

Guidance for Maternal and Neonatal Management of Substance Exposure, Neonatal Withdrawal, and Other Drug Effects

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Section One: General Provisions

Legal Basis

Rhode Island General Law (RIGL)

- RIGL 42-72: Department of Children, Youth, and Families (DCYF)
- RIGL 40-11-2: Definitions
- RIGL 40-11-3: Duty to report – Deprivation of nutrition or medical treatment
- RIGL 40-11-6: Report by physicians and healthcare providers of abuse or neglect

Federal law

- Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) section 106(b)(2)(B)(iii)

Statement of Intent

Healthcare professionals have an important role in identifying the substance-exposed pregnant woman and her newborn. These guidelines have been established to help healthcare professionals:

- Identify substance-exposed women during pregnancy, and newborns after delivery;
- Refer these women or their newborns to the appropriate facility for treatment;
- Implement standardized guidelines for the treatment of the substance-exposed newborn; and
- Assist healthcare providers in meeting mandatory reporting requirements.

These guidelines provide a community standard and consensus approach to screening and testing pregnant women and their newborn(s) for drugs during pregnancy, and for identifying the signs of Neonatal Abstinence Syndrome (NAS) and the need for nursing and pharmacologic intervention.

Definitions

NAS refers to any of the negative effects resulting from the abrupt cessation of in-utero exposure to maternally administered illicit or prescribed drugs, such as opiates, that result in dependence.

Background

In 2009, the incidence of NAS in the United States was 3.39 per 1,000 births¹. In 2014, the incidence of NAS in Rhode Island was 9.2 per 1,000 births. Identifying pregnancies that are complicated by substance use has implications for maternal, fetal, and neonatal health. Testing for substance use during pregnancy is a complex issue and has medical, social, ethical, and legal implications. For the purposes of this document, screening refers to a verbal assessment obtained by taking a history and using a standardized tool (see Section Three). Testing refers to laboratory data gathered from a bodily fluid (urine, meconium, serum).

Disclaimer

This guidance should not be considered an exclusive course of management. Variations that incorporate individual circumstances or institutional preferences may be appropriate.

Section Two: Clinical Considerations

Establish substance-exposure risk

- The Rhode Island Department of Health (RIDOH) recommends that all pregnant women be screened for substance use at the beginning of pregnancy, at 28 weeks, and when presenting for delivery. While universal laboratory testing is not required by the College of Obstetrics and Gynecology (ACOG) or the Academy of Pediatrics (AAP) at the onset of prenatal care, careful consideration should be given to performing a drug test on patients who are considered at-risk based on screening or a known history of substance use or misuse. Identifying substance use or misuse during pregnancy allows for early education and treatment opportunities.
- RIDOH recommends that hospitals work with legal counsel, risk management, nursing, social services, and medical staff to develop guideline for identifying women and newborns with substance use/abuse or exposure. In addition to screening, hospitals should define risk criteria for laboratory testing, type of testing, and consent issues (written/verbal). All healthcare providers should be informed of the guideline and educated on its use.

Criteria for screening

All women should be screened for drug use and alcohol exposure/abuse using a recommended standard tool such as the *5 Ps Screening Tool (Parents, Peers, Partner, Past, Present)* or *CAGE-AID* (see Section Three). The screening can be incorporated into the SBIRT (Screening, Brief Intervention, Referral, and Treatment). Screening should be performed at the first prenatal visit, at 28 weeks, and when the mother is admitted to labor and delivery.

Women who answer no to the screening tool questions are considered low-risk, those who answer yes to one question are considered moderate-risk, and those who answer yes to two or more questions are considered high-risk. Screening all pregnant women will allow for early identification, improve provider comfort with using the tool, eliminate user bias, and provide an opportunity for education on limitation of potential, future use/abuse. A complete list of outpatient and residential treatment providers can be found at <http://www.bhddh.ri.gov>.

Laboratory testing for maternal substance use

Laboratory testing of pregnant women and their newborns should be driven by evidence-based criteria. Indications for performing testing at any point in pregnancy or at the time of delivery includes, but is not limited to:

- Inadequate or no prenatal care (inadequate: fewer than four prenatal visits, late transfer or initiation of care);
- Unusual behavior (disorientation, somnolence, loose associations, unfocused anger);
- Smell of alcohol or chemicals;
- Physical signs of substance use or withdrawal;
- History of substance abuse or treatment in the past five years and/or currently on medication assisted therapy (MAT). (Participation in MAT does not always infer sobriety.)

Other risk factors that may be associated with substance use can include:

- History of physical abuse or neglect;
- Intimate partner violence;
- Mental illness;
- Unexplained growth restriction;

- Placental abruption;
- Fetal distress;
- Unexplained pre-term labor;
- Unexplained Hepatitis C; and
- Previous child with NAS.

Consent for testing

Hospital guidelines should allow for testing without consent for unconscious or intoxicated patients, or patients who have complications of intoxication (seizure). Hospital guidance should also determine if written or verbal consent is required for all other drug testing and should clearly identify who is responsible for obtaining consent (nurse, physician). Review of the patient's test results and any verbal consent should be documented in the patient's medical record. If a pregnant woman refuses to have drug testing performed, the refusal should be documented in her medical record, and suggested further actions may include:

- Notifying the treating physician and hospital social worker and requesting further discussion;
- Automatically testing the neonate without parental consent; or
- Notifying Child and Family Protective Services (Rhode Island: DCYF; Massachusetts: Department of Children and Families, DCF)

A newborn may be presumed substance-exposed if the mother is on MAT and/or has a positive drug test on admission to delivery. This does not preclude performing a separate test on the neonate if it is medically indicated or if there are concerns of substance use during pregnancy. Newborn testing is performed for the purpose of determining appropriate treatment for the baby and to ensure an appropriate plan of care. Without a maternal history of substance use, indications to perform urine and meconium testing on the neonate may include:

- Hyper-irritability, hyper-alert state without interval sleep periods;
- Diarrhea;
- Tremors or jitters;
- Recurrent yawning or hiccups; or
- Frantic feeding, sucking, or poor/disorganized feeding skills.

Neonatal signs of withdrawal or drug effect may be delayed for as long as 10-14 days, depending on the half-life of the drug in question. This time frame may be confounded by in-utero exposure to other psychotropic medications or nicotine.

Hospitals should be aware of the specific toxicology tests performed in their laboratory, as well as cut-off values, and which opiates are included in an opiate panel. Not all toxicology screens test for buprenorphine, methadone, or oxycontin, and some screenings' cut-off values are too high and only detect overdose drug levels.

If a neonatal urine test is positive, it is important to exclude positive results for medications given to the mother during labor.

Confirmatory testing may be indicated as false-positive testing has been reported⁶. The original sample should be sent for confirmation. Toxicology results are to be used for medical purposes and not for legal or employment purposes.

If a toxicology test is pending at the time of discharge, it is the responsibility of the practitioner and/or DCYF/DCF to follow the result as an outpatient.

Neonate

Prenatal Consultation

Prenatal consultation with neonatal/pediatric providers is encouraged to help families anticipate the needs for their newborn after delivery. This is an opportunity for the parents to meet the staff, learn common therapeutic interventions, discuss methods of feeding, understand anticipated length-of-stay, based on exposure, and have questions answered. The model of family-centered care should be considered so that parents are actively involved in the assessment and care of their child. Rooming-in has been associated with an amelioration of NAS. If able, identifying a place for parents to stay with their child, when appropriate, should be considered.

Reporting to Child and Family Protective Services

Hospitals should have a written policy for reporting to DCYF/DCF, in accordance with state regulations, which can only occur after the birth of the neonate. Policies may include provisions to encourage collaborative work of a multidisciplinary team, including nurses, social workers, and medical staff, for the best interest of the newborn and family. Policies should also include an action plan for reporting positive test results for the mother and/or the neonate.

Post-natal evaluations

Neonatal withdrawal is a condition that results from the abrupt cessation of in-utero exposure to maternally administered, addictive drugs, such as opiates. These drugs can be prescribed or illicit. Compared to non-opiate exposure, the degree of withdrawal experienced from opiates is generally more severe and of greater duration. In addition, infants can also demonstrate drug effects that can mimic neonatal abstinence syndrome (NAS) from exposure to non-opiate, prescribed or illicit substances. Symptoms of neonatal drug effect can occur in newborns who were exposed to the mother's prescribed medications (benzodiazepines, antidepressants, SSRI, anxiolytics), alcohol, and cigarettes. While these are not considered illicit, there is potential morbidity for the neonate if these symptoms are not recognized, and anxiety for the family if the situation is not anticipated. These issues should be discussed with the parents as they relate to ongoing care, duration of hospitalization, and methods of feeding.

If a hospital chooses to treat newborns with opiate withdrawal, staff education on proper use and validation of scoring tools should be included within the policy. Referral to a treatment centers currently caring for babies with neonatal abstinence should be considered should the birthing hospital choose not to manage it.

Family-centered care

There is a growing body of evidence demonstrating the importance of family involvement in the care of a newborn with neonatal abstinence syndrome. The opportunity for parents to partner with the medical team and actively participate in the evaluation and care of their baby has led to a reduction in medication used to treat withdrawal and shorter hospital stays. Consideration should be given to unlimited visitation or boarding, when available. For families who utilize extended stays, hospitals may want to consider the use of contracts that clearly outline expectations and responsibilities and that the privileges can be rescinded.

Social services consult

A social-services consult should be obtained for all substance-exposed women and their neonates. A signed release form from the mother is required to access information from a treating provider. The release may be obtained from the treating facility. It is suggested that decisions regarding whether to file a Physician Report of Examination (PRE) with or without a

72-hour hold (Rhode Island) or a 51-A (Massachusetts) be discussed with social workers and the medical staff. (See Appendix A for screening tools.)

Assessment/Monitoring of the substance-exposed neonate

Newborns with confirmed or suspected drug exposure require monitoring for drug withdrawal or toxicity. Use of a standardized scoring tool is recommended to allow for consistency (Finnegan tool). Clinically significant withdrawal may not occur in all opiate-exposed newborns during the first several days, AAP recommends that all newborns with confirmed opiate exposure remain hospitalized for a minimum of five days to fully assess any need for pharmacologic intervention. Assessment should begin within the first two hours of life and every three to four hours thereafter. Infants should not be awoken solely for scoring.

Newborns exhibiting withdrawal-like symptoms or toxicity from non-opiates should be assessed in an objective fashion until symptoms resolve or are minimal and manageable with comfort measure only. In addition, the newborn should meet all other criteria for discharge, including but not limited to:

- Stable vital signs, adequate feeding behavior, appropriate weight gain;
- Clearance by the social services department, if appropriate; and
- Scheduled follow-up with child's pediatrician in two to three days.

With known substance exposure, implementation of non-pharmacologic interventions should begin upon admission. These include skin-to-skin with parents, low lighting, low noise, swaddling, pacifier, clustering care, and allowing for infant cues for handling, infant massage, developmental intervention, and family education.

Recent evidence has demonstrated shorter hospital stays and a decreased need for medication for newborns rooming in with their mother for the duration of the newborn hospitalization. If feasible, hospitals should facilitate keeping mothers and infants together. This can optimize care of the newborn during the hospital period and allow the parent to partner with the medical team in defining the extent of symptoms.

Growth Assessment

Excessive weight loss can be associated with withdrawal. Daily weight and fluid intake and output should be documented, and specific attention should be given to growth. Interventions may include:

- Limiting intake if the baby is overfeeding;
- Supplementing with increased calories if growth is inadequate; and
- Using alternative formulas, such as lactose-free or soy, for newborns who are not receiving breastmilk and have notable diarrhea

Breastfeeding is encouraged for mothers who are compliant with an opioid-maintenance program. The bioavailability and/or transfer of methadone and buprenorphine into breastmilk is minimal. Breastfeeding will not treat neonatal abstinence syndrome; however, recent evidence has demonstrated a reduction in the severity of withdrawal when newborns are given their mother's milk. If a mother plans to provide breastmilk, it is recommended that she demonstrate compliance with treatment (including negative toxicology screens) and not taking medications or other drugs that might preclude the feeding plan. Cases should be considered individually.

Pharmacologic treatment for neonatal abstinence syndrome

There is no clear, evidence-based recommendation regarding cardiorespiratory monitoring of newborns who are being medicated for withdrawal; however, hospitals should include guidance as to whether newborns being treated will be monitored.

Guidance for medication treatment for opiate withdrawal is based on an objective symptom scoring tool (Finnegan) and the physical exam.

Currently, no one standard treatment regimen is considered superior. In general, opiates are used as the first-line treatment option for opiate withdrawal, and most birthing facilities use Morphine⁴. Recent data have demonstrated that using a guideline instead of one specific drug regimen has the greatest impact on duration of treatment and length of hospital stay. Hospitals that choose to manage neonatal withdrawal should develop a guideline that allows for consistency-of-care for all providers⁷. Until further evidence is available demonstrating the superiority of a particular pharmacologic regimen, guidelines for dosing of medications should be hospital-specific. Assessments and weaning strategies should be documented in the patient's medical record and in hospital discharge paperwork.

Safe plan of care

The *Child Abuse Prevention Treatment Act of 2016* require a safe Plan of Care (POC) to be developed prior to hospital discharge and addresses the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder. The POC must also address the needs of the affected caretaker and include procedures for ongoing monitoring and evaluating if and how local entities are providing referrals to, and delivery of, appropriate services for substance-exposed infants and affected caregivers. Rhode Island's Neonatal Abstinence Syndrome Task Force and DCYF will work with birthing hospitals and treatment providers to develop and document a POC.

Discharge Planning

Discharge planning should begin upon admission. Encouraging parental involvement will help parents understand withdrawal and cues that are unique to their baby. Parents and/or caregivers (including foster families) should be advised that newborns exposed to in-utero opiates may require a prolonged hospital stay. Education on infant comfort measures, development, and medication administration should be provided.

A safe transition home can be facilitated with follow-up. Pediatric follow-up and communication with the outpatient provider will enhance a seamless transition home. Additional resources are listed in Appendix B.

Referral to Early Intervention (EI)

All infants who are exposed to addictive prescriptive or illicit substances are automatically eligible for Rhode Island's EI program under the category of *single established condition*. Either the birthing hospital or DCYF can make a referral to EI. In turn, EI staff will work with the family and/or caregiver(s) to support understanding of the child's medical, behavioral, and developmental needs. Babies with a diagnosis of Neonatal Abstinence Syndrome are eligible for EI for one year. After one year, EI staff will conduct an evaluation to determine continued eligibility.

References

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- ³ Coyle MG, Ferguson A, Lagasse L, Oh W, Lester B. Diluted Tincture of Opium (DTO) and phenobarbital versus DTO alone for neonatal opiate withdrawal in term infants. *J Pediatr* 2002;140:561-4.
- ⁴ Tolia, VN Patrick, SW, Bennett, MM, Murthy, K, Sousa, J, Smith, PB, Clark RH, Spitzer, AR; *N Engl J Med* 2015; 372:2118-212.
- ⁵ American Academy of Pediatrics, Committee on Drugs. Neonatal Drug Withdrawal, *Pediatrics* 120(2), February 1, 2012;e540-60.
- ⁶ *Am J Health Syst Pharm* 2010;67(16):1344-1350.
- ⁷ Hall et al. *Pediatr.* 2014;134(2):e527-e534.
- ⁸ AAP Policy Statement: Breastfeeding and the use of Human Milk. *Pediatrics* 2012;129(3) ACOG Committee Opinion: Opioid Abuse. Dependence and Addiction in Pregnancy, 2012, number 524.
- ⁹ ABM Clinical Protocol #21 Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015. *Breastfeeding Medicine*, 2015 10(3); 135-141.
- ¹⁰ Wexelblatt SL, Ward LP, Torok K, Tisdale E, Meizen-Derr JK, Greenberg JM. Universal Maternal Drug Testing in a High[Prevalence Region of Prescription Opiate Abuse. *J Pediatr* 2015;166:582-6.
- ¹¹ Rhode Island Kids Count, 2014.

Appendix A: Screening Tools

CAGE –AID

(Quick Approach)

1. In the last three months, have you felt you should **Cut down** or stop drinking or *using drugs*? Yes No

2. In the last three months, has anyone **Annoyed** you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs*? Yes No

3. In the last three months, have you felt **Guilty** or bad about how much you drink or *use drugs*? Yes No

4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs (Eye-opener)*? Yes No

- Each affirmative response earns one point.
- A score of one or less indicates risky use.
- A score of two or more may warrant further diagnostic evaluation and referral.

A2. 5 P's Screen for Alcohol/Substance Use: Prenatal and Postpartum visits**

PARENTS: Did any of your parents have a problem with alcohol or drug use? Yes No

PEERS: Do any of your friends have a problem with alcohol or drug use? Yes No

PARTNER: Does your partner have a problem with alcohol or drug use? Yes No

PAST: In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? Yes No

PRESENT: In the past month, did you drink any alcohol or use other drugs? Yes No

1. How many days per month do you drink? _____

2. How many drinks on any given day? _____

3. How often did you have 4 or more drinks per day in the last month? _____

**Adapted from the Institute for Health and Recovery 5 P's

Appendix B: DCYF Criteria for Investigation and/or Removal

The *Child Abuse and Prevention Treatment Act* requires states to have policies and procedures in place to notify child welfare agencies when an infant is affected by substance-abuse exposure, withdrawal symptoms, or Fetal Alcohol Syndrome.

Criteria for DCYF involvement with families

- Positive toxicology screen at birth;
- Evidence of withdrawal symptoms;
- Positive prenatal toxicology screen; and
- Past history of DCYF involvement

DCYF is in the process of changing its agency culture to foci of supporting all families and of continued interest in collaborating on future changes. DCYF wants families together. There are laws and criteria to report to DCYF; however, not all investigations result in removal.

When criteria are met to initiate an investigation on a newborn at a hospital, the result of the investigation generally results in one of four possible outcomes:

1. Unfounded: No indicated finding of abuse/neglect and no condition that presents a safety concern to the child
2. Indicated, but decision to discharge child home from hospital, no family court involvement: Indicated case of abuse/neglect but a suitable, safe POC can be developed and DCYF's Intake or Monitoring Unit coordinates supports to meet the family's needs
3. Indicated, Straight petition, Child discharged from hospital to home with Family Court involvement: Indicated case of abuse/neglect but a suitable, safe POC can be developed; family is involved with DCYF's Family Service Unit and Family Court. These cases most often present with risk factors, such as prior child welfare involvement, history of substance abuse, and/or history of behavioral health challenges. The cases may also present with mitigating factors, such as family member involvement/service provider involvement that, at the time of the decision, prevents the removal of the child.
4. Indicated, Ex-parte Petition, Child discharged from hospital to substitute care: Reasonable assurance cannot be provided that the newborn will be safe if discharged home. Ex-parte Petition is filed and the child goes to substitute care. The family is usually involved with DCYF's Family Service Unit and with Family Court with the goal of reunification.

Outcomes one and two options do not involve a legal status. In limited cases, outcome one can include DCYF's Intake or Monitoring Unit if it is determined that the family would benefit from service referral and support for a limited period of time. The status of these conditions can be fluid based on the family situation and are subject to change based on ongoing assessment of risk and safety factors.

For patients who are case-managed in Rhode Island but who live in Massachusetts or Connecticut, child welfare decisions will take into consideration Massachusetts or Connecticut regulations:

- <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section51A>
- <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section21>
- <http://www.ct.gov/dcf/cwp/view.asp?a=2556&Q=314384>
- https://www.cga.ct.gov/current/pub/chap_319a.htm

Appendix C: Pre-Natal and Post-Partum Support Services

Families may be involved with one or multiple programs.

General Information

- **(401) 942-STOP (7867)**

Rhode Island's recovery helpline is staffed 24/7 by English and Spanish-speaking counselors who are licensed in chemical dependency. Callers can confidentially be connected to local treatment and recovery resources.

- **PreventOverdoseRI.org**

PreventOverdoseRI.org offers a public dashboard to track Governor Raimondo's Overdose Prevention and Intervention Task Force's Action Plan and provides linkages to resources for individuals at-risk of an overdose and the family members or friends who could help them. Resource materials can be downloaded, printed, and shared from the [current campaigns](#) section of the website. Follow the Task Force's Twitter messages @PreventOD_RI

- **Centers for Disease Control and Prevention (CDC)**

CDC has launched new online maps that show annual opioid prescribing rates from 2006 to 2016, by state and by county. This resource includes data not previously reported elsewhere. Visit the [U.S. Prescribing Rate Maps](#) and select a state or county map by year (see right side of page).

Residential Substance Abuse Treatment Programs

SStarbirth

Rhode Island's only residential substance-abuse treatment program for pregnant/postpartum mothers and babies, up to age nine

80 East St., Cranston

401-463-6001

<http://www.sstar.org/sstarbirth/>

Eastman House

Women's residential treatment (pregnant and non-pregnant women)

166 Pawtucket Ave., Pawtucket

401-722-4644

<http://caritasri.com/services/eastman-house/>

Adcare of RI Residential

Women's residential treatment (pregnant and non-pregnant women)

1950 Tower Hill Rd., North Kingstown

401-294-6160

<http://adcare.com/programs/adcare-rhode-island/>

Phoenix House James Ottmar Residential Center for Women

Women's residential treatment (pregnant and non-pregnant women)

205 Waterman St., Providence

844-388-0232

<http://www.phoenixhouse.org/locations/rhode-island/james-ottmar-residence/>

Intensive Outpatient Treatment (IOPs)

IOPs are for either adults only or for adolescents only. All IOPs require individual and family counseling and can include children as needed. All women's IOPs will accept pregnant women.

Project Link: The Providence Center

Project Link is an outpatient treatment program that specializes in improving the health and well-being of pregnant women and women with young children who are impacted by substance abuse and mental health issues. Project Link provides intensive and non-intensive outpatient treatment (group and individual), case management, parenting and self-care education, and on-site childcare. In addition, the program collects and distributes donated items such as blankets, diapers and baby clothes.

134 Thurbers Ave., Suite 212, Providence

401-453-7618

<https://providencecenter.org/services/adult-services/womens-day>

Butler Hospital Partial Hospital Program (PHP)

345 Blackstone Blvd., Providence

401-455-6223

<http://www.butler.org/services/alcohol-drug-addiction/>

Adcare of RI IOP

1950 Tower Hill Rd., North Kingstown

401-294-6160

400 Bald Hill Rd., Warwick

401-732-1500

<http://adcare.com/programs/adcare-rhode-island/>

Community Care Alliance IOP

800 Clinton St., Woonsocket

401-235-7000

<http://www.communitycareri.org/ProgramsServices/AdultMentalHealthAddictionsTreatment.aspx>

Continuum Behavioral Health (formerly Meadows Edge)

580 Ten Rod Rd., North Kingstown

401-294-6170

<https://continuumri.com/>

Phoenix House IOP

120 Wayland Ave., Providence

401-330-7974

<http://www.phoenixhouse.org/locations/rhode-island/phoenix-house-rhode-island-outpatient-centers/>

SStarbirth

Rhode Island's only residential substance-abuse treatment program for pregnant/postpartum mothers and babies, up to age nine

80 East St., Cranston

401-463-6001

<http://www.sstar.org/sstarbirth/>

Mothers on Methadone (MOM) Program: Kent Hospital Special Care Nursery

Comprehensive educational and support program for expectant and postpartum women receiving methadone maintenance and/or opiates for other medical conditions. Only available to mothers delivering at Kent Hospital. (If an expectant woman is looking for an OB, program can facilitate physician referral.)

455 Toll Gate Rd., Warwick

401- 737-7010, ext. 31471

<http://www.kentri.org/services/pregnancy/childbirth-education.cfm>

Family Visiting Program

The Family Visiting Program provides free, prenatal support and services to pregnant women and families with children younger than age three. Family visitors (nurses, social workers, and family support workers) can answer any questions about newborn and infant care, infant feeding and nutrition, developmental screening, home safety, family well-being, and referral coordination. Family Visiting Programs include:

- **First Connections**

First Connections provides free support to pregnant women and families with children younger than age three who live in Rhode Island. First Connections can help parents and families who have questions about their new baby or toddler or can give parents a little extra short-term support. Family visitors can also help families sign up for community services such as low-cost child care, healthy foods, and programs for their children.

- **Nurse-Family Partnership**

Nurse-Family Partnership provides free support to first-time mothers until the child is age two. Women are eligible to participate if they live in Rhode Island, are first time mothers, and are less than 28 weeks pregnant. The program also supports families who have babies born with NAS. The program provides guidance on preventive health and prenatal practices and can help link clients to appropriate care and resources.

<https://www.nursefamilypartnership.org/locations/Rhode-Island/>

- **Healthy Families America**

Healthy Families America works with expectant mothers and families of newborns in Rhode Island. This program helps identify a family's needs; promotes bonding, attachment, and positive parenting practices; provides emotional support; and links the family to appropriate community resources. Pregnant mothers and families with children three months or younger are eligible for this program.

<http://www.healthyfamiliesamerica.org/>

- **Parents as Teachers**

Parents as Teachers serves expectant mothers and families with infants in Rhode Island. Parent educators work with families to identify medical homes and provide families with developmentally appropriate activities for their children. Pregnant mothers and families with children younger than age two are eligible to enroll. In North Kingstown, Westerly, Warwick, and Woonsocket, families with children age three or younger may be eligible to enroll.

<http://parentsasteachers.org/>

Youth Success

This statewide program provides free, supportive services to young expectant mothers and fathers who are age 20 or younger. Youth Success assists pregnant and parenting teens with daily living, completing school or education goals, and parenting.

<http://www.communitycareri.org/ProgramsServices/ChildFamily/YouthSuccess.aspx>

Prenatal Classes

Birthing hospitals in Rhode Island offer various educational classes for expecting and new parents. Contact your birthing hospital for information on prenatal, breastfeeding, or childbirth classes.

- **South County Hospital:** 401-788-1225
- **Landmark:** 401-769-4100 ext. 2218
- **Newport Hospital:** 401-845-1547
- **Kent Hospital:** 401-736-2229
- **Women & Infants:** 401-276-7800

Post-Partum Support Services

The Day Hospital: Women & Infants

The Day Hospital offers a perinatal partial hospital program for pregnant women and new mothers who have depression, anxiety, or other emotional distress. The goal of this program is to help patients understand that negative feelings are not their fault and to give women ways to overcome them.

<http://www.womenandinfants.org/services/behavioral-health/index.cfm>

Project Connect: Children's Friend

Project Connect works with families, identified by DCYF, to keep children safe and to strengthen families by helping parents achieve a substance-free lifestyle. Project Connect is intensive, home-based, and provides services to families for, on average, one year.

<http://www.cfsri.org/projectconnect.html>

Early Childhood Support Services

Early Intervention (EI)

Children who are born with NAS are referred to EI at birth. Children referred to EI receive a comprehensive developmental evaluation to determine if they are eligible. Rhode Island's EI program promotes the growth and development of infants and toddlers who have a developmental disability or delay in one or more areas. Developmental disabilities or delays can affect a child's speech, physical ability, or social skills.

<http://www.eohhs.ri.gov/Consumer/FamilieswithChildren/EarlyIntervention.aspx>

DCYF's Family Care Community Partnership (FCCP)

FCCPs were developed by DCYF to provide children and families with needed supports and guidance to assist and promote healthy family developments. Each FCCP uses a nationally recognized practice model (Wraparound) to successfully bring a family to its full potential. Wraparound teams of professionals collaborate with a family to develop a personalized, coordinated care plan that surrounds the family with services that address the issues

confronting the family, including basic needs, mental health and behavioral counseling, and healthcare.

<https://www.familyserviceri.org/fccp>

- **Northern Rhode Island office**
401-766-0900
Burrillville, Cumberland, Foster, Gloucester, Johnston, Lincoln, North Providence, North Smithfield, Scituate, Smithfield, and Woonsocket
- **Washington/Kent County office**
401-789-3016
Charlestown, Coventry, East Greenwich, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, Warwick, East Greenwich, West Warwick, Wakefield, and Westerly
- **East Bay office**
401-849-2300
Barrington, Bristol, East Providence, Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton, and Warren
- **Urban Core office**
401-331-1350
Central Falls, Cranston, Pawtucket, and Providence

Early Head Start

Early Head Start is a federally funded program that offers a wide range of services to pregnant women, infants, and toddlers up to age three. Services are comprehensive and can include healthcare, oral health, and childcare.

Head Start

Head Start is a federally funded program that offers a wide range of services to low-income children age three to five years. Services include healthcare, oral health, mental health, and nutrition. Head Start also provides intensive social services, parent education programs, and early-learning childcare for children.

<http://www.riheadstart.org/>

Incredible Years

Incredible Years is a research-based program that helps parents reduce children's aggression and behavior problems and increase social competence at home and school. This program promotes positive parenting strategies and assists parents in managing behavior problems. Groups are offered by infant, toddler, and pre-school age ranges.

<http://www.incredibleyears.com/>

KIDS CONNECT

KIDS CONNECT is a program that provides specialized services at DCYF-licensed childcare centers that helps children with special needs participate, play, and learn with their typically developing peers.

https://www.accesspointri.org/Cornerstone_KidsConnect_Early_Childhood_program.htm

Bright Stars

BrightStars is a program run by the Rhode Island Association for the Education of Young Children (RIAEYC) to assess, improve, and communicate the level of quality in early care, education, and school-age settings.

<http://www.brightstars.org/>

Other Support Services

Day One Rhode Island

Day One's mission is to reduce the prevalence of sexual abuse and violence and to support and advocate for those affected by it. Day One provides treatment, intervention, education, advocacy, and prevention services to people of all ages.

<https://www.dayoneri.org/>

Family Planning and Preconception Health Program

This program aims to increase access to high-quality reproductive health and family planning services for men, women, and teens in Rhode Island. The program provides affordable services, including contraceptives and education about birth control, reproductive health, and sexually transmitted diseases. The program also offers screenings, testing, and referral services.

http://www.health.ri.gov/programs/detail.php?pgm_id=98

Sojourner House

Sojourner House is a comprehensive domestic violence agency that provides shelter, advocacy, referrals, and other resources for those affected by any type of domestic violence (physical, emotional, verbal, digital, financial, or sexual).

<http://www.sojournerri.org/>

WIC

The mission of WIC is to safeguard the health of low-income women, infants, and children up to age five who are at nutrition risk. WIC benefits are available to women who are pregnant or just had a baby and to children younger than age five whose household meets income guidelines. Women who apply early in their pregnancy are more likely to have a healthy baby. Children who stay on WIC until age five are better prepared and more likely to succeed in school.

<http://www.health.ri.gov/programs/wic/>