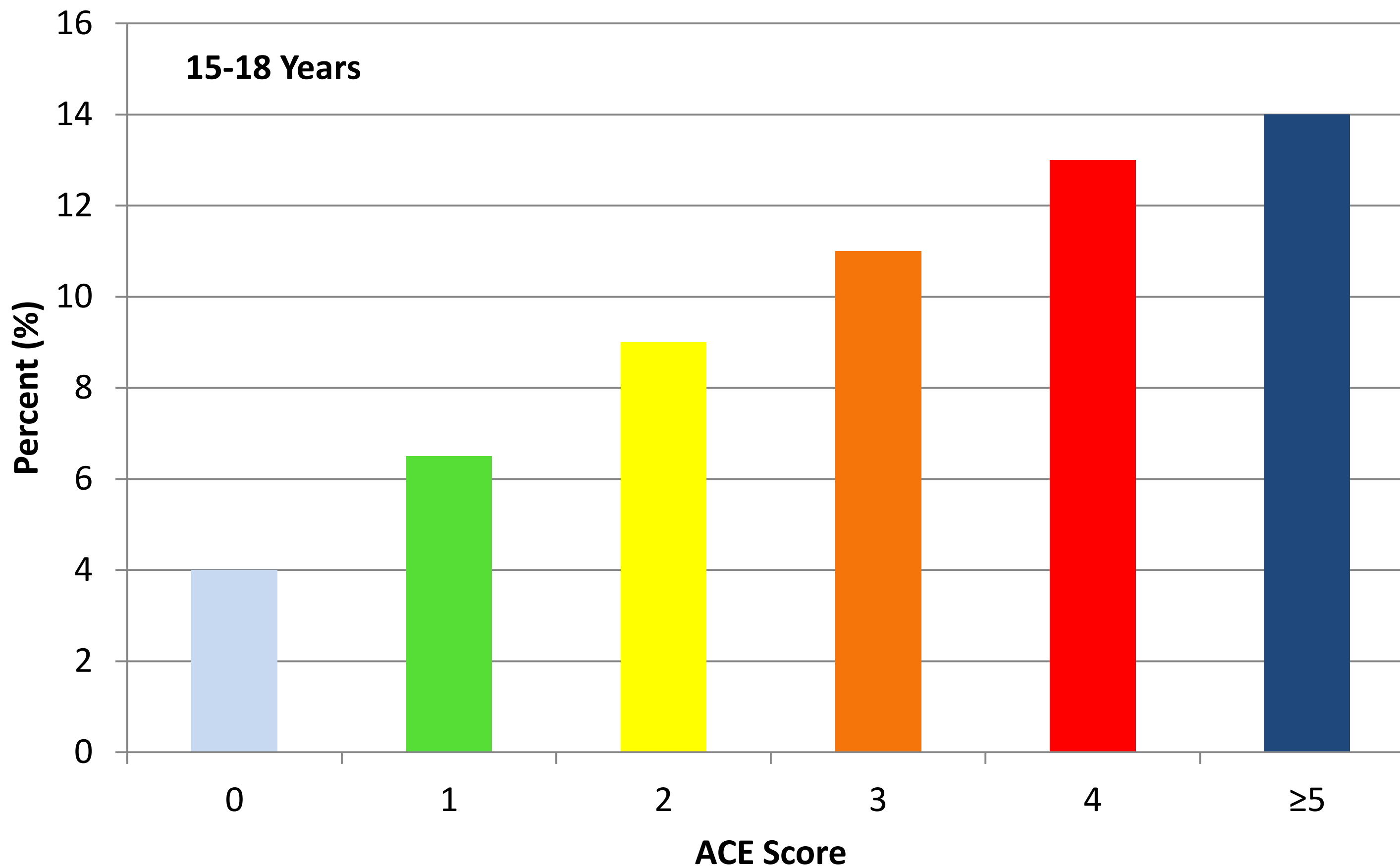
Dube, 2003, Pediatrics

Relationship Between the ACE Score and Attempting Suicide During Adolescence



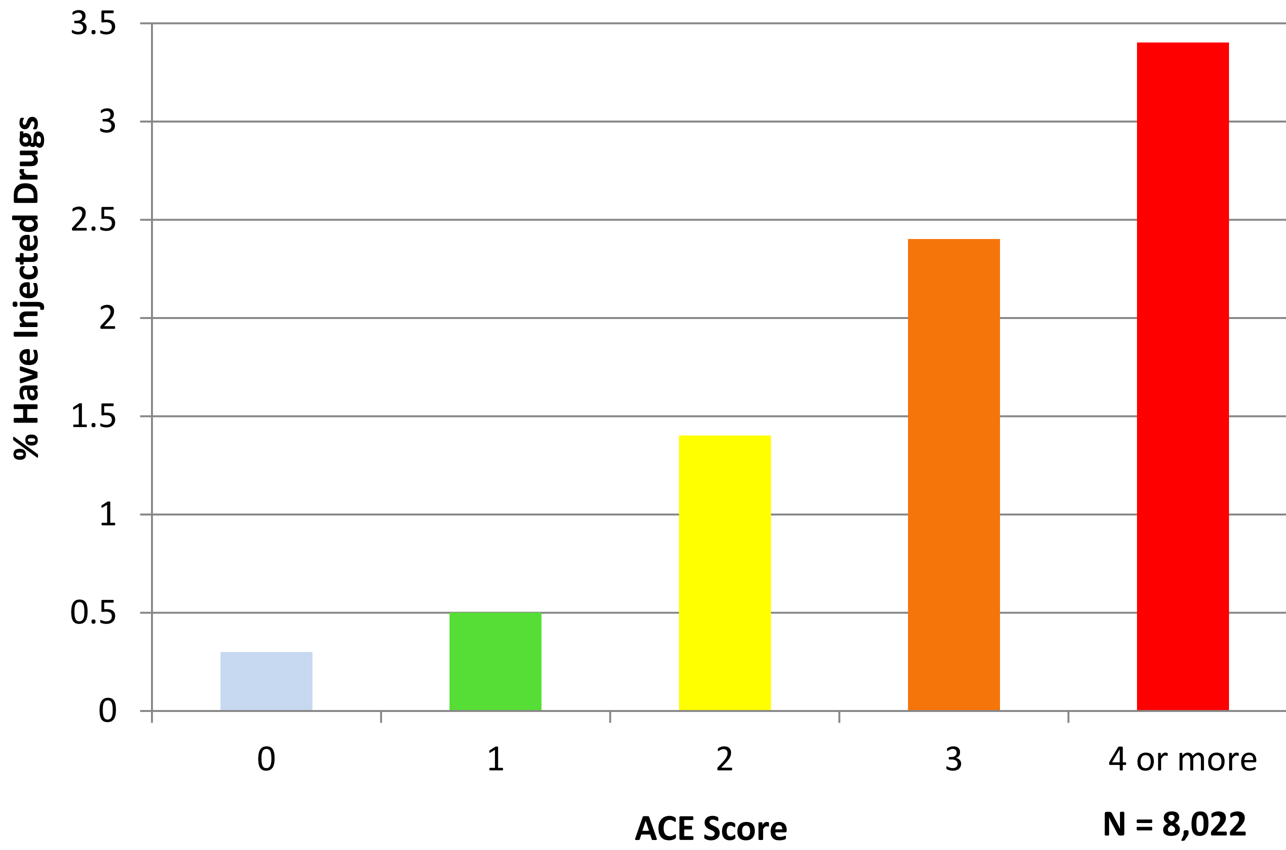
Dube et al., JAMA, 2001

Relationship Between Number of ACEs and the Age at Initiation of Illicit Drugs



Dube et al., 2003, Pediatrics

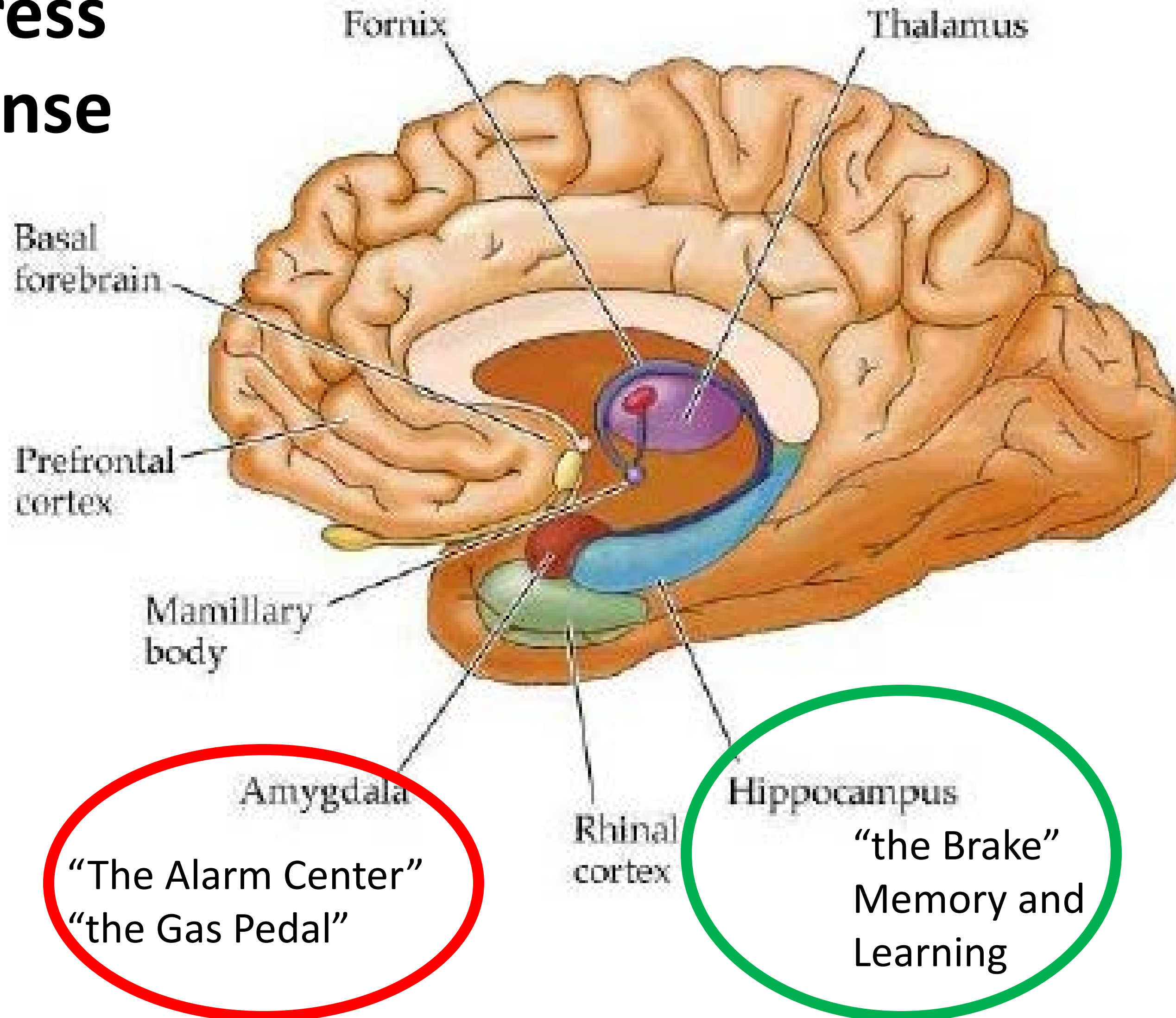
ACE Score and Intravenous Drug Use



N = 8,022
p<0.001

Dube, 2003, Pediatrics

Brain Centers for Stress Response



A Balance of Risk and Protective Factors

Secure Relationships

- Strong social-emotional pathways
- Cognition, problem solving
- Trusting relationships with caring adults
- Ability to explore their environment without fear; curiosity
- Tolerate disappointments
- Stay on task, persevere
- Able to form close friendships, networks of support

ATTACHMENT

HARDWIRING OF THE BRAIN for Social-emotional fxn

Poor Relationships

- Speech/Language delays
- Behavior problems
- Developmental delay/ Learning problems
- Poor coping & problem solving skills
- Alienation, Inability to form relationships
- Lack of trust, compassion, remorse
- Aggression, Violence, Anti-social behavior

Life Course Trajectory: A Balance of Risk and Protective Factors

Symptoms from toxic stress

Executive Function

- Ability to problem solve
- Self-control
- Self confidence
- Able to calm self
- Follows directions
- Persists on task
- Able to manage their tempers when provoked
- Able to delay gratification
- Able to plan

With a nurturing caregiver

"Amydgala Hijack"

- Impaired memory, esp. "working" and contextual memory
- Inability to concentrate
- Harder to follow directions
- Hard to sit still
- Constantly on edge
- Easily provoked
- Impulsive
- Lack self-control

Without a nurturing caregiver

Substance Exposed Infants/Neonatal Abstinence "Drug Endangered Children"

Emotional Problems:
- Attachment Disorders
- Anxiety
- Depression
- Complex emotions
- Lack of empathy

Behavioral Problems:
- Interpersonal Problems
- Inappropriate sexual behaviors
- Impulsive, low threshold for stimulation
- Eating disorders

Cognitive Problems
- Difficulty talking and listening
- Difficulty Paying Attention
- Difficulty Remembering
- Trouble reading
- Do not learn from mistakes or experiences
- Do not pick up on social cues

Moriarty L, 2014 National Conference on Drug Endangered Children

EXHIBIT 3

Prevalence Of Adverse Childhood Experiences (ACEs) Among Children Age 0–17, By Eleven Chil And Risk Factors, By Number Of ACEs, 2011–12

Category of children	Study population (%)	Prevalence of ACEs (%)		
		1 ACE	2 or more ACEs	
All	100.0	25.3	22.6	
In fair or poor overall health	3.2	31.8	39.3	
With special health care needs	19.8	25.9	36.0	
With special health care needs and EBD	7.2	23.7	51.9	
At high or moderate risk for developmental, behavioral, or social delays	26.2	26.9	18.8	
With asthma	8.8	27.3	33.4	4 X
With ADHD	7.9	24.8	45.2	6 X
With autism spectrum disorder	1.8	27.1	34.4	
Who are overweight or obese	31.3	25.5	37.1	
With a behavior problem	3.2	23.6	61.4	20X
Who bully[d]	2.2	23.0	55.4	25X

SOURCE Authors' analysis of data from the 2011–12 National Survey of Children's Health. **NOTES** AOR is race/ethnicity). EBD is emotional, behavioral, or developmental problems. ADHD is attention deficit h variation remains ($p < 0.05$), after adjustment for child-level characteristics across states using mult

Bethell, C, Newacheck, P, Hawes, E, Halfon, N. Adverse childhood experiences: assessing the impact on health and school engagement and the mitigating role of resilience. (2014) Health Affairs Dec; 33(12);210-2016

Odds for Academic and Health Problems with Increasing ACEs in Spokane Children

	Academic Failure	Severe Attendance Problems	Severe School Behavior Concerns	Frequent Reported Poor Health
Three or More ACEs N =248	**3X**	**5X**	**6X**	**4X**
Two ACEs N=213	**2.5X**	**2.5X**	**4X**	**2.5X**
One ACE N=476	1.5	2	2.5	2
No Known ACEs =1,164	1.0	1.0	1.0	1.0

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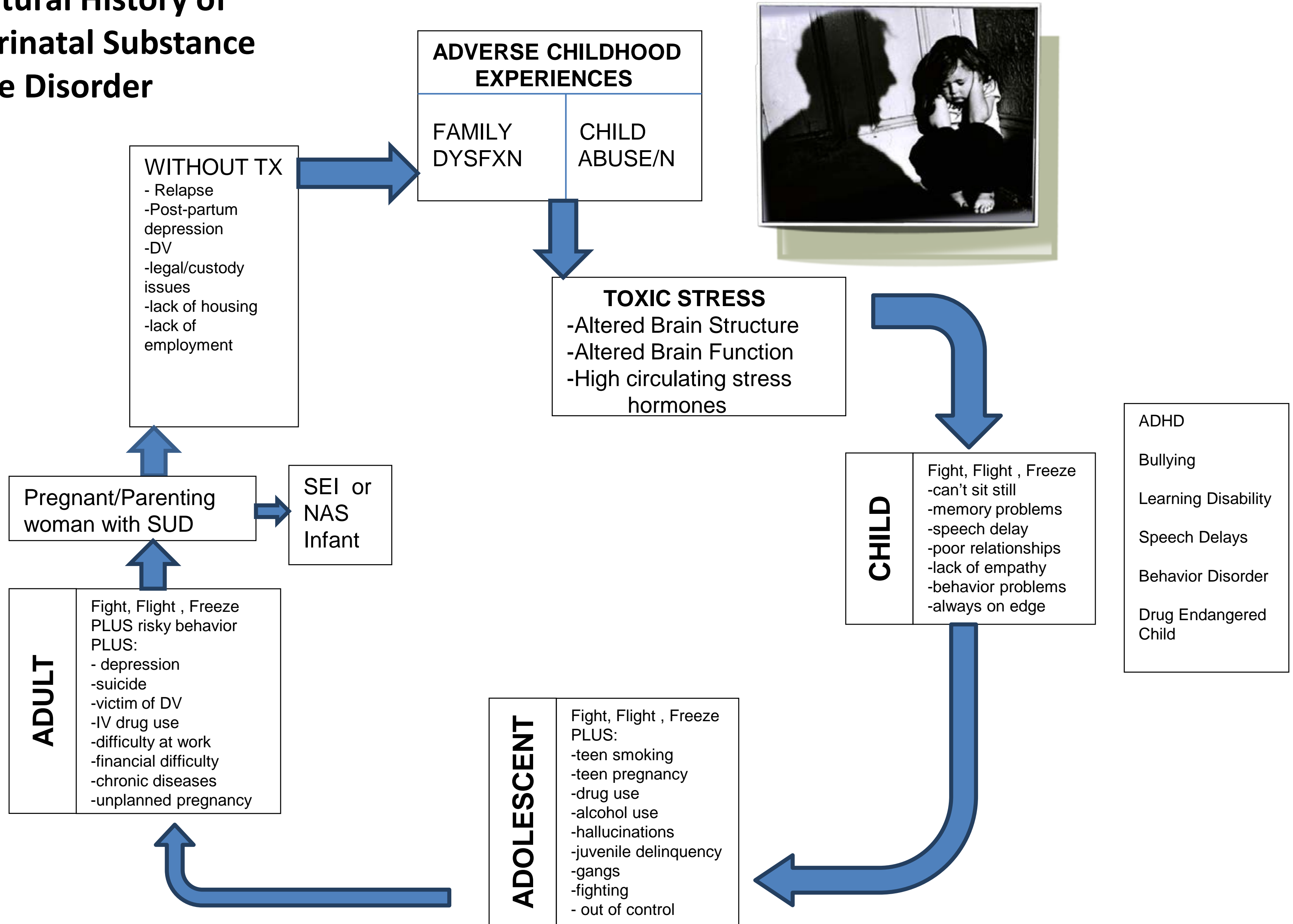
Natural History of Perinatal Substance Use Disorder



Source: Felitti VJ. 2003. The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study.

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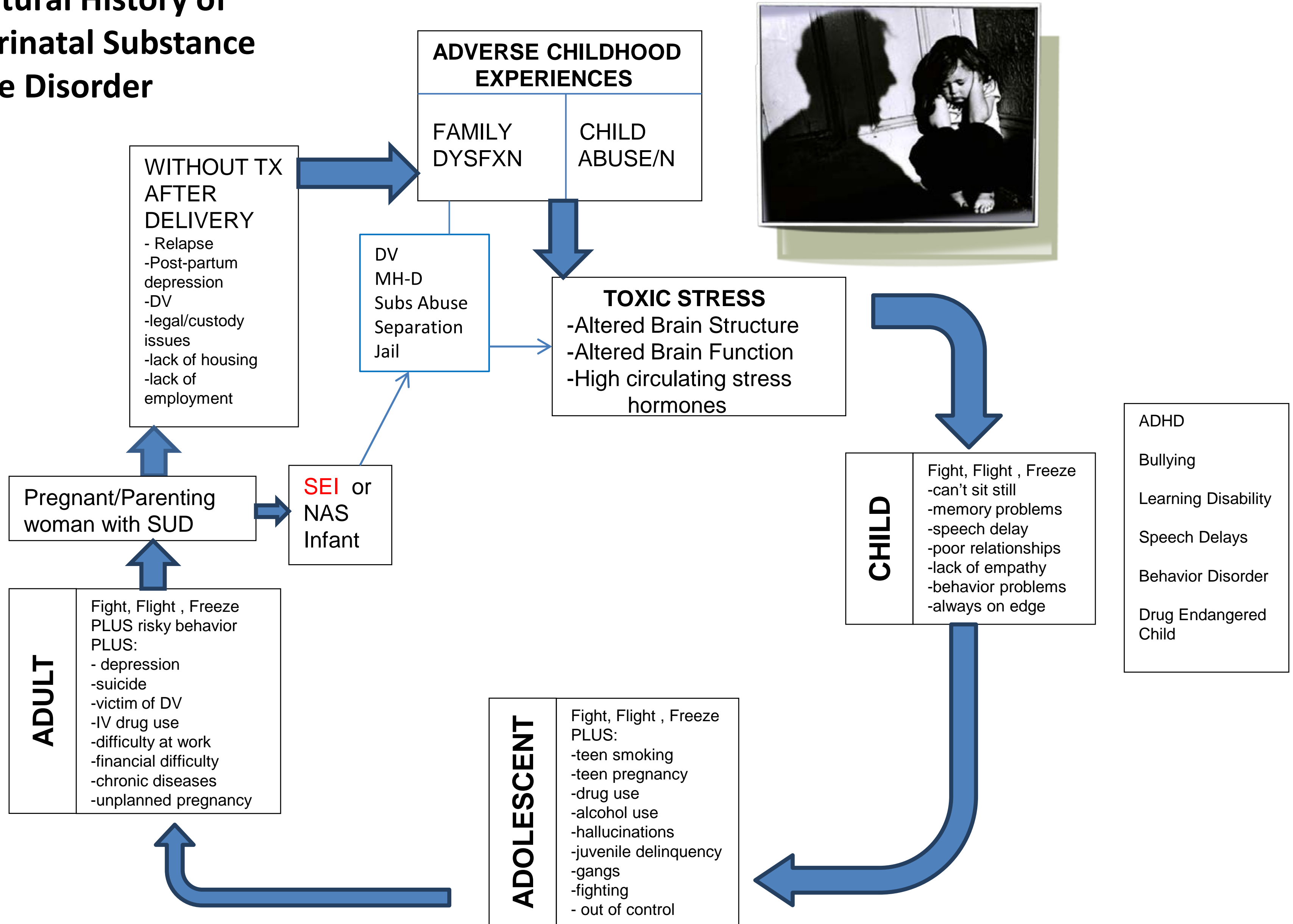

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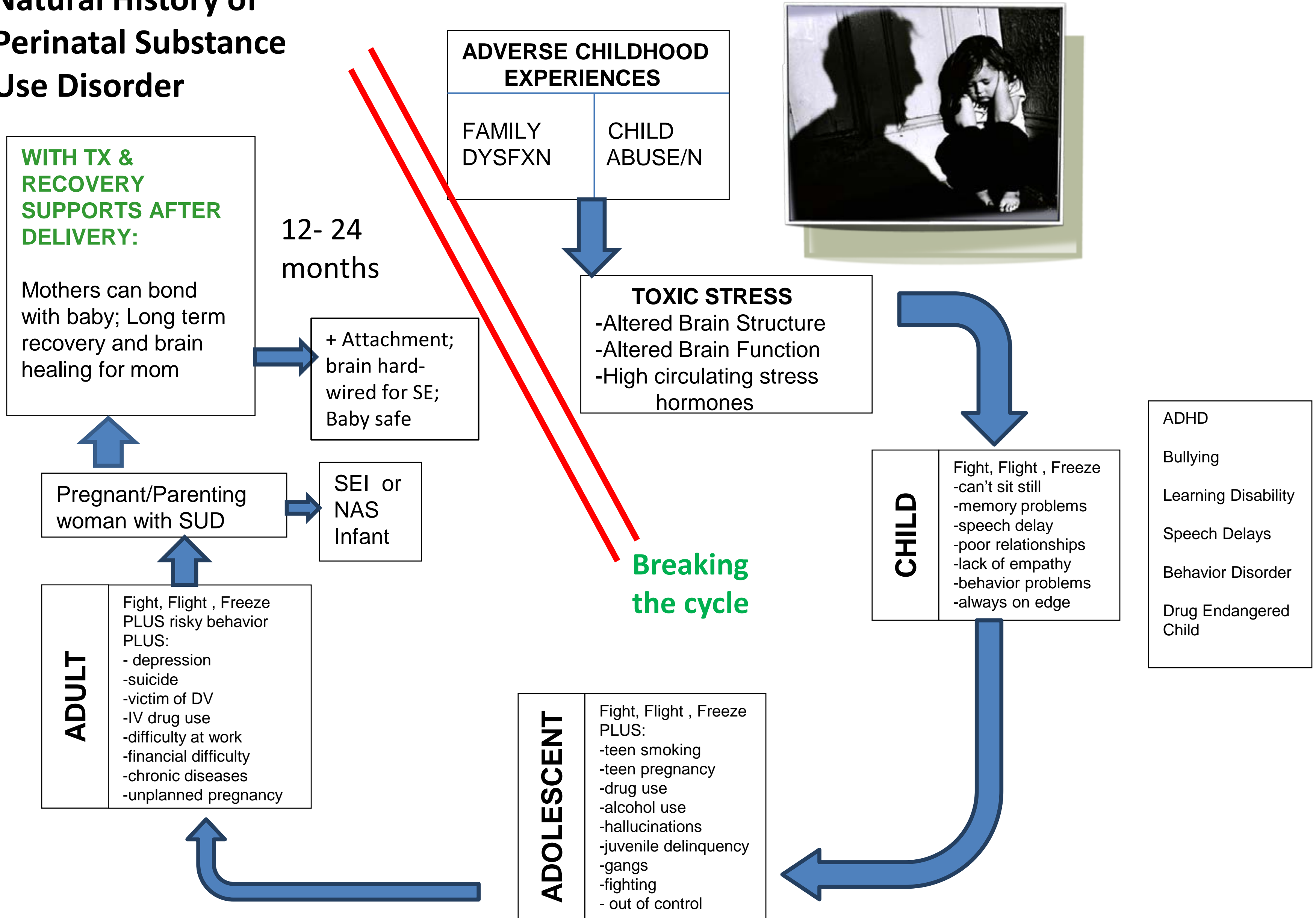

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PLAN OF SAFE CARE

Mother/Newborn identified with substance use disorder →
- Substance exposed infant
  Neonatal Abstinence Syndrome

Hospital Discharge/ Transition Plan

Behavioral Health Case Manager

Assurance of ongoing stabilization and support

Medical Home

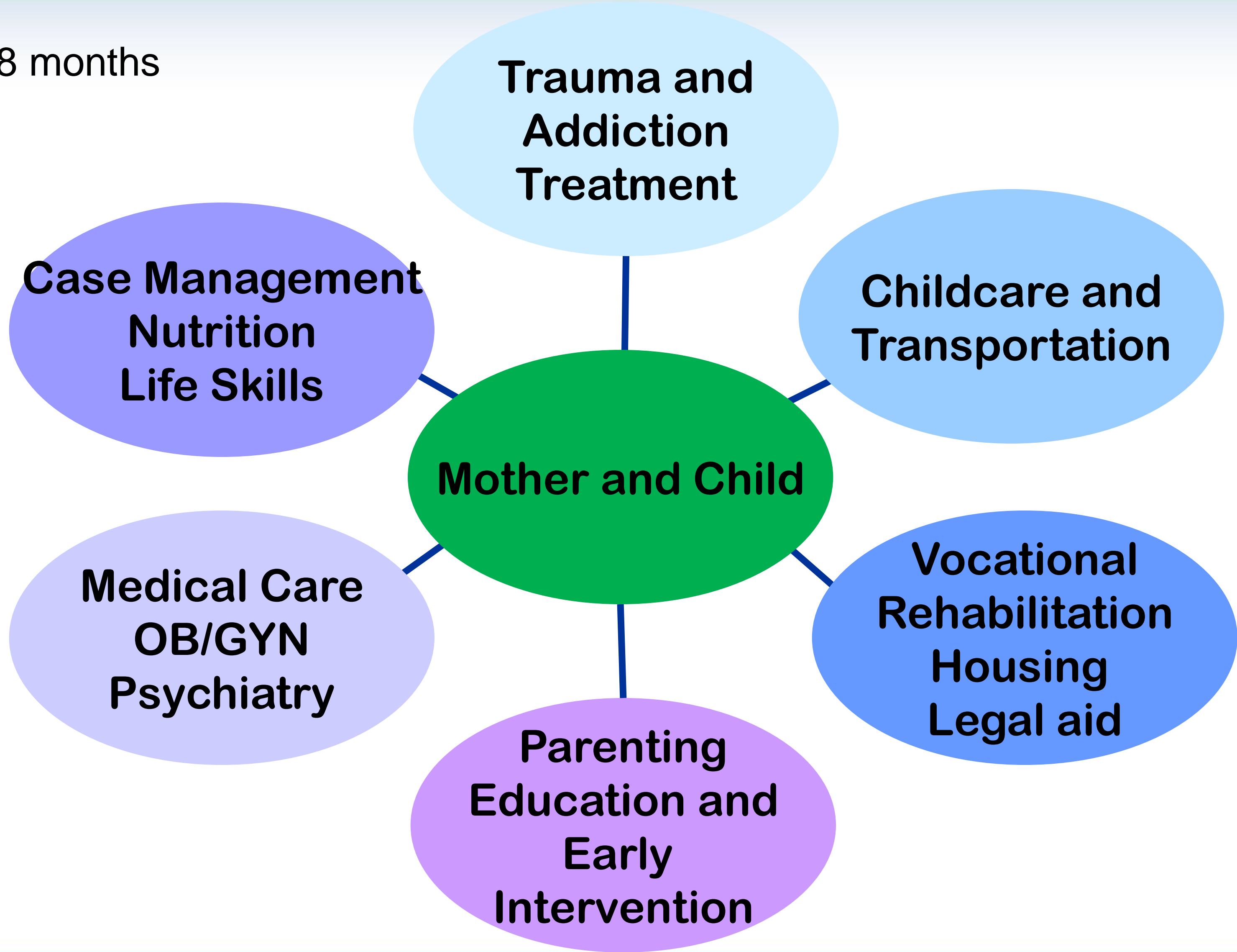
Community Services/ Resources

Transition to community treatment and supports

Child Protective Services

Immediate Safety

What works: Model Care for Women and Children



Slide from Dr. Hendree Jones, UNC Horizons Program

Plan of Safe Care System of Care

The **Plan of Safe Care** is intended to:

- ensure the safety and well-being of children;
- address the health, including mental health and substance use disorder treatment, needs of the child, and of the family or affected caregiver, involved; and
- determine whether and to what extent local entities are capable of providing referrals to and delivery of appropriate services for the child and family.

The **System of Care (SOC)*** is intended to:

- Help children with or at risk of behavioral health or other challenges and their families to function better at home, in school, in the community and throughout life
- Establish a spectrum of effective, community-based services and supports for children and youth with or at risk for behavioral health or other challenges and their families
- Organize services into a coordinated network
- Build meaningful partnerships with families and youth

An effective Plan of Safe Care requires a System of Care

In Kentucky, the SOC is governed by the State Interagency Council (SIAC). SIAC membership is comprised of the primary agencies that provide services and supports to children, youth, and young adults who have, or are at-risk of developing, behavioral health challenges, including mental health, substance use, and co-occurring mental health and substance use disorders. SIAC's mission:

"Promoting healthy children across Kentucky: Building a collaborative System of Care to promote children's social, emotional and behavioral well-being where they live, learn and play."

The **Core Values*** support all SOC efforts in being:

- Family-driven, person-centered
- Community-based
- Culturally- and Linguistically-appropriate
- Trauma-informed
- Recovery-oriented

A System of Care that supports newborns and children affected by parental substance abuse will promote better social-emotional, and behavioral well-being for all children in the community and move towards true prevention.

The **Guiding Principles*** of the SOC support children, youth, and families in having access to:

- A comprehensive array of effective, community-based services and supports
- A service planning process that is strength-based and individualized
- Evidence-informed and promising practices
- Services and supports that are delivered in the least restrictive, most normative environments possible
- Partnerships with families and youth
- Effective care management supports
- Developmentally appropriate services
- A continuum of behavioral health promotion, prevention, early identification, intervention, and recovery services and supports
- A system that supports provider accountability and quality improvement tracking
- Protection of their rights
- Services and supports that are provided without discrimination

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PLAN OF SAFE CARE

Mother/Newborn identified with substance use disorder →
Substance exposed infant
Neonatal Abstinence Syndrome

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Behavioral Health Case Manager

Medical Home

Community Services/ Resources

Child Protective Services

RIAC – local Systems of Care

Assuring ongoing stabilization and support

Transition to community resources and tx

Immediate Safety

Establish a spectrum of effective, community-based services and supports

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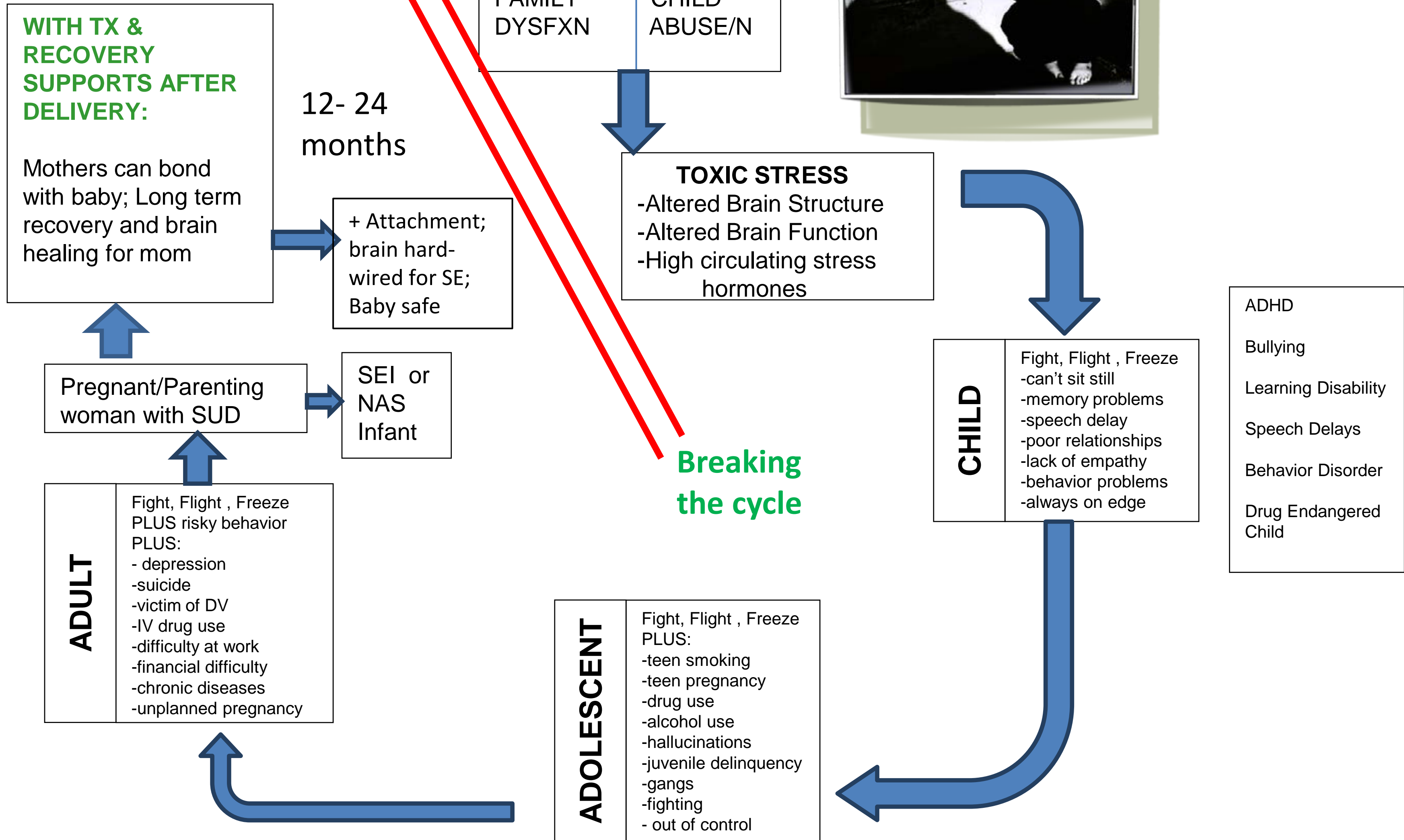

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