

**Task Force on the Mental Health, Social, and Emotional Needs of Young Children and
Their Families**

Friday, May 20, 2011

North Carolina Institute of Medicine, Morrisville

10:00am-3:00pm

Meeting Summary

Attendees:

Workgroup Members: Marian Earls (co-chair), Beth Melcher (co-chair), John Thorp (co-chair), Rosie Allen, Karen Appleyard Carmody, Patti Beardsley, Shannon Dowler, Catharine Goldsmith, Crystal Hayes, Mary Lloyd, Judy McKay, Robert Murphy, Laura Muse, John Pruette, Dawn Rochelle, Kevin Ryan, Maria Satterfield, Jean Smith

Steering Committee Members: Melissa Johnson, Marcia Mandel, Deborah Nelson, Susan Robinson, Adele Spitz-Roth

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Emily McClure, Arijit Paul, Sharon Schiro, Rachel Williams, Berkeley Yorkery

Other Interested Persons: Gary Ander, Anna Bauer, Betsy Bledsoe, Susan Cupito, Samantha Meltzer-Brody, Starleen Scott Robbins, Mark Strange, Kathy Sulik, Donna White

Welcome and Introductions

Marian F. Earls, MD, FAAP, Medical Director, Guilford Child Health, Inc., Co-chair

Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, North Carolina Department of Health and Human Services, Co-chair

John Thorp, MD, Division Director and Distinguished Professor, Department of Obstetrics and Gynecology, UNC Health Care, Co-chair

Dr. Earls welcomed everyone to the meeting.

Perinatal Substance Abuse among Women of Reproductive Age

Mark Strange, LCAS, LPC, L.Ac., Residential Director, Department of Obstetrics and Gynecology, UNC Health Care

Mr. Strange discussed perinatal substance abuse and recommendations to address the problem. Nationally, about 12% of pregnant women use some alcohol, about 10% smoke, and almost 4%

use illicit drugs during pregnancy. Women who are depressed, have experienced past abuse or assault, and/or have parents or significant others with addictions are more likely to suffer from substance abuse. Conducting perinatal substance abuse screenings on the initial prenatal visit, throughout pregnancy, after pregnancy, and after significant life stressors is recommended to identify women at risk.

Substance abuse can have significant effects on fetal development. Alcohol, cigarettes, and illicit drugs can cause a multitude of problems including birth defects, learning and behavioral problems, addiction in the neonate, low birth weight, and spontaneous abortion. After the child is born, living in an environment with substance abuse can cause problems such as cognitive and developmental delays and poor mental health. Parents with substance abuse tend to have inconsistencies in routine, discipline, and mood. Addicted parents also tend to provide inadequate supervision to the child and have an increased risk of abusing or neglecting the child.

Effective interventions for children affected by substance abuse include play therapy, positive reinforcement, and cognitive behavioral therapy (CBT). Interventions for the parents include education, positive discipline and communication skill building, stress management, and gender-specific treatment.

Mr. Strange recommends substance abuse screening, education of the public and providers, increased coordination between providers and communities, child behavioral assessments, and using available curriculums and programs to address perinatal substance abuse.

Mr. Strange's presentation can be found here: [Perinatal Substance Abuse](#).

Selected questions and comments:

- Q: Can you say a little more about the UNC Horizons Program? The program started as a perinatal program which identified high-risk women at the hospital. It expanded to an outpatient program for women with substance abuse. Women receive comprehensive outpatient treatment four hours a day and case management. There are three residential treatment programs and two perinatal residences for pregnant women and women with up to a one-year old child. The program uses a recovery model and parenting skills education to assist the mothers in getting back to work. There is also the CASAWORK program which helps mothers get employed in order to get off of public assistance. The residential program can serve 25 families at a time. Forty percent of women in the program stay for the full 12 months. The outpatient program can serve 10-15 women at a time. Many women stay connected with to the program since recovery is an ongoing process. Even participants who relapse end up not using as long as before because they call and get help again. The program also provides

child services, therapists, assessments, speech, language, occupational therapy, and other services.

Impact of Substance Abuse on Fetal Development

Kathy Sulik, PhD, Director, Fetal Toxicology Division, Bowles Center for Alcohol Studies, UNC School of Medicine

Dr. Sulik explained the effects alcohol can have on physical and mental development. Alcohol consumption during pregnancy can cause deficits in executive functioning, information processing/memory, and fine motor skills in children. Many of these children are considered hyperactive, disruptive, impulsive or delinquent as a result of these deficits. Fetal alcohol syndrome (FAS) is a condition characterized by distinctive facial features (such as a small head and a smooth philtrum), central nervous system dysfunction, and growth deficiencies. Fetal alcohol spectrum disorder (FASD) is less severe than FAS and causes lower intelligence and a lessened ability to live independently due to mental and behavioral problems. The amount and timing of alcohol consumption during pregnancy determines the type and extent of birth defects.

Recommendations to prevent consequences of alcohol use during pregnancy include education to adolescents, the general public, and governments to increase awareness. Support and early intervention for those affected by alcohol fetal disorders is also recommended.

Dr. Sulik's presentation can be found here: [Impact of Maternal Alcohol Use on Fetal Development](#).

NC DMHDDSAS Perinatal and Maternal Substance Abuse Initiative

Starleen Scott Robbins, MSW, LCSW, Best Practice Team, NC DMHDDSAS, NC Department of Health and Human Services

Ms. Scott Robbins gave an overview of the North Carolina Perinatal and Maternal Substance Abuse Initiative. The Initiative consists of 21 programs located in 12 different counties and is funded through a block grant. Programs within the initiative provide and coordinate outpatient services for pregnant women and mothers with substance abuse related disorders. Services include screening, primary care, substance abuse treatment, child care and transportation, residential services, interventions for children, and case management. Other programs in the state that address perinatal and maternal substance abuse include CASAWORKS, Work First/CPS Substance Abuse Initiative, and Oxford Houses.

Increasing access to residential programs in the western and northeastern areas of the state, provisions for safe and affordable transitional and permanent housing, transportation and childcare for outpatient services, and education on child mental health trauma are recommended.

Ms. Scott Robbins' presentation can be found here: [NC Perinatal and Maternal Substance Abuse Initiative](#).

Selected questions and comments:

- Q: How many women participating in the Initiative have Medicaid? A: Most substance abusers are not Medicaid eligible; but, women who are pregnant and have children are eligible. About 70% of the population the Initiative serves have Medicaid or are eligible.
- Q: What does the funding for residential services cover? A: Funding does not build buildings, but it starts programs in community apartment complexes. Funding is needed for leasing the apartments. Money for the Initiative has historically come from block grants or state funds. Medicaid doesn't pay for the residence, but it pays for the treatments.
- Q: Will there be any changes in funding due to the local management entities (LME) going to a waiver? A: Even with the waiver, the Substance Abuse Prevention Block Grant has requirements in place that won't be changing. The block grant funds can only be used to support those requirements. There will be difficulty with the Medicaid piece that would pay for outpatient services as women move through treatment. It will take some more analysis to make sure the waiver isn't a barrier for these women to get into services.
- There seems to be an advantage to have private insurance in terms of getting access to substances since there are more insured people with addictions than those in Medicaid.
- Q: What is the current treatment capacity for the Initiative? A: The residential program has almost 200 beds across the state. We will accept any and all outpatients.

Impact of Perinatal Mental Health on Women and Developing Infants

Samantha Meltzer-Brody, MD, Associate Professor, Department of Psychiatry, Director of the Perinatal Psychiatry Program, UNC Center for Women's Mood Disorders

Dr. Meltzer-Brody explained postpartum depression (PPD), which affects 10-15% of women, and its effects on the developing fetus. Women with PPD are more likely to have a cesarean section, preterm labor, anemia, diabetes and hypertension. A family history or previous episode of PPD, depression before pregnancy, poor support, stress and thyroid dysfunction are all risk factors for developing PPD. PPD also has effects on the child including growth restriction, abnormalities, distress, death, and possible behavioral problems.

There are many effective treatment options for PPD including psychotherapy, antidepressant medications, monitoring and lifestyle changes. The University of North Carolina's Perinatal Psychiatry Inpatient Unit provides assessment and treatment for mothers with PPD. Services

include medication, counseling, family therapy, protected sleep times, and extended visiting hours with her child.

Universal PPD screening, education for patients and providers, triage and referral for women at risk of PPD, and assessments of maternal mood in all state-funded children's programs are all recommended to help identify and treat women with PPD.

Dr. Meltzer-Brody's presentation can be found here: [Understanding PPD](#).

Selected questions and comments:

- Breastfeeding might help mitigate stress and be protective against postpartum.
- The American Academy of Pediatrics (AAP) believes that pediatricians should be doing postpartum screening; but, there is some resistance from providers since the infant is the actual patient, not the mother.
- A lot of variability on whether depression or emotional stress is viewed as an indicator among programs.
- Mental health should be included in health insurance plans as a part of general health. Poor mental health impairs the ability of a woman to parent and get through daily activities.
- Pediatricians become frustrated when giving referrals to mothers they screen for postpartum depression and are positive. Sometimes the doctor has to go through a primary care provider in order to make the referral.
 - The difficulty of making referrals is one of the biggest barriers to doing screenings.
 - UNC has demonstrated that when a referral source is guaranteed, screening rates increase dramatically. There has to be treatment and referral available and it has to be incentivized.
 - One incentive that the AAP is pushing is that pediatricians know the impact the mental health of the mother has on a child's development. The AAP statement focuses on the infant-mother dyad as being the patient, not just the child.
- Twelve weeks is worst possible time for Medicaid coverage to end for postpartum women because it is about the time women enter treatment for postpartum depression.

Treating Perinatal Depression in High-Risk Populations

Betsy Bledsoe, PhD, MSW, LCSW, Assistant Professor, UNC School of Social Work

Dr. Bledsoe discussed barriers and effective treatments for perinatal depression in high-risk populations. Common barriers to treatment in high-risk populations include lack of health insurance, lack of transportation and child care, stigma, and culture. Treatments that have been

found the most effective for perinatal depression can include medication, CBT, or a combination of both.

The presentation highlighted four different interventions in high-risk populations have shown effectiveness in treating perinatal depression. Promoting Healthy Families targeted low-income minority women and used a brief interpersonal therapy (IPT) intervention in prenatal care clinics. Better Beginnings targeted adolescent mothers and used both IPT and CBT in public health clinics. The Hilda and Alas Projects targeted low-income, depressed mothers of infants/toddlers. The projects used an in-home intervention.

Dr. Bledsoe's presentation can be found here: [Treating Perinatal Depression](#).

Selected questions and comments:

- Q: What has the research shown on the impact of anti-depressant medications on mom and the baby? A: Medication in combination with psychotherapy has the greatest effect on treating depression in the mothers. The main problems with medication are convincing the mothers to take it or a lack of health insurance.
 - The literature shows that medications are helpful. When the mother is healthy, the baby is healthy. Untreated mothers can have children that are born with an altered HPA axis causing abnormally high levels of cortisol. There have been no complications found yet on taking antidepressants while pregnant. Taking antidepressants while pregnant has to be a careful discussion and individually tailored for each patient based on severity of symptoms.
 - A number of medications have shown no effects on the developing fetus. However, it is difficult to convince a mother to take antidepressants when she knows she cannot drink, smoke, etc.
 - There is a general cultural bias against medications that also contributes to women not wanting to take antidepressants.

Discussion of Potential Recommendations

Public Comment Period

No further public comments were given.